

# Medicare Urged to Use Clout to Reduce Disparities

BY ALICIA AULT

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WASHINGTON — As one of the biggest and most influential payers in medicine, Medicare should use its clout to help reduce and eliminate the disparities in care for racial and ethnic minorities, according to a report from an independent panel of the National Academy of Social Insurance.

The report, along with an updated survey on health plans' progress in identifying disparities, was released at a press briefing sponsored by the journal Health Affairs. NASI, a Washington-based nonprofit organization of experts in Social Security, Medicare, and social insurance, made 17 recommendations on how Medicare can improve quality of, and access to, care for minorities, educate health care providers in cultural competence, and hold them accountable for reducing disparities.

About 9 million of Medicare's 42 million beneficiaries are minorities. Those minority beneficiaries generally are in poorer health, according to NASI. For example, more black Medicare beneficiaries than white beneficiaries have diabetes, 30% and 18%, respectively.

Medicare is uniquely positioned to influence practice patterns, and has a duty

to ensure that its recipients get care on a fair and equitable basis, said Bruce C. Vladeck, Ph.D., chairman of the NASI panel and Interim President of the University of Medicine and Dentistry of New Jersey, Newark.

NASI's report was funded by the Robert Wood Johnson Foundation, the California Endowment, and the Joint Center for Political and Economic Studies.

The panel recommended that the federal government start addressing gaps in care by creating incentives to improve quality.

To increase access, Medicare should ensure that minorities are enrolled in Medicare supplemental insurance—or Medigap—plans, said the report. Health systems should increase the number of minority providers and staff, and enhance cultural competence training. Providers should collect data that will help identify minorities and assess their special needs, according to the panel.

Health plans already collect such data, according to Karen Ignani, president and

CEO of America's Health Insurance Plans. AHIP, with funding from the Robert Wood Johnson Foundation, queried 260 plans on how and why they collect data on minority enrollees. According to the responses—from 156 plans, covering 87 million people—there has been a 500% increase in data collection since a previous query in 2001, said Ms. Ignani.

Overall, 58.2 million of the 87 million enrollees are in plans that collect race and ethnicity data. Medicare and Medicaid plans were most likely to collect that data. Race and ethnicity data were collected on 94% of

enrollees in Medicare and Medicaid plans, compared with 63% of enrollees in commercial plans.

The top three reasons for collecting the data were to support language and culturally appropriate communications to enrollees, to identify racial and ethnic disparities in health care, and to implement or strengthen quality improvement efforts, according to the AHIP report. Commercial plans also say they use the

data to conduct research and to identify patients with risk factors for some diseases.

Although more plans are collecting data, "we think we have much more to do," Ms. Ignani said.

But barriers to data collection exist. Six states have laws or rules that prevent insurers from collecting race and ethnicity data, although only as part of an application process. However, those laws have led to the mistaken perception that any data collection is illegal, said Ms. Ignani.

Title VI of the federal 1964 Civil Rights Act prohibits discrimination on racial or ethnic grounds, which has led to some concern that data collection might be seen as illegal.

But a June 2006 analysis by the George Washington University School of Public Health and Health Services found that not only is it legal for insurers to collect and report health quality data by race and ethnicity, but that it might be seen as proof of complying with Title VI when it is used to improve quality of care. The researchers asked the Department of Health and Human Services' Office of Civil Rights to issue guidance in this area, but have not gotten a response yet, according to Sara Rosenbaum, chairman of the university's health policy department. ■

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## Study Shows Physicians Divided Over Whether to Accept Free Drug Samples

BY PATRICE WENDLING

Chicago Bureau

TUCSON, ARIZ. — Physicians are divided over whether it is ethical to use free sample medications in their primary care practices, Nancy Sohler, Ph.D., and Dr. Diane McKee reported at the annual meeting of the North American Primary Care Research Group.

Accepting samples was viewed either as being ethically questionable or as a useful way of helping provide health care to low-income patients, according to findings from a study of 24 family medicine and general internal medicine physicians, nurses, and administrators. The respondents were all in practices affiliated with a large urban medical center serving low- and middle-income patients in New York.

Interactions with pharmaceutical representatives were viewed as a direct conflict of interest, an influence that could be controlled, or a source of useful information that helped keep the practice up to date on new medications. Of the total, 10 respondents felt that they could control the influence of drug firm representatives by keeping them away from residents, by setting limits on what gifts or favors could be accepted, or by always being mindful that representatives are selling a product, Dr. Sohler said in an interview.

For the respondents who drew a hard ethical line, "it was not that they thought giving out samples [to patients] was unethical, but that it wasn't good practice," she said. "They understood why others did it, but they worried about conflicts of interest with their interactions with the reps."

Those who accepted samples said that inadequacies in the health care system forced them to rely on gifts to care for their most needy patients.

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All the respondents evaluated marketing practices from the perspective of protecting and serving their patients, said Dr. Sohler, professor of community health and social medicine, City University of New York, New York. None of the respondents was concerned that physicians were ignoring clinical symptoms to prescribe the "right drugs."

The study included in-depth, qualitative interviews and was prompted by an administrative decision at the medical center to ban samples and pharmaceutical representatives from the community practices. That decision left many providers uncertain about how to care for patients without adequate health care coverage.

Others suggested that the policy was changed because the administration at the medical center didn't want physicians taking the time to talk to sales representatives, didn't trust that staff would avoid entering into agreements with pharmaceutical firms, and did want a single policy, because teaching sites had a "no-rep" policy and other sites didn't need samples.

Dr. Sohler asserted that further study would be needed to determine whether samples help poor patients more than they harm them, and to assess whether pharmaceutical company representatives influence prescribing practices in mostly helpful or harmful ways.

"The empirical, quantitative evidence isn't good on whether free medications help or harm our patients," she said. "We realize that all marketing has an influence, but we don't know if it harms our patients."

"People are drawing on their different values and perspectives to make a decision," Dr. Sohler concluded. "We need hard evidence to make a policy, but in the meantime, we should keep these perspectives in mind as the data come in." ■

## Detailed Contract Is Key to Good Physician Extender Relationship

DALLAS — When hiring a physician extender, be sure to spell out all responsibilities in the contract, Dr. Raymond Blackburn said at the annual meeting of the National Medical Association.

"You must delineate in their contract every little detail that you want them to do so that when any dispute comes up it's there," said Dr. Blackburn, a Dallas dermatologist who employs two physician assistants in his office.

A good contract should include a listing of all the duties expected of the physician extender, from performing history and physicals to returning patient calls and handling refills, he said.

Furthermore, consider specifying the physician extender's work hours ahead of time, Dr. Blackburn recommended. Extenders need to know if they will be responsible for making after-hours patient calls, working weekends, and staying until the last patient has been seen each day. "I find that's very important because that's not going to be at the same time everyday," he said.

Benefits should also be detailed in the contract. For example, physicians should outline what they will cover in terms of health insurance, paid holidays, vacations, continuing education, sick days, professional-organization dues, medical liability coverage, and retirement.

The average starting salary for a physician assistant (PA) across all medical specialties is about \$65,000 a year in the United States, Dr. Blackburn said. And a PA with 6 years of experience averages about \$70,000, he said.

Experienced dermatology PAs can command \$87,000 a year plus benefits, Dr. Blackburn said, adding that a PA in a busy dermatology practice can bring in gross revenues between \$600,000 and \$700,000 a year.

—Mary Ellen Schneider