MEETING THE HEALTH CARE NEEDS OF OUR NATION'S BLACK ELDERLY

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Thank you for this opportunity to submit testimony to your committees regarding how best to accomplish the goal of meeting the health care needs of our nation's black elderly. As president of the National Medical Association (NMA) and as a practicing internist, I am here on behalf of an organization which represents over 16 000 physicians from throughout the United States, the Virgin Islands, and Puerto Rico, who are among the primary providers to the medically underserved and low income minority populations. The majority of NMA members are African-American physicians, however, we welcome as active participants any health care professional who is interested in promoting the science of medicine and better health care for all Americans.

Today, I will focus on the problems facing NMA member health care providers in caring for the African-American elderly. Specifically, the vital statistics, the significance of the problem, the diseases that represent the greatest threat, the status and need to strengthen federal health care programs, such as of Medicare, the issues of financing long-term care for the elderly, and NMA's recommendations to address these vexing problems.

VITAL STATISTICS

In 1988, the overall elderly population in the United States consisted of 18 million women and approximately 12 million men. Persons reaching 65 years of age have an average life expectancy of 16.9 additional years. One in nine Americans is over the age of 60, and that population is continuing to grow. This growth should be relatively small during the 1990s because of the small number of babies born during the depression era. A rapid increase is however expected between the years 2010 and 2030, when the baby boom generation reaches age 65.

The African-American elderly community is currently the fastest growing segment of the total African-American population. Between 1970 and 1980, the African-American population increased by 34%, whereas the total population of the United States increased by only 16%. Data from the United States census bureau indicate that as of March 1988, two million African-Americans were over age 55, one million over age 65, and approximately 900 000 over age 75. It is projected that by the year 1999, the number of African-Americans over age 65 will increase to three million.

African-Americans continue to be victims of adverse economic and social conditions, and the elderly community is particularly susceptible to problems associated with these societal ills; economically, African-Americans generally have less personal post-retirement income than their white counterparts and are more dependent on Social Security benefits for the majority of their retirement income. The medium income of the African-American elderly is considerably less than the white elderly, eg, $4113 for African-American men and $2825 for African-American women—as compared to $7408 for white men and $3894 for white women.

Geographically, approximately one fifth of the African-American elderly live in rural areas compared to a somewhat lower proportion of white elderly (about one fourth). In these rural areas, one in every two African-American elderly lives in poverty. Broken

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down by sex, almost two thirds, or 68%, of African-American women are in or near poverty, as compared to 40% of white women. In urban areas, one in three African-American elderly persons lives in poverty, compared to a ratio of one in nine by the elderly white community.

In terms of mortality, African-Americans have a life expectancy of 69.6 years compared to 75.2 years for whites—a gap of over 5 years which continues to demonstrate the excess deaths occurring among African-Americans which has been well-documented in the Heckler report of 1984, not seriously addressed in any meaningful way to this date. Although African-Americans who reach the age of 70 enjoy a higher survival rate than whites, they usually suffer from higher rates of poverty and illness.

SIGNIFICANCE OF THE PROBLEM

Most recently, the Department of Health and Human Services released the *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. In this report it was revealed that the leading causes of death among people ages 65 and older are heart disease, cancer, stroke, chronic obstructive pulmonary disease, pneumonia, and influenza. It was further noted that health problems such as osteoporosis, arthritis, incontinence, dementia, and visual or hearing impairments, although not common causes of death, have a significant effect on the quality of life.

There are many factors which may explain some of these alarming trends from a scientific standpoint. But history will ultimately judge our generation on our ability to effectively address the technological problems of health care at a time when there are competing demands to limit governmental expenditures in all arenas, including health care delivery. Various tax revolts throughout the nation, the growing federal deficit and, as we meet, the budget negotiator's appearance of a deadlock on a plan to allocate our nation's expenditures, make it abundantly clear that we must wisely spend our precious tax dollars on programs that give us the most for our money, particularly in the health care arena. At this juncture, let us review the particular impact of some of the leading killers on the target population.

