Health Care for Black Americans: The Public Sector Role

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THE "GREAT SOCIETY" AND THE "WAR ON POVERTY" in the mid-1960s brought a major expansion in the federal government's commitment to ensuring access to health care for many of the nation's most vulnerable people—the elderly, the poor, and minorities (Davis and Schoen 1978). Medicare and Medicaid, enacted in 1965, pay the health bills of almost 50 million elderly, disabled, and low-income people. Primary care programs with direct federal government funding provide health care services through about 876 health centers to approximately 6 million people, many of whom are members of minority racial and ethnic groups (Davis 1985).

These programs have helped many millions of Americans obtain needed health care and have contributed to improvements in the health and well-being of those they have touched (Davis and Schoen 1978). Black Americans have been particularly helped, with major gains in access to physician and other health care services.

Despite these programs and the very significant gains that have been made since the mid-1960s, over 35 million Americans continue to have no health insurance coverage. Cutbacks in funding for Medicare, Medicaid, and primary health care programs in the 1980s—coupled

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with the growth in poverty—threaten to reverse some of the gains that have been made in the past. It is a critical time to assess the trends in financing and delivering health care services to black Americans, identify major remaining gaps, and reflect on what the future holds.

Trends in Health and Use of Health Services

Improvements in Health

The United States has experienced major gains in health in the last twenty-five years. Minority and low-income population groups have shared in these gains. Increased access to and use of health services, which occurred with the Medicaid and Medicare programs, the development of neighborhood health centers, and the recruitment and placement of minority and other health care providers in underserved communities, are some of the factors contributing to improvements in health (Hadley 1982; Davis and Schoen 1978)

Life expectancy is one measure of health where gains by blacks are particularly noteworthy. In the period from 1960 to 1983, life expectancy at birth in the United States increased a total of 5 years—from 69.7 years to 74.7 years (U.S. Department of Health and Human Services 1985a). Blacks experienced greater gains than whites, with especially marked improvements for black females. Life expectancy of black females at birth increased almost 8 years—from 65.9 years in 1960 to 73.8 years. Although in 1983 black males continued to have the shortest life expectancy at birth (65.2 years), from 1960 to 1983 their life expectancy increased slightly more than that of white males—4.5 years versus 4.2 years.

Longer life expectancy at birth reflects lower infant mortality and lower death rates throughout life. Gains in health status have been most notable for causes of illness and death amenable to medical care intervention. As shown in table 1, the infant mortality rate for blacks declined by more than 50 percent between 1960 and 1980, dropping from 44 deaths per 1,000 live births to 21 per 1,000 live births. Although the infant mortality rate among blacks continues to be twice that of whites, considerable progress has been achieved since 1960.

Table 1 also records declines in age-adjusted mortality rates for some of the leading causes of death in the United States. Included among these are deaths from influenza and pneumonia, which dropped by 67 percent among blacks between 1960 and 1980 and deaths from tuberculosis which dropped by 51 percent. These are causes of death that historically have been greater among the poor than among higher income individuals. Mortality rates from cerebrovascular diseases and arteriosclerosis declined by more than 50 percent. This dramatic decline

TABLE 1
Percentage Change in Death Rates from Selected Causes by Race and Years, United States, 1950-1980

	Percentage change 1950-1960	Percentage change 1960-1980
Infant deaths*		
White	−14.6%	−52.0%
Black	1.0	−51.7
Influenza & pneumonia		
White	7.4	−50.4
Black & other	−3.0	−67.4
Tuberculosis**		
White	N/A	−64.4
Black & other	N/A	−50.8
Cerebrovascular disease		
White	−10.8	−48.8
Black & other	− 9.4	−53.3
Arteriosclerosis		
White	−19.1	−57.3
Black & other	−12.7	−57.2
Diseases of the heart		
White	−6.3	−29.8
Black & other	−13.6	−27.8
Diabetes		
White	−7.9	−28.9
Black & other	25.6	−13.0

* Change in deaths per 1,000 live births. All others are change in deaths per 100,000 population.
** Data not available by race for 1950-1961; percentage change is for 1962-1980.
Source: Computed from death rates in U.S. Department of Health and Human Services 1985b.

in mortality represents both the lower rate of uncontrolled hypertension in the population and improved access to health services. Deaths from heart disease and diabetes dropped by 28 percent and 13 percent, respectively. Although blacks showed modest gains in reductions of deaths from diabetes, these gains represent a sharp departure from the 26 percent increase in diabetes mortality between 1950 and 1960. Deaths from cancer, suicide, homicide, and cirrhosis showed upward trends between 1960 and 1980. With the exception of cancer, however, mortality from these conditions could not be expected to be significantly affected by the availability of improved health services.

Measures of mortality are a readily available and reliable source of data used to monitor health over a long period of time. Since some improvements in health may not be reflected in mortality data for years, other indicators of improved health that show an increase in functioning capacity or reduced suffering, disability, or risk of dying are important. The monitoring of risk factors for heart disease and stroke provide evidence that hypertension prevention and treatment efforts during the last decade have been successful in motivating the public to adopt healthier patterns of living and in reducing elevated blood pressure levels of blacks. Physical exams from a nationwide sample of adults during the years 1960 to 1962 and 1976 to 1980 found a decline of 17 percent in the proportion of the United States population with elevated blood pressure. Blacks experienced the greatest gains, with a 25 percent decline. The proportion of the adult black population with elevated blood pressure levels dropped from 33 percent in 1960 to 1962 to 25 percent in 1976 to 1980 (U.S. Department of Health and Human Services 1985b).

Contrasting health status measures of blacks prior to and after 1960 provides some indication of the progress achieved in recent years. Indications of improvements are particularly significant given that many health status measures showed minimal if any change in the ten years preceding the federal government's major involvement in the financing and delivery of health services. While it is difficult to sort out the relative contribution of different factors that influence health status, increased access to and use of health services can be considered as one of the more important contributing factors. Recognition of improvements in health shows that progress can be achieved when the financial and health care resources of this country are made available to increasing numbers of Americans.

Increased Use of Health Services

Prior to 1965, the use of physician and hospital services differed dramatically by race and income. Table 2 records that between 1965 and 1980 racial differences in the use of health services narrowed considerably. These changes occurred after the introduction of Medicaid, Medicare, and other health programs for underserved areas and provide evidence of their success in improving access to care.

