Thirty Years of Medicare: A Personal Reflection on Medicare's Impact on Black Americans

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Thank you for inviting a Medicare beneficiary to participate in this celebration. I just celebrated my 84th birthday with 1,000 of my closest friends. On my next birthday, I will join the 2.6 million other Medicare beneficiaries who are in the category called the "oldest-old." I will be in the young group of the oldest old!

To President Clinton, Secretary Shalala, and Administrator Vladeck, I extend my congratulations. I commend you for bringing us together for this celebration and for having the foresight to hold it here in Austin at the LBJ School of Government. In Austin, which served as the base for Lyndon Baines Johnson, who gave such strong leadership to the civil rights movement, and at an institution where Barbara Jordan spent many hours leading and teaching by extraordinary example.

Barbara Jordan would have approved of the gathering as she approved of and advocated for a society in the tradition of Mary McLeod Bethune—a society in which no one is left behind. Mrs. Bethune, born of slave parents, was a tireless advocate and educator: Her accomplishments included being an advisor to FDR, founder of a college, and founder of the National Council of Negro Women.

In that same spirit, Medicare can be seen as one of this country's major vehicles that has kept older Americans from being left behind. Medicare has provided one means of helping to ensure life with dignity and death with dignity for older Americans.

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Medicare has changed and continues to change health care delivery for all Americans. Medicare has provided hope and help for all older Americans, and it has had a significant impact on older black Americans. Medicare has gone a long way toward minimizing racial disparities in the use of medical services and access to care. Reflecting on history, President Roosevelt urged this country toward national security and social security. He envisioned social security as much more than what is embodied in a Social Security card. He believed, as do I, that Americans are entitled to adequate housing, food, and health care. We have allowed "entitlement" to become a dirty word. It is not. It goes to the very heart of democracy.

Medicare was one of three critical events that provided access to medical care for black Americans and all people of color: the Civil Rights Act of 1964, Medicaid, and Medicare.

Title VI of the Civil Rights Act prohibited racial discrimination in any institution receiving Federal funds. This was a powerful incentive for hospitals to review and change their policies and practices. The law required that those receiving Federal funds be prohibited from denying admission to patients based on race; subjecting patients to separate treatment based on race; or denying admitting privileges to medical personnel solely on the basis of race.

The combination of Medicaid, Medicare, and the civil rights legislation changed the health care landscape forever for black Americans and minorities of all ages. Everyone benefited from these policies.

Before Medicare, black Americans often were denied access to our hospitals: In 1967, the first full year of Medicare, program data showed that 189 white persons per 1,000 enrollees received inpatient hospital services, while only 138 persons of all other races received such services (Gornick et al., 1985). Today these racial differences in the overall hospital user rates have been eliminated.

Before Medicare, black Americans often were denied access to physicians: In 1967 the number of white persons receiving physician services was 49 percent higher than the number of persons of other races receiving services (Gornick et al., 1985). By 1994 the racial differential had been reduced to 8 percent.

Even with the Civil Rights Act and its enforcement, some of these problems continue today. According to the National Caucus on Black Aged and an AARP report, elderly black persons are more likely to be sick and disabled and to see themselves as being in poor health than elderly white persons. We have higher rates of chronic disease, functional impairment, and indicators of risk, such as high blood pressure. Black males have a higher incidence of prostate cancer. Overall, black people have a life expectancy of 69.2 years, compared with 76.4 years for white people, a differential of about 7 years. A recent look at applied research literature on black aging found not only that black persons experience more health problems and less access to services than white persons, but also that some of the gains made in the past are being lost.

According to a 1986 report from the Department of Health and Human Services' Secretary's Task Force on Black and Minority Health, there were six medical conditions for which gaps in mortality between white and black people were the greatest: accidents and homicides, infant mortality, heart disease and stroke, cirrhosis, cancer, and diabetes. Those six causes of death accounted for almost 86 percent of the excess black mortality in relation to the white population.