Heart Disease

The number one health problem facing the elderly population as a whole, is heart disease. A senate special committee of aging reported that heart disease accounted for 10% of doctor visits, 18% of short-stay hospital and bed disability days, and 45% of all deaths in 1980. A large number of the 750 000 Americans who die each year of heart disease are elderly.

Heart disease remains a strong contributor to poor health and death among the elderly in the general population. There has generally been a marked decline in death rates from this disease but this has not been true of the African-American population. The decrease could be the result of the public awareness of the link between dietary fat and heart disease. A national survey recently revealed that public awareness rose from 45% in 1982 to 80% in the mid-1990s. However, the report also showed that misunderstandings remain about the terms fat and cholesterol. For example, only 29% of those surveyed knew that a product characterized as cholesterol-free could still be high in saturated fat. These factors, as well as the traditional ethnic eating habits of the target population, could be an explanation for the absence of a decline in the disease among African-American elderly. We must also remind you that one's socioeconomic status plays a significant role in determining the types and quantities of foods purchased. Many of these foods have the potential to impact negatively when eaten without regard to proper distribution of calories. Thus, there appears to be a particular need for better educational programs focused on this population. If we are to obtain equivalent advances in reversing the negative trend in the target population.

Cancer and High Blood Pressure

The death rate for esophageal cancer is 10 times higher for African-American men. We have a 25% higher incidence of cancer, with cancer of the lungs, prostrate, stomach, colon, and pancreas being more frequent. Breast cancer is also highly prevalent in African-American women.

While high blood pressure affects more than 28 out of every 100 white adults, it affects more than 38 out of every 100 African-Americans. One in three African-Americans has hypertension, while African-American women over 65 are more at risk than any other group in the United States.

Special Problems of African-American Women

Today, there are 17 million women over the age of 65. Many of these women suffer from inadequate health care because of the lack of research concerning the

health of older women, misunderstandings, and ignorance of older women's needs, as well as a disproportionately high level of limited insurance coverage.

While women comprise 59% of the population over 65, they make up 72% of the elderly poor. One third of older single women rely on Social Security benefits for at least 90% of their income. In 1986, it was reported that 35% of older African-American women and 25% of older Hispanic women lived in poverty. Medicare pays only 33% of medical bills for single women.

The Department of Health and Human Services reported that the average American woman with a life expectancy of 85 years has a 1 in 10 chance of getting breast cancer. While many older women believe that they have to worry less about getting this disease as they age, the fact is, 80% of all breast cancers occur in post-menopausal women. Despite these statistics, early detection allows more options and presents a better prognosis for women diagnosed with breast cancer. Yet, a study by the American Cancer Society showed that fewer than 50% of physicians refer women over 40 for a mammogram. Periodic mammogram screening, however, is not a benefit covered under Medicare. It is important that older women ask their physician for a mammogram, and, if possible, get one through available community programs. The difficulty for elderly African-American women is that since a disproportionately high number of these individuals are from the lower economic sector of the population, they are less likely to have competent, regular medical advice, care, and attention.

The American Cancer Society also reports that there is an increase in the incidence of lung cancer among women to the extent that it has surpassed breast cancer. Additionally, heart disease, which I mentioned earlier as the number one health problem facing the elderly, is the leading cause of death among women. Previously thought to be a man's problem, statistics reveal that 350 000 of 750 000 Americans who die each year of heart disease are women. All of these ailments continue to adversely affect elderly African-American females at a greater rate than it does their white counterparts.

MEDICARE

Status and Strength of Program

The NMA was supportive of and endorsed the original implementation of the Medicare program in the 1960s, and at that time was the only national medical organization to do so publicly and enthusiastically. Although history has taught that to the victor belongs the spoils, with Medicare as with other programs, the NMA and those we represent have received fewer benefits than those in opposition.

Current projections reveal that by the end of 1990, 30 million elderly Americans will receive Medicare benefits in some manner. As you know, Medicare consists of two trusts that pay for the acute costs of the elderly—the Hospital Insurance Trust, (also known as part of Medicare), and the Supplementary Medical Insurance Trust (part B). According to the President's budget for fiscal year 1991, the hospital trust is expected to spend $63 billion for hospital and related care costs of individuals over age 65, and of the permanently disabled. This trust is financed primarily through Social Security payroll tax contributions paid by employers, employees, and the self-employed. The Hospital Insurance Trust has had a surplus for many years, and its income is expected to exceed outlays by $26 billion in 1991. However, this surplus is due in large part to the temporary presence of the baby boom generation in the tax paying work force. It is projected that this trust fund will be depleted after the turn of the century when the baby boom generation begins to retire.