Primary and Preventive Care. In the early 1960s blacks, although more likely to report their health as poor or fair and to suffer from chronic conditions, saw physicians less frequently than whites. In 1964 poor blacks and other minorities saw physicians an average of 3.1 times per year compared to an average of 4.7 times for whites. By the period of 1976 to 1978 the average number of visits for poor blacks and whites, unadjusted for health status, were similar (U.S. Department of Health and Human Services 1980). Regardless of income, blacks prior to 1964 were less likely than whites to have seen a physician in two years or more. As shown in table 2, poor blacks and other minorities were the least likely to have seen a physician in two or more years. By 1976 the proportion of the population seeing a physician over a two-year period did not vary substantially by race or income (U.S. Department of Health and Human Services 1980).

More women are now getting care early in pregnancy. Studies have shown that receiving prenatal care in the first trimester is important in reducing the proportion of low birth weight infants and infant mortality. The proportion of black women receiving prenatal care in the first trimester increased from 44.4 percent in 1970 to 62.4 percent in 1981 (U.S. Department of Health and Human Services 1985a).

Although in 1980 black children were less likely than white children to receive immunizations for preventable diseases, there has been considerable improvement in the proportion of black and white children vaccinated. This has led to a marked decline in many diseases once considered major killers. Negligible cases (one case per 100,000 population or less) of diphtheria, pertussis, measles, rubella, and polio were reported in 1981—all down substantially from rates in 1960 (U.S. Department of Health and Human Services 1985a).

Routine physical examinations are important for health maintenance and for the early detection of an illness. In 1980, about two out of every five blacks (42 percent) and whites (41 percent) reported a general

TABLE 2
Use of Health Services by Selected Indices

	Poor			Nonpoor		
	White	Black & other	Ratio white:black	White	Black & other	Ratio white:black
Average no. of M.D. visits per person per year *						
1964	4.7	3.1	1.5	4.7	3.6	1.3
1976-1978	5.7	5.0	1.1	4.9	4.4	1.1
Percentage with no M.D. visits in past two years *						
1964	25.7%	33.2%	0.8%	17.1%	24.7%	0.7%
1976	15.1	14.9	1.0	12.9	13.4	1.0
Hospital discharges per 100 persons **						
1964	15.0	10.0	1.5	13.0	10.0	1.3
1979	21.0	17.0	1.2	13.0	12.0	1.1

Source: * U.S. Department of Health and Human Services, 1980.
** President's Commission for the Study of Ethical Problems in Medical and Biomedical and Behavioral Research 1983.

check-up within the past year. This reflects a major improvement from the 1970 data which showed that whites were about 20 percent more likely than blacks and other minorities to receive a general check-up (U.S. Department of Health and Human Services 1985b).

Hospital Care. Similar findings are evident in the use of inpatient hospital services. National Health Interview Survey data in table 2 show that hospital discharge rates of blacks and other minorities increased from 1964 to 1979 (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1983). In 1964 the poor were hospitalized at similar rates as higher income people; poor whites were hospitalized at a rate 50 percent greater than that of poor blacks and other minorities. By 1979 the poor were hospitalized at a higher rate than the nonpoor, reflecting their poorer health status and greater need for care.

Long-term Care. Access to long-term or extended care facilities for black Americans aged 65 years and older improved greatly with the Medicaid and Medicare programs. In 1963 whites were much more likely to receive care in a nursing home than blacks and other minorities. There were only 10 black or other minority nursing home residents in 1963 for every 1,000 blacks and other minorities aged 65 and older (U.S. Department of Health and Human Services 1985b). This was in comparison to 27 white nursing home residents for every 1,000 whites aged 65 and older. By 1977 the gap had narrowed considerably, although blacks 85 years and older were still much less likely to receive extended care services than whites.

Assessment of Overall Trends. Clear evidence exists that sizable gains in access to care have been achieved nationwide. It cannot be concluded from this data, however, that no further problems remain and that every American now has equitable access to health care. Striking differences in the use of health services persist in this country, particularly for blacks who are uninsured and who live in the South (Davis and Rowland 1983). Data on the use of health services for specific medical conditions also show differences by race that are not explained by differences in the need for care (Davis and Lillie-Blanton 1986). And finally, questions about the quality and adequacy of care obtained by blacks and other beneficiaries of government health care financing programs deserve attention in order to evaluate more fully the progress achieved.

The record of accomplishment, however, remains remarkable. Gov-

ernment-supported health care financing and delivery programs established in the 1960s have enabled large numbers of black Americans—along with many other poor, disabled, and elderly Americans—to share in the benefits of modern medicine.

Medicaid

The enactment of Medicaid in 1965 greatly expanded the federal government's role in financing health care for the poor. Medicaid was designed to assist states in improving access to care for the poor and to enable the poor to receive mainstream medical care. Since about one-third of the poor were black, it was assumed that Medicaid would reduce disparities in access to care by race, as well as by income.

Medicaid is a joint federal-state program administered by each state. Each state determines its own eligibility, benefits, and reimbursement policies within broad federal guidelines. As a result, the Medicaid program varies widely among states. States are required to cover individuals receiving cash assistance under the Aid to Families with Dependent Children (AFDC) program and most elderly, blind, and disabled recipients of Supplemental Security Income (SSI). At a state's discretion, similar persons whose incomes are slightly above the cash assistance level may be covered as "medically needy."

Scope of Coverage

Medicaid has provided large numbers of low-income black and white Americans with coverage for medical expenses. In 1984, 19.3 million Americans—about 8 percent of the total population—were covered by Medicaid. About one-third of Medicaid beneficiaries, or 6.6 million individuals, were black (U.S. Bureau of the Census 1985).

In the last twenty years, Medicaid has proved to be a major source of health coverage for black Americans. Table 3 records that since 1978 Medicaid has provided health coverage for nearly one out of every five blacks under the age of 65. Nearly half of black children under 6 years of age were covered by Medicaid in 1980 (O'Brien, Rodgers, and Baugh 1985). Guaranteeing health coverage for children is clearly one of the most important policies this government can

TABLE 3
Medicaid Coverage of Persons under 65 years of age, 1978, 1980, 1982

Insurance status	1978	1980	1982
Total	6.1%	5.9%	5.6%
White	4.0	3.9	3.6
Black	19.7	17.9	17.2

Source: U.S. Department of Health and Human Services 1985a.

pursue to ensure adequate access to health care and a healthy start in life for this vulnerable segment of the population.

