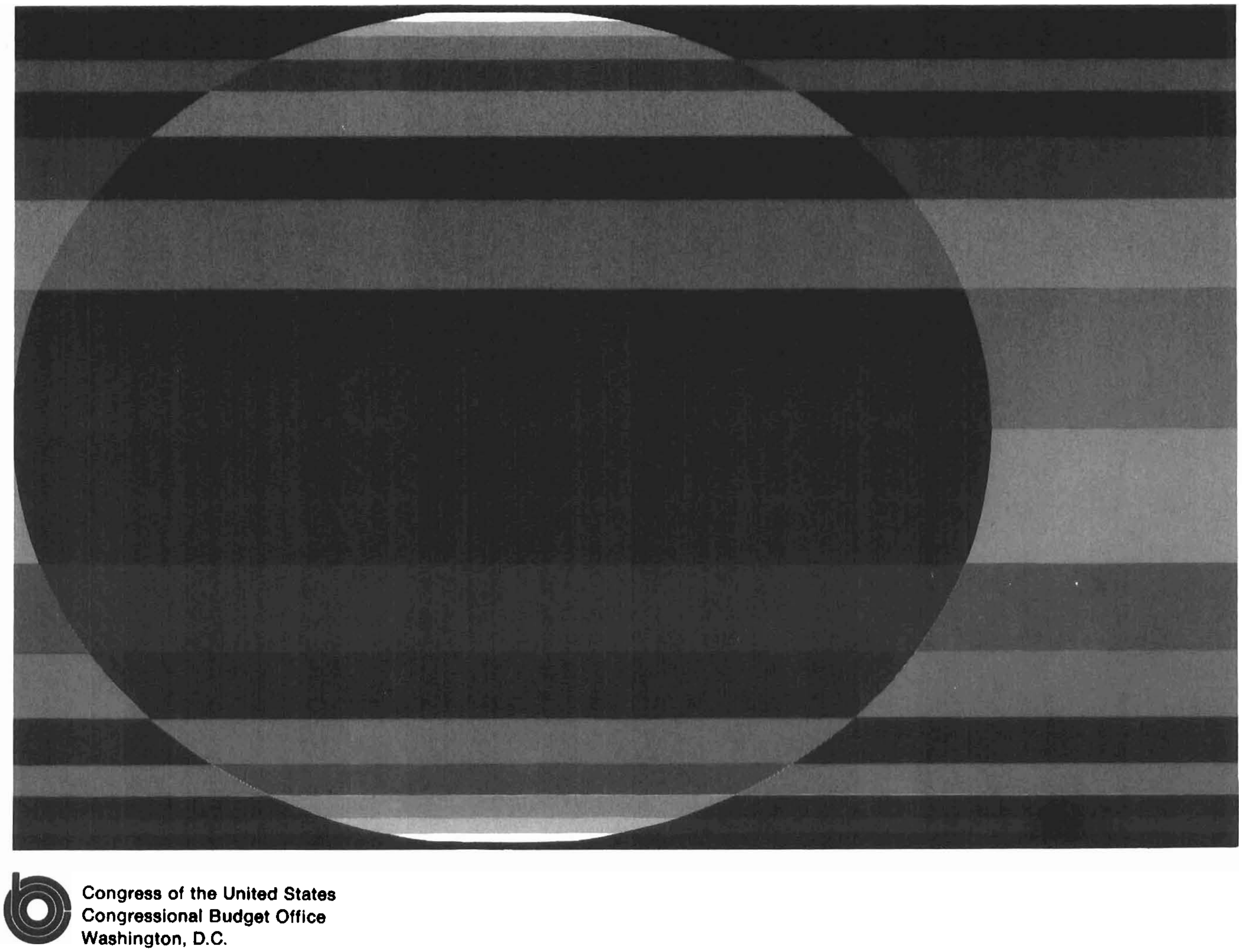
BACKGROUND PAPER

Health Differentials Between White and Nonwhite Americans

September 1977



Congress of the United States
Congressional Budget Office
Washington, D.C.

HEALTH DIFFERENTIALS BETWEEN WHITE AND NONWHITE AMERICANS

Congress of the United States
Congressional Budget Office

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NOTE

Throughout this paper, unless otherwise noted, the term white applies to Caucasians and to all persons of Hispanic heritage, whatever their racial background. This follows the method of counting used in most government programs. The term nonwhite includes blacks, American Indians, and Orientals.

PREFACE

Health Differentials Between White and Nonwhite Americans is part of a series of studies undertaken by the Congressional Budget Office to examine the causes of and possible remedies for racial inequalities. It was prepared at the request of Parren J. Mitchell, Chairman of the Task Force on Human Resources, and Louis Stokes, Chairman of the Task Force on Community and Physical Resources, House Budget Committee. Topics of the related papers will include inequalities in education and wealth.

This paper was prepared by Bonnie Lefkowitz of CBO's Division of Human Resources and Community Development, under the supervision of Robert D. Reischauer and Stanley Wallack. The author wishes to acknowledge the research assistance of Robert H. Meyer, Mark Chandler, and Matthew Stiefel and the helpful comments of David Allen, Laura Murphy, and Nathaniel Thomas. This author especially thanks the National Center for Health Services Research for providing much of the data on health status and utilization. The manuscript was edited by David Howell Jones and typed for publication by Toni Wright.

In keeping with CBO's mandate to provide nonpartisan and objective analysis, the paper makes no recommendations.

Alice M. Rivlin
Director

August 1977

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SUMMARY

The health of nonwhites is not as good as that of whites, yet nonwhites get less -- and possibly less effective -- health care than whites do. This disparity, the magnitude and effectiveness of federal efforts that could address it, and ways in which the situation could be improved, are discussed in this paper.

THE PROBLEM

Differentials in health status between whites and nonwhites persist, despite considerable recent progress in narrowing the gap. Nonwhites still experience nearly 50 percent more bed disability days, 70 percent higher infant mortality, and a life expectancy six years shorter than that of whites. Nonwhites are more likely than whites are to suffer from a number of specific conditions known to be improved by health care, which may indicate failure to receive needed prevention or treatment.

Some observers question whether more or better care can be effective when environment plays such a large role in determining health status. Past increases in the availability of care, however, can be related to improvement in the health of nonwhites. Infant mortality is particularly susceptible to increased access to care, that among nonwhites having been cut in half since the initiation of medicaid. Care may be needed for the relief of pain and suffering, moreover, even if it does not produce measurable improvement in health status. Thus, despite the significance of nonmedical factors, it is important to identify and correct differentials in health care received.

With respect to use of health care, whites make about 10 percent more visits to physicians on the average than do nonwhites. This is primarily because fewer nonwhites see a physician at all, which is in turn attributable to lack of a regular source of care. The proportions of whites and nonwhites hospitalized each year do not vary significantly, but nonwhites, especially those who are poor, tend to remain in the hospital longer because they are sicker.

So far as effectiveness is concerned, the care nonwhites receive is more likely to lack continuity and personal attention. Twice as many visits to physicians by nonwhites as by whites occur in institutions; when nonwhites do visit private physicians it may be those who specialize in high-volume, high-turnover medicaid practices. Finally, conditions affecting nonwhites disproportionately, such as alcohol and drug abuse, may be ignored or not treated appropriately.

FEDERAL EFFORTS

By far the largest federal health care efforts affecting racial differentials are the financing programs, medicare and medicaid. These programs pay for care provided eligible persons by the public and private sectors. Together, they made up about 80 percent of the $33.1 billion health budget administered by the U.S. Department of Health, Education, and Welfare (HEW) in 1976. Medicaid, the primary means of financing health care to the poor, served 24.4 million beneficiaries in 1976. It is a state-run program with federal guidelines and federal financial contributions. Because of varying state requirements, an estimated third of the nation's poor are not covered, and benefits vary greatly from state to state. Many of the states with the lowest coverage are in the South, where there are large nonwhite populations. In addition, benefits for those who do receive them are distributed quite unequally at state as well as national levels. In 1974, the national average expenditure per nonwhite beneficiary was $321 and per white beneficiary, $560 -- 75 percent higher.

Medicare, the federally funded and operated health insurance plan for the elderly and disabled, served about 24 million enrollees in 1976. Although, unlike those administered under medicaid, eligibility and benefits are uniform throughout the nation, the benefits of medicare are still distributed unequally among whites and nonwhites. One reason for the disparity is that the program requires all beneficiaries, regardless of income, to contribute an identical proportion of the cost of the services they receive. Thus, the cost-sharing provision is a disproportionate burden and a greater deterrent to care for the poor, more of whom are nonwhite.