In 1991, the Supplementary Medical Insurance Trust Fund is estimated to spend $47 billion for physician services and other medical expenses of the elderly and disabled. Unlike the Hospital Insurance Trust, financing under this trust is established annually, and depends on whether assets are sufficient to cover liabilities expected to be incurred by the end of the year. Financing is derived from premiums paid by the beneficiaries and payments from general revenue.

Both part A and B of Medicare require the recipient to pay deductibles and coinsurance amounts. Deductibles and coinsurance are not based on ability to pay. Therefore, a greater financial burden is still placed on the elderly, particularly those in poverty. Since a higher proportion of the African-American elderly population is composed of lower income individuals, including those in poverty, who as noted above rely more heavily on Social Security and Medicare, the absence of a plan based on the ability to pay under these programs most adversely effects this population.

Homebound and Nursing Home Care

As you know, most elderly individuals would rather be cared for in the home than in a hospital or nursing home. The high cost of institutionalization far exceeds the cost of providing quality homebound care. Like-

wise, we of the NMA would like to put more emphasis on homebound care not only because it is less expensive, but because it is also less disturbing to senior citizens' waning cognitive and coping abilities and their intense desire to remain independent. The Bush Administration's fiscal year 1991 budget continues to target budget reductions disproportionately higher on physician and other services that reduce the elderly's ability to receive home care. The NMA is opposed to any further budget reductions to the Medicare and Medicaid programs that would prevent African-American elderly patients to remain in their homes and to receive adequate quality medical care.

Since 1983, through the prospective payment system, Medicare is pressuring hospitals to discharge patients earlier, and often sicker, than before. The use of new medical technologies such as ventilators, nutritional feedings, and chemotherapy recently have been developed which makes this all possible.

However, since the hospitals are discharging patients earlier, sufficient nursing home beds are unavailable so many patients must return home. Members of the NMA are caring for more Medicare patients at home. Medicare patients now need to receive improved quality of homebound care.

As the African-American elderly get older many of them have health problems that require them to be placed in a nursing home facility. In some cases this occurs because they lack the access to quality home care services. These individuals are often discharged from the hospital settings sicker and require more medication, equipment and services than do the majority of elderly. The African-American elderly often experience great difficulty obtaining access to a quality nursing home facility due to their limited incomes. Once they do obtain a bed in a facility, the nursing home is often many miles away from relatives, friends, and loved ones. Consequently, institutionalization for the African-American elderly often further isolates them from their family members. The NMA's quality assurance task force made a series of recommendations, namely:

1. Medicare and home health agencies need to use innovative approaches to provide quality home health care to the elderly African-Americans directly, including paid escorts, hazardous duty compensation to staff, both of which would increase availability of homebound services to elderly African-Americans in poorer, crime-ridden neighborhoods.
2. Improve patient education to African-American patients to assure better understanding of how to obtain home health medical services in the existing fragmented health care delivery system.
3. Medicaid programs must reduce burdensome requirements that limit the patient's access to vital medications on a monthly basis.

Therapeutic Substitution

In the area of drug treatment, quality care should not be sacrificed due to budgetary restraints which result in the poor and elderly receiving therapeutically substituted drugs as a means to reduce Medicaid expenditures. In June of this year, the Office of Management and Budget proposed to the Budget Summit Conference a plan to include classifying drugs and selecting the least expensive drug in each class as the preferred drug. Pharmacists would be required to substitute the preferred drug in all Medicaid prescriptions without the knowledge or consent of the patient's physician. The NMA recognizes the inherent and real danger in using cost alone to substitute a medication prescribed by a physician, who has personally examined the patient and written the prescription based upon the individual patient's entire medical history and health milieu. Drug allergies, harmful side effects, lesser effectiveness in differing populations, or even death may result from slight variations in the quality and strength of medication. Furthermore, changing a prescription without the knowledge or consent of the physician is not legal in most jurisdictions.