In 1982 Medicaid provided coverage for 17 percent of blacks under the age of 65 as compared with 4 percent of whites. As is evident from this data, blacks are more likely to be covered by Medicaid than whites. The difference in Medicaid coverage largely reflects the greater concentration of blacks in poverty. Three times as many blacks as whites have incomes below the federal poverty level. Poor blacks are also more likely than poor whites to be covered by Medicaid (53 percent vs. 32 percent) (U.S. Bureau of the Census 1986). Since a greater proportion of poor black than poor white families are single-parent households, a greater proportion of blacks are thus categorically eligible for Medicaid. In addition, nearly two-thirds of poor blacks reside in urban areas where the extent of Medicaid coverage is greater.

Program Spending

Medicaid is an extremely important source of financing for health care services obtained by black Americans. Reflecting more extensive coverage of the black population, Medicaid paid on average 30 percent of the hospital expenses incurred by blacks compared to 6 percent for whites (Taylor 1983).

Analysis of 1964 and 1974 data found that Medicaid benefits were unevenly distributed by race and geographic region. Average Medicaid payments per white beneficiary were 74 percent higher than payments per black beneficiary (Davis and Schoen 1978). By 1980 the differences had narrowed, with average charges about 50 percent higher for whites than for blacks. The average per person charge for black Medicaid

beneficiaries in 1980 was $598 compared with an average of $878 for white Medicaid beneficiaries (Howell, Corder, and Dobson 1985). Further investigation will be required to explain factors that may account for racial differences among Medicaid beneficiaries. Among the possible explanations are that whites differ from blacks in the quantity and mix of services used and in the use of higher cost providers.

Medicaid expenditures also vary across the major eligibility groups. Despite the common perception that Medicaid largely benefits "welfare mothers and their children," the expenditure data show that AFDC Medicaid beneficiaries incurred less than one-third (25 percent) of all costs in 1984 (Department of Health and Human Services 1985a). The aged, blind, and disabled represented less than 30 percent of total Medicaid beneficiaries, but incurred over 70 percent of the costs. Most of these costs were for nursing home services and intermediate care facilities for the mentally retarded, as well as prescription drugs. These data show that Medicaid provides an important "safety net" for elderly and disabled persons with limited financial means and high medical bills.

Accomplishments

The Medicaid program deserves much of the credit for gains in access to health care achieved by poor and ethnic minority population groups. Twenty years ago, black Americans with limited financial resources faced both economic and racial barriers to obtaining care which was timely and appropriate to their needs. The Medicaid program has been instrumental in reducing both of these barriers to care. Medicaid not only provided a source of financing for poor blacks, but also hastened the process of desegregation in health care facilities. Hospitals receiving Medicaid funds were required to be in compliance with Title VI of the 1964 Civil Rights Act. This act prohibited racial discrimination in any institution receiving federal funds. This provision helped to increase access to care for poor, as well as nonpoor, black Americans.

Differences in utilization rates for the uninsured poor and the insured poor serve as an indicator of Medicaid's impact on access to care. On average, poor blacks with health coverage make twice as many physician visits as their uninsured counterparts. Poor insured blacks made an average of 3.8 visits to physicians in 1977 compared

with 1.8 for poor uninsured blacks (Wilensky and Walden 1981). The poor, excluded from Medicaid, are much less likely to use health services than their counterparts.

Data averaged for the period of 1978 to 1980 provide further evidence of Medicaid's impact on the use of ambulatory services. About one-third of uninsured blacks (33 percent) and whites (31 percent) under the age of 65 reported not seeing a physician in the past year compared with about one-fourth of blacks (24 percent) and whites (22 percent) with private coverage—and one-sixth of blacks (15 percent) and whites (15 percent) with Medicaid (Trevino and Moss 1983). Current surveys provide evidence that blacks and whites without health coverage continue to face serious problems in obtaining medical care comparable in amount to that obtained by those with coverage.

Several national studies have examined Medicaid's effectiveness by analyzing 1976 and 1980 survey data using multivariate levels of analysis adjusting for socioeconomic characteristics and health status (Link, Long, and Settle 1982; O'Brien, Rodgers, and Baugh 1985). These studies found no major racial differences in use of physician services among Medicaid beneficiaries, but significantly lower use of hospital inpatient services by blacks compared to whites. For Medicaid beneficiaries, there exists fairly conclusive evidence that racial and economic disparities in the use of health services have been substantially reduced.

Another indicator of Medicaid's impact is the dramatic decline in infant mortality. As described in the preceding section, after little change in the decade before the enactment of Medicaid, rates have plummeted since the mid-1960s.

Remaining Problems and Future Issues

Medicaid's accomplishments in improving access to care and health status are undeniable. Its shortcomings, however, should not be overlooked. Some of the issues which warrant attention are: limitations in the extent of coverage of the poor; limited participation of physicians in the program; and the quality of care received by Medicaid beneficiaries.

Extent of Coverage of the Poor. Medicaid covered only one-half of poor blacks (53 percent) and one-third of poor whites (32 percent) in 1983 (U.S. Bureau of the Census 1986). Use of health care services for the uninsured poor lags well behind that of Medicaid beneficiaries

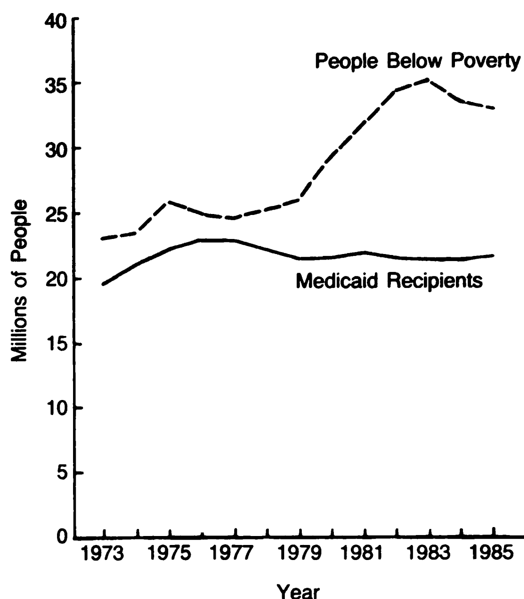

FIG. 1. Number of Medicaid recipients and people below poverty

Source: U.S. Bureau of the Census 1986; U.S. House of Representatives 1987.