A small proportion of the HEW health budget -- about 2 percent in 1976 -- is attributable to programs that attempt to influence the development and allocation of resources in the private sector. In the past, hospital construction programs were concentrated on expansion, mostly in middle-income areas. The National Health Planning and Resources Development Act of 1974 has greater, but unproven potential to channel resources to rural and inner-city areas where nonwhites are found. Federal aid for training in health professions was also concentrated on increasing supply in the past. Legislation passed in 1976 included the first major effort to increase the number of physicians specializing in primary care and to place new graduates in geographic areas where shortages exist.

A third area of federal activity affecting racial differences is delivery of health services, either directly or through projects financed by grants. Such programs accounted for about 6 percent of the HEW health budget in 1976. Because they control the organization of care, they can address more of the problems facing nonwhites than can financing or resource programs. Service delivery programs are relatively small in scope, however. Programs providing comprehensive medical services, such as community health centers, serve an estimated total of 3.7 million persons, a majority of them nonwhites or Hispanic. Programs providing mental-health and related services serve an estimated 2.2 million persons. The proportion of nonwhite beneficiaries ranges from a low of 12 percent in community mental-health centers to 36 percent in drug-abuse projects. With the exception of family planning, programs providing other services, such as rat control or treatment of venereal diseases, serve a majority of nonwhites.

APPROACHES TO IMPROVEMENT

In order to reduce white/nonwhite health differentials and better meet the needs of nonwhites, federal programs would have to address four types of problems: financial barriers to the receipt of health services; nonfinancial barriers, including lack of providers and discrimination against consumers; absence of continuity when services are provided; and insufficient emphasis on some conditions affecting nonwhites.

Some of the financial barriers in medicaid could be overcome by equalizing all benefits and levels of eligibility. Beyond this step, financial barriers in both medicare and medicaid could be addressed by ensuring that any sharing of costs is negligible for poor persons and that physicians do not bill patients for additional amounts. The monetary incentives available through financing programs may have limited success in dealing with other barriers to the receipt of care and the assurance of continuity of services, although enforcement of civil rights could be broadened and greater reimbursement could be provided for more comprehensive or prepaid services. Monetary incentives may not be specific enough to induce more emphasis on particular problems without adverse side effects.

Access to care for specific groups, including nonwhites and poor persons, could be made an explicit goal of programs concentrated on development of resources in and regulation of the private sector. Capital expenditures by health institutions that serve the inner city and poor rural areas and by those that provide comprehensive ambulatory care could be given priority. Present efforts to place new health professionals in areas where shortages exist could be strengthened by greater attention to the settings in which these professionals practice and, to some degree, by more vigorous affirmative action on the part of medical schools. A major question is whether regulation of existing health professionals -- telling them where to practice and whom to treat -- is a viable way of assuring access by nonwhites to the services of physicians.

Most of the programs that deliver health services already reach and serve nonwhites more effectively than do financing programs dependent on the private sector. Such programs could be expanded as a "resource of last resort" where neither financing nor regulatory efforts can guarantee access to and quality of care. The focus of some health-service delivery programs, such as community mental-health centers, on nonwhites and their problems could be improved.

CHAPTER I. PLAN OF THE PAPER

Despite considerable progress in narrowing the health gap between white and nonwhite Americans in the last 20 years, substantial differences persist. According to most indicators, nonwhites are less healthy than whites. Yet nonwhites see physicians somewhat less often and are less likely to have sources of regular care. They are hospitalized less often than whites but for longer periods. They continue to receive far less in benefits per person from the financing programs that constitute about 80 percent of the health budget of the Department of Health, Education, and Welfare (HEW). 1/ With few exceptions, other federal health programs are small in scope or have yet to produce a significant effect on the quantity or quality of health care received by nonwhites.

In this paper white/nonwhite health differentials and possible remedies are discussed in detail. In the first section, the basic problem is described: nonwhites are less healthy than whites, they get less care, and the care they do get may be less effective. The magnitude and effectiveness of federal programs addressing racial differentials in health care are reviewed in the second section. The third section is a discussion of short-term and long-term approaches to the problem.

1/ The health budget referred to is limited to HEW programs, as is the discussion throughout, and does not include health services provided by the Veterans Administration or the Department of Defense.

CHAPTER II. THE PROBLEM

Racial differences exist in summary measures of health status, and a number of specific conditions affect nonwhites disproportionately. Although the ability of more and better care to affect health status is limited by genetic and environmental factors, such care has helped to narrow racial gaps. Pain and suffering, moreover, must be relieved, regardless of the ultimate outcome. Thus, the fact that nonwhites continue to get less health care than whites, and the indications that the care they get is less effective, may be considered a major health problem. The economic costs of this problem can be seen in longer hospital stays because nonwhites tend to be sicker when they do receive care, in decreased ability to work and increased dependency upon welfare, and in the persistence of conditions that block full educational and emotional development.

DIFFERENTIALS IN HEALTH STATUS

Summary measures of health status that subsume many conditions include number of bed disability days and rates of life expectancy, infant mortality, and death. Table 1 shows that in 1974 or 1975, according to each of these measures, nonwhites were less healthy than whites. 1/

Bed disability days are also shown by level of family income within each racial group and individually for persons over 65. Both whites and nonwhites with family incomes of less than $5,000 had more illness, but poor nonwhites had the most. The white/nonwhite differential was largest for those with family incomes of less than $5,000 but nearly as great for those with family incomes between $5,000 and $10,000. This suggests that problems exist for near-poor nonwhites as well as for those with incomes below the official poverty

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1/ Figures from National Center for Health Statistics, unpublished data from the Health Interview Survey, 1975, and National Center for Health Statistics, Advance Report, Final Mortality Statistics, 1974, Monthly Vital Statistics Report, 24:11, February 3, 1976, Supplement.

Table 1. SELECTED MEASURES OF HEALTH STATUS, BY RACE AND INCOME

	White	Nonwhite
Number of Bed Disability Days Per Person, 1975 a/		
All incomes	6.2	8.8
less than $5,000	10.9	13.5
$5,000-$10,000	7.2	8.8
greater than $10,000	4.9	4.8
Number of Bed Disability Days Per Person Over 65, 1975 a/		
All incomes	11.7	24.6
less than $5,000	13.8	29.6
$5,000-$10,000	10.2	19.5
greater than $10,000	9.9	--
Deaths Under 1 Year Per 1,000 Live Births, 1974 b/		
All incomes	14.8	24.9
Average Years of Life Expectancy at Birth, 1974 b/		
All incomes	72.7	67.0
Age-Adjusted Deaths c/ Per 1,000 Persons, 1974 b/	6.4	9.0

a/ National Center for Health Statistics, unpublished data from the Health Interview Survey, 1975.

b/ National Center for Health Statistics, Advance Report, Final Mortality Statistics, 1974. Monthly Vital Statistics Report, 24:11:4-6, February 3, 1976, Supplement.

c/ If death rates for recent years are not age-adjusted, they are slightly higher for whites than for nonwhites. This reflects recent improvements in health status plus sufficient nonwhite deaths in the past to bias their average age downward, resulting in fewer deaths today.

level. Interestingly, there was very little racial difference for those with incomes of more than $10,000. Bed disability days for persons over 65 show the same pattern but with much greater racial differences for those with incomes under $10,000.

Data on specific conditions indicate not only that some problems are more prevalent among nonwhites but also that nonwhites fail to receive necessary care. For example, a nonwhite is more than three times as likely to die of hypertension as is a white of the same age group. 2/ He or she is also more likely to die from other conditions that can result from untreated hypertension: 60 percent more likely to die of cerebrovascular disease and almost four times as likely to die of hypertensive heart disease. Nonwhites are also twice as likely to die from diabetes and four times as likely to die of chronic kidney disease, other conditions requiring continued treatment that are more prevalent among nonwhites.

A nonwhite is 60 percent more likely to die of influenza or pneumonia and five times as likely to die of tuberculosis -- the latter a disease with causes related to poverty but which has presumably been "conquered" through modern drug therapy. He or she is nearly twice as likely to die of cirrhosis of the liver and more than seven times as likely to be a victim of homicide -- both of which are indicative of social or psychological problems. Finally, a nonwhite woman is five times as likely to die of complications in childbirth than is a white woman; this fact, combined with the higher infant-mortality rate for nonwhites, suggests a continuing lack of prenatal care.