Dispensing medication to Medicaid recipients based solely on price creates another objectionable distinction in medical services provided to the poor, many of whom are African-American or other minorities. The Office of Management and Budget proposal clearly implied that the elderly, blind, disabled, and indigent are only worthy of the cheapest medication regardless of its efficacy, and not the prescription that best fulfills their vital medical requirements. The NMA is opposed to this treatment of Medicaid recipients that is clearly discriminatory and assigns a diminished value of life to this group of disadvantaged patients. A new low would have been reached if this new form of disparate treatment is permitted.

Long-Term Care Financing Needs for the Elderly

Availability of health care resources for the chronically ill, most of whom are over 65 years of age, remains a major public policy concern. This is particularly true because many African-American elderly have a mistaken impression that the expenses of

chronic illnesses are covered by the existing Medicare program. Many others believe that their retirement private health insurance plan will adequately cover long-term care expenses. They fail to realize that neither Medicare nor most private health insurance will cover essential long-term health care services.

The NMA's board of trustees recognized this problem, and in 1988 established a long-term health care task force. The task force made a series of recommendations, as follows:

1. Medicare must establish a part C to finance the long-term care needs of Medicare beneficiaries who require lengthy institutionalization in a nursing home facility.
2. Medicare and Medicaid programs must expand their early detection and preventive medicine programs. This must be achieved by financing mammography screening, high blood pressure check-ups, and greater efforts to educate the elderly about the importance of preventive health care.
3. Medical schools and colleges of allied health sciences must expand their training programs to include gerontology medicine to understand the health care needs of long-term patients.
4. Medicare and Medicaid programs should require more frequent physician visits to nursing home patients as a requirement of the treatment plan.

RECOMMENDATIONS

An increase in federal funding and federal programs is neither sufficient to alleviate the problems faced by the elderly in terms of adequate health-care and the costs associated with it, nor is it a prudent recommendation in the current climate which demand budget restraint. The Congress must determine which programs work and those must be strengthened. It must likewise eliminate programs that do not. Funds must be shifted from ineffective and unnecessary programs to those that are most essential. With the fastest growing segment of the American population being that of minorities, the health of our nation is inextricably intertwined with the health of African-Americans and other minority populations in this country.

Community-based programs represent one such effective and essential program. It is important to establish community-based programs which monitor and educate the elderly in ways to maintain good health. For example, recognizing the prevalence of high blood-pressure among African-Americans. A Rhode Island affiliate of the American Heart Association established a program whereby members met with church leaders of the Black Church Alliance to introduce the idea of an ongoing screening program to reach the black community through churches.

The 1988 Surgeon General's Workshop on Health Promotion and Aging emphasized good nutrition as an essential element to a high quality of life for the elderly. The report identified priorities related to:

1. Sound public education tailored to the special concerns of old age, such as multiple drug regimens, appropriate energy intakes, and the effects of existing chronic diseases on nutritional status.
2. Professional education on geriatric concerns integrated into the core curriculum, service timing, and continuing education of dietitians and other health care professionals.
3. Credentialed nutrition professional counseling in institutional or community-based programs to provide health services to the elderly.
4. Provision of essential financing of nutrition services for the elderly as part of routine and long-term care.

Education, community support, and effective and essential federal assistance are necessary to insure that the health care needs of the elderly population, in general, and the additional requirements of African-American elderly in particular, are met.

CONCLUSION

It is imperative that the President of the NMA bring to your attention a very serious breach in our health care delivery system which will impact the elderly and all other Americans served negatively. We are beginning to lose physicians at an alarming rate in ghettos and underserved areas both rural and urban, primarily because of inadequate reimbursement. The NMA is currently in the process of defining on a national basis the extent and causes of a loss of physician practices. Once we have these data in hand, we will most likely have to come before the appropriate congressional committees to seek legislation for correcting the loss of so valuable a human resource, physicians, and especially those who serve in ghetto and underserved areas. Finally, let me emphasize that the NMA stands ready to assist the Congress in structuring effective programs that lead to an improved health care delivery system for all Americans, but especially for elderly.