(Davis and Rowland 1983). Furthermore, as shown in figure 1, while the number of individuals in poverty has been increasing, Medicaid enrollment has been stable or declining.

Restricting Medicaid eligibility to welfare categories needs to be reexamined. Half of the uninsured are in the work force, but are earning marginal wages. Many of the working poor do not receive employer-provided health coverage and cannot afford to purchase coverage.

State income standards are also inadequate. Half of the states have income standards below 50 percent of the federal poverty level. In Mississippi, Alabama, and Georgia—states with large numbers of poor blacks—there were 35 Medicaid beneficiaries for every 100 poor persons in 1980 (Intergovernmental Health Policy Project 1981).

In 1984 and 1985 Congress required states to cover all pregnant women and young children under state income standards regardless

of family composition. Recent action by the Congress to permit states to cover all pregnant women, children under age 6, and elderly and disabled people up to the federal poverty level is an important step. Implementation of this legislation should be carefully monitored to determine if states will expand Medicaid coverage to those poor not on welfare. Some minimum income floor on Medicaid eligibility, however, is likely to be required to assure that the poorest receive coverage. Efforts should also be pursued to encourage employers to offer coverage to all workers and their dependents.

Limited Participation of Physicians. Access to care for Medicaid beneficiaries is impeded because of limited participation in the program by physicians. While the majority of physicians nationwide report participating in the Medicaid program, almost one out of every four office-based physicians (23 percent) report that they do not accept Medicaid. Ten percent of all primary care physicians provide care to about half of Medicaid beneficiaries treated in private offices (Mitchell and Cromwell 1983).

The problem of nonparticipation is even greater within certain geographic regions and specialities. About one-third of physicians in the South (34 percent), Northeast (30 percent), and large urban areas (35 percent) report that they do not accept Medicaid patients. These findings are particularly troublesome given the concentration of poor blacks in the South and urban areas. More than one-third of obstetricians and gynecologists (37 percent), cardiologists (39 percent), and psychiatrists (40 percent) also report that they do not accept Medicaid patients. These are specialties for which there are potential benefits from improved access, given chronically high infant mortality rates among blacks and high mortality rates among black adults from diseases of the heart and violent injuries. Access to physicians with specialized knowledge and training in these disciplines could be critical for black beneficiaries who are at high risk.

Medicaid fees, by law, must be lower than fees for Medicare or private insurers. Medicaid beneficiaries, therefore, are competing with higher paying patients from the public and private sectors. Limited participation by physicians results in Medicaid beneficiaries having fewer choices and, thus, creates the conditions for a concentration of Medicaid beneficiaries with few providers. There also may be less incentive to provide high-quality care when physicians realize dissatisfied patients have a limited number of providers from which to select.

Physicians consistently cite lower reimbursement rates as the major reason for not participating in the Medicaid program. Other frequently cited important reasons were payment delays, administrative paperwork, and opposition to government's involvement in medicine. If serious attention is not given to how best to address the concerns of providers, it is conceivable that government cost-containment measures and provider fiscal constraints will further erode physicians' willingness to provide services to public program beneficiaries. The issues are complex and require careful consideration of the needs and rights of both physicians and Medicaid beneficiaries.

Quality and Adequacy of Care. Concerns about quality of care received prominent attention in the mid-1970s following reports before the U.S. Special Committee on Aging (1976) of physicians with large Medicaid practices who were considered to provide poor quality care. Research on the quality of care received by Medicaid beneficiaries is limited. Of the studies conducted, some provide evidence of unnecessary or poor quality care; others do not (Wyszewianski and Donabedian 1981). Data do show that blacks are more likely than whites to use hospital outpatient departments and emergency rooms as their usual source of care—health care settings where the potential for some of the essential elements of good quality of care are not optimal.

The lack of data has seriously hindered the evaluation of differences in the quality and adequacy of care obtained. Although empirical evidence of inequities in quality are minimal, ample evidence exists to suggest cause for concern and to recommend an expanded focus for research on quality and continuity of care. Given the data collection mechanisms that already exist, it seems appropriate to develop and incorporate measures that can evaluate and monitor differences in the quality as well as the quantity of care obtained in the American health care system.

Medicare

Medicare, authorized under Title XVIII of the Social Security Act, finances health care for the aged and some disabled. The program has had widespread political support since its enactment in 1965 and can be credited for greatly improving access to health care services for the elderly. In 1984 almost 10 percent of the black population—2.6

million black elderly and disabled Americans—had health insurance coverage through the Medicare program (U.S. Bureau of the Census 1985).

The Medicare program was established out of desire to lessen the financial burden many of the aged faced for medical care. The 1963 Social Security survey of the aged documented that about half of the aged had no private health insurance (Merriam 1964). Insurance companies, fearful of financial losses resulting from insuring an excessive number of poor risks, were reluctant to write individual comprehensive policies for the elderly. Available policies were generally inadequate, offering limited coverage, exempting preexisting conditions, and rarely covering nursing home care in the event of infirmity or senility. Blacks particularly benefited from Medicare coverage because they tended to have lower incomes and poorer employer-related health benefits, and thus were at high risk for large uncovered medical expenses.

The Medicare program, however, went beyond relieving financial barriers to address racial barriers to health care. In part, the Medicare program worked as a vehicle for enforcement of Title VI of the Civil Rights Act of 1964. Hospitals participating in the Medicare program were required to make services available to all persons on a nondiscriminatory basis (Ball 1973). Because most hospitals chose to participate, the Medicare program helped to desegregate many hospitals, especially in the South.

Scope of Coverage

Medicare covers people aged 65 and over who receive Social Security or Railroad Retirement benefits. Beginning in 1974, benefits were also extended to disabled persons who had been receiving Social Security disability benefits and to persons with chronic renal disease. Medicare consists of two complementary parts: Part A covers hospital, nursing home, and home health services; Part B covers physician, outpatient hospital, home health and some ambulatory services.

Medicare coverage of the aged population is almost universal. Twenty-eight million aged and 3 million disabled beneficiaries were enrolled in 1986. Blacks and other minorities comprise about 10 percent of aged and 17 percent of disabled beneficiaries (U.S. Department of Health and Human Services 1984).

