Racist Health Care: Reforming an Unjust Health Care System to Meet the Needs of African-Americans

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RACIST HEALTH CARE: REFORMING AN UNJUST HEALTH CARE SYSTEM TO MEET THE NEEDS OF AFRICAN-AMERICANS

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PRELUDE

"RACIST" AND "RACISM" are provocative words in American society. To some, these words have reached the level of curse words in their offensiveness. Yet, "racist" and "racism" are descriptive words of a reality that cannot be denied. Ethnic-Americans live daily with the effects of both institutional and individual racism. Race issues are so fundamental in American society that they seem almost an integral component. Some Americans believe that race is the primary determinant of human abilities and capaci-

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1. See generally, STOKELY CARMICHAEL & CHARLES E. HAMILTON, BLACK POWER: THE POLITICS OF LIBERATION IN AMERICA 2-32 (1967) (detailing the effect of race relations on African Americans politically, socially, and economically in the United States. "[Racism] has represented daily reality to millions of black people for centuries, yet it is rarely defined perhaps just because that reality has been such commonplace." Id. at 3.)

2. The remainder of this paper will refer primarily to African-Americans because my academic research focuses on African-Americans. However, it is important to note that other ethnic Americans (Native-Americans, Latino-Americans, Asian-Americans) have similar or greater health care access problems and are similarly plagued by the effects of institutional racism in the health care system.
ties. Some Americans behave as if racial differences produce inherent superiority in European-Americans. In fact, such individuals respond to African-Americans and European-Americans differently. See generally, R. J. Hernstein, Still An American Dilemma, 98 PUB. INTEREST 3-17 (1990) (criticizing the methods and conclusions of A COMMON DESTINY: BLACKS AND AMERICAN SOCIETY (1989) for ignoring the possibility that different outcomes, between African-Americans and European-Americans may be the product of psychological and intelligence differences between the two races. The author argues that costs to society of attempting to benefit African-American disproportionately may outweigh the benefits); RONALD TAKAKI, BRAINS OVER MUSCLES: THE MEANING OF INTELLIGENCE AND RACE IN AMERICAN HISTORY (1984) (explaining how intelligence has been viewed historically in the United States, and how the “idea of intelligence” has “influenced and been influenced by the idea of race in American history.”); See also, PAUL R. EHRLICH & SHIRLEY FELDMAN, THE RACE BOMB: SKIN COLOR, PREJUDICE, & INTELLIGENCE (1977); ANDRE JOSEPH, INTELLIGENCE, IQ & RACE: WHEN, HOW & WHY THEY BECOME ASSOCIATED (1977); DANIEL LAWRENCE, RACE, INTELLIGENCE AND CULTURE (1975) (reviewing critical books published between 1969-1974 in Great Britain and the United States that support the idea of racial differences in intelligence); ELIZABETH WARS, RACIAL DIFFERENCES IN INTELLIGENCE: AN ANTHROPOLOGICAL APPROACH, HUMAN MOSAIC 47-53 (1973-1974) (discussing controversial views concerning the existence of population differences in mental ability); Josephine Schuyler, Race, Diet and Intelligence, 76 CRISIS 207-10 (1969) (criticizing Arthur R. Jensen of the University of California who holds that intelligence is determined by heredity).

4. In a national poll, when asked, “What are your personal feelings about . . . people who believe whites are racially superior to all other races” 1% were extremely favorable, 4% were favorable and 23% were neither favorable or unfavorable. National Opinion Research Center February, 1990 available in Westlaw, Poll (Sept. 1993).

5. For purposes of this Article, I use the term “African-American” as a synonym for the terms “colored,” “Negro,” “Afro-American,” and “Black.”

The predicament of African-Americans cannot be overstated. We arrived as “Africans” and were slaves to be sold. We were given Anglo names and became their “negroes” - their property. After Reconstruction there was a push by African-American leaders to give dignity to the name by capitalizing it. So “negroes” became “Negroes”. Even still, in the 1900 “Colored” competed with “Negroes”. Many thought that “colored” showed that we were no longer possessions. “Afro-American” was first proposed in 1880, but it never caught on. Through the social unrest of the 1960’s we became “Blacks”. We wanted respect. We wanted opportunity. We wanted to be proud of our heritage. The change to “African-American” denotes double consciousness and dual cultural heritage. It comes close to describing who we are as a people. See generally, Jewell Holmes Guinn, From African to Black, An American Evolution, PHOENIX GAZETTE, Feb. 27, 1989.

Each change in label represents a change in attitudes of African-Americans toward ourselves and toward others. Ultimately, the changing names of descendants of African slaves represents a continuing struggle by us to gain the power to define ourself. It represents a struggle to gain social and political power. While powerful groups do not appear to care about how they are labeled (i.e. Americans of British descent and Jews), powerless groups frequently try to relabel themselves. Powerful groups who are unwilling to give up power often meet these efforts with ridicule and hostility. “The power to name is frequently also the power to define. The power to name a group can be the power to position it socially and politically”. Charles Paul Freud, Rhertorical Questions: The Power of, and Behind, a Name, WASH. POST, Feb. 7, 1989, at A23.

6. I use the term “European-Americans” to denote individuals usually called “white”. Historically, ethnic Americans have been designated in a hyphenated name: “Black-Americans” “Asian-Americans” “Native-Americans” “Hispanic-Americans”. Presumption seem-
ently merely because of race.\(^7\) As a consequence, many African-

White people didn’t bother to define themselves racially in any particular way until rather recently. According to usage historian Stuart Berg Flexner, general references to “white men” entered the language only in the 1830s, and didn’t gain wide usage until the Civil War. What did whites call themselves until then? They called themselves “people” or “citizens.” In other words, they occupied, unchallenged, the center of their racial universe, and needed no further definition of the sort assigned to such outsiders as Indian “savages” or black slaves. “White” became an important term at the time of Emancipation; a reaction to the power threat presented by another racial group.

See, e.g., Freud, supra note 5, at A23.

Similarly, I reject the designation of “minorities” because of its connotation of subordination. It would be “nice” if no designations at all were needed, but the reality of the situation requires us to discuss the needs of specific ethnic groups. I used the term European-American rather than Anglo-Saxon to provide balance with the other designations; that is, designations which identifies the geographic region from which the original ancestors migrated.

7. See generally, Andy Dabilis, Racial episodes decried in Medford, Winchester, BOSTON GLOBE, Jan. 16, 1993, at 34 (maintaining “We’re for the white race. We believe in separation because mixing doesn’t work, We are miles apart in culture and intelligence. They are a couple of notches below us.”); MICHAEL KRONENWETTER, UNITED THEY HATE: WHITE SUPREMACISTS IN AMERICA (1992); Jill Hodges, A Surge of Hate: Number of Racist Incidents on rise STAR TRIB., Feb. 2, 1992, at 1B; John Carmody, Is U.S. Racist?, LOS ANGELES TIMES, Feb. 12, 1990, at P7, P8, C6 (surveying 204 stories about race relations that were aired on the three major networks shows that one out of three sources interviewed said America is racist); The Doug Wilder Solution, WASH. TIMES, Jan. 11, 1990, at F2 (asserting that the United States has gotten itself into a first-class race-relations mess because many otherwise intelligent, decent, good-hearted people have dedicated their lives to giving moral and legal force to racial stereotypes); Jonathan Kaufman, The Color Line, BOSTON GLOBE, June 18, 1989, at 16 (maintaining that whites have become disillusioned with blacks and lack interest in race relation); KEVIN FLYNN & GARY GERHARDT, THE SILENT BROTHERHOOD: INSIDE AMERICA’S RACIST UNDERGROUND (1989) (asserting that the movement has gathered a large majority of ordinary people. They see the underground’s survivalist creed as the way whites can protect their race from “living off of welfare”); Mary Katherine Joeckel, A Critical Study of Ideologies of Women in Contemporary White Supremacy, Dissertation, The University of Nebraska—Lincoln (1989) (maintaining that White supremacy is enjoying a new era of appeal in the United States. Today’s white supremacists differ from their ancestors in that they agitate for demolition of rather than changes in the existing social order); C. N. Hallman, L. F. Lister, White Supremacy and its Associated Groups: An Associated Bibliography; 17 REFERENCE SERVICES REV. 7-18 (1989) (reviewing recent scholarly and popular periodical literature, as well as recent books, reports, and curriculum guides about white supremacy and white supremacist groups in the U.S. Included are reports on the Ku Klux Klan, and neo-Nazi groups like Aryan Nations, and skinheads); Courtland Mulley, Racism Alive, Thriving, WASH. POST, May 23, 1985, at D1 (maintaining that race relations, is a matter of overwhelming concern among these African-Americans. The students raised questions about reports they had heard about the Aryan nation and the rise of white supremacist groups and racial violence).

In a national poll, when asked “In general, how do you think people in the United States feel about people of other races?”, 35% indicated that many white persons disliked blacks and 2% indicated that almost all white persons disliked blacks. Gallup Poll, May 10, 1992. On another question, when told that “on the average (negroes/blacks) have worse jobs, in-
Americans are injured by judgments or actions that are directly or indirectly racist.

Much of the attention of the last 20 years has focused on individual racist behavior. However, just as individuals can act in racist ways, so can institutions. Institutions can behave in ways that are overtly racist (i.e., specifically excluding African-Americans from services) or inherently racist (i.e., adopting policies that while not specifically directed at excluding African-Americans, nevertheless result in their exclusion). Therefore, institutions can respond to African-Americans and European-Americans differently. Institutional behavior can injure African-Americans; and, when it does, it is nonetheless racist in outcome if not in intent.

I. INTRODUCTION

Health care reform is a major initiative in the United States today. The concern regarding health care is widely discussed and recorded in literature that includes books, articles, and editorials.