There are a number of conditions more prevalent among nonwhites than among whites whose effects are not reflected in death rates. These include nearly three times the proportion of teenagers and women with low or marginal incomes at risk of unintended pregnancies, 3/

2/ This and subsequent age-adjusted death rates from National Center for Health Statistics, Advance Report, Final Mortality Statistics, 1974, op. cit., and from unpublished data, DVS-SRB.

3/ Derived from the Alan Guttmacher Institute, Data and Analyses for 1974 Revision of DHEW Five-Year Plan for Family Planning Services, HSA Contract No. 105-74-193, May 1974.

nearly four times the amount of narcotic drug abuse, 4/ a 40 percent greater likelihood of psychiatric hospitalization, 5/ and twice as many speech impairments and 60 percent more severe vision impairments. 6/

Does More and Better Health Care Improve Health Status?

Before going on to discuss the quantity and quality of health care received by nonwhites, one might ask whether more and better care will, in fact, improve their health. Many factors other than care affect health status. Poverty contributes to problems of housing, sanitation, and nutrition which have strong negative effects on health. Discrimination in education and employment keeps economic status low and also contributes to lack of knowledge about symptoms of disease or services available, a higher proportion of unsafe jobs, and psychological problems. In addition, nonwhites possess both strengths (for examples, less likelihood of skin cancer, arthritis, and ischemic heart disease) and weaknesses (greater likelihood of hypertension, diabetes, and sickle cell anemia) that may be related to genetic as well as environmental factors.

Particularly in recent years, some researchers have claimed that in view of these other factors, the argument for improvements in health care is less compelling. There are two kinds of counterarguments. First, while sizable gaps remain, progress in narrowing racial differences has occurred and can be related, at least in part, to increased availability of care. Table 2 shows reductions in death rates and infant mortality and increases in life expectancy for whites

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4/ Nonwhites represented roughly 45 percent of narcotic drug "mentions" in Project DAWN III: Drug Abuse Warning Network, Phase III Report, April 1974-April 1975, Drug Enforcement Administration and National Institute of Drug Abuse, Bureau of Narcotics and Dangerous Drugs Contract No. 72-47.

5/ National Institute of Mental Health, Utilization of Mental Health Facilities, 1971, DHEW Publication No. NIH-74-657, 1973.

6/ Health Resources Administration, Prevalence of Selected Impairment, United States, 1971, Data from the National Health Survey, Series 10, Number 99, DHEW Publication No. HRA-75-1526, 1975.

and nonwhites between 1950 and 1975. 7/ Death rates and life expectancy are less amenable to health care alone; thus they show about the same gains for nonwhites both before and after 1965, when medicare for the elderly and medicaid for many poor persons were initiated. The infant-mortality rate, which is particularly susceptible to increased availability of care, decreased for nonwhites less than 10 percent between 1950 and 1965 but was cut almost in half between 1965 and 1975.

Table 2. TRENDS IN SELECTED HEALTH STATUS INDICATORS, BY RACE, 1950-1975

	Age-Adjusted Deaths Per 1,000 Persons a/			Infant Mortality Per 1,000 Live Births b/			Life Expectancy at Birth c/ d/		
Year	White	Nonwhite	Ratio of Nonwhite to White	White	Nonwhite	Ratio of Nonwhite to White	White	Nonwhite	Ratio of Nonwhite to White
1950	8.0	12.3	1.54	26.8	44.5	1.66	69.1	60.8	0.88
1960	7.3	10.5	1.44	22.9	43.2	1.89	70.6	63.6	0.90
1965	7.1	10.3	1.45	21.5	40.3	1.87	71.0	64.1	0.90
1970	6.8	9.8	1.44	17.8	30.9	1.74	71.7	65.3	0.91
1974-1975	6.4	9.0	1.41	14.8	24.9	1.68	72.7	67.0	0.92

a/ National Center for Health Statistics, Unpublished data, DVS-SRB, 1976.

b/ Monthly Vital Statistics Report, 24:13, June 30, 1976. op. cit.

c/ Monthly Vital Statistics Report, 24:11, February 3, 1976, Supplement, op. cit.

d/ National Center for Health Statistics: Life Tables, Vital Statistics of the United States, 1973, Volume II, Section 5.

7/ Figures from various Vital Statistics publications and from unpublished data, National Center for Health Statistics. See Table 2 for specific sources.

Second, there are reasons for providing care even where major improvements in health status will not result. Health care may be required by those with genetically related conditions although its margin of effectiveness is greatly reduced. It may be an interim solution to problems related to external factors because fundamental economic and environmental reforms, potentially more effective, are not readily available. 8/ Finally, it may be needed to relieve pain and anxiety in the significant number of patients who seek care for noncontagious acute illnesses.

DIFFERENTIALS IN CARE RECEIVED

Utilization of health care is illustrated by data on the services of physicians (including services received in clnics, hospital outpatient departments and emergency rooms, and home and phone consultations), and hospitalization. While it is more difficult to demonstrate the degree of effectiveness, some assumptions can be made from data on where and how care is received and from the evidence that many conditions affecting nonwhites disproportionately go untreated.

Utilization

Table 3 presents data from the national Health Interview Survey for 1975 showing that whites averaged 5.1 visits to a physician per person, while nonwhites averaged 4.7. This difference was attributable more to the proportion of the population who saw a physician at all during the year than to the number of visits by those who did see a physician. 9/ When data for varying levels of family income within each racial group were examined, the largest difference between whites and nonwhites who saw a physician occurred when the level of

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8/ Irving Leveson, "The Challenge of Health Services for the Poor," Annals of the American Academy of Political and Social Science, 399:22-29 (January 1972).

9/ National Center for Health Statistics, unpublished data from the Health Interview Survey, 1975.

Table 3. SELECTED MEASURES OF HEALTH CARE UTILIZATION, BY RACE AND FAMILY INCOME, 1975 a/

	White	Nonwhite
Number of Visits to a Physician per Person per Year		
All incomes	5.1	4.7
less than $5,000	6.1	5.6
$5,000-$10,000	5.2	4.9
greater than $10,000	4.9	3.8
Percentage of Population Who Saw a Physician During Year		
All incomes	75.7%	71.5%
less than $5,000	76.4	73.0
$5,000-$10,000	74.3	69.7
greater than $10,000	76.7	74.1
Number of Visits to a Physician per Person Who Saw a Physician		
All incomes	6.7	6.5
less than $5,000	8.0	7.7
$5,000-$10,000	7.0	7.0
greater than $10,000	6.4	5.2
Number of Short-Term Hospital Discharges per 1,000 Persons per Year		
All incomes	141.5	137.4
less than $5,000	201.7	183.0
$5,000-$10,000	165.6	135.8
greater than $10,000	120.0	107.6
Average Length of Stay in Short-Term Hospitals		
All incomes	7.9	8.9
less than $5,000	10.1	10.7
$5,000-$10,000	8.0	7.8
greater than $10,000	6.8	7.4

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a/ National Center for Health Statistics, unpublished data from the Health Interview Survey, 1975.

income was between $5,000 and $10,000. 10/ This may be related to the lower private insurance holdings of nonwhites who are neither poor nor elderly and are therefore unlikely to receive public payments for health care.

With regard to hospitalization, Table 3 also shows that whites in the 1975 national Health Interview Survey had only slightly more discharges from hospitals than nonwhites had -- 142 per 1,000 persons compared with 137. Data by family income within each racial group indicated a much higher rate of discharge for both low-income whites, who averaged 202 discharges per 1,000 persons, and low-income nonwhites, who averaged 183. Average length of stay for those who were hospitalized was 7.9 days for whites and 8.9 days for nonwhites. In addition, the length of stay was 10.7 days for low-income nonwhites, longer than for any other group, regardless of race. This is generally accepted as evidence that when nonwhites, particularly poor nonwhites, do reach the hospital their illnesses have progressed further, and they require more care.

Thus, present utilization of health care appears to be inequitable because it is influenced by factors such as race and income. But what happens when each of these factors is isolated, also adjusting for such indicators as illness, age, and sex?