Income and poverty status are critical factors to consider for elderly black Americans. Social Security benefits are central to the retirement income of many elderly people. We must not forget, however, that black people are less likely than their white counterparts to receive Social Security benefits and are more likely to receive lower benefits. The lower Social Security benefits of black Americans reflects our lower earnings. Even with the lower Social Security benefits, black Americans still rely on Social Security for much of their income: In 1994, 76 percent of black persons relied on Social Security for 50 percent or more of their income, compared with 65 percent of white persons (Grad, 1996).

There are substantial differences in the income distributions of Medicare beneficiaries across races. An analysis in a recent study looking at access to care in Medicare distributed the black and white beneficiary populations into income quartiles. The data show that 27 percent of all white beneficiaries fell into the highest income quartile (greater than $20,500), compared with only 6 percent of all black beneficiaries. In contrast, 19 percent of all white beneficiaries fell into the lowest income quartile (less than $13,100), while 73 percent of all black beneficiaries were in the lowest income quartile (Summary Report, 1995). The health literature has long documented that having low income is a risk factor for poor health status.

A recent study of older women and Medicare again reminds us that people who cannot afford to pay for health care often go without it. The study, by Robert Butler, showed that older women with low incomes are less likely to receive preventive services, such as Pap smears and

mammograms, because they cannot afford the copayments. Thus, when you recall the statistics on income and older black Americans and combine that with the fact that this group is less likely than white Americans to have supplemental insurance, this bodes poorly for preventive health care. Because of the substantial amount of cost-sharing required in the Medicare program and because Medicare does not cover many items and services important to the elderly, many elderly persons purchase medigap insurance to supplement Medicare coverage. The Secretary's Task Force on Black and Minority Health states that aged white persons supplement Medicare with private insurance at two times the rate that black elderly persons do.

In addition, a recent analysis by the Health Care Financing Administration (1995) showed that race and income have substantial effects on mortality and use of services among Medicare beneficiaries. This study is particularly notable because it showed that adjusting for differences in income distribution between black and white beneficiaries only slightly reduced the racial disparities. Black beneficiaries and low-income beneficiaries were shown to have fewer visits to physicians for ambulatory care, fewer mammograms, and fewer immunizations against influenza. However, the study also found that such beneficiaries are hospitalized more often and have higher mortality rates. This suggests that they may be receiving less primary and preventive care than white persons or higher income beneficiaries. Another example this study highlights is differences in surgical procedures. Black beneficiaries and lower income white beneficiaries had higher rates of amputation of all or part of the lower limb, which is often due to advanced diabetes mellitus. Similarly, black men had higher rates of a certain surgical procedure (bilateral orchiectomy, which is performed primarily to treat metastatic prostate cancer). These differences could not be explained entirely by differences in the prevalence of the disease but more likely suggest that these groups may not be receiving the appropriate level of care necessary to manage certain chronic diseases.

There are other issues related to access that I believe we should be monitoring closely, in particular, the implementation of managed care. I am concerned that if managed care disrupts long-standing doctor-patient relationships, it could have a deleterious effect on access for black elderly.

So today we celebrate 30 years of Medicare and improvements in the health and life expectancy of older Americans. And as we celebrate, we must also concentrate on the health problems of older black Americans. Because Medicare is the principle source of insurance for health care for the vast majority of aged black Americans and other older Americans, we must raise our voices to ensure not only that we maintain the integrity of Medicare but also that we continue the struggle for health care reform; that we focus on quality, and that we expand our efforts on health promotion and health education.

We need to continue looking at issues and concerns about the health status of minorities and pursue a range of solutions that will improve the health status of black Americans. We need to know more about the health care problems that face older black Americans and particularly those faced by the black elderly who are 85 years of age or over. We must improve the long-term care system, particularly home care, for black elderly.

I encourage policymakers and Medicare policy developers to review a new publication from the National Council of Negro Women: *Voices of Vision* (National Council of Negro Women, 1996). African-American

women authors write eloquently about many of the issues faced by black women, including health issues.

Mary McLeod Bethune said our children must never lose their zeal for building a better world. We must not lose our zeal for building a better world. She said we have a powerful potential in our youth. We have a powerful potential ourselves to speak the word entitlement and support it, to strive for health reform that provides universal access to health care that is affordable and of high quality, and to ensure a society of equality and justice.

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