Part A covers all eligible persons. Those covered under Part A may

voluntarily enroll in Part B by paying a premium. Nearly all beneficiaries enrolled in Part A participate in Part B. Participation in Part B has increased over time, particularly for blacks and other minorities. In 1967, 93 percent of whites were enrolled in Part B, compared to 83 percent of minorities. By 1976 this difference had narrowed considerably, with 98 percent of whites and 96 percent of minorities enrolled in Part B (Ruther and Dobson 1981).

The improvement in coverage of blacks under Part B has been attributed to the growth of the state buy-in program under the Medicaid program (Ruther and Dobson 1981). This program permits states to pay the Part B premiums, coinsurance, and deductibles for those aged and disabled on welfare. In 1967 only 27 states participated in this program; currently, all states, except Wyoming, participate in buy-in agreements (Unpublished data from the Health Care Financing Administration 1986).

Studies show that persons bought-in to Medicare by Medicaid, are older, sicker, and more likely to be minority group members than other Medicare beneficiaries. They have higher mortality rates and higher rates of hospitalization for chronic conditions, especially diabetes (McMillan et al. 1983).

About 10 percent of all Medicare enrollees are bought-in by the Medicaid program, but this varies dramatically by race and age. McMillan's study found that 9 percent of whites were bought-in to Medicare, compared to 31 percent of other races. For minorities aged 85 and over, 51 percent are covered by buy-in agreements. Recent legislation allows states the option of extending the buy-in program to Medicare enrollees with incomes up to the poverty line.

For poor elderly blacks, Medicaid is an important supplement to Medicare beyond payment of the Part B premium. Medicaid fills in the gaps in Medicare by paying the deductibles and cost-sharing requirements and providing coverage for additional services, most notably prescription drugs, dental care, and nursing home services.

Program Spending

In 1982 Medicare spent $48 billion on the elderly and disabled, of which 10 percent went toward services for minorities. As shown in table 4, two-thirds of Medicare expenditures went toward inpatient hospital care. Of the remainder, most (31 percent) went toward physician

TABLE 4
Medicare Reimbursement by Service and Race, 1982 (amount in millions)

	Hospital insurance and/or supplementary insurance	Hospital Insurance				Supplementary Medical Insurance			
		Total	Inpatient hospital services	Skilled nursing facilities	Home health services	Total	Physician and other medical services	Outpatient services	Home health services
TOTAL	$47,698	$33,092	$31,610	$402	$1,081	$14,605	$11,700	$2,900	$30
Aged	41,526	29,214	27,834	388	992	12,311	10,311	1,982	19
Disabled	6,172	3,878	3,776	14	89	2,294	1,385	909	7
WHITE									
Total	41,422	28,790	27,515	365	910	12,632	10,358	2,262	12
Aged	36,613	25,702	24,508	354	841	10,911	9,239	1,660	12
Disabled	4,809	3,088	3,007	11	69	1,721	1,119	602	—
BLACK & OTHER									
Total	5,048	3,451	3,281	26	144	1,597	1,036	556	6
Aged	3,805	2,736	2,586	24	126	1,069	797	267	6
Disabled	1,243	715	695	2	18	528	239	289	—

Source: Annual Medicare program statistics, 1982, 224, 248.
NOTE: Totals do not necessarily equal sum of rounded components.

and outpatient services. Blacks accounted for about 10 percent of these expenditures. Less than 3 percent of total expenditures were spent on home health services and skilled nursing facilities.

In the early years of the Medicare program, substantial disparity in the use and reimbursement of services among white and black aged existed but, during the past twenty years, many of these differences have narrowed (Davis 1975). As shown in table 5, Medicare reimbursement per aged person enrolled averaged $1,565 for whites in 1982 and $1,604 for blacks. In contrast, in 1968 reimbursement was 40 percent higher for whites compared to blacks. This apparent gain in equity, however, provides an incomplete picture because this measure fails to account for differences in health status. Substantial evidence indicates that blacks are sicker and, therefore, require more services (Manton, Clifford, and Johnson 1987). In addition, disparities in the use of specific services continue to persist.

For aged beneficiaries, racial differences in the use of hospital inpatient services rapidly narrowed. Among the aged in 1966, whites had 70 percent higher inpatient hospitalization rates than other races (Davis 1975). This gap closed to 25 percent in 1968, 14 percent in 1975, and by 1981 elderly blacks and whites used hospital inpatient services at similar rates (U.S. Department of Health and Human Services 1984). This is also evident in reimbursement rates for inpatient services. In 1968 whites received 28 percent higher payments per person enrolled, but by 1982 blacks were receiving reimbursement at a slightly higher level than whites—$1,142 vs. $1,061.

The Medicare program has been less successful in assuring equality of treatment in other types of medical services. Differences for physicians' services have narrowed from 65 percent higher reimbursement per white enrollee compared to blacks in 1968, to 14 percent by 1982—$406 vs. $357. The remaining differential appears to reflect minorities greater use of outpatient departments. When considering reimbursement for physician and outpatient services together, there is no differential.

The most obvious remaining inequality appears to be in the distribution of benefits for skilled nursing facility (SNF) care. In 1968 whites received more than double the extended care facility benefits received by blacks and other races. In 1982 whites continued to receive one-third more benefits (U.S. Department of Health and Human Services 1984). These differences warrant further examination to determine whether disparities reflect such factors as population group

TABLE 5
Medicare Reimbursement per Aged Person Enrolled, by Type of Service and Race, 1968 and 1982

Service	1968			1982		
	White	Black & other	Ratio white:black	White	Black & other	Ratio white:black
All Medicare services	$273	$195	1.40	$1,565	$1,604	0.98
Hospital insurance	194	147	1.32	1,112	1,208	0.92
Inpatient hospital	175	137	1.28	1,061	1,142	0.93
Skilled nursing facility	17	8	2.17	15	11	1.36
Home health	—	—	—	36	56	0.64
Supplemental medical insurance	83	54	1.53	480	479	1.00
Physician	79	48	1.63	406	357	1.14
Outpatient services	3	5	0.62	73	120	0.61
Home health	—	—	—	1	3	0.33

Source: Davis 1975; annual Medicare program statistics, 1982, 226.