Data from a 1970 household health survey have been analyzed in this way and the relative importance of each factor in determining utilization has been estimated. Table 4 summarizes the pattern that emerged for the proportion of the population who saw a physician in the survey year (physician contact), the number of visits to a physician for those who saw a physician, the number of hospital

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10/ According to unpublished data from the 1974 Health Interview Survey, 72 percent of whites and 59 percent of nonwhites under the age of 65, with family incomes between $5,000 and $10,000, had private hospital insurance. Far fewer are believed to be covered for visits to physicians. This may be because near-poor nonwhites are less likely than near-poor whites to work at jobs where insurance is provided.

Table 4. DETERMINANTS OF UTILIZATION OF HEALTH CARE AND EXPLANATORY FACTORS [a]

1. Physician Contact

Major determinant: Illness perceived by patient.

Importance of factors suggesting inequity:

Race: Nonwhites were significantly less likely to see a physician at all; this was mostly explained by lack of a regular source of care.

Income: Little variance.

Location: Rural farm families were less likely to see a physician; this was explained by less illness.

2. Visits to Physicians by Those Who Saw a Physician

Major determinant: Illness perceived by physician.

Importance of factors suggesting inequity:

Race: Little variance.

Income: Low-income families had more visits; this was explained by greater age and more illness.

Location: Little variance.

3. Hospital Admissions

Major determinant: Illness.

Importance of factors suggesting inequity:

Race: Nonwhites were slightly less likely to enter the hospital; this was mostly explained by lesser age.

Income: Low-income families were more likely to enter the hospital; this was explained by higher prevalence of illness.

Location: Inner city and rural farm families were less likely to enter the hospital; this was unexplained.

4. Days in the Hospital for Those Admitted to the Hospital

Major determinant: Illness and age.

Importance of factors suggesting inequity:

Race: There appears to be little variance, but nonwhites spent somewhat fewer days in the hospital than would have been indicated by their higher prevalence of illness.

Income: Low-income families appear to spend considerably more days in hospital, but their stays have been indicated by their higher prevalence of illness.

Location: Rural farm families spent more days in the hospital; this was explained by greater age.

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[a] Andersen, Ronald, "Health Service Distribution and Equity," in *Equity in Health Services: Empirical Analyses in Health Policy*, edited by Ronald Andersen, Joanna Kravits, and O.W. Anderson (Cambridge, Massachusetts: Ballinger Publishing Company, 1975), pp. 9-32.

admissions, and the number of days in the hospital for those admitted. 11/ For all measures of volume and some measures of contact, much of the apparent variance in utilization by race and income could be explained by factors of age and illness. The most notable exception was the variance in physician contact by race, which was also present in the 1974 Health Interview Survey. This variance was attributable to still another "inequity" factor, lack of a regular source of care, partly because physicians were not located in nonwhite areas. Inner city and rural farm families, many of whom are nonwhite, were also less likely to be hospitalized. Income alone was of minimal importance in determining utilization.

Effectiveness

Table 5 provides data from the 1975 national Health Interview Survey on source of visits to physicians. 12/ Here racial differences were far more important than income. The proportion of visits to institutions (clinics, hospital outpatient departments, emergency rooms) rather than to private physicians is highest for nonwhites with family incomes of less than $5,000 and next highest for nonwhites with family incomes between $5,000 and $10,000. Low-income whites were more likely to receive care from private physicians than were any nonwhites, regardless of income. This is significant because care received from hospital outpatient departments and emergency rooms, in particular, is believed to be fragmented and episodic.

In addition, even where poor nonwhites do receive care from private physicians, it may lack continuity. Evidence from some states and localities indicates that a small number of physicians is usually responsible for a large proportion of the medicaid billings in inner-city areas populated by nonwhites. For example, in New York City, 10 percent of physicians participating in medicaid were responsible for more than 60 percent of the billings during the first half of

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11/ Ronald Andersen, "Health Service Distribution and Equity," in Equity in Health Services: Empirical Analyses in Health Policy, edited by Ronald Andersen, Joanna Kravits, and O. W. Anderson (Cambridge, Massachusetts: Ballinger Publishing Company, 1975), pp. 9-32.

12/ National Center for Health Statistics, unpublished data from the Health Interview Survey, 1975.

Table 5. PERCENTAGE DISTRIBUTION OF SOURCES OF VISITS TO PHYSICIANS, BY RACE AND FAMILY INCOME, 1974 a/

	White	Nonwhite
Physician's Office		
All incomes	69.0	60.6
less than $5,000	66.8	56.3
$5,000-$10,000	67.0	61.6
greater than $10,000	69.8	67.4
Patient's Home		
All incomes	0.8	--
less than $5,000	1.5	--
$5,000-$10,000	0.9	--
greater than $10,000	0,6	--
Telephone		
All incomes	13.3	6.9
less than $5,000	10.4	5.2
$5,000-$10,000	11.8	6.0
greater than $10,000	14.9	10.3
Hospital OPD or Emergency Room		
All incomes	11.7	22.0
less than $5,000	14.6	24.2
$5,000-$10,000	14.6	22.3
greater than $10,000	10.0	16.6
Other b/		
All incomes	5.2	10.5
less than $5,000	6.7	14.3
$5,000-$10,000	5.7	10.1
greater than $10,000	4.7	5.6

a/ National Center for Health Statistics, unpublished data from the Health Interview Survey, 1975.

b/ Other includes free-standing clinics, some of which are government-sponsored health centers.

1975. These physicians may practice in high-volume, high-turnover settings. They are often not certified as specialists. 13/ A large proportion are believed to be foreign-trained and to lack hospital-admitting privileges. The latter makes it particularly difficult for them to coordinate inpatient and outpatient care.

Many of the same circumstances that tend to make the care of nonwhites uncoordinated also suggest, if not lower quality, absence of the personal attention and health counseling that might help to overcome problems related to life style or lack of knowledge. Finally, conditions affecting nonwhites in particular may be ignored or not treated appropriately. Among the major complaints is the fact that many mental-health professionals are not sensitive to or interested in the problems of nonwhites. One author has described a tendency of community mental-health professionals to misdiagnose blacks' conditions and to classify blacks in groups with a worse prognosis. 14/ Other problems may include a lack of interest among health professionals in alcoholism or drug abuse, and a lack of emphasis on detection and treatment of such conditions as hypertension.

13/ Information on the medicaid program in New York City from Medical Assistance Program, New York City Department of Health. Information on medicaid programs in New Jersey, Indiana, and Connecticut from Applied Management Sciences, A Study of Selected State Medicaid Programs: An Analysis of Utilization, Cost and Quality, National Center for Health Services Research, Health Resources Administration, Department of Health, Education, and Welfare, Contract No. HRA-106-74-145, June 16, 1975.

14/ Richard Shapiro, "Discrimination and Community Mental Health: Challenging Institutional Racism," Civil Rights Digest, 8:192-23, Fall 1975.

CHAPTER III. FEDERAL EFFORTS -- HOW BIG AND HOW SUCCESSFUL?

As we have seen, four kinds of problems are responsible for differences in health care between races. First, a disproportionate number of nonwhites are poor and face financial barriers to care. Income alone is a decreasing problem, but poor nonwhites experience the most inequity. Second, nonwhites also face nonfinancial barriers which may include shortages of health manpower or facilities in areas where they live and discrimination in areas where providers do exist. Third, the services available to nonwhites tend to be less continuous. Both the second and third problems diminish access to a regular source of care, thus discouraging contact with physicians. Fourth, there may be insufficient emphasis on conditions affecting nonwhites. Together with lack of continuity, this means that even when nonwhites receive care, it may not meet their needs as effectively as it should.

The magnitude and effectiveness of federal programs in addressing the four problem areas listed above will be reviewed in this section. Federal efforts to provide health care include financing programs such as medicare and medicaid, which pay for care provided to eligible persons by the public and private sectors; resource programs, which develop and sometimes regulate health facilities and manpower; and health-services programs, established to deal with specific conditions or to deliver comprehensive care to target populations.

FINANCING PROGRAMS

Together, medicare and medicaid accounted for $26.4 billion of a $33.1 billion HEW health budget in fiscal 1976. 1/ Since their inceptions in 1965, these programs have done much to increase access to care for the elderly and poor, and are probably responsible for

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1/ Figures for medicare from U.S. Office of Management and Budget, The Budget of the United States Government, Fiscal Year 1978, Appendix. Figures for medicaid from HEW, Social and Rehabilitation Services, Medicaid Statistics, Fiscal Year 1976, NCSS Report B-5, March 1977.

the declining importance of income as a determinant of utilization. 2/ Yet because they address themselves almost exclusively to patients' ability to pay, they perpetuate many other inequities.

