

Strengthening Medicare's Role in Reducing Racial and Ethnic Health Disparities

By the Study Panel on Medicare and Disparities

Introduction

The National Academy of Social Insurance's Study Panel on Medicare and Markets found significant racial, ethnic, and income-related disparities in preventive care, primary care, and essential medical and surgical treatments for Medicare beneficiaries and called for immediate remedial actions. In response to that charge, the academy convened a Study Panel on Medicare and Disparities to identify steps that Medicare can take to reduce disparities. The panel, chaired by Bruce C. Vladeck, included academics, health care practitioners, health plan administrators, and executives of health care companies and provider associations or alliances. This brief summarizes the panel's report. The full report is available on the academy's website, www.nasi.org. The Robert Wood Johnson Foundation provided the primary financial support for this project. Additional funding was provided by The California Endowment and the Joint Center for Political and Economic Studies.

Disparities in health care for racial and ethnic minorities and low-income persons pose a pressing national problem. This report of a study panel convened by the National Academy of Social Insurance examines Medicare's role in moving towards a solution. The panel concludes that Medicare is obligated to take the lead in reducing disparities—both for its beneficiaries and throughout the health system—and makes 17 recommendations to those who set policy for and administer the Medicare program.

Disparities are evident in the sources of health care, in the amount and type of care received, and in health outcomes. Hurricane Katrina in 2005 revealed that Louisiana essentially had a two-tier health system—one system for the insured population (including those with Medicare and Medicaid), and another serving a largely poor, minority population. At Charity Hospital, the hub of the health care safety net in New Orleans, nearly three-quarters of the patients were African American, and 85 percent had annual incomes of less than \$20,000. But not only Louisiana has two health care systems. Nationwide, black patients and white patients are to a large extent treated by different physicians, and the physicians treating black patients report facing greater difficulties in obtaining access to important clinical resources.

Summary Table Recommendations of the Study Panel on Medicare and Disparities

Quality of Clinical Care

Improve the ability of individual providers and the health care system to provide high-quality care to beneficiaries who are members of underserved racial and ethnic minorities.

- 1.1 Increase the focus of quality improvement programs on reducing disparities
- 1.2 Strengthen the capability of providers, medical groups, health care organizations, and the health system to improve quality and reduce disparities.
- 1.3 Structure incentives for quality in ways that will reduce—not exacerbate—disparities.
- 1.4 Ensure that beneficiaries have a primary provider of care.

Access to Care

Increase the access of underserved minority beneficiaries to health care by promoting programs that provide supplementary coverage, improving access to providers, and expanding educational and outreach activities.

- 2.1 Ensure that minority beneficiaries are enrolled in existing programs that supplement Medicare coverage.
- 2.2 Set deductibles and copayments to encourage the use of services that have the potential of reducing disparities in care.
- 2.3 Improve access to providers for minority beneficiaries.
- 2.4 Educate beneficiaries and their families about promoting good health and accessing health care services.

Education of Health Professionals

Educate health professionals to improve the health system's diversity and cultural competence.

- 3.1 Increase the number of minority providers, medical staff, and medical school faculty.
- 3.2 Encourage and enhance training in cultural competence for providers.
- 3.3 Ensure that all types of training promote reductions in disparities.

Capability and Practice of Institutions

Hold individual and institutional providers responsible for reducing racial and ethnic health disparities.

- 4.1 Collect the data necessary for assessing, monitoring, and targeting disparities.
- 4.2 Strengthen the role of accreditation organizations in reducing disparities.
- 4.3 Ensure that all providers comply with the guidelines for services to patients with limited English proficiency and the standards for providing culturally and linguistically appropriate services issued by the Department of Health and Human Services.

Administrative Priorities and Structure

Make the reduction of disparities a top priority and administrative focus at the Centers for Medicare & Medicaid Services (CMS).

- 5.1 Establish CMS performance goals for the reduction of racial and ethnic disparities among Medicare beneficiaries.
 - 5.2 Enhance the organizational structure of CMS to support the reduction of disparities.
 - 5.3 Address racial and ethnic disparities as a civil rights compliance issue.
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Disparities in access to health care and medical treatment have been documented again and again, notably in the Institute of Medicine's 2002 report *Unequal Treatment*. The 2005 *National Healthcare Disparities Report* finds that "disparities related to race, ethnicity, and socioeconomic status still pervade the American health care system." Even among Medicare beneficiaries, marked disparities persist in health care, although disparities in the use of health care services by race and income have diminished since Medicare's implementation.

Minorities also fall short of whites on many measures of health status. Blacks, for example, have a shorter life expectancy than whites, and blacks are more likely to have many chronic medical conditions. The life expectancy of a black male is 6.3 years less at birth than that of a white male and 2.0 years less at age 65. Former Surgeon General David Satcher has estimated that some 83,000 excess deaths could be prevented each year if the black-white mortality gap could be eliminated. Thirty percent of black Medicare beneficiaries live with diabetes, compared with 18 percent of white beneficiaries. Medicare cannot immediately close a gap in health status caused by a lifetime of disparate care.

Because of its dominant influence over the entire health care sector, Medicare has unique opportunities to, and responsibility for, reducing racial and ethnic health disparities. Along with its ability to improve the care provided to its 9 million minority beneficiaries,

Medicare's leverage as the largest purchaser and regulator of health care provides an ability to achieve reductions in disparities. As a social insurance program, Medicare has the responsibility to ensure that all those who have contributed to the program receive appropriate care on a fair and nondiscriminatory basis.

The panel's recommendations fall into five categories:

1. Improving the quality of clinical care,
2. Increasing access to care,
3. Educating health professionals to improve diversity and cultural competence,
4. Holding health care providers responsible for reducing disparities, and
5. Making the reduction of disparities a top administrative priority and focus.

In each of these areas, Medicare has tools that it can use to help reduce disparities. The summary table lists the recommendations, and the panel's report details both the recommendations and their rationale. Some of the recommendations would require legislation, but most could be implemented by the Centers for Medicare & Medicaid Services and the Department of Health and Human Services within their current statutory authority. Most of the recommendations would require additional Medicare spending—especially for program administration—and the panel urges the Congress to appropriate the necessary funds.

Also of interest from the National Academy of Social Insurance:

Medicare Brief No. 15, *Improving Medicare's Data on Race and Ethnicity*
by A. Marshall McBean, October 2006

Medicare Brief No. 14, *Medicare, the National Quality Infrastructure, and Health Disparities*
by Lawrence P. Casalino, October 2006

Medicare Brief No. 13, *Medicare Finances: Findings of the 2006 Trustees Report*
by Paul N. Van de Water and Joni Lavery, May 2006

Medicare Brief No. 11, *Medicare and Communities of Color*
by Reginald D. Williams II, November 2004

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