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50 YEARS LATER

Medicare's Pathway to Racial Integration

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On July 2, 1964, with Dr. Martin Luther King, Jr. and others looking over his shoulder, President Lyndon B. Johnson signed the landmark Civil Rights Act of 1964 into law. The most sweeping legislation since Reconstruction, the new law widely banned racial discrimination and segregation in schools, the workplace, and public facilities. The bill held enormous implications for improving key social determinants of health for African Americans, including employment, education, and housing. The bill also held great promise for improving healthcare access. Indeed, one year later, on July 30, 1965, LBJ would sign into law a second momentous piece of legislation – amendments to the Social Security Act – creating Medicare and Medicaid, pillars of healthcare for the elderly and the poor. President Harry Truman, who had been a long supporter of the idea, stood by LBJ at the bill-signing and received the first Medicare card in U.S. history[1]. But the passage of the Medicare Bill, as the law came to be known, would do more than create access for the elderly and the poor. It would also – in concert with the Civil Rights Act – take on Jim Crow in hospitals across the country.

President Lyndon B. Johnson signs the Civil Rights Act, July 2, 1964. Credit: White House Press Office

Indeed, it is a seldom told story that the hard-fought Medicare bill was key to desegregating the nation's hospitals and to paving the road toward diversity and cultural competency in the healthcare workforce. The Civil Rights Act alone was hardly enough to remove "white only" signs from hospital doors. Prior to the passage of Medicare (and for a few more years after its passage), segregated hospitals were the norm throughout much of the South and even in parts of the North. As late as 1959, only 83% of general hospitals in the North – and a mere 6% of hospitals in the South – admitted African American patients without any restrictions. Of the

remaining 94% of Southern hospitals, 33% refused to admits any black patient, 50% had "colored only" wards, and the remainder had some artful mix of Jim Crow policy[2].

Racial segregation also posed a roadblock for African American healthcare providers. In the North, a paltry 10% of hospitals allowed African American interns and residents, and only 20% permitted African American physicians to serve as medical faculty staff. In the South, where the African American population comprised an even larger proportion of the overall U.S. population, only 6% of hospitals allowed African American interns and residents, and only 25% granted medical staff privileges to black doctors.

Thus, at the promising new dawn of Medicare, hospital segregation policies in both the South and North still posed formidable access barriers for African American patients and providers.

This brings us back to the crucial significance of the Civil Rights Act. In 1964, the nation's 7,000 hospitals – as places of public accommodation – were subject to the new law's antidiscrimination provisions. In the face of obstinate resistance to hospital integration, LBJ astutely deployed the power of Title VI of the Civil Rights Act to secure compliance from recalcitrant southern hospital administrators. Under his direction, the Department of Health, Education and Welfare (HEW) used a carrot-and-stick approach to carry out the bold federal mandate for hospital integration. That is, HEW dangled a treasure chest of Medicare reimbursement dollars as the "carrot," while threatening to withhold those same dollars as the "stick."[3]

Nurses serve meals to African American women in the separate and unequal "colored only" maternity ward at Johns Hopkins Hospital Women's Clinic, 1939. Credit: Johns Hopkins Nursing

To be sure, resistance to hospital integration was no small challenge in the 1960s. Indeed, prior to Medicare and the Civil Rights Act, integration advocates had already won judicial backing to desegregate the nation's hospitals. In the 1963 appellate case of *Simkins vs. Moses H. Cone Memorial Hospital*, the federal court had already upheld hospital integration, thwarting the 1946 Hill-Burton Act that had previously permitted racially separate hospital facilities (under the guise that "separate was equal.")[4] But the auspicious *Simkins* ruling was merely on the books; it could not actually enforce hospital integration in local hospital admissions departments – or even in local emergency departments. Taken together, the 1963 *Simkins* ruling, the Civil Rights Act of 1964, and the 1965 arrival of Medicare purse strings brought the triple policy play needed to release Jim Crow's deadly grip on the U.S. healthcare system.