Medicaid

Medicaid, the primary vehicle for financing health care to the poor, is a state-run program with federal guidelines and financing contributions. States set their own income cutoffs for eligibility, often below the official poverty level. Single adults and, in some states, male-headed families, are not eligible at all. An estimated third of the nation's poor, many of them in southern states with large nonwhite populations, remain uncovered. 3/ In addition, benefits for those who are eligible vary greatly from state to state and again are lower in the South. Thus racial inequity in the medicaid program results in part from the fact that financial barriers to care are not overcome. Unequal distribution of funds to beneficiaries, however, within states where the same eligibility requirements and benefits apply to whites and nonwhites alike suggest that nonfinancial barriers are a more significant problem.

For the 24.4 million beneficiaries in whose behalf the program paid claims in fiscal 1976, expenditures totaled $15.5 billion, $8.6 billion of which was borne by the federal government. 4/ These funds have been and continue to be distributed quite unequally with regard to race. In 1969, according to figures from 24 states, an average sum of $213 was expended for each nonwhite beneficiary, while $375 was expended for each white beneficiary -- 75 percent more. 5/

2/ Karen Davis, "Medicaid Benefits and Utilization of Medical Services by the Poor," Inquiry, 13:2:122-135, June 1976.

3/ If turnover of the eligible population is counted, the proportion of poor persons not covered at any given time may be higher. See Karen Davis, "Achievements and Problems of Medicaid," Public Health Reports, 91:4:309-316, July-August 1976.

4/ U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, NCSS Report B-5, op. cit.

5/ Karen Davis, "Medicaid Payments and Utilization of Medical Services by the Poor," op. cit.

Table 6 provides similar figures by region for 1974, the most recent year for which data have been tabulated. Expenditures per nonwhite beneficiary averaged $321 and those per white beneficiary $560 -- still 75 percent more. 6/ It should be noted that the 1974 figures represent 42 of 50 states, but only half of all recipients of medicaid, since some of the largest states, including New York and California, did not report benefits by race. The racial differences were substantial in all but one of the 10 regions, however, and, within those regions, for a great majority of the states.

While racial tabulations are not available by age, a substantial portion of the difference in expenditures per beneficiary may be attributable to elderly persons in nursing homes. The expenditures for such beneficiaries, who are overwhelmingly white, tend to be much higher than expenditures for persons receiving acute hospital and professional care. Expenditures for patients in nursing homes accounted for more than 35 percent of medicaid payments in 1974.

Whatever the age of the beneficiaries, there are four types of nonfinancial barriers to care that medicaid does not appear to overcome.

First, medicaid does not address shortages of physicians or facilities in rural farm areas or the inner city, where nonwhites reside. Second, discrimination takes the form of refusal to serve medicaid patients. The percentage of nonfederal physicians who did serve medicaid patients in 1974 ranged from 30 in Florida and 36 in the District of Columbia to 97 in West Virginia; the nationwide average was 51 percent. 7/ It was noted earlier that nonparticipation of physicians is most likely to occur in inner-city areas. While hospitals may not legally refuse medicaid patients and still receive other federal funds, requirements that patients be admitted by a physician with staff privileges (when nonwhite medicaid patients are less likely to have access to such a physician) produce the same effect.

6/ Data tabulated by National Center for Social Statistics, Social and Rehabilitation Service, Department of Health, Education, and Welfare.

7/ Figures compiled by Medical Services Administration, Social and Rehabilitation Service, Department of Health, Education, and Welfare. They are reported by states whose definitions of participants may vary and therefore are not completely reliable.

Table 6. AVERAGE MEDICAID PAYMENT PER BENEFICIARY, BY RACE AND REGION, FISCAL YEAR 1974 a/

Region	Average Payment per White Beneficiary	Average Payment per Nonwhite Beneficiary
TOTAL	$560	$321
I. Connecticut, Maine, New Hampshire (missing Vermont, Massachusetts, Rhode Island)	641	377
II. New Jersey (missing New York)	643	385
III. Delaware, D.C., Maryland, Pennsylvania, Virginia (missing West Virginia)	351	356
IV. Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	451	226
V. Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	717	393
VI. Arkansas, Louisiana, New Mexico, Oklahoma, Texas	619	302
VII. Iowa, Kansas, Missouri, Nebraska	430	261
VIII. Montana, North Dakota, South Dakota, Utah (missing Colorado, Wyoming) b/	679	261
IX. Hawaii, Nevada (missing California)	567	379
X. Alaska, Idaho, Oregon, Washington	465	302

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a/ Data tabulated by National Center for Social Statistics, Social and Rehabilitation Service, Department of Health, Education, and Welfare.

b/ Arizona has no medicaid program.

Third, there is some indication of racial discrimination. With regard to physicians, for whom Title VI of the Civil Rights Act (forbidding discrimination in federal programs) is not actively enforced, such indications are anecdotal and difficult to document. 8/ Legally acceptable evidence of discrimination does exist with respect to nursing homes. In 1974 nonwhites represented 5 percent of all patients in nursing homes, although 9 percent of all persons over 65 are nonwhite and elderly nonwhites average more than twice as many bed disability days as do elderly whites. By comparison, nonwhite patients in acute-care hospitals were somewhat overrepresented in relation to the proportion of the general population that they represent. 9/ In part, the lower proportion of nonwhites in nursing homes may be accounted for by the fact that more are cared for by relatives. Although definitive evidence does not exist, however, there are believed to be disproportionate numbers of nonwhites placed inappropriately in institutions such as public mental hospitals when nursing home care is indicated instead.

Fourth, medicaid has not been successful at overcoming the barrier to care posed by lack of knowledge and fear of discrimination on the part of potential users. The federal government's major attempt to increase utilization of primary care through the medicaid system -- the Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT) for children under 21 -- after seven years of existence has succeeded in reaching annually only 15 percent of those eligible. One reason is that states are reluctant to seek greater utilization when they must pay part of the additional cost. 10/ Another is that outreach and case management are provided mainly by notices mailed from welfare departments, since most medicaid programs do not employ community liaison workers.

8/ For example, see reports of waiting rooms segregated by race in U.S. House of Representatives Committee on the Judiciary, Subcommittee on Civil Rights and Constitutional Rights: Title VI Enforcement in Medicare and Medicaid Programs, 1973, p. 74.

9/ Figures from U.S. Census, 1975, and National Center for Health Statistics: Health, United States, 1975, DHEW Publication No. HRA 76-1232, 1975.

10/ U.S. Congressional Budget Office, "Prospects for Meeting Health Care Needs of Children Eligible for Medicaid Under EPSDT," in Working Papers on Major Budget and Program Issues in Selected Health Programs, Committee on the Budget, U.S. House of Representatives, December 10, 1976.

Besides its limited ability to overcome barriers to care for many nonwhites, medicaid exerts little or no influence on the organization or types of services available. In fact, the dominance of fee-for-service medicaid payments at lower than market rates encourages the kind of high-volume, high-turnover practice described earlier. This perpetuates fragmented and episodic care.

Medicare

Medicare, the federally funded and operated health insurance plan for the elderly and disabled, is unlike medicaid in that the services covered are uniform throughout the nation. Hospital insurance covers 24.5 million enrollees, including approximately 95 percent of all elderly persons. Supplementary medical insurance covers 24.0 million persons who pay minimal monthly premiums, or, if they are poor, have their states pay the premiums for them.

In fiscal 1976, medicare paid $12.6 billion in behalf of those enrolled in its hospital insurance plan and $5.2 billion in behalf of those enrolled in its supplementary medical insurance plan for a total of $17.8 billion. 11/ Although medicare theoretically treats everyone the same, its benefits, like those of medicaid, have been distributed unequally between whites and nonwhites. In 1968 medicare payments per nonwhite enrollee averaged $195 while payments per white enrollee averaged $273 -- 40 percent more. 12/ The white/nonwhite disparity was much smaller, however, when payments per beneficiary were calculated. This suggests that whether or not an enrollee used the program at all was more important than the amount of care received by those who did use the program.