8. See generally, John T. Harvey, Institutions and the Economic Welfare of Black Americans in the 1980s, 25 J. Econ. Issues 115-35 (1991) (explaining that the overall system that has developed since the civil rights movement has taken racism underground. The growing black underclass is still trapped in a circle of discrimination); Darnell F. Hawkins, The “Discovery” of Institutional Racism: An Example of the Interaction Between Law and Social Science, 6 RES. IN RACE & ETHNIC REL. 167-82 (1991) (discussing public policy implications of the distinction between individual and institutionalized forms of racial bias in the 1990s); Richard Lowy, Yuppie Racism: Race Relations in the 1980's, 21 J. Black Studies 445-64 (1991) (maintaining that Yuppie racism refers to the assumption by young urban professionals that the civil rights movement of the 1960's has corrected racial injustice in the US. The author argues that racism remains a major problem because young adults are ignorant of history and perpetuate the structural inequalities in American society); Benjamin P. Bowser, Race Relations in the 1980s: The Case of the United States, 15 J. Black Studies 307-24 (1985) (asserting that contrary to many social scientists' assumptions, ending overt prejudice and legislated segregation has not assured racial equality in the United States. Studies show how discrimination serves white self-interest as elite white groups protect their historic privilege through institutional racism and internal colonialism); Jenny Williams, Redefining Institutional Racism, in ETHNIC AND RACIAL STUDIES 323-48 (1985) (arguing that the historical use of the term "institutional racism," is a simplistic and misleading label for a complex situation); Eugene Victor Wolfenstein, Race, Racism and Racial Liberation, 30 W. Pol. Q. 163-82 (1977) (maintaining that institutional racism results when the charismatic group effect is routinized. Racial conflict of this sort prevents black and white workers from uniting); Charles S. Bullock, Harrell R. Rodgers Jr., Institutional Racism: Prerequisites, Freezing and Mapping 37(3) PHYLON 212-23 (1976) (arguing that even though blatant forms of discrimination have been banned by law, but subtle forms continue to exist. Discrimination still persists especially through the use of institutional subordination); Terry Jones, Institutional Racism in the United States, 19 Soc. Work 218-25 (1974) (examining the concept of institutional racism and some of the ways that these systems develop and maintain themselves).

9. For instance, according to the computerized legal search program Nexis, between
Most of the discussion focuses on reforming health care to control cost or to provide better access. Very little of that discussion observes the needs of persons of color, in general, and African-Americans, in particular.\(^{10}\)

The need to focus specific attention on African-American health care and health care reform is overwhelming. Not only are African-Americans sicker than European-Americans, they are dying at a significantly higher rate.\(^{11}\) These are undisputed facts. This disparity in health care has the effect of precluding African-Americans from gaining full access to the economic system. Decent health is a precursor to getting the other attributes, such as money, education, contacts, know-how, necessary to exploit the American system to full advantage. When people are sick and poor, they are just as enslaved as if the law made them so.\(^{12}\)

Factors affecting health include socioeconomic status, biology, and environment. Yet, in a racist society such as ours, the effect of race is all-encompassing. Race not only affects socioeconomic status, biology, and physical environment; it also affects the way health care institutions function to provide services. Independent of economics, race affects access to care. Independent of economics, race affects the type and quality of health care treatment received. Consequently, to improve the health of African-Americans, it is not sufficient merely to remove economic barriers to access. To improve the health of African-Americans, health care institutions must be more than affordable. They must be just.\(^{13}\) If we want justice in

\(^{10}\) During the same period mentioned infra., only forty articles mention minority interests and its relationship to health care reform.

\(^{11}\) See, text infra section F and notes accompanying footnotes.

\(^{12}\) See generally, NORMAN DANIELS, JUST HEALTH CARE (1985) (arguing that health care is of special moral importance because it affects an individual's share of the range of opportunities normal for his society).

\(^{13}\) Distributive justice involves the dissemination of social goods or ills. To have distributive justice, not only should like cases be treated the same but unlike cases should be treated differently. However, there must be a morally relevant reason for treating people differently. A "just" society is one in which, at a minimum, a person can take advantage of the "normal" range of lifetime opportunities in that society. Since individuals must have "normal species-typical functioning" to avail themselves of that normal range of opportunities. A just society would assure access to some basic level of services and assure that those services are provided in a culturally sensitive non discriminatory manner. See, e.g., NORMAN DANIELS, supra note 12, at 1-17 (arguing that health care should be distributed more equally than other social goods); P. MENZEL, MED. COSTS, MORAL CHOICES: A PHILOSOPHY OF HEALTH CARE ECONOMICS IN AMERICA 85 (1983) (emphasizing that if health care is a necessity, it should be realistically accessible to all, including those who cannot easily afford it); Buchanan, The Right to a Decent Minimum of Health Care, 13 PHIL. & PUB. AFF. 55, 55
health care for African-Americans, then every effort must be made to design a system that provides needed health care by assuring complete access and by eliminating institutional racism. Consequently, a just health care system will focus on eliminating the disparity in health care between African-Americans and European-Americans. Several policy approaches can be taken to deal with this issue: 1) expanding insurance coverage, 2) targeting special health services to African-Americans, and/or 3) using Title VI of the Civil Rights Act of 1964\textsuperscript{14} to eliminate racist practices in health care delivery and health care education.

This paper evaluates these policy options and the feasibility of reforming an unjust health care system to meet the needs of African-Americans. Part I explores the disparity between the health status of African-Americans and European-Americans. Part II discusses the health care system and the manifestations of institutional racism. Part III analyzes selected policy options for making the health care system more just.

II. DISPARITY IN AFRICAN-AMERICAN AND EUROPEAN-AMERICAN HEALTH STATUS

Negroes (or African-Americans) have been subject to victimization in the sense that a system of social relations operates in such a way as to deprive them of a chance to share in the more desirable material and nonmaterial products of a society which is dependent, in part, upon their labor and loyalty. They are 'victimized' also, because they do not have the same degree of access which others have to the attributes needed for rising in the general class system—money, education, contacts, know-how and health.\textsuperscript{15}

Full participation in a society requires money, education, contacts, know-how and health.\textsuperscript{16} Health is not only significant in itself, but it also affects availability of and decisions regarding choices throughout one's life.\textsuperscript{17}


\textsuperscript{16} See infra text accompanying notes 20-30.

\textsuperscript{17} National Research Council, A Common Destiny: Blacks and American Society 393 (Gerald D. Jaynes & Robin M. Williams, eds. 1989).
For example, lack of prenatal care leads to greater likelihood of infant death, neurological damage, or developmental impairment; childhood illnesses and unhealthy conditions can reduce learning potential; adolescent childbearing, substance abuse and injuries cause enormous personal, social and health effects; impaired health or chronic disability in adults contributes to low earning capacity and unemployment; chronic poor health among older adults can lead to premature retirement and loss of ability for self-care and independent living.\textsuperscript{18}

Thus, health status is an important ingredient in a person's "social position, . . . present and future well-being,"\textsuperscript{19} and a critical one for African-Americans. When one is born poor, with limited opportunity for quality education and with the burden of racism, one's "good" health becomes the only fungible asset. Understanding the nature of African-Americans health, is critical to appreciating the racist nature of health care institutions.

Health is a complex concept that is difficult to measure.\textsuperscript{20} The difficulty in assessing one's health may result, in part, from a general inability to conceptualize good health. In addition, widespread professional disagreement over the meaning of health contributes to the difficulty in measuring it.\textsuperscript{21}

The World Health Organization defines health as "... a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."\textsuperscript{22} However, for African-Americans that definition has little validity. Given the fact that the pervasive nature of racism in American society affects African-Americans at all economic levels, there cannot be "complete . . . mental and social well-being"\textsuperscript{23} for African-Americans until the problem of racism in society is addressed and resolved.

Health is also defined as a "lifestyle in which an individual attempts to maintain balance and to remain free from physical incapacity while maximizing social capacity."\textsuperscript{24} That definition

\textsuperscript{18} Id.
\textsuperscript{19} Id.
\textsuperscript{20} \textit{See}, U.S. DEPT. OF HEALTH & HUMAN SERVICES, HEALTH STATUS OF MINORITIES AND LOW INCOME GROUPS: THIRD EDITION 5-8 (1991) (exploring different facets of health care that affect the overall health of minorities and low income groups).
\textsuperscript{21} One reason the definition presents a problem is that the professionals tend to use such subjective measures to define health.
\textsuperscript{23} Id.
\textsuperscript{24} Id.
currently has more validity for African-Americans because it recognizes that an individual's lifestyle impacts health and that lifestyle is influenced by social class. It recognizes that African-Americans, surrounded by racism, cannot strive for complete mental well-being, but can strive to maintain a balance. The definition recognizes that what the African-American must do to maintain balance and remain free from physical incapacity will be different from what is required of the European-American. For instance, recent discussions regarding hypertension among African-Americans hypothesize that the ongoing continued stress of living in a racist society may be a significant factor in the development of hypertension. If this is true, then a lifestyle of dieting and exercise (recommended preventive activity for hypertension) would not be sufficient to prevent hypertension in African-Americans although it might suffice for European-Americans.

Whatever the definition of health, generally speaking, "health" may mean the presence or absence of disease. Using that definition of health, there are several ways to determine health: by direct observations, records, and self-report. Each of these ways of measuring health presents its own measurement problems. First, inaccuracies can occur in direct observations because medical practices and diagnostic labeling may vary. That variation may be not only by geographic area but by physician and hospital. Second, interpretation errors can result if researchers misinterpret symptoms and results, or when researchers inappropriately generalize based on a condition of another time or a more general population group. Finally, failure to consider intra-ethnic diversity may lead to erroneous conclusions about African-American health.

Whatever the difficulty in measuring health status, understanding the full extent of differences in health between African-Americans and European-Americans is essential to fully appreciate the need for reform in the health care system and to understand inadequacies in current reform approaches that ignore, dismiss, or do not

26. Id. at 75-76. See generally, Ronald M. Anderson et al. Total Survey Error: Applications to Improve Health Surveys (1979).
27. Andersen et al., supra note 25, at 76.
29. Id.; See also, J.J. Jackson, Urban Black Americans, in Ethnicity and Medical Care 37-129 (A. Harewood eds., 1981) (noting that studies need to account for potentially large differences between northern and southern blacks, urban and rural blacks, native and foreign-born blacks).
recognize these difference. To describe the health status of African-American, this paper presents research on the amount of dissatisfaction, discomfort, disability, disease, low-birth weight, and death that occurs in the African-American population as compared to the European-American population.\(^\text{30}\)

**A. Health Status: African-Americans' Dissatisfaction**

Dissatisfaction is the degree of discontentment a person has with his or her health.\(^\text{31}\) As a measure of health, it is assumed that a person who has poor health will be more dissatisfied overall than a person with good health. Because it relies on this self-evaluation, dissatisfaction is the *most* subjective of the health measurements. In fact, the reasons for dissatisfaction with health vary not only based on an individual's situation, but also on ethnicity, race, and culture. Consequently, it is subject to many potential interpretive errors.\(^\text{32}\)

Nevertheless, 17% of African-Americans report their health as fair or poor compared to 9% of European-Americans.\(^\text{33}\) That is, 88.8% more African-Americans than European-Americans reported their health as fair or poor.\(^\text{34}\) Similarly, 50% more African-

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30. D.L. Patrick and J. Elinson, *Methods of Sociomedical Research*, in *HANDBOOK OF MED. SOC.* 437-59 (H. Freeman et al. eds., 1979). Articles discussing health status of African-Americans often only utilize death rates. I attempt to utilize a broad range of health status measurements to give the reader a more thorough view of African-American health status and a broader basis for assessments. Although more complete, such an approach raises some conflicts. Some of the more subjective measurements don't always support a position that African Americans have "poorer" health status than European-Americans. While it is the position of this paper that African-Americans suffer from a "poorer" health status, the contradictory results of subjective measurements does not disprove the thesis of this paper. In fact these apparent discrepancies are important in that they show subjective reporting differences and the problem institutions will face if they rely only on subjective data for health status analysis.