For sure, even with the triple play, the racial transformation of hospital beds did not occur overnight. One year after signing Medicare into law, LBJ cautioned: “Medicare will succeed—if hospitals accept their responsibility under the law not to discriminate against any patient because of race.” That was a *big* “if.” As late as 1967, the federal government was still dispatching a team of inspectors to enforce the required integration compliance needed for Medicare certification. Nonetheless, when Medicare rolled out on July 1, 1966, the nation’s healthcare delivery system had overturned the official reign of Jim Crow in American medicine.

With former President Harry S. Truman at his side, President Lyndon Baines Johnson signs the Medicare bill into law, July 30, 1965. Credit: SSA History Archives

In reflecting on the social gains brought by the Medicare bill, former HEW Secretary Wilbur Cohen would later write:

> *“There is one other important contribution of Medicare and Medicaid which has not yet received public notice – the virtual dismantling of segregation of hospitals, physicians offices, nursing homes, and clinics as of July 1, 1966.... If Medicare and Medicaid had not made another single contribution, this result would be sufficient to enshrine it as one of the most significant social reforms of the decade…”*[5]

Today – 50 years later – while remarkable progress has clearly been made in removing racial barriers to healthcare, much work lies ahead. According to the congressionally-mandated report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care[6], minorities are more likely to receive a lower quality of care even when they hold the same insurance coverage as their white counterparts. For example, the report, published in 2002, showed that minority patients are less likely to be given the appropriate heart medications and less likely to receive kidney dialysis or transplants. As noted in the more recent National Healthcare Disparities Report[7], despite some gains healthcare disparities among racial and ethnic groups remain “large and persistent.” These disparities hold true for both quality of care and health outcomes.

Such disparities also persist among Medicare patients, evidence that Medicare could open the door to care but not ensure equity on the other side. For example, today, compared to their white counterparts, African American patients under Medicare receive fewer office visits, mammograms, and colonoscopies[8]. They are also less likely to receive beta-blockers after a heart attack or have eye examinations if diabetic[9].

Moreover, according to the Bureau of Health Professions, many racial and ethnic minorities continue to be underrepresented in the healthcare professions – even though “current evidence supports the notion that greater workforce diversity may lead to improved public health, primarily through greater access to care for underserved populations and better interactions between patients and health professionals.”[10]

In 2000, African Americans and Hispanic Americans represented 12.3% and 12.5%, respectively, but only 4.5% and 5.1% of physicians/surgeons, 3.4% and 3.6% of dentists, 1.7% and 2.7% of optometrists, and 9.0% and 3.3% of registered nurses[11].

This matters, especially given the huge number of people who become eligible for Medicare every day, a number currently estimated at around 10,000[12]. With increased demand for Medicare services because of the aging 'Baby Boomers', and the reduced supply of primary care providers, including physicians[13] along with the continued shortage of minority providers, demographic pressures require that policymakers keep a close eye on the program's viability.

There is reason, however, to be optimistic. Medicare's trustees[14] have reported that the Medicare Trust Fund's solvency has been extended by several years, pursuant to the successes of the Affordable Care Act (ACA). In addition, Medicare expenditures[15] have grown at a slower rate in the few years since the ACA has been the law of the land. There is also evidence that the cost savings have not sacrificed quality[16]. In fact, Medicare is, in many ways, providing better quality care[17] for less money. Indications are the members like being part of the club. Medicare beneficiaries report high rates of customer satisfaction[18].

The hard-won gains notwithstanding, the challenge of achieving racial equity in healthcare continues a half century after the passage of both the Civil Rights Act and Medicare. Still, the passage of the landmark Medicare law in 1965 was no small achievement in the history of the U.S. healthcare system. Medicare created access to vital healthcare resources for the elderly and the disabled. And it demonstrated – in a powerful and unprecedented way – the indispensable role of federal policy and leadership in addressing health equity.