One reason for the disparity is that the program requires all beneficiaries, regardless of income, to contribute an identical proportion of the cost of the services they receive. This places a disproportionate burden on the poor and is a greater deterrent to their care. Further, while few physicians refuse all medicare patients, many will not limit their bills to the "assigned" rate. They may bill patients for additional amounts, thereby posing another financial barrier.

11/ U.S. Office of Management and Budget, op. cit.

12/ Karen Davis, "Equal Treatment and Unequal Benefits: The Medicare Program," Milbank Memorial Fund Quarterly, 53(4):449-488 (Fall 1975). Later figures are not available but the disparity in benefits is believed to have continued.

Like medicaid, medicare does little to lower nonfinancial barriers or to influence organization of care or type of services offered. Its "usual and customary" reimbursement rates for specific regions may actually reinforce maldistribution of resources. As with medicaid, there are suggestions of racial discrimination in nursing homes. Finally, nonwhites receive less expensive care than do whites, for two reasons. First, there are disproportionate numbers of elderly nonwhites in the South, where prices are lowest. Second, nonwhites are less likely to receive care from specialists. Both factors widen the gap in the dollar amounts of benefits received by the two groups, but that fact is not necessarily indicative of a disparity in the quality of the care received.

RESOURCE PROGRAMS

Health planning, facility development, and manpower programs attempting to influence allocation of resources throughout the private sector account for a small proportion of the HEW health budget -- less than $750 million in fiscal year 1976. The scope of such programs extends across the entire health system, however. Thus, they can potentially affect the availability of care and, to a lesser degree, the type of services offered to nonwhites. These resource programs probably exacerbated inequities in the past and have only recently begun to consider factors relevant to needs of nonwhites.

Planning and Facility Development

Federal involvement with the development of health facilities began with enactment of the Hill-Burton program to build hospitals in 1946. [13] By 1971, Hill-Burton had contributed to the construction of more than 470,000 inpatient beds, an estimated 73 percent of them in communities with populations less than 100,000. More than 50 percent of the funds went to hospitals in middle-income counties -- those in which the median family income in 1960 was between $5,000 and $7,000. [14]

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[13] Since the advent of medicare and medicaid, expansion of hospitals has also been encouraged by inclusion of depreciation allowances in reimbursement rates.

[14] Judith R. Lave and Lester Lave, The Hospital Construction Act: An Evaluation of the Hill-Burton Program, 1948-1973 (Washington, D.C.: American Enterprise Institute, 1974).

A separate federal program was initiated in 1966 to establish statewide and areawide comprehensive health-planning agencies. A principal tenet of this program was participation by consumers, including, in areas where they resided, some nonwhites. But while the health-planning agencies may have raised the consciousness of consumers, they had very little power to implement decisions.

In 1974, primarily in response to claims that many areas now had too many hospital beds, the Hill-Burton program, already vastly reduced, was subsumed in a new health-planning and resource-development effort. 15/ This time, the planning network was tied to mandatory state authority to control the supply of new facilities. Although federal planning guidelines have not yet been issued, some of the more sophisticated agencies have tried to stop the flight of existing hospitals from poor and inner-city areas and to make improved inner-city or community services a condition of approval of new construction. 16/ This does not mean that when the new program is fully implemented, all agencies will be willing or able to do the same.

Manpower

Federal involvement in health manpower development began in 1963 with special programs to aid both schools and students of health professions. For years, these efforts, dominated by fears of a shortage of doctors, were concentrated on the training of more professionals. While the supply of such professionals increased substantially, geographic maldistribution (not enough doctors in public institutions or rural-farm and inner-city areas, where nonwhites tend to live) and overspecialization (not enough providers of primary care, which nonwhites lack the most) persisted. 17/ In fact, federal funding priorities probably increased the proportion of research-oriented physicians who would provide little or no community care.

15/ Public Law 93-641.

16/ These examples are drawn from plans and criteria of the New York City and Central Maryland (Baltimore City and surrounding counties) Health Systems Agencies.

17/ U.S. Congressional Budget Office, The Role of Aid to Medical, Osteopathic and Dental Students in a New Health Manpower Policy. Staff Working Paper, August 10, 1976.

Legislation passed in 1976 included the first major effort to affect the type and location of practice after graduation. It requires schools to ensure that large proportions of residents are trained in primary care, authorizes 15,000 to 20,000 all-expense scholarships in exchange for service in areas where shortages exist, and expands the National Health Service Corps as a vehicle for placement of obligated graduates. It also provides first-year scholarships for disadvantaged students and gives recipients of such aid priority in receiving shortage-area scholarships subsequently. Thus levels of funding for both kinds of scholarships will determine how many graduates go to shortage areas and who those graduates are. 18/

The federal government has also supported recruitment and training of more nonwhite health professionals since 1968. Nonwhites are believed to be more sensitive to nonwhite patients and their particular problems; they may also be more likely to serve in shortage areas, although this has not been demonstrated conclusively. The proportion of medical students belonging to minorities has in fact increased from 3.1 percent in 1969 to 8.1 percent in 1975, but the percentage has stabilized in the last two years. 19/ In addition, it will take a good many more years before these increases among students have a substantial impact on the proportion of minority physicians in practice. In 1970, for example, only 2.2 percent of all U.S. physicians were black. 20/

Other recent efforts to address shortages include federal support for training paramedical personnel and nurse practitioners to perform some of a doctor's functions. Aims of this program have been blocked, in part, by the fact that the financing programs rarely reimburse for the services of these mid-level health professionals.

18/ Public Law 94-484.

19/ Figures include Mexican-Americans and Puerto Ricans but exclude Orientals. Michael Koleda and John Craig, New Realities in Medical School Finance, 1976-80 (Washington, D.C.: National Planning Association, Center for Health Policy Studies, July 1976).

20/ Health Resources Administration, Bureau of Health Manpower, Minorities and Women in the Health Field, DHEW Publication No. HRA-76-22, September 1975.

Health Service Programs

Programs that provide specific services or comprehensive care to target populations -- primarily poor or medically underserved groups -- accounted for roughly $2.1 billion of the HEW health budget in fiscal 1976. [21] Because they often establish and control the mechanism through which services are delivered, such programs are able to address all of the problems contributing to racial inequity in health care. Some do so with a high degree of effectiveness. Funding for the health service programs is quite limited, however, enabling them to serve only a small proportion of the target populations envisioned by those who planned them. In addition, many programs experience difficulty in obtaining reimbursement from medicare and medicaid. Table 7 lists the major service programs together with numbers of their white and nonwhite beneficiaries.

Comprehensive Care Programs

The Indian Health Service is operated and paid for directly by HEW. Other comprehensive care programs provide local or state agencies with grants to establish projects serving geographic areas that are poor or lacking in resources. Such programs include community and migrant health centers and maternal and infant care and children and youth projects. In addition to direct federal funds, roughly 30 percent of the costs of community and migrant health centers are covered by payments made by patients or insurers (private or public). The figure is kept low by state restrictions on the type of services paid for and the rate paid for a given service and by the fact that the programs treat poor and near-poor persons who are not eligible for medicaid.

These comprehensive care programs serve an estimated total of 3.7 million persons. As indicated in Table 7, a majority of their beneficiaries are nonwhite, or, in the case of migrant programs,

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[21] 1976 appropriations for health, mental health, and disease prevention programs, including $135 million for swine flu, a one-time expense, was $2.2 billion.
The total figure does not include Public Health Service hospitals and related facilities, which are not subjects of this paper. These facilities provide care to their beneficiaries (mostly Coast Guard personnel and merchant seamen) because they are part of federal organizations formerly on a quasi-military nature rather than because they are particularly needy.

Hispanic. 22/ Other data suggests that at least 80 percent of patients in the projects have incomes below the federal poverty line. Thus both financial and nonfinancial barriers to care are overcome for nonwhites in areas where projects exist.

Of particular interest are indications that the continuous care received in these programs is more effective, less hospitalization is required, and total health-care expenditures per person are lower than if the patients had to rely on a financing plan alone. 23/ Many, but not all, comprehensive care programs incorporate special efforts to address problems that affect nonwhites disproportionately. Outreach, community workers, and home visits are usually among the services offered. Other examples of problem-oriented services offered are screening programs for hypertension and sickle cell anemia or clinics and health education programs for diabetics. The tendency has been for the executive branch to emphasize straight medical care, however, which is more often reimbursible through medicaid, at the expense of the socially oriented services. Another problem is that some programs fail in dealing with the general medical needs of patients who are drug abusers or alcoholics.