31. Dissatisfaction information is collected by means population surveys, individual and household surveys, and surveys of hospitalized patients. Andersen et al., *supra* note 25, at 81.

32. *Id.*

33. *Id.* at 82-83.

34. The excess percent is calculated by dividing the European-American rate into the African-American rate multiplying by 100 and subtracting 100. For example, to obtain the 1987 excess death rate for both sexes you divide the European-American death rate (511.1 per 100,000) into the African-American Death Rate (778.6 per 100,000) to obtain 1.5234. You multiple 1.5234 by 100 to obtain 152.34%; and you subtract 100 to obtain the excess death rate of 52.34%.

The disparity in perception of health status is present in all age groups. To illustrate this point consider that the percent of African-Americans between the age of five and seventeen who assessed their health status as fair or poor was 4.2%, while the percent of European-Americans in that same age range and making the same assessment was only 2.1%. IRENE JILLSON-BOOSTROM, *SHATTERED HOPES, ENDANGERED LIVES: THE HEALTH AND WELLBEING OF ADOLESCENT MINORITY MALES IN THE UNITED STATES, A REPORT PREPARED FOR THE OFFICE OF MINORITY HEALTH* (Sept. 30, 1990).
Americans than European-Americans report themselves as having some, little, or no satisfaction with their health and physical condition. Notwithstanding interpretive errors, these figures reflect a significant difference between African-Americans' and European-Americans' dissatisfaction with their health.

B. Health Status: African-Americans' Discomfort

Discomfort is the level of such feelings as aches and pains, tiredness, and sadness experienced by an individual. As for dissatisfaction, this information is obtained through self-reporting and is subject to considerable measurement error. Surveyors asked individuals to check fifteen symptoms that were (or were not) experienced in the last year. Some symptoms related to the various body systems representing both acute and chronic problems. Some symptoms were common experiences such as sore throat or runny nose. Other symptoms were infrequent and often associated with serious problems such as the loss of more than ten pounds in weight. The mean number of symptoms reported represents the score for a population group.

Measuring health status by the results of reported discomfort surveys presented some interesting results. One such result is the fact that African-Americans under 45 years of age actually reported fewer symptoms than European-Americans. There are several ways to interpret this result. The most obvious is that the African-American age group, in fact, has fewer and less severe symptoms. However, that interpretation would be at variance with results of

35. Andersen et al., supra note 25, at 83 (quoting National Opinion Research Center, 1985). Twelve percent of African Americans compared to 8% of European-Americans report "some, little, or no satisfaction" with their health and physical condition. Id.
36. Id. at 80.
37. Id.
38. Id. at 81.
39. Id. at 83 (quoting Center for Health Administration Studies, University of Chicago, unpublished data study described in Andersen et al., Ambulatory Care and Insurance Coverage in an Era of Constraint, Ch. 6 and app. A (1987)). During 1985, African-Americans in the age group under 18 reported 0.4 symptoms per person per year while European-Americans reported 0.6 symptoms resulting in a -33.3% excess discomfort. Id. In the age group 18-44, African-Americans reported 1.1 symptoms per person per year while European-Americans reported 1.3 symptoms resulting in a -15.4% excess discomfort for African-Americans. Id. African-Americans 45-64 years old reported 1.9 symptoms per person per year while European-Americans reported 1.7 symptoms resulting in a 11.8% excess discomfort for African-Americans. Id. Finally, African-Americans over 65 reported 2.1 symptoms per person per year while European-Americans reported 2.0 symptoms resulting in a 5% excess discomfort for African-Americans. Id.
studies based on more objective measurements, i.e., death rates. A second interpretation of this interesting result is that there is considerable under-reporting among African-Americans, particularly of the more serious symptoms. That interpretation is strengthened by a finding that once African-Americans with symptoms are in the health care system, they require more visits than their European-American counterparts. Thus, it is more likely that the under-reporting of symptoms contributes to an inaccurate reflection of health status.

C. Health Status: African-Americans’ Disability

Health status based on disability can be defined as the inability to engage in gainful employment; or as the temporary or long-term reduction of a person’s activities because of a health condition. Health researchers generally use three measurements of disabilities: restricted activity days, work loss days and bed disability days. This paper uses restricted activity days as a measure of health status since restricted activity days is a broader measurement than work loss days, and work loss days would not necessarily include unemployed individuals. It is also broader than bed disability days, since an individual could be sick enough to have many activities restricted without necessarily being confined to bed.

As in the other measurements, using restricted activity days to represent health status can lead to significant interpretive error. First, there are a number of reasons a person may lose workdays. Employees may take sick days to stay home with a sick child; children may miss school for physician appointments; and, people may falsely claim disability to collect insurance money. Second, instead of being a measure of disease, disability may be more a mea-

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40. Death rates include homicide rates since death by means of violence is considered a public health issue. See infra note 71.

41. There are a number of reasons why African-Americans might under-report symptoms. First, in a culture that has limited access to health care, it might be viewed as futile to complain about “aches and pains” Second, African-Americans may actually expect some “aches and pains” as normal and not a sign of illness. Third, African-Americans may be reluctant to complain to a stranger about their health. While all these reasons can be articulated by other populations subgroups, it may be that given the impact of racism, African-American are more reluctant than other to complain about their health and/or to seek help.

42. Andersen et al., supra note 25, at 95; Joanna Kravitis & John Schneider, Health Care Need and Actual Use by Age, Race and Income, in EQUITY IN HEALTH SERVICES, 186 (R. Andersen et al., 1975).

43. Andersen et al., supra note 25, at 80.

44. Id.

45. Id.; See generally, Patrick & Elinson, supra note 30, at 437-59 (H. Freeman et al. eds., 1979).
sure of morale and conformity. Despite the risk of interpretive error, restricted activity days are accepted as a general measure of health status.

Using the number of days of restricted activity per year, African-Americans under age five have no extraordinary disability. This outcome is entirely predictable since a child under five is involved in neither school nor work. What is not predictable is the 22.8% fewer restricted activity days for African-Americans in the age group 5-17. Given the higher death rate and disease rate of African-Americans to that of European-Americans in this age group, it is likely that this difference is either an interpretation or reporting error. This assessment of error would seem particularly true since African-Americans in the eighteen-and-over age group reported 37.5% more days of activity restriction per year than European-Americans.

D. Health Status: African-Americans’ Disease Rate

Health status may also be based on the presence of which disease can be divided into acute conditions and chronic conditions.

47. Id. at 83, quoting National Health Statistics 1985, Table 69.
48. African-Americans have higher death rates for every age group except 85 years and older. The African-American to European-American Death ratio for 1 to 4 years old is 1.80, for 5-9 years it is 1.62, for 10-14 years it is 1.25 and for 15-19 years it is 1.04. See U.S. DEPT. OF HEALTH & HUMAN SERVICES, *supra* note 20, table 16 at 30.
49. It is interesting to note that when looking at the number of school-loss days associated with acute conditions per 100 youths aged 5-17, African-Americans had 427.2 days whereas European-Americans had 322 days. National Center for Health Statistics, CURRENT ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY, 1988D.
50. For example, the 5-17 year old age group could in fact have more illness but fewer restricted days because of cultural differences. African-American culture tends to encourage individuals to continue activity despite illness. This is especially true for children since families may not afford to take the child to the doctor or to take off work to stay at home with a sick child. Thus, it could be that African-American children are actually encouraged to continue activities despite illness.
51. Andersen, et al, supra note 25, at 83 quoting National Center for Health Statistic, 1985, Table 69. African-Americans under 5 had the same number of days of restricted activity (9 days) as European-Americans. Id. African-Americans between the age of 5 and 17 reported fewer (7 days) of restricted activity than European-Americans (9 days) resulting in an excess disability for African-Americans of -22.2%. Id. Finally, African-Americans over 18 reported more (22 days) of restricted activity than European-Americans (16 days) resulting in an excess disability for African-Americans of 37.5%. Id.
52. Acute conditions are those diseases or injuries that last less than two weeks. Commonly, those diseases reported as acute conditions are respiratory problems such as colds and minor injuries. Andersen et al., *supra* note 25, at 85.
tions. The most common method of determining the presence of disease in a population is by reviewing hospital medical records. When measuring African-American health based on reported acute conditions, it would appear that African-American health is better than that of European-Americans. For the age group under eighteen, 36.3% fewer African-Americans than European-Americans reported acute health conditions; for the 18-44 age group, 15.9% fewer African-Americans than European-Americans reported acute conditions; and, for ages 45 and above, 10.1% reported fewer conditions. Interestingly, despite the seemingly lower incidence of acute diseases among African-Americans, they have a higher mortality rate from acute conditions than European-Americans have.

The percentage calculated for limitations in activity due to chronic diseases is higher in African-Americans than in European-Americans for all age groups. For instance, for the under-18 age group, 20% more African-Americans than European-Americans reported limitations in activity because of chronic disease; for the 18-44 age group, 22.5% more African-Americans than European-Americans reported limitations; in the 45-64 age group, 34.8% more African-Americans than European-Americans reported limitations; and in the 65-69 age group, 31.6% more African-Ameri-

53. Chronic conditions are those conditions that have lasted two weeks or longer. Chronic conditions include diseases or impairments that are likely to be irreversible. These diseases range from the major killers such as heart disease to others less likely to kill but which can result in considerable debilitation such as arthritis. Andersen et al., supra note 25, at 84.