TABLE 6
Persons Served and Medicare Reimbursements per Person Served for Aged, by Type of Service and Race, 1982

Services	White	Black & other	Ratio white : black
PERSONS SERVED PER 1,000 ENROLLEES			
All Medicare services	648.1	585.8	1.11
Hospital insurance	253.4	229.4	1.10
Inpatient hospital	245.7	218.5	1.12
Skilled nursing facility	9.7	5.9	1.64
Home health	40.4	50.0	0.81
Supplementary medical insurance	658.7	611.2	1.08
Physician services	642.7	573.7	1.12
Outpatient services	288.9	310.4	0.93
Home health	0.5	2.2	0.23
REIMBURSEMENT PER PERSON SERVED			
All Medicare services	$2,415	$2,739	0.88
Hospital insurance	4390	5264	0.83
Inpatient hospital	4318	5224	0.83
Skilled nursing facility	1578	1804	0.87
Home health	901	1112	0.81
Supplement medical insurance	729	784	0.93
Physician services	632	623	1.01
Outpatient services	253	386	0.66
Home health	1053	1136	0.93

Source: Annual Medicare program statistics, 1982, 223, 225.

differences in age or choice of service or continuing discrimination. For home health services, blacks and other races receive a higher reimbursement than whites; reimbursement, however, for all races was small.

In 1968 most of the difference in Medicare reimbursement between the races reflected a difference in the number of persons exceeding the Medicare deductible—40 percent of whites received reimbursement, compared to 30 percent of blacks (Davis 1975). In 1982, as shown in table 6, the percentage of enrollees receiving reimbursement had increased for all aged, but a differential between whites (65 percent) and blacks (59 percent) persists. Once an aged person has exceeded

the deductible, reimbursement has been fairly similar throughout the program, regardless of race.

Program Impact

The burden of heavy medical expenses on the aged and their families created the impetus behind Medicare. Medicare was created to remedy the private sector's failure to provide adequate health insurance by extending comprehensive coverage to virtually all aged. It has succeeded.

Medicare has improved access to medical care. Hospital utilization, particularly by those most in need of care—individuals living alone with low incomes, minorities, residents of the South and nonmetropolitan areas—has increased significantly. Medicare may also deserve credit for the increases in life expectancy in old age. As described in the first section, there have been notable improvements in life expectancy for blacks. In addition, gains in health since the enactment of Medicare have been especially rapid for those causes of death influenced by medical care intervention and which historically have been higher among blacks. Some of this improvement reflects advances in medical practice, but the significant improvement in access to health care services resulting from financing through the Medicare program cannot be ruled out.

Remaining Problems

Despite significant progress, gaps do remain. Under the current Medicare program, beneficiaries can be liable for substantial out-of-pocket expenses. The Medicare program covers less than half of the elderly's total health care costs, requires high levels of cost-sharing, and excludes many health care services such as prescription drugs, dental care, eyeglasses, and hearing aids (Waldo and Lazenby 1984).

The incidence of illness and the financial burden of cost sharing are not related to ability to pay. Out-of-pocket health care expenditures, excluding nursing home care, represent only 2 percent of total income in families with incomes in excess of $30,000, but 21 percent of the total in families with incomes less than $5,000 (U.S. Congressional Budget Office 1983).

Elderly blacks are particularly at risk because they are more likely to have low incomes. It is estimated that today 64 percent of aged

minorities have incomes below 200 percent poverty compared to 37 percent for whites. (Commonwealth Fund Commission on Elderly People Living Alone 1987). Even routine expenses can be catastrophic for many blacks.

Fear of large out-of-pocket expenses leads many aged to purchase Medicare supplementary policies to fill the gaps resulting from Medicare deductibles, coinsurance, and some of the uncovered benefits. Many older black Americans are, however, unable to afford "Medigap." Only 39 percent of elderly blacks, compared to 58 percent of elderly whites are covered by private insurance (Rowland and Lyons 1987). Some of this difference can be attributed to income. Blacks are more likely to have lower incomes and, therefore, be unable to afford Medigap policies which cost on average $400 per year (Rice and McCall 1985). As shown in table 7, however, elderly blacks are less likely to be covered by private insurance even after adjusting for income. Lack of group health insurance among blacks may reflect their employment history. Blacks are more likely to have been employed in lower paying jobs that do not offer comprehensive retirement benefits, including health insurance.

For the aged poor, some gaps are closed by Medicaid, but the current program only covers 35 percent of this vulnerable population (U.S. Bureau of the Census 1985). Recent legislation permitting states to increase Medicaid coverage of the elderly poor may offer some relief, provided that states act. In the interim, however, many poor Americans face serious financial burdens.

In recent years improvements in Medicare have been stymied by pressure to restrain federal government spending. Today, however, there is the potential for improvement by expanding the program to include catastrophic coverage for Medicare-covered services. Improving catastrophic coverage is obviously very important for the elderly and disabled with high expenditures, but it does not offer protection for lower income aged who struggle to pay for even routine medical expenses. The future agenda for Medicare ought to include help for both groups.

Primary Care

The provision of medical care depends not only on the finances to drive the system but on the physicians and clinics that make it

TABLE 7
Health Insurance Coverage of the Elderly by Income and Race

	Poverty level							
	Below poverty		100–149%		150–200%		200% +	
Insurance coverage	White	Black & other	White	Black & other	White	Black & other	White	Black & other
Total	100%	100%	100%	100%	100%	100%	100%	100%
Medicare & Medicaid	24	50	7	14	3	17	2	15
Medicare only	28	33	24	44	17	29	13	23
Medicare & private	48	17	69	42	80	54	85	62

Source: Rowland and Lyons 1987.

function. In the 1960s a consensus emerged that the United States had a physician shortage and that major new programs would be required to get physicians to the areas of greatest need (U.S. Department of Health, Education, and Welfare 1967; Carnegie Comission Report on Higher Education 1970). Poor populations in general and ethnic minority communities, in particular, were the most underserved. Although the provision of Medicare and Medicaid benefits to elderly or poor black people made them more economically attractive to the medical community, it did them little good if there were no physicians in their communities or those that were there already were fully committed.

Programs to Expand Capacity

What was called for was a strategy that would build the "capacity" of the system to treat more people—especially blacks and others in low-income, doctor-short areas. The outcome was a series of legislative measures that, while not designed as a single strategy, resulted in a formidable array of programs to augment service delivery in poor communities that generally came to be known as the "primary care programs."