22/ Data compiled by U.S. Department of Health, Education, and Welfare, Office of the Assistant Secretary for Health, Budget Branch.

23/ See Leon Gordis, "Effectiveness of Comprehensive Care Programs in Preventing Rheumatic Fever," New England Journal of Medicine, 289:331-335 (1973); John Newport and Milton Roemer, "Comparative Perinatal Mortality under Medical Care Foundations and Other Delivery Models," Inquiry, 12:10-17 (March 1975); C. M. G. Buttery and Lula Holland, "The Use of Health Care Aides in a Medical Assistance Program," unpublished report from the Portsmouth, Virginia Department of Public Health to HEW Social and Rehabilitation Service, February 1974; M. Klein, et al, "The Impact of the Rochester Neighborhood Health Center on the Hospitalization of Children," Pediatrics, 51:833-838 (1973); S. S. Bellin, H. J. Geiger, and D. Gibson, "Impact of Ambulatory Health Care Services on the Demand for Hospital Beds," New England Journal of Medicine, 280:808-812 (1969).

Table 7. DISTRIBUTION OF FEDERAL HEALTH SERVICE PROGRAM BENEFICIARIES, BY RACE AND ETHNICITY a/

	Alcohol, Drug Abuse, and Mental Health Administration			Center for Disease Control			
Group Served	Community Mental Health Centers	Alcoholism Community Programs	Drug Abuse b/ Community Programs	Lead Based Paint Poisoning in Children	Rat c/ Control	Venereal Diseases	Immunization d/
Total Beneficiaries (thousands)	1,843	186	153	500	5,000	9,700	15,000
Total White (percent)	88	68	63	40	35	42	40
Hispanic (percent)	5	5	12	30	25	NA	NA
Other White (percent)	83	63	51	10	10	NA	NA
Total Nonwhite (percent)	12	31	36	60	65	58	60
Black (percent)	11	18	35	60	65	NA	NA
American Indian (percent)	--	12	--	--	--	NA	NA
Other (percent)	1	1	--	--	--	NA	NA

a/ Estimates compiled by Budget Branch, Office of the Assistant Secretary for Health, HEW, for the following programs and fiscal years: ADAMHA, 1976; CDC, 1975; Indian Health Service, 1975. Estimates for Community Health Centers, Family Planning, Migrant Health, Maternal and Infant Care and Children and Youth projects from Bureau of Community Health Services, Health Services Administration, BCHS-NHI Study, 1976.

Table 7. (continued)

Group Served	Health Services Administration					
	Community Health Centers b/	Family Planning	Migrant Health	Maternal and Infant Care Projects	Children and Youth Projects	Indian Health Service
Total Beneficiaries (thousands)	2,000	2,600	400	250	560	500
Total White (percent)	12	70	80	43	31	--
Hispanic (percent)	3	16	67	19	19	--
Other White (percent)	9	54	13	24	12	--
Total Nonwhite (percent)	87	31	20	58	68	100
Black (percent)	84	29	17	56	67	--
American Indian (percent)	--	--	--			100
Other (percent)	3	2	3	2	1	--

b/ Total includes some unclassified recipients.

c/ Residents of target areas.

d/ Doses administered.

Programs Dealing with Specific Conditions. Some programs treat problems with a strong mental health component. They provide grants for community mental health centers serving specific geographic areas and alcoholism and drug-abuse projects serving target populations. 24/ In addition to direct federal funds, up to 30 percent of the costs of community mental health centers may be covered by payments made by patients or insurers, but such revenues are negligible for drug and alcohol programs.

There are approximately 2.2 million beneficiaries of these mental health programs. The proportion of nonwhites served compares with some recognized indicators of need as follows: 25/ Admissions to public inpatient psychiatric facilities occur nearly twice as frequently among nonwhites as among whites and 22 percent of all such admissions are for nonwhites. 26/ Yet community mental health centers, which are supposed to decrease institutionalization, serve a population that is only 12 percent nonwhite. This may be indicative of the location of the centers, lack of outreach and effective liaison with the community, or the lack of racial sensitivity referred to in the first section.

Narcotic drug abuse is estimated to occur four times as frequently among nonwhites as among whites from the fact that roughly 45 percent of all narcotic drug mentions to the Drug Abuse Warning Network were nonwhite. 26/ Drug abuse community programs serve a population that is 36 percent nonwhite. This may reflect a desire to balance the focus of projects between abusers of narcotics and abusers of other drugs, of whom a much smaller proportion are nonwhite.

24/ Despite the fact that grantees are local agencies, mental health programs operate with considerably more state involvement than do the comprehensive care programs. In the case of alcoholism and drug abuse, formula grants also go to states for more general purposes.

25/ If criteria for funding are to be reconsidered, other indicators may also be relevant.

26/ National Institute of Mental Health, Utilization of Mental Health Facilities, 1971, op. cit.

27/ Project DAWN III, op. cit.

Alcoholism may also be more prevalent among nonwhites since they account for 17 percent of all deaths from alcoholic cirrhosis. 28/ The proportion of nonwhites served by HEW's alcoholism community programs -- 31 percent -- reflects in part a policy of filling gaps left by state, local, and private programs; only one of those gaps is the lack of services for nonwhites.

Other programs deal with specific conditions of a public health or preventive nature. They provide grants, primarily to local agencies, for family planning services, treatment and prevention of lead-based paint poisoning in children and venereal diseases, immunization, and rat control. 29/

While beneficiaries of these programs are counted in varying ways, Table 7 indicates that all except family planning serve a majority of nonwhites. This is especially true of the lead poisoning and rat control programs, which are located in inner-city areas. With respect to continuity, having these services delivered by separate agencies may further fragment all health care. It does provide emphasis on followup for specific problems, however, and in some cases (family planning for teenagers; venereal disease), patients might not seek the service in a comprehensive setting.

28/ Reported by National Institute on Alcohol Abuse and Alcoholism.

29/ A small hypertension program was enacted in 1976 but has not yet been implemented. Hypertension screening and treatment are also under study by the National Institutes of Health, where results of clinical trials indicate more research into effective treatment is needed.

CHAPTER IV. APPROACHES TO IMPROVEMENT

In this section, possible ways of improving the responsiveness of each type of federal program to nonwhite health care needs will be discussed, and short-term steps will be described. In addition, because of widespread interest in a national health insurance plan and in view of the Carter Administration's announced intention to propose such a plan, actions consistent with more comprehensive financing will also be described. The descriptions are brief, and alternative possibilities are not rigorously evaluated.

FINANCING PROGRAMS

In general, inequities in health-financing programs might be addressed by equalizing all benefits and levels of eligibility through mandatory federal minimum standards. Then, with the lesson of medicare in mind, incentives might be provided to deal with remaining problems. A major question either now or if national health insurance is enacted is whether monetary incentives alone can equalize access to care or address questions of effectiveness.

Short-Term Steps

The remaining financial barriers in the medicaid program might be overcome by a federally mandated comprehensive benefit package and uniform standards for eligibility, adjusted for differences in the cost of living. This could be done with or without a complete federal takeover of the program, but the federal government would probably have to bear the cost of the additional benefits -- roughly \$10 or \$11 billion in 1978. 1/ Financial barriers in medicare might be addressed by cost-sharing provisions that are graduated by income and by requiring physicians to accept the "assigned" fee without billing patients for additional amounts. Both these changes might

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1/ U.S. Congressional Budget Office, "Short-Term Options for the Medicaid Program," in Working Papers on Major Budget and Program Issues in Selected Health Programs, U.S. House of Representatives, Committee on the Budget, December 10, 1976.

have to await enactment of national health insurance, however. The first would require major changes in the administration of medicare and the second might cause some physicians to withdraw from participation in the absence of a universal program.

Of the nonfinancial barriers, shortages of manpower might be partially addressed by reimbursement and tax incentives to serve in areas where shortages exist. It should be noted, however, that studies have shown financial factors to be relatively unimportant in determining whether physicians locate in these areas. 2/ Thus, other incentives would also be needed. Assuring reimbursement of nurse practitioners and paramedical personnel is another way of addressing shortages, but care should be taken that an appropriate balance of services by physicians and nonphysicians is maintained.