54. Like other records, hospital medical record also have their deficiencies. For example, because not all illnesses are covered in medical records, the records may present a biased picture of the illnesses of a population due to non-coverage of all illnesses. Id. at 79. See generally, Kravitis & Schneider, supra note 42, at 169-87.

55. Andersen et al., supra note 25, at 83 quoting National Center for Health Statistics, 1985, table 3. CURRENT ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY, 1985, series 10, no. 160. African-Americans under 18 had fewer acute conditions (183 per 100 persons per year) than European-Americans (283 per 100 persons per year) resulting in an excess disease-acute conditions of -36.3%. Id. African-Americans 18-44 had fewer acute conditions (130 per 100 persons per year) than European-Americans (174 per 100 persons per year) resulting in an excess disease-acute conditions of -15.9%. Id. African-Americans 18-44 had fewer acute conditions (98 per 100 persons per year) than European-Americans (109 per 100 persons per year) resulting in an excess disease-acute conditions of -10.1%. Id.

56. Id.

57. See, U.S. DEPT OF HEALTH & HUMAN SERVICES, supra note 20, at 154-57. For instance, African-American males have 58% more deaths from pneumonia than European-American Males. African-American females have 26% more deaths from pneumonia than European-American females. Id. at 155-56 (Table 23-24).

58. Chronic diseases can be divided into those which limit activities and those that do not. As a measurement of severity, those chronic diseases that limit activity are more severe.
cans reported limitations than European-Americans. Finally, in the seventy-and-over age group, 23.8% more African-Americans than European-Americans reported limitations. Therefore, while African-Americans report fewer acute conditions, they tend to report more limitations based on chronic conditions.

E. Health Status: African-Americans’ Low Birth Weight Rate

Low birth weight is a common measurement of the health of infants. Low birth weight is defined as weight of less than 2500 grams. Prior to the 1960’s, low birth weight infants had a very low chance of survival. As survival rates improved, low birth weight babies were often found to suffer extensive handicaps, including severe and moderate mental retardation, cerebral palsy, seizure disorder, blindness, hearing defects, and behavioral, learning, and language disorders. Therefore, low birth weight can be an objective measurement of future health status.

In 1980, European-Americans had a low birth weight rate of 5.7%, while African-Americans had a low-birth-weight rate of 12.5%. The evidence indicates that while low birth weight is holding steady at 5.7% for European-Americans, it has actually risen over the last 12 years to 12.7% for African-Americans. Therefore, African-American infants are 222.81% more likely to suffer from low birth weight and its accompanying handicaps.

F. Health Status: African-Americans’ Death Rate

The most objective measure of health is the death rate. De-
spite some subjective self-reporting (dissatisfaction, discomfort and acute disease), which might suggest equal, if not better well-being among the African-American population, the objective statistics based on death show just the opposite.

Wounded, [racism] retreated to more subtle expressions from its most deeply entrenched bunker . . . [F]orms of sophisticated racism attached to economic opportunities unfortunately can still be found today.

. . . NOWHERE IS THAT BETTER EXEMPLIFIED THAN IN THE RATE OF EXCESS DEATH AMONG BLACK AMERICANS.64 (emphasis added).

"Excess death" is the number of deaths actually observed prior to the age of 70 years, minus the number of deaths that would be predicted when age- and sex-specific death rates of the U.S. European-American population are applied to the African-American population.65 African-American women have 53.12% excess deaths and African-American men have 52.67% excess deaths.66

increasing age, comparisons among populations over time must be adjusted for differing age distribution. Thus mortality rates are adjusted in accordance with the weights in the age distribution of a standard population. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH STATUS OF MINORITIES AND LOW-INCOME GROUPS: THIRD EDITION.

However, even this information presents measurement problems. The number and causes of deaths for African-Americans and European-Americans is usually obtained from death certificates and autopsy reports. However, the amount and quality of data on deaths varies and depends on a number of factors including: the extent to which the deceased were medically studied before death, the degree of familiarity that certifying physicians had with them, changes in diagnostic and demographic terminology, frequency of misclassifications and the accuracy and completeness of the information. Andersen et al., supra note 25, at 78-79. Furthermore, comparisons of deaths for African-Americans to European-Americans may reflect "survivor effects as well as selection by competing causes which can lead to interpretive errors". Id. at 79. See also, Richard Cooper & Brian E. Simmons, Cigarette Smoking and Ill Health among Black Americans, 83(7) N.Y. ST. J. MED. 344, 349 (1985).

64. Joe Feagin, Slavery Unwilling to Die: the Background of Black Oppression in the 1980s, 17 J. Black Studies 173, 200 (1986) (arguing that the theory of internal colonialism views blacks as slaves of society. The history of blacks in the US is traced, beginning with the introduction of slavery during the 1600s. The features of slavery—legal until the passage of the 13th Amendment in 1865 — persisted as a form of semi-slavery 1960 and as a different form of institutionalized racism later). See also, Lonnie R. Bristow, Mine Eyes Have Seen, 261 JAMA 284, 284-85 (1989). Since the civil rights and voting rights laws of the early 1960s the United States has seen significant changes in the status of African-Americans. However, it is arguable whether "apartheid-U.S. . . . or whether economic segregation and the perpetuation of our essentially feudal status amount to its continuation, in fact, if not in law." Romona Hoage Edelin, Toward An African-American Agenda: An Inward Look, in THE STATE OF BLACK AMERICA 173, 177-79 (Janet Dewart ed., 1990). Death rate statistics seem to suggest that the feudal status of African-Americans has continued in fact.

65. Bristow, supra note 64, at 284.

66. European-American males had aged adjusted death rates of 668.2. African-American males had aged adjusted death rates of 1023.2. The excess death rate for African-American males was 53.13%. European-American females had aged adjusted death rates of 384.1. African-American females had aged adjusted death rates of 586.2. The excess death rate for
In fact, African-Americans experience 60,000 excess deaths a year compared to mortality rates of European-Americans. When death rate statistics are broken down by causes of death, the data are striking. For instance, African-American women had 324.1% more deaths due to homicides, 67 163% more deaths due to diabetes, 77.6% more deaths due to cerebrovascular disorders, 78.4% more deaths due to cirrhosis of the liver, and 78.4% more deaths due to heart disease than European-American women. Furthermore, African American women have a 178.43% excess maternal rate. African-American men had 598.7% more deaths due to homicides, 100% more deaths due to diabetes, 92.6% more deaths due to cerebrovascular disorders, 88.4% more deaths from cirrhosis of the liver, and 81.8% more deaths due to pulmonary infectious disease than European-American men.

Deaths in the first year of life have consistently been used as an objective determination of health of a population. Therefore, it is

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African American females was 52.62%. European-American (both sexes) had aged adjusted death rates of 511.1. African-American females had aged adjusted death rates of 778.6. The excess death rate for African American females was 52.34%. Department of Health and Human Services, supra note 20, at Table 13, p. 26-27, and Table 3, p. 143.


68. Health status includes not only physical health but mental health as well. Thus, in a racist, oppressive society, homicides is as much an indication of mental health and public health as suicide. See generally, Beth Alexander, Violence: a public health problem. (Editorial), 8 PEDIATRICS FOR PARENTS, 1 (1992); Laurie Jones, Gun violence as Public Health Issue 35 AM. MED. NEWS 3 (1992); C. Everett Koop & George Lundberg, Violence in America: a Public Health Emergency, 267 JAMA 3075 (1992); Antonia C. Novello et al., A Medical Response to Violence, 267 JAMA 3007 (1992). Violence takes a high toll in mortality, morbidity, quality of life, and use of health care resources. Belloni et al., Application of Principles of Community Intervention, 106 PUBLIC HEALTH REP. 244, 244-47 (1991). It has been a community problem from early American history. "Before there was professional law enforcement, everyone in a community was involved in crime prevention." Id. at 245-46. Thus, recognizing homicide as a health issue is a return to deep rooted ideas of community. Id. at 245. See generally, D.E. Beauchamp, Community: The Neglected Tradition of Public Health, HASTINGS CTR. REP. 28, 28-36 (1985).

69. Andersen et al., supra note 25, at 84 (quoting National Center for Health Statistics 1986a, Table 21).

70. This is the rate of death per 100,000 live births from deliveries and complications of pregnancy, childbirth and the immediate period after childbirth (the puerperium). Department of Health and Human Services, supra note 20, at 100 Table 1.


72. Andersen et al., supra note 25, at 84 quoting National Center for Health Statistics 1986a, Table 21.
significant that in the first year of life, 108.14% more African-American infants die than do European-American infants. Finally, not only is infant mortality used as an objective determination of the health of a population, but it is also used as a measure of the health of a nation. Generally, the United States infant mortality rate is reported as one general rate: 8.6 which places the United States twenty-second among nations. However, as indicated, that rate is misleading. When compared to the infant mortality of other nations, African-Americans rank thirty-second among countries compared to European-Americans' twelfth-place ranking.

G. Summary

The picture that is clearly painted by these health measurements is one of significant disparity between two races. While there are some age group variations in the more subjective health measurements (e.g., dissatisfaction), the most objective health measurement (death) clearly indicates that African-Americans are sicker than European-Americans.

If African-Americans are sicker as a result of disparate treatment in the health care system, then they are victims of unequal access to health care. Without decent health, it becomes nearly impossible for African-Americans to gain the other attributes (money, education, contacts, know-how) necessary to gain access to the American economic system. Therefore, when African-Americans are sick and poor, they are just as enslaved as if the law made them so.

73. See also, U.S. DEPT. OF HEALTH & HUMAN SERVICES, supra note 20, at 113 (Table 14); Antonio A. Rene, Racial Differences in Mortality: Blacks and Whites, in Jones, supra note 22, at 21. African-Americans had more infant deaths (17.9 per 1,000 live birth) than European-Americans (8.6 per 1,000 live birth). Id. Thus, the excess infant mortality for African-Americans was 108.2%.

74. U.S. Department of Health and Human Services, supra note 25, at 104, Table 5.

75. NATIONAL RESEARCH COUNCIL, supra note 17, at 398. On an international level African American ranked 32nd after Portugal (17.8) and Cuba (16.5). European-Americans ranked 12th after Spain (8.5) and France (8.3). Japan Ranked 1st with only 5.5 infant deaths per 1,000 live births. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH STATUS OF MINORITIES AND LOW-INCOME GROUPS: THIRD EDITION, 104, Table 5: Infant Mortality Rates: 36 Selected Countries, 1980-1985.