In 1965 the Office of Economic Opportunity (OEO) undertook its first health projects by funding eight demonstration health centers in poor communities. These proved to be the first of more than 100 neighborhood health centers funded by the OEO and, subsequently, by the Department of Health, Education, and Welfare between 1965 and 1971 in a program that became the centerpiece of the strategy to build medical capacity in poor communities (Zwick 1972). It should be noted that the centers were conceived as agents of community development providing opportunities for community management of health services as well as employment opportunities (Geiger 1982).

In 1963 and again in 1965 amendments were made to the Social Security Act establishing a program of Maternal and Infant Care (M&I) and Children and Youth (C&Y) centers designed to meet the comprehensive needs of mothers and children in poor communities. In 1966 the Migrant Health Act was passed providing grants to establish special clinics for migrant and seasonal workers. In 1970 the National Health Service Corps was enacted for the expressed purpose of providing physicians to staff practices in underserved areas. This was followed

in 1972 by the National Health Service Corps Scholarship Program designed to link support for medical education to a period of service in a shortage area (Mullan 1982).

The 1970s saw these programs grow and stabilize. The neighborhood health centers were consolidated within the Public Health Service in 1972 where they have continued as community health centers with an increased emphasis on self-sufficiency and standard medical services. The National Health Service Corps grew rapidly through the late 1970s and into the 1980s staffed increasingly by the service-obligated graduates of the National Health Service Corps (NHSC) scholarship program. In 1986 the program had 3,127 health professionals serving in shortage areas, many of which had large black populations.

Program Impact

The Community Health Center Program has fared well in recent years, despite a restrictive federal budgetary climate. In 1986 there were 650 community and migrant health centers delivering care to 5.3 million people. About 31 percent of its users nationally are black, meaning that 1.64 million blacks receive their primary care in community health centers. The percentage of community health center users that are black in the Southeast is particularly high, with states such as Mississippi and South Carolina reporting rates in excess of 70 percent.

Numerous studies have documented the effectiveness of community health centers in improving the health of the communities they have served (Davis 1985; Grossman and Goldman 1981). Black infant mortality rates have shown particular improvement in communities served by primary health care centers.

Remaining Problems and Future Issues

Other programs have not fared as well in the restrictive budgetary climate of the 1980s. The C&Y and M&I programs were included in the Maternal and Child Health Block Grant under the 1981 Omnibus Budget Reconciliation Act. While total Maternal and Child Health funding has increased from $374 million in 1982 to $458 million in 1986, states do not report specifically on the M&I and C&Y programs, and their continued growth and effectiveness cannot be assessed.

The National Health Service Corps was a principal target of the Reagan administration. Unable to stem the tide of scholarship recipients becoming available for service, they eliminated new scholarship awards. New placements in the NHSC will, therefore, fall from 1,000 in 1986 to 200 or less from 1987 on. Over the next several years, as a result, the numbers of National Health Service Corps physicians will drop drastically, creating manpower problems in many underserved communities. Although the physician-to-population ratio in the United States is far higher now than it was at the inception of the NHSC, the "diffusion" of physicians into endemically poor communities has not been demonstrated, and, in the absence of a new, federal physician manpower program, the staffing of community health centers and the maintenance of the current levels of access to services for poor and black populations may become problematic in the near future.

Black Physicians

Another way in which the public sector has made an impact on the health care of black Americans has been through the support of medical education and training. Over the past 20 years there have been enormous gains made in the number of black medical school enrollees and black physicians. Federal initiatives in social programs, civil rights, and affirmative action in the 1960s in part spearheaded this effort.

Since the mid-1960s, the federal government has played a direct role in influencing the supply of health care providers in terms of numbers, content, and distribution. Several factors prompted the federal government's direct involvement in the health labor market, including consistent reports and forecasts of shortages in health personnel, changing societal views about public responsibility in this regard, and the context of the civil rights movement. The federal government attempted to address problems of high unemployment and access to health care for the nation's poor and ethnic minorities concurrently.

To ensure greater access to education and job training programs, the federal government developed a number of special initiatives for underrepresented minority groups and the economically disadvantaged. Between 1963 and 1976 there were four major legislative acts designed to address problems of inequities in the supply and distribution of health professionals. They included: the 1963 Health Professionals

Education Assistance Act, the 1968 Health Manpower Act, the 1971 Comprehensive Manpower and Training Act, and the 1976 Health Professionals Education Assistance Act.

As a result of these legislative acts and their amendments, massive sums of federal dollars were infused into health education and training programs. Federal expenditures grew from $122 million in 1965 to $539 million in 1974 (Wallach 1976).

In 1970 an American Association of Medical Colleges (AAMC) task force on expanding educational opportunities in medicine for blacks and other minorities put forth the goal of increasing black medical student enrollment from 2.8 percent to 12 percent based on the model of population parity—the proportion of blacks in medical school should equal the proportion in the general population—(Shea and Fullilove 1985). Between 1968 and 1986 the percentage of black medical students in first-year classes of American medical schools increased over two and a half fold—from 2.8 percent to 7.0 percent. This increase was not steady during these years. Black medical student enrollment peaked in 1974 at 7.5 percent, and has ranged from 6.4 percent to 7.0 percent between 1975 and 1986. Only 3 percent of all physicians currently in practice are blacks. Although there are several forces which led to an increase in black enrollment in medical schools and an increase in the number of black physicians over the past 20 years, there is little doubt that public-sector support contributed to this increase.

Program Impact

One rationale for public-sector promotion of the education of blacks in medical careers is to increase the availability of health services to the black population. This would be the case if black physicians, having finished their medical training, diffused into geographic areas and medical specialties resulting in better access to health care for black Americans.

Several studies have indicated that this is occurring. Lloyd, Johnson, and Mann (1978) interviewed 311 physicians from the graduating classes of Howard University from 1955 to 1975 and found that black graduates had a higher percentage of black and low-income patients than all American graduates combined. A study of 1975 medical school graduates fround that 56 percent of black graduates had practices

composed primarily of black patients, as opposed to 8 to 14 percent of other groups of graduates that year (Keith et al. 1985).

Black medical students are somewhat more likely to receive public-sector financial support than are other students. A higher percentage of black medical school enrollees come from low- and moderate-income families, compared to white enrollees. The Association of American Medical Colleges (1983, 1985) annual survey of seniors in medical school found that the proportion of minorities who had NHSC scholarships was higher than the proportion for nonminority students. The Health Professions Scholarship Program, the Health Professions Loan Program, the federally insured (and subsidized) student loan programs and armed forces scholarships also have helped many black physicians from low-income families support their years in training. Indirect support has also come from institutional aid to medical schools. Howard University along with Meharry Medical College, which prior to 1968 educated the majority of graduating black physicians and practicing black physicians, receives substantial federal support.