Participation of physicians in medicaid might be increased by bringing rates for their services closer to those in the private sector and streamlining administrative procedures to speed up reimbursement. A more drastic remedy would be to require physicians to participate as a condition of licensure or of receiving other federal funds. Discrimination could be attacked by more vigorous enforcement of Title VI of the Civil Rights Act. A number of witnesses complained at hearings held in 1973 that enforcement in the health area had fallen off precipitously and that reliance on state action was proving ineffective. At that time there were 89 employees assigned to health and social services in HEW's Office of Civil Rights. 3/ While the number of employees authorized for enforcement of civil rights in these areas has risen to 111, the published operating plan for fiscal 1977 of the Office of Civil Rights indicated that only 19 persons are actually assigned to health and social services. 4/

2/ Sinclair Coleman, Physician Distribution and Rural Access to Medical Services, Rand Corporation Contract No. R-1887-HEW, prepared for the Health Resources Administration, April 1976.

3/ U.S. House of Representatives Committee on the Judiciary, Subcommittee on Civil Rights and Constitutional Rights, op. cit.

4/ Federal Register, 41:196:41776-41797, September 23, 1976.

Continuity could be encouraged by assuring reimbursement of government-sponsored programs for the delivery of services and other freestanding clinics and by incentives for prepaid care, delivered by the private or public sector. In addition, it has been suggested that some of the high-volume urban providers, or "medicaid mills," do provide care efficiently, and their quality might be upgraded by affiliations with nearby hospitals and training programs for physicians. 5/ Finally, treatment of conditions affecting nonwhites disproportionately (alcoholism, drug abuse, hypertension) could be reimbursed at a higher rate than other services. It should be noted, however, that a financing system may not be specific enough to ensure that these "preferred" services are made available to those who really need them. Expensive distortions and abuses might occur. 6/

Steps Consistent with National Health Insurance

National health insurance offers an opportunity to overcome financial barriers faced by near-poor nonwhites as well as those now covered by medicaid. A mandatory, universal program would accomplish this best. All persons could be provided equal coverage whether or not they are now enrolled in private insurance plans through their employers. Any sharing of costs or payment of premiums could be minimal for the poor and near-poor and graduated smoothly by income, avoiding the earnings disincentive that may be the result of a large step up in required contributions. First-dollar coverage of initial visits to a physician might be desirable for the poor and near-poor. Any sharing of costs for those with higher incomes should not be so high as to discourage anyone from seeking needed primary care.

Nearly all the other short-term steps described above would also apply. One difference is that physicians would be more likely to participate without coercion in a universal program, but avoidance of poor nonwhite neighborhoods and overt racial discrimination could possibly increase.

5/ Conversation with Martin Paris, M.D., Director, New York City Medical Assistance Program, November 1976.

6/ An example of such a distortion is the earlier growth in New York City of private methadone clinics, the quality of which is difficult to control.

RESOURCE PROGRAMS

Resource programs have been too recently revised to suggest many additional steps for dealing with racial inequities in health care. One major question is how far regulation of the private sector can go in assuring access to nonwhites, particularly if those to be regulated are individuals rather than institutions.

Short-Term Steps

Since criteria and guidelines for the new planning and regulatory network are developed at the federal level, access to care for specific populations, including nonwhites and poor persons, could be made an explicit goal. The program would then not merely seek to prevent or eliminate overall surpluses but would also ensure that facilities serving nonwhites are treated with due consideration. The tradeoffs necessary to assure access to nonwhites could be facilitated further by extending control of existing as well as new institutions to the agencies. Renovation of needed but outmoded inpatient facilities, especially in inner cities, and construction of outpatient facilities could be funded at more than the present minimal levels and possibly directed toward specific areas.

The 1976 health manpower legislation can put many more new physicians in areas where shortages exist. Considerable attention (by both the federal government and the communities served) to the way in which the settings in which physicians practice are organized could increase productivity and help attract and keep physicians. Organized community health centers, for example, have succeeded in attracting physicians to shortage areas. National Health Service Corps sites may be seen as smaller, more flexible versions of delivery programs rather than as isolated office practices. The federal government could also provide more technical assistance to establish health maintenance organizations in underserved areas. Links with teaching institutions are important to physicians in any shortage area, and problems of physical security should be addressed in inner-city neighborhoods.

In addition, more paramedical personnel and nurse practitioners who will practice in poor nonwhite areas could be trained. The latter are especially well equipped for the patient-education function of primary care. Affirmative action programs in medical education could be revitalized by funding private organizations as well as schools to recruit and prepare potential physicians for professional training.

Continuing financial support throughout medical school could be assured by funding at high levels scholarships for disadvantaged students and those that obligate graduates to practice in shortage areas. Finally, education could be focused more heavily on nonwhite health-care problems.

Steps Consistent with National Health Insurance

The greater federal financial involvement suggested by most national health insurance proposals could call for additional regulation of resources. National health insurance, moreover, may increase demand for primary care. If financial incentives alone are not sufficient to assure nonwhites adequate access in the face of rising demand by all persons, there are two forms of more direct intervention: expanding government-sponsored programs or exerting control over the locations in which physicians practice. The latter may be advantageous in that it uses private rather than public sector resources. Such control may be resisted by private physicians, however, and if they are forced to serve patients they consider undesirable, individual physicians may provide unsympathetic care.

HEALTH SERVICE PROGRAMS

Most health service programs are reaching and serving nonwhites more effectively than financing programs that depend to a large degree on the private sector. There are two ways of using these programs to correct racial inequities in health care: Expanding their funding and the populations they serve and further improving their focus on nonwhite health problems.

Short-Term Steps

Expansion of those programs serving nonwhites most effectively could be accomplished by additional funding. Without additional funding of service programs, but consistent with the short-term expansion of medicaid discussed above, community and migrant health centers could serve roughly 40 percent more people because their reimbursements would increase. 7/ While maternal and infant care and children

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7/ Medicare and medicaid would spend most of the additional funds -- possibly less effectively -- even if service programs did not expand.

and youth projects have also been effective in aiding nonwhites, it would be more difficult to achieve expansion through increased reimbursements, because such projects are subsumed in a formula grant to states. Some expansion of the population served with no increase in overall appropriations might be possible for mental health programs. This is because federal funding for individual centers is set to decline each year, freeing money for new projects.

Steps to improve care in existing programs might include special family-planning projects for teenagers (because of the higher maternal and infant mortality rates for teenagers in general and especially nonwhite teenagers); research, outreach, and treatment designed to reach nonwhites in community mental health centers; a greater emphasis on nutrition and the education of patients within all comprehensive care programs; and requirements that mental health and medical treatment programs learn to deal with alcoholic and drug-abusing patients rather than excluding them. In addition, criteria for funding could be reexamined and priority given to nonwhite locations for any new projects. This would apply to community mental health centers, which serve a comparatively low proportion of nonwhites, but also to such programs as community health centers, which can be used to increase access in nonwhite shortage areas.

Steps Consistent with National Health Insurance

If neither financing nor regulatory solutions can guarantee access to care, organized service delivery programs may be the "resource of last resort." Such programs might also help ensure that national health insurance funds are spent more effectively. While some have argued that government programs for the disadvantaged perpetuate "two class" health care, the recent evidence from the medicaid program indicates that this separation has evolved in the private sector as well.

National health insurance providing broad health coverage for low-income persons would probably cover roughly 80 percent of existing costs in community health and migrant centers, as opposed to the 30 percent of costs now covered by payments made by patients. (About 20 percent of the costs in such programs, attributable to social and supporting services, would remain uncovered). The increased reimbursement would allow the programs to increase the number of persons served more than threefold, while still confining additional expenditures to the financing plan. To the extent that insurance covered mental health, alcoholism, and drug-abuse services, these programs could also expand further with added costs in the financing plan only. It might be easier, however, to control and coordinate mental health and substance-abuse services if they were funded directly through centers operated or approved by the government.

CONCLUSION

Evidence indicates that nonwhites have made important gains in health status in the last 20 years. They remain less healthy than whites, however; they still get less health care, and the care they do get may be less effective. Four factors contribute to this situation: financial barriers to care; nonfinancial barriers such as shortages of providers and discrimination; lack of continuity when care is received; and too little emphasis on some conditions affecting nonwhites. Experience with present federal programs indicates that financing solutions alone may help perpetuate white/nonwhite health differentials. Thus, approaches for dealing with remaining problems would include not only increased financing, but also reallocation of resources and the ability to provide services directly where the private sector falls short.