76. See generally, H.R. REP. No. 804, 101st Cong., 2nd Sess. 1990, 1990 U.S.C.C.A.N. 3296 (finding that African-Americans are disproportionately represented among individuals from disadvantaged backgrounds and that the health status of individuals from disadvantaged backgrounds, including racial and ethnic minorities, in the United States is significantly lower than the health status of the general population of the United States).

77. Andersen et al., supra note 25, at 82.

78. See KNOWLES & PREWITT, supra note 15, at 1 (inferring from others quotes that African-Americans have been denied opportunities that they have helped develop).
III. INSTITUTIONAL RACISM AND AFRICAN-AMERICAN HEALTH STATUS

Racism is both overt and covert, it takes two closely-related forms: individual whites acting against individual blacks, and acts by the total white community against the black community. We called these 'individual racism and institutional racism'. The first consists of overt acts by individuals, which causes death, injury or the violent destruction of property. The second type is less overt, or more subtle, less identifiable in terms of specific individuals committing the acts. But, it is no less destructive of human life. The second type originates in the operation of established and respected forces in the society, and thus receives far less public condemnation than the first type.

When white terrorists bombed a black church and killed 5 black children, that is an act of individual racism, widely deplored by most segments of the society. But, . . . [when] black babies die each year because of the lack of proper food, shelter, and medical facilities, and thousands more are destroyed and maimed physically, emotionally, and intellectually because of conditions of poverty and discrimination in the black community, that is the function of institutional racism.79

African-Americans are sicker than European-Americans.80 Knowing that African-Americans are sicker than European-Americans does not explain why. It certainly does not indicate the presence of institutional racism. To understand the role of institutional racism in health status requires an understanding of how health status is determined.

Many things affect health status. An individual’s personal lifestyle choices affect health status because they affect an individual’s personal behavior and psycho-social health, which affect his or her physical health. Physical environment and biology also affect health status. Health care institutions affect health status because both personal behavior and human biology are affected by an individual’s access to health care, and by the quality of health care the individual receives from health care institutions.81

Class theory maintains that the primary factor affecting differences in health care status between racial groups is socioeconomic.82 According to the class theory, socioeconomic class affects

79. CARMICHAEL & HAMILTON, supra note 1, at 4.
80. See supra text and accompanying notes 15-78.
81. Trevor Hancock, Beyond Health Care: From Public Health Policy to Healthy Public Policy, 76 CAN. J. PUB. HEALTH 9, 11 (Supp. 1985).
82. When individuals are separated into different racial population groups, there is general recognition of a health disparity between them. The explanation usually given for this disparity is that differences exist in socioeconomic status or class.
life-style, psycho-social behavior, personal behavior, human biology, physical environment, access to health care, and the behavior of the system and its institutions toward the individual. According to the class theory, it is lack of money, not racism, that explains the disparity in health.

Certainly, access to health care services is related to ability to pay, and ability to pay is related to access to health insurance. It is estimated that 37 million Americans are uninsured. The spiraling costs of health care and health insurance make it impossible for many individuals to afford to purchase either privately. And yet, only about half of the poor meet government assistance programs' eligibility requirements. Many African-Americans are unemployed or employed in jobs that do not provide health care insurance. Many African-Americans are above the poverty line, disqualifying them for government assistance programs. Other African-Americans, approximately 25%, fall between the cracks, uninsured, without government assistance and without equitable access to health care. Consequently, many policy makers are suggesting health care reform proposals designed to minimize the effect ability (or inability) to pay has as a barrier to health care.

Even if any of the health care reform proposals are successful, the effect of socioeconomic class on health status will not be eliminated. In fact, its major effect will still exist, since socioeconomic class will continue to affect personal behavior and psycho-social health, physical environment, and human biology. Nevertheless, theoretically, access to health care will no longer be based on economics and ability to pay. If one accepts the class theory, then one must believe that establishing a universal health insurance will minimize the impact of class on health care access and should result in improved health for African-Americans.

The class theory, however, oversimplifies the issue and com-

83. Certainly, poverty is a major factor in health. The poor are unable to afford the food, housing, clothing and education which would allow them to be equal participants in America society. Notwithstanding the role of poverty in health, in America, race has a separate and independent role which has never fully been addressed.

84. See generally, Lawrence D. Brown, The Medically Uninsured: Problems, Policies and Politics, 15 J. HEALTH POL., Pol'y & L. 315, 318 (1990); Karen Davis, Closing the Gap in Health Insurance Coverage for African-Americans (Unpublished paper on file at Case Western Reserve, Health Matrix); Jack Hadely et al., Comparison of Uninsured and Privately Insured Hospital Patients, 265 JAMA 374, 376 (1991) (suggesting that the amount of care an individual receives is related to whether the individual has health insurance).

85. See infra note 206 and accompanying text.

86. See infra notes 204-27 and accompanying text.
completely ignores the independent role of race in American society.\textsuperscript{87} Race influences not only life-style, personal behavior, psycho-social behavior, physical environment, and biology, but also socio-economic status. Thus, race has a double influence.

Racism in America establishes separate and independent barriers to health care institutions and to medical care. Those who advocate for the class theory ignore the fact that removing economic barriers does not remove racial barriers. Racial barriers to health care are exhibited in two areas. First, institutional policies based on race establish barriers to access to health care to African-Americans. Second, practitioners provide disparate medical treatment to African-Americans based on their race which is not related to their socioeconomic class.

A. Racial Barriers to Access

It is hard to separate the effects of discrimination from those of concentration of Negroes in those areas where medical facilities are not easily accessible and in those income brackets that do not permit the purchase of medical facilities in the competitive market. Discrimination increases Negro sickness and death both directly and indirectly and manifests itself both consciously and unconsciously. Discrimination is involved when hospitals will not take in Negro patients; or when—if they do permit Negro patients—they restrict their numbers, give them the poorest quarters, and refuse to hire Negro doctors and nurses to attend them. . . . Ill health reduces the chance of economic advancement, which in turn operates to reduce the chance of getting adequate medical facilities or knowledge necessary for personal care.\textsuperscript{88}

Discrimination in health care has its foundation in the historical relationship between African-Americans and southern medical institutions. As slaves, African-Americans were perceived as property.\textsuperscript{89} While slave owners attempted to protect their own economic interests by providing minimal health care, most left the


\textsuperscript{88} Gunnar Myrdal, \textit{An American Dilemma} 174 (1944).

\textsuperscript{89} Slavery in North America was one of the "harshest form of social relations ever to exist." Alphonso Pinkney, \textit{Black Americans} 2 (1969). The slave had no rights and received no protection from society. The slave owner had absolute power over the slave. \textit{Id.}
slaves to live or die as fate might befall them.\(^{90}\)

After the Civil War, the Bureau of Refugees, Freedmen and Abandoned Lands (Freedman Bureau) was instituted to “furnish supplies and medical services” to the former slaves.\(^{91}\) However, the Freedman Bureau had very limited effect in providing services to former slaves. In fact, the Compromise of 1877 effectively ended the period of Radical Reconstruction which had been an attempt by the nation to make affirmative efforts in helping African-Americans.\(^{92}\)

During the Post-Reconstruction era, African-Americans were excluded from health care either by prohibition or discrimination.\(^{93}\)

[Even] where segregation and discrimination [were] not required by law they became deeply ingrained in the mores. Such behavior became part of the American Way of Life'. . . . \(^{94}\)

This “way of life” remained visible until the Civil Rights Move-

\(^{90}\) Pinkney, supra note 89, at 6. Jones & Rice, supra note 22, at 6; see also, Mitchell Rice, On Assessing Black Health, 9 URB. LEAGUE REV. 6, 6-12 (Winter 1985-1986). The dual status of slaves as valuable property and as persons with human rights may have encouraged some slave owners to provided, at least minimal health care. See generally, J. Thomas Wren, A. “Two-Fold Character: The Slave as Person and Property in Virginia Court Cases, 1800-1860, 24 S. STUD. 417-31 (1985) (maintaining that although slaves were perceived as property in the antebellum South, Virginia courts often recognized their humanity as well. By 1860, the Southern legal system had begun to accept an implicit duality in the states of the slaves as both property and person); Arthur Howington, “A Property of Special and Peculiar Value: The Tennessee Supreme Court and the Law of Manumission, 44 TENNESSEE HIST. Q. 302-17 (1985); Winstanley Briggs, Slavery in French Colonial Illinois, 18 CH. HIST. 66-81 (1989-90) (arguing that the high cost of slaves and the risk of offending tribal neighbors,” led the settlers to treat their slaves as subordinate, but valuable property).

\(^{91}\) Pinkney, supra note 89, at 24 (citing John H. Franklin, Reconstruction After the Civil War 36-37) (1961)).

\(^{92}\) Throughout the period of Reconstruction, attempts were made to obstruct the progress toward “racial democracy.” Pinkney, supra note 89, at 26. The 1876 election was in dispute between Rutherford B. Hayes (Republican) and Samuel Tilden (Democrat). Hayes was declared winner with the understanding the remaining troops in the South would be withdrawn, the south would be accorded home rule, and with the assurance that the “dominant whites [would have] political autonomy and nonintervention in matters of race policy.” Pinkney, supra note 89, at 26 (citing Woodward, Reunion and Reaction 246 (1966)). Thus, the Republican Party “abandon[ed] the Negro to former slave holders [and] the compromise signaled a return toward slavery.” Pinkney, supra note 89, at 26

\(^{93}\) Jones & Rice, supra note 22, at 6.

\(^{94}\) For instance, in 1875 Congress passed the Civil Rights Act which made it a crime for a person to deny any citizen equal access to accommodations in inns, public conveyances, theaters, and other places of amusement. Civil Rights Act of 1875, 18 St. 335. In 1883, the Supreme Court declared the Civil Rights Act of 1875 unconstitutional. The Civil Rights Cases, 109 U.S. 3 (1883). In 1896 the Court ruled that separate (segregated) facilities for African-Americans and European-Americans did not violate the Thirteenth or Fourteenth Amendment. Setting the pattern for race relations for more than three decades, the ruling declared that “If one race be inferior to the other socially, the Constitution of the United States cannot put them on the same plane.” Plessy v. Ferguson, 163 U.S. 538 (1896).
ment of the 1960s. After the 1960s, health care institutions either fled predominant African-American communities or instituted policies which resulted in limited access for African-Americans.