Endnotes

[1] Social Security Administration. Social Security History: Medicare is Signed into Law. Available online at http://www.ssa.gov/history/lbjsm.html

[2] Reynolds, PP. The federal government's use of Title VI and Medicare to racially integrate hospitals in the United States, 1963 through 1967. Am J Public Health. 1997 November; 87(11);1850-1858. Available online at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1381169/

[3] Reynolds, PP. The federal government's use of Title VI and Medicare to racially integrate hospitals in the United States, 1963 through 1967. Am J Public Health. 1997 November; 87(11);1850-1858. Available online at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1381169/

[4] Reynolds, PP. Hospital and Civil Rights, 1945-1963L the case of Simkins v Moses H. Cone Memorial Hospital. Ann Intern Med. 1997 Jun 1;126(11):8908-906. Available online at http://www.ncbi.nlm.nih.gov/pubmed/9163292

[5] W. Cohen, "From Medicare to National Health Insurance," in Toward New Human Rights, ed., D. C. Warner (Austin. Tex.: University of Texas, 1977), 150.

[6] Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. 2002. Available online at http://iom.nationalacademies.org/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx

[7] 2014 National Healthcare Quality and Disparities Report. Rockville, MD: Agency for Healthcare Research and Quality; May 2015. AHRQ Pub. No. 15-0007. Available online at http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/2014nhqdr.pdf

[8] Gornick, M. 2000. Vulnerable Populations and Medicare Services: Why Do Disparities Exist? A Century Foundation Report. New York: The Century Foundation Press.

[9] Schneider, E. et al. 2002. Racial Disparities in the Quality of Care for Enrollees in Medicare Managed Care. Journal of the American Medical Association 287 (10): 1288–94. Available online at

http://www.commonwealthfund.org/publications/in-the-literature/2002/mar/racial-disparities-in-the-quality-of-care-for-enrollees-in-medicare-managed-care

[10] The Rationale for Diversity in the Health Professions: A Review of the Evidence. U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. October 2006. Available online at: http://bhpr.hrsa.gov/healthworkforce/reports/diversityreviewevidence.pdf

[11] The Rationale for Diversity in the Health Professions: A Review of the Evidence. U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. October 2006. Available online at: http://bhpr.hrsa.gov/healthworkforce/reports/diversityreviewevidence.pdf

[12] The Next Generation of Medicare Beneficiaries. MedPac June 2015 Report, page 37. MedPac.gov. http://www.medpac.gov/documents/reports/chapter-2-the-next-generation-of-medicare-beneficiaries-(june-2015-report).pdf?sfvrsn=0. Retrieved from the Internet, July 28, 2015.

[13] Physician Supply and Demand Through 2025: Key Findings. AAMC. https://www.aamc.org/download/426260/data/physiciansupplyanddemandthrough2025keyfindings.pdf Retrieved from the Internet. July 28, 2015.

[14] A Summary of the 2015 Annual Reports. Social Security and Medicare Boards of Trustees. Social Security Administration. http://www.ssa.gov/oact/trsum/. Retrieved from the Internet. July 28, 2015.

[15] The Facts on Medicare Spending and Financing. Overview of Medicare Spending. The Henry J. Kaiser Family Foundation. http://kff.org/medicare/fact-sheet/medicare-spending-and-financing-fact-sheet/ Retrieved from the Internet. July 28, 2015.

[16] Krumholz HM, Nuti SV, Downing NS, Norman ST, Wang Y. Mortality, Hospitalizations, and Expenditures for the Medicare Population Aged 65 Year or Older, 1999-2013. JAMA. 2015;314(4):355-365. Available online at: http://jama.jamanetwork.com/article.aspx?articleid=2411282

[17] Medicare ACOs Continue to Improve Quality, Some Reducing Costs. Brookings Institution. McClellan, Mark B., et al. September 22, 2014. http://www.brookings.edu/blogs/up-front/posts/2014/09/22-medicare-aco-results-mcclellan . Retrieved from the Internet, July 28, 2015.

[18] High Satisfaction with Medicare. BenefitsPro. http://www.benefitspro.com/2015/03/31/high-satisfaction-with-medicare