Remaining Problems and Future Issues

Despite efforts to increase the number of black physicians, the original goal was not achieved. Little progress has been made in the past decade to increase further the number of black physicians. This is particularly troubling in the current climate of forces that are shaping the health industry. Although there appears to be an overall adequate supply of physicians, there is a clear deficit in the number of black physicians (Iglehart 1986).

Career choices in medicine by talented black students may be further hindered by perceptions of the experiences of black physicians. There is a growing concern among some black leaders and medical societies that national policy goals of a health care market free of government intervention with more competition will lead to erosion of their current market share by large for-profit enterprises and that quality of care will ultimately suffer. This could potentially lead to a further displacement of black physicians and patients from the mainstream of American medicine.

There is also the concern that new payment innovations in federal programs such as prospective payment and capitation that employ fixed payments will discriminate against black physicians since their

case mix is different. Patient populations of black physicians are largely Medicaid, low-income, and chronically ill patients. Some black physicians claim that their opportunities to compensate for such changes by diversifying their patient populations are limited due to discrimination by institutions, physicians, and patients.

Economic pressures may also work against the future supply of black physicians. Medical school tuitions are increasing and the NHSC scholarship program is being phased out. Although the medical profession as compared to other professions has been an excellent investment for most physicians, this is less true for black physicians since their incomes generally are less and their debt is higher. If the opportunity costs are too high, black students may not enter the medical field or once having entered the field, may choose to abandon it.

There is little likelihood that population parity of black physicians will come about under the status quo. Public-sector initiatives have helped in making great strides in the number of black physicians over the past twenty years. Private-sector support cannot be relied on alone to respond to this crisis. New directed programs to stimulate black enrollment in medical schools and continued sources of support for low-income blacks will be necessary in the current health care environment.

Implications for Future Public Policy

This article presents evidence that access to health care has improved considerably for many black Americans. Yet, on several important indicators of access, black/white differences remain. Moreover, gains achieved have not been shared evenly across subgroups of the black population. Disparities persist for blacks who are uninsured, who are under the age of 17 or over the age of 65, and who live in the South or in rural parts of the country. Some of the findings have immediate implications for public policy.

First, although the gap between blacks and whites with no health coverage has declined, the trend since 1978 has been an increase in the percentage of both black and white Americans with no health coverage. With 6.3 million black Americans estimated to be uninsured in 1984, it would mean that about one in four black Americans face a potential financial barrier in access to ambulatory and hospital care.

(Sulvetta and Swartz 1986). Efforts to expand health coverage to black Americans along with other Americans who lack coverage are therefore crucial.

Second, black Americans are still twice as likely as whites to be without a regular source of care and to identify a hospital outpatient department or emergency room as the source of physician visits. In the last twenty years, noticeable gains in reversing these patterns have been achieved. The consequences of not having a health care provider who serves as an entry point into the health care system or who monitors the care received, however, could be more serious now than ever before. It unquestionably presents a barrier in access to care. It also leaves an individual vulnerable to the more costly forms of care which could have been avoided with earlier entry into the system or better management of care. The American health care system is highly decentralized and complex with its specialties and subspecialties. For a system that seems large and impersonal, a primary provider who can facilitate the linkage with the most appropriate form of care could conceivably make a difference in when and if health services are sought. Since black Americans suffer disproportionately from chronic conditions such as hypertension, diabetes, and heart disease, continuity in management of care is as essential as access to care.

Concerns about a regular source of care are critical at this juncture in history for several reasons. In recent years, the federal government has reduced financial support for programs designed to improve the supply of physicians in underserved areas. One of the barriers to identifying a regular source of care is the physical availability of providers in a neighborhood. The findings of this study suggest that further efforts to expand the physical availability of services may be warranted. Strengthening community health centers, establishing incentives for providers to work in shortage areas, and supporting blacks entering medical school are ways of fulfilling that need.

Third, much of the data reported do not yet reflect the effects of federal changes in health financing and delivery programs in the 1980s. The federal government's retreat from the regulation and financing of health services will likely exacerbate existing differences. The changing health marketplace has advantages and disadvantages for black Americans. Those who must compete in a marketplace with limited bargaining power will be met with the greatest resistance.

Although blacks and whites have shown comparable gains in health

status during the last two decades, major disparities by race remain. According to a number of other indicators, the health of black Americans continues to lag behind that of whites and contributes to suffering, disability, work-loss days, and medical expenditures. Black infants are still twice as likely as white infants to die during the first year of life and black adults are twice as likely as white adults to die of stroke, diabetes, and certain types of cancer. The gap that persists presents an agonizing dilemma for the health care system and this nation. Government health financing and delivery programs, however, have played a critical role in improvements in health and access to care which have occurred thus far.

More research is obviously needed to look at factors explaining these differentials and to form a groundwork for policy proposals to eliminate these differences. Most important, the consequences of cutbacks in major health financing and delivery programs in the last few years need to be monitored closely to detect any possible reversal of the gains that have been achieved with such difficulty over the last twenty years.

To redress remaining differences in equitable access to health care services for black Americans, the following policy actions are recommended:

1. Expand health insurance coverage under Medicaid and private employer-based health insurance plans to close the gaps in health care coverage.
2. Develop new systems of financing long-term care services, including home health and nursing home care.
3. Maintain and expand funding of primary care programs that serve disadvantaged populations and assure the availability of care in underserved communities. Renew efforts to encourage blacks to enter the medical profession.
4. Encourage physician and hospital participation in the Medicaid program by bringing reimbursement rates into line with the Medicare program.
5. Assure freedom of choice of a range of health care providers to all beneficiaries of Medicare, Medicaid, and employer health plans, including choice among managed care plans such as health maintenance organizations and among fee-for-service providers.
6. Enforce quality standards and nondiscrimination provisions on

all providers participating in public and private insurance plans, with particular attention to nursing home care and new managed-care plans.

7. Expand efforts to improve use of preventive health services and to assure ongoing continuity in the management of chronic health conditions.

8. Expand funding for data collection, monitoring, and research to further identify and understand the contributing causes of racial differences in health status and access to care.

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