Discrimination can take two forms. Discrimination can be based on racist conduct that is intentional or it can be based on conduct which, although not intentional, nevertheless results in a disproportionate disparate impact on African-Americans. Much of the institutional racism has historically moved from intentional conduct to unintentional. While this classification may offer a distinction when assigning fault or culpability, the classification makes little difference to the African-American feeling the adverse affects of discrimination.

This legacy of a racist health care system persists today in African-Americans who are sicker than European-Americans and who continue to experience racial barriers to access. Racial barriers to access can be divided into three major groups: barriers to hospitals, barriers to nursing homes, and barriers to physicians and other providers.

1. Barriers to Hospitals

The institutional racism that exists in many hospitals manifests itself in a number of ways including the adoption, administration and implementation of policies that restrict admission; the clo-

95. In 1954, the court questioned the "separate but equal" doctrine of *Plessy v. Ferguson*. In particular, in a unanimous decision, the court found that legally sanctioned racial segregation is usually interpreted as connoting the inferiority of blacks, which adversely affects the educational development of black children. "Any language in *Plessy v. Ferguson* contrary to this finding is rejected." *Brown v. Board of Education*, 347 U.S. 483, 494-95 (1954).

*Brown v. Board of Education* was a significant milestone in civil rights. However, it was the civil rights-movement of the 1960s which culminated in the Civil Rights Act of 1964 and the Voting Rights Act of 1965, which resulted in many of the overt signs of discrimination being eliminated.

In particular, the Civil Rights Act of 1964 (Public Law 88-352) prohibited the denial of the right to vote in national elections because of race and made a sixth grade education a presumption of literacy (Title I). Title II prohibited discrimination in places of public accommodation. Title III authorized the Justice department to file suits to desegregate public facilities. Title IV authorized the Justice Department to file suit to desegregate public schools or colleges. Title V established the Commission on Civil Rights. Title VI prohibited discrimination in federally-financed programs. Title VII prohibited discrimination in employment. Title VIII authorized the gathering of registration and voting statistics based on race. Title IX allowed for federal appeals court intervention in civil rights cases to be remanded to state courts. Title X established the Community Relations Service in the Department of Commerce.

96. See infra notes 97-182 and accompanying text.

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sure, relocation or privatization of hospitals that serve the African-American community, and the transfer of unwanted patients (known as "patient dumping") by hospitals and institutions.

ADMISSION RESTRICTIONS. Many hospitals discriminate by using patient referral and acceptance practice standards that limit access. These practices restrict the admission of African-Americans to hospitals. Discriminatory admission practices include:

- Layoffs of recently hired African-American physicians where those African-American physicians admit most of the African-American patients served by the hospital;
- Not having physicians on staff who can accept Medicaid patients;
- Requiring pre-admission deposits as a condition of obtaining care;
- Refusing to participate in programs to finance care for low-income patients not eligible for Medicaid; and,
- Accepting only patients of physicians with staff privileges when the patients of such physicians do not reflect the racial composition of the local community.

Such practices may have a devastating effect on African-Americans. The practices may banish African-Americans to distinctly substandard institutions treating mostly minority groups. They may completely prevent care where African-Americans have no access to other sources of care.

COMMUNITY AVAILABILITY. Racial barriers to health care access are based, in large part, on the unavailability of services in a community. Increasingly, hospitals that serve the African-American community are either closing, relocating or becoming private. In a study done between 1937-1977, researchers showed that the likelihood of a hospital’s closing was directly related to the percent-

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100. Stan Dorn et al., Anti-Discrimination Provisions and Health Care Access: New Slants on Old Approaches, CLEARINGHOUSE REV. 439, 441 (Special Issue, Summer 1986).

101. Id.
102. Id.
103. Id.
104. Id.
105. Id.
age of African-Americans in the population. Throughout the 1980s many hospitals relocated from heavily African-American communities to predominantly European-American suburban communities.107

This loss of services to the community resulted in reduced access to African-Americans. Geographic availability and proximity are important determinants to seeking health care services early. If African-Americans fail to seek early health care, they are more likely to be sicker when they do enter the system; and the cost for the patient to receive service and for the system to provide services at that point is likely to be greater than at an earlier state. Therefore, not only does the loss of services significantly increase health care costs to African-Americans, but also, it increases health care costs to the society in general.108

Another devastating trend that affects the access of African-Americans to health care is the privatization of public hospitals. Quite a few hospitals (public and non-profit) have elected to restructure as private, for-profit corporations. As public hospitals, many were obligated to provide uncompensated care under the Hill-Burton Act.109 As private hospitals, these institutions are most likely to discontinue providing general health services to the indigent popu-

106. Sager, supra note 98, at 2. A total of 210 hospitals either closed or relocated during the period studied. A disproportionate number of the hospitals that closed or relocated were originally located in communities where the population was predominately African-American.

107. See generally, NAACP v. Wilmington Medical Ctr., Inc., 657 F.2d 1322 (1981) (proposal to reduce urban facility which served predominantly minorities and to construct a new suburban facility); Byran v. Koch, 627 F.2d 612 (1980) (closure of a New York City hospital whose patients were 98% minorities).


109. In 1946 Congress passed the Hospital Survey and Construction Act, presently codified as Title VI of the Public Health Service Act, 42 U.S.C. § 291. One goal of the Hill-Burton Act was to assure that hospitals would provide medical services to the residents in their communities, including those who were indigent. GEORGE ANNAS ET AL., AMERICAN HEALTH CARE LAW 80-81 (1990).

Specifically, hospitals which receive funds under the Hill-Burton Act are obligated to perform a community service requirement. Id. at 75. In order to comply with the community service requirement, subpart G of the regulations requires that recipient health facilities be made available to all residents and prohibits exclusion of anyone in the area served by the hospital on the basis of any factor unrelated to need. Id. at 77.

The Hill-Burton community services requirement was completely ignored for 30 years. Privately initiated lawsuits during the 1970's gave rise to the 1972 regulation changes. Id. These regulations outlined a program for monitoring compliance by Hill-Burton facilities relying on state agencies for implementation. Id. Unfortunately, the 1972 regulations did not amend or specify the meaning of community service. Kenneth R. Wing, The Community Service Obligation of Hill-Burton Health Facilities, 23 B.C.L. REV. 577, 613-14 (1982). It was
lations, \textsuperscript{110} and essential primary health care services to serve African-American communities. \textsuperscript{111}

The problem of limited resources is not new and has plagued the African-American community since slavery. Historically, African-American communities attempted to address the problem by establishing African-American hospitals. At one point there were more than 200 African-American hospitals in the United States. African-Americans relied on these institutions to "heal and save their lives." \textsuperscript{112}

Now, these institutions are fighting for their own survival. By the 1960s, only 90 African-American hospitals remained. Between 1961 and 1988, 57 African-American hospitals closed and 14 others either merged, converted or consolidated. By 1991, only 12 hospitals continued to "struggle daily just to keep their doors open". \textsuperscript{113} As a result of closures, relocations, and privatization, many African-Americans are left with limited, if any, access to hospitals.

\textbf{PATIENT DUMPING.} An African-American seeking care at a private hospital faces the possibility of being "dumped", that is, the hospital may transfer an "undesirable" patient to a different facility. \textsuperscript{114} The transfer is medically appropriate only when the care re-

\textsuperscript{110} Under Hill-Burton, a hospital is released from the uncompensated care requirement under the statute buy-out provision. 42 U.S.C. § 291a(1).
\textsuperscript{111} Cf., N.A.A.C.P v. Medical Ctr., 657 F.2d 1322 (medical center proposing to close high-risk obstetrical care, inpatient pediatric care and gerontology services).
\textsuperscript{113} \textit{Id.}
\textsuperscript{114} \textit{See generally}, Judith Waxman & Molly McNulty, \textit{Access to Emergency Medical Care: Patients' Rights and Remedies}, 22 CLEARINGHOUSE REV. 21-27 (Nov. 1991); Gearld-
quired is not available at the transferring hospital. However, many transfers are for economic reasons, i.e., the patient was either uninsured or unable to make admission deposits. African-Americans are disproportionately affected by these practices.In 1986, Congress passed the Emergency Medical Treatment and Active Labor Act which became effective as Section 9121 of the Consolidated Omnibus Reconciliation Act (COBRA). The Act provides a cause of action against hospitals that “dump” patients with emergency conditions from their emergency rooms, or who “dump” pregnant patients in active labor. Several states have make “patient dumping” illegal.

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116. A study of transfers among 467 medical transfers to Cook County Hospital showed that 89% were African-Americans or Hispanic-Americans. The study concluded that most of the patients were transferred for economic reasons and without their consent. Schiff, supra note 99, at 552-57.


118. Under COBRA, hospitals are required to provide appropriate medical screening examinations within the capabilities of the hospital. If a person has an emergency or is in active labor, the hospital must stabilize the medical condition or provide treatment for labor or transfer under certain conditions. In particular, there can be no transfer until stabilized except at the request of patient or if it is medically necessary and another facility is more appropriate. A transfer is appropriate if: the receiving facility has available space and qualified personnel and has agreed to accept the transfer. The transferring facility must provide appropriate medical records. The transfer must be made using qualified personnel and equipment. Enforcement is through termination of Medicare provider agreement, civil monetary penalties, and civil action for personal injury or financial loss. 42 U.S.C.A. §§ 1395 dd(a)-(d) (West Supp. 1992).

119. See generally, ARIZ. REV. STAT. ANN. § 11-297.01 1-3d (1956) (providing for transfers in three situations: where no hospital exists, where the existing hospital is overcrowded, or where the necessary services are not provided at the transferring hospital.); CAL. HEALTH & SAFETY CODE § 1317.2 (West 1990) (providing for various conditions to be met prior to the transfer of a patient such as exams, evaluations, emergency treatment. The transfer may not create a medical hazard, the hospital receiving the patient must have an appropriate bed, personnel and equipment necessary for treatment; relevant transfer information must be given to the receiving hospital.); FLA. STAT. ANN. § 401.45 1 (West 1943) (providing that no person shall be denied emergency medical treatment); IDAHO CODE § 39-1391 (1947) (providing for emergency treatment to persons appearing seriously sick or injured without admission of that person. This can have the effect of requiring stabilization prior to transfer. However, since the patient is never actually admitted, the hospital can realistically transfer the patient at any time); ILL. ANN. STAT. ch. 111 1/2, para 6151 (Smith-Hurd 1934) (providing that no health care provider can refuse needed emergency treatment to a person whose life would be threatened in the absence of such treatment due to an inability to pay.); MASS. GEN. LAWS ANN. ch 111 § 70E (West 1958) (providing for prompt life saving treatment in an emergency without discrimination or delay. There is an exception stating that a delay may not impose a material risk.); N.C. GEN. STAT. § 131E-117 15 (1943) (providing for no transfers or discharges but allows many exceptions including consideration of the patient's own or other patients' welfare, and nonpayment for the stay. The effect of the exceptions is that
However, limited enforcement of these legislative enactments makes patient dumping an ongoing problem. For instance, as of October 30, 1990, only 530 facilities had been investigated; only 139 facilities were found in violation of the statute; and only five facilities actually lost their Medicare contracts. A high percentage of African-Americans are uninsured or under-insured. Consequently, patient dumping continues to be an issue that plagues African-Americans. Furthermore, hospitals have developed methods to dump the patient without invoking the statute. For instance, the statute provides that hospitals receiving federal funding must accept any patient who "comes to an emergency room." If hospitals reroute the patient before the patient arrives then the statute will not apply.

In Johnson, a parent called the paramedics after her baby went into cardiac arrest. The paramedics contacted University of Chicago hospital. The hospital told the paramedics to take the child to another hospital even though it was only five blocks away. The child was taken to a hospital without a pediatric intensive care unit and had to be transferred to another hospital. The child died after admission to the second hospital. The plaintiff sued on

patients are not protected from nonmedical transfers.); PA. STAT. ANN. tit. 35, § 449.8 (1930) (providing that transfers may only occur in instances where the facility lacks the staff or facilities to properly render definitive treatment.); TENN. CODE ANN. § 68-11-701 (1955) (requiring stabilization prior to transfer and such efforts necessary to sustain the patient during the transfer.); TEX. CODE ANN. § 241.027 b (West 1986 & Supp. 1992) (providing for medically appropriate transfers from physician to physician and from hospital to hospital by providing the following: notification to the receiving hospital prior to the transfer, stabilizing prior to and during the transfer, provisions for the appropriate personnel and equipment for the transfer, necessary records. Transfers may not be based on discrimination or economic status.) But see, COLO. REV. STAT. ANN. § 26-15-106 8b (West 1989) (providing for transfers of indigent patients without any restrictions except for a prior agreement to the transfer by the receiving contract provider.) DEL. CODE ANN. tit 16 § 1121 18 (allowing transfers for the patient's own welfare or the welfare of other patients, and for nonpayment); WASH. REV. CODE ANN. § 70.168.100 e (West 1961 & Supp 1992) (requiring only that prior to transfer, agreements with providers outside the region are established to facilitate the transfer; See also, Dorn & Waxman, States Take the Lead in Preventing Patient Dumping 22 CLEARING-HOUSE REV. 136 (1988).

120. Waxman & McNulty, Access to Emergency Medical Care, supra note 114, at 21-27.
121. Id.
122. Id.
123. See infra notes 207-09 and accompanying text.
125. Id. at 231.
126. Id.
127. Id.
128. Id.
129. Id.
common law claims and for violation of COBRA. The district
court dismissed and the Seventh Circuit upheld the dismissal of the
COBRA claim. The Seventh Circuit noted that "In accordance
with the plain meaning of the statutory language, we do not believe
that the infant ever 'came to' the hospital or its emergency depart-
ment. For purposes of COBRA, a hospital-operated telemetry sys-
tem is distinct from that same hospital's emergency room." The
court went on to acknowledge that a "... hospital could conceiva-
bly use a telemetry system to dump patients"; nevertheless, the
court held that the "statute does not expressly address the question
of liability in such a situation." Thus, the Seventh Circuit leaves
the door open for other hospitals to continue dumping patients,
most of whom will be African-Americans.

2. Barriers to Nursing Homes

Nursing homes are the most segregated publicly licensed health
care facilities in the United States. Smith, in his study, con-
cludes that racial discrimination is the major factor explaining that
type of segregation. It has been suggested that any difference in
African-American use of nursing homes can be explained by cul-
tural biases against using nursing homes as care source for disabled
or aged family members. However, in some areas (such as Dela-
ware and Detroit Metropolitan) African-Americans make up a
higher portion of nursing home residents than European-Ameri-
cans. This suggests that African-Americans do not consistently de-
cide against nursing homes.

130. Id.
131. Id. at 232.
132. Id.
133. "Nursing homes" is a generic term used to describe two types of facilities: Interme-
diate care facilities (ICF) and skilled nursing care facilities (SNF). Intermediate Care facil-
ities provide institutional, health-related services above the level of room and board, but at a
level of care below that of hospital or SNF care. See 42 U.S.C. §§ 1396c(d) (1988); see also 42
C.F.R. § 440.150 (1991). Skilled Nursing Facilities provide institutional care above the level
of ICF services but below the level of a hospital. See, 42 U.S.C. § 1396d(l) (1988); 42 C.F.R.
134. Cassandra Butts, The Color of Money: Barriers of Access to Private Health care Facil-
ties for African-Americans, (Unpublished manuscript on file at Case Western Reserve, Health
Matrix Office) (citing David A. Smith, Discrimination in Access to Nursing Homes in Penn-
sylvania (1991)).
135. But see, Linton v. Carney, 779 F.Supp 925, 933 (M.D. Tenn 1990) (rejecting defend-
ants' assertion that "self-selection preferences" of the minorities, based upon the minorities'
reliance upon the extended family, lack of transportation, and fear of institutional care, ade-
quately explain the disparate impact).
136. Butts, supra note 134, at 5-7. For instances, although African-Americans rely on
family and friends for long term care, the rate of use of nursing homes is rising faster for
Furthermore, even where racially neutral policies exist, institutional racism is still a factor. For instance, evidence about the use of nursing homes under Medicaid demonstrates that institutional racism has an impact even without regard to economic class. For instance, although African-Americans constitute only 12% of the nation's total population, the African-American poverty rate (31%) is three times greater than the European-American poverty rate (10%). However, African-Americans constitute only 29% of the Medicaid population and 23% of the elderly poor. Medicaid expenditures for African-Americans are only 18% of total expenditures. If, indeed, African-Americans are sicker, then Medicaid expenditures for African-Americans should at least be equal to, if not greater than, the percentage of Medicaid's African-American population. It is this combination of under-representation and under-spending in Medicaid that suggests racism.

In part, this disparity in expenditure is based on the limited access that African-Americans on Medicaid have to nursing homes, both intermediate and skilled nursing facilities. Only 10% of

African-Americans than for European-Americans. 

137. An individual's eligibility for Medicaid is based on certain personal characteristics relating to need, such as old age, disability or blindness, and on the basis of the person's indigence. Indigence is measured by certain state and federal financial standards. To obtain Medicaid coverage for nursing home care, the patient must first establish financial eligibility and then meet additional medical need requirements demonstrating eligibility for ICF or SNF services. The medical requirements are established by the state to guard against unnecessary treatment.

In order to determine a patient's medical eligibility, states generally require that each Medicaid recipient's need for admission to a nursing home be evaluated prior to the recipient's admission to the institution or, if the patient has already been admitted, prior to an authorization of Medicaid reimbursement for his or her care. See 42 C.F.R. §§ 456.271 and 456.372. This process is referred to as the pre-admission evaluation (PAE) process.

Once a patient has been admitted to a nursing home, his or her continued need for ICF or SNF care is annually reviewed by state Medicaid officials pursuant to a process referred to as utilization review. 42 U.S.C. § 1396a(a) (30).


140. Id.

In part, this limited access is caused by the rules that the government generates. For instance, federal law authorizes state agencies who perform review and certification functions to certify facilities for either SNF or ICF reimbursement. Such certification may be of a "distinct part of an institution." See 42 U.S.C. § 1395x and 42 U.S.C. § 1396a(a)(28). A "distinct part" SNF or ICF must be an entire separately identifiable unit consisting of all the...
Medicaid intermediate care patients are African-Americans.\textsuperscript{142} Similarly, only 9\% of Medicaid skilled nursing care facilities' patients are African-Americans.\textsuperscript{143} This disparity may be due in part to a policy allowing limited bed certification. Under limited bed certification, nursing homes determine the number of beds that are certified to participate in Medicaid. Federal regulations permit a distinct part of intermediate care facilities to be certified.\textsuperscript{144} Some states will certify a limited number of beds.\textsuperscript{145} Thus, the certified portion of a facility need not contain all intermediate care facilities residents.\textsuperscript{146} Furthermore, some states will certify beds which are not in a separately administered unit of a facility, but are instead part of a wing or ward that also contains non-certified beds.\textsuperscript{147}

Limited bed certification programs allow nursing home operators to give preference to private pay patients by reserving for their exclusive use beds which are unavailable to Medicaid patients.\textsuperscript{148} It also allows the nursing home operators to change the bed certification, resulting in disruption of the care of Medicaid patients by displacing them after they have been admitted to a nursing home.\textsuperscript{149}

Displacement can occur in several ways. It occurs when a patient exhausts his or her financial resources. The patient needs to make a transition from private pay to Medicaid.\textsuperscript{150} At that point, a patient may be told that his or her bed is no longer available.\textsuperscript{151} Furthermore, displacement occurs when a patient with insurance (private, medicaid or medicare) is transferred from a skilled nursing facility to an intermediate care facility. If the insurance will not cover intermediate care, the patient may not have financial re-

\textsuperscript{142} Racial Disparities in Medicaid Coverage for Nursing Home Care (1991) (Unpublished Data located at the University of Dayton School of Law).
\textsuperscript{143} Id.
\textsuperscript{144} 42 U.S.C. § 1395 (federal Medicare statute recognizing "distinct part" certification); 42 U.S.C. § 1396a(a)(28) (applying "distinct part" certification to Medicaid SNF certification).
\textsuperscript{145} See, Linton v. Carney, 779 F. Supp. 926, 931. ("Tennessee, at the provider's instructions, certified a limited component of beds in a facility which provides the same ICF level of care in all beds.")
\textsuperscript{146} Id.
\textsuperscript{147} Id.
\textsuperscript{148} Id. at 932.
\textsuperscript{149} Id.
\textsuperscript{150} Id.
\textsuperscript{151} Id.
sources to continue obtaining nursing home care.\textsuperscript{152} Similarly, displacement can occur when a patient already on Medicaid and authorized to receive skilled nursing care is reclassified for intermediate care only.\textsuperscript{153}

A nursing home can manipulate the availability of nursing home beds by certifying (and decertifying) beds. This certification and decertification process limits access to minorities. \textit{Linton v. Carney}\textsuperscript{154} effectively challenged the practice.

In \textit{Linton}, Mrs. Linton was threatened with an involuntary transfer from the facility she occupied. The threatened transfer was due to a change in her classification status by the Tennessee Medicaid program.\textsuperscript{155} Although Mrs. Linton occupied a bed in the nursing home certified for her new classification, the nursing home threatened to decertify her bed.\textsuperscript{156} No other beds were available in the facility.\textsuperscript{157} Joining Mrs. Linton (as a plaintiff-intervenor) was Mrs. Carney. Mrs. Carney was an 89-year-old African-American who could not find an available nursing home in the state of Tennessee.\textsuperscript{158} The District Court found the limited bed certification policy to violate both Title VI of Civil Rights Act and the Medicaid statute.\textsuperscript{159}

The \textit{Linton} court recognized that Title VI prohibits policies and practices with adverse disparate impact on ethnic and racial minorities.\textsuperscript{160} According to the court, the plaintiffs showed that the defendants' limited bed certification policy had a disparate impact on

\begin{thebibliography}{99}
\bibitem{152} Id.
\bibitem{153} Id.
\bibitem{155} Id. at 928-30.
\bibitem{156} Id. at 928.
\bibitem{157} Id.
\bibitem{158} The policy of decertification particularly affected African-Americans. Despite representing 39.4\% of the Tennessee's Medicaid recipients, African-Americans comprised only 15.4\% of the Medicaid recipients in nursing homes. Id. at 932. Furthermore, the court noted that the health of African-Americans was generally poorer than that of European-American resulting a in correspondingly greater need for nursing home services. Despite this "greater need", the system of licensed nursing homes served European-Americans "[relegating African-Americans] to substandard boarding homes which receive no Medicaid subsidies. Id.
\bibitem{159} Id. at 933-34.
\bibitem{160} In particular the court cited to Guardians Ass'n v. Civil Service Comm'n, 463 U.S. 582 (1983), which recognized that Title VI extends to unintentional disparate impact discrimination as well as deliberate discrimination. Further, \textit{Linton} acknowledged that in Alexander v. Choate, 469 U.S. 287, 292-94 (1985), the Supreme Court delegated to agencies responsibility to determine "what sorts of disparate impacts upon minorities constituted sufficiently significant social problems, and were readily enough remediable, to warrant altering the practices of the federal grantees that had produced those impacts." Id. at 934.
\end{thebibliography}
racial minorities.\textsuperscript{161} While the defendants argued the "self-selection preferences" of the minorities adequately explained the disparate impact\textsuperscript{162}, the court rejected that interpretation as "sufficient justification for minority under-representation in nursing homes."\textsuperscript{163} Therefore, the defendants did not meet their burden of proof.\textsuperscript{164}

\textit{Linton} demonstrates that health care programs can operate in a racist way despite the appearance of racial neutrality. Any reform to the health care system that does not specifically address race has the potential of being racist and discriminatory.

3. Barriers to Physicians and Other Providers

Another important aspect of access to care is the availability of health care providers who serve the African-American communities.\textsuperscript{165} It should go without saying that proximity increases utilization. At this point, data on the actual numbers of white physicians who have offices in the African-American community are not available. There are probably very few. Consequently, African-American physicians have been an important aspect of filling the availability gap. Without physicians and providers in their communities, African-Americans are likely to delay seeking health care. That delay can result in more severe illness, increased health care cost, increased mortality and increased costs to society.

Given the increased morbidity and mortality among African-Americans logically one would expect more health care providers in their communities not fewer, and more African-Americans in health care fields. Scrutiny of the physicians heading in the Yellow Pages of any major city, clearly indicates that many physicians do not physically serve the African-American community.

Furthermore, despite being 12\% of the population, African-Americans are seriously under-represented in health care professions. Only 3\% of the physicians in the United States are African-Americans;\textsuperscript{166} only 2.5\% of the dentists in the United States are

\textsuperscript{161} \textit{Id.} at 935.
\textsuperscript{162} According to the defendants, such self-selection preferences were based on minorities reliance on the extended family, on the lack of transportation, and on the fear of institutional care. \textit{Id.} at 935.
\textsuperscript{163} \textit{Id.}
\textsuperscript{164} \textit{Id.}
\textsuperscript{165} Providers include physicians, nurses, pharmacists, dentists as well as the many other health care professionals who serve a community.
\textsuperscript{166} Jones & Rice, \textit{supra} note 22, at 10-13. Lack of African-American representation in medicine is traceable to segregation in medical schools. \textit{Id.} at 11. For instance, an African-American did not receive a degree in an American school until 1847. While some white schools (nine) admitted African-Americans prior to the Civil War, most schools did not. In
African-Americans; and only 3.6% of the United States pharmacists are African-Americans. While this lack of representation is particularly significant for African-American communities which rely on African-American physicians for care, it also impacts the entire community. Shortage of adequate care results in sicker individuals and an increase in overall health care costs. If African-Americans are sicker, they need more physicians, not fewer. Yet, we see the same limited availability of providers, as of hospitals, to service African-American communities.

The shortage of African-American professionals further affects health care availability by limiting African-American input into the health care system. While the control of health care distribution is ultimately in the hands of the individual physician, that control is


170. In addition, even programs (i.e., Medicaid) do not necessarily expand access since many primary care providers either do not accept Medicaid patients or limit the number of such patients they will accept. Karen Davis et al., *Health Care for Black Americans: The Public Sector, in Health Policies and Black Americans*, *supra* note 98, at 225-26. It is only natural to look to the African-American physician to "fill" this gap. *See generally*, H.R. Rep. No. 804, *supra* note 76, at 20, reprinted in 1990 U.S.C.C.A.N. 3299 (finding that minority health professionals historically tended to practice in low-income areas and to serve minorities; that minority health professionals tended to engage in the general practice of medicine and specialties providing primary care; and that access to health care among minorities can be substantially improved by increasing the number of minority health professionals).

171. *See*, H.R. Rep. No. 804, *supra* note 76, at 20, reprinted in 1990 U.S.C.C.A.N. 3299 (finding that the number of individuals who are from disadvantaged backgrounds [including racial minorities] in health professions should be increased for the purpose of improving the access of other such individuals to health services).
influenced and limited by law, hospital practices and policies, and the medical organization of the physician’s practice. With so few African-American health care professionals, the control of the health care system lies almost exclusively in European-American hands.

The result is an inadequate, if not ineffective, voice on African-American health care issues. This lack of African-American voice leads to increased ignorance on the part of European-Americans regarding issues pertaining to African-American health. When health care issues are defined, the policy makers’ ignorance results in their overlooking African-Americans’ health concerns.

B. Racial Disparities in Medical Treatment

Racial barriers to access is only one aspect of institutional racism. Another aspect of institutional racism is the occurrence of racial disparities in type of services ordered and in the provision of medical treatment itself, well-documented in studies done in cardiology, cardiac surgery, kidney disease, organ transplantation, internal medicine and obstetrics.

Cardiology and Cardiac Surgery. African-Americans and European-Americans have similar rates of hospitalization for circulatory system disease. Yet, studies have found that European-Americans are one-third more likely to undergo coronary angiography and two to three times more likely to undergo bypass surgery.

Kidney Disease and Kidney Transplantation. The aggressive treatment of long-term kidney disease is based in part on race. Studies indicate that European-Americans are 5% to 15% more likely to receive aggressive treatment. In fact, the most favored

172. One wonders how much of the disparity treatment is a legacy in medical practice from slavery when "... doctors frequently complained that they were unable to administer treatment because the slaves were not amenable to the same medical treatment as white patients." PINKNEY, supra note 89, at 6.


175. Council on Ethical and Judicial Affairs, Black-White Disparities in Health Care,
patient for long term hemodialysis is a European-American male between the ages of 25 to 44.\textsuperscript{176} A European-American on dialysis is two-thirds more likely to receive a kidney transplant than a non-European-American.\textsuperscript{177} While the likelihood of receiving a kidney transplant is related to income, the effects of income and race are independent from each other,\textsuperscript{178} meaning that middle-income African-Americans are less likely to receive a kidney transplant than middle-income European-Americans.

\textit{Internal Medical Treatment.} The patient's race has been correlated with the intensity of medical treatment. For example, when hospitalized with pneumonia, African-Americans were less likely than European-Americans to receive intensive care.\textsuperscript{179} This disparity in medical treatment persisted even after controlling for clinical characteristics and income.\textsuperscript{180}

\textit{Obstetrical Treatment.} African-Americans were more likely to be classified as "clinic" patients despite comparable ability to pay for care. Private patients were more likely than clinic patients to have caesarean sections.\textsuperscript{181} This is true even though clinic patients were in poorer health and were more likely to have low birth weight babies.\textsuperscript{182}

These studies all raise the issue that African-Americans receive health care treatment different from the "preferred" patient the European-American male. Whether this difference is based on individual prejudices or medical school training, it is evidence of institutional racism that cannot be tolerated. Any patient seeking

\textsuperscript{176} See also, Council on Ethical and Judicial Affairs, \textit{Black-White Disparities in Health Care}, supra note 173, at 2345; Kjellstrand & Logan, supra note 175.

\textsuperscript{177} Id.; See also, C.M. Kjellstrand, \textit{Age, Sex and Race Inequality in Renal Transplantation}, 148 ARCHIVES INTERNAL MED. 1305, 1305-09 (1988); P.W. Eggers, \textit{Effect of Transplantation on the Medicare End-Stage Renal Disease Program}, 318 NEW ENG. J. MED. 223-29 (1988) (reporting that while African-Americans accounted for 33% of patients with end-stage renal problems, they were only 21% of the patients who received kidney transplants).

\textsuperscript{178} \textit{Black-White Disparities}, supra note 173, at 2345; See also, P.J. Held et al., \textit{Access to kidney transplantation: Has the United States Eliminated Income and Racial Differences?} 148 ARCHIVES INTERNAL MED. 2594, 2594-00 (1988).

\textsuperscript{179} \textit{Black-White Disparities}, supra note 173, at 2345; See also, John Yergan et al., \textit{Relationship between Patient Race and the Intensity of Hospital Services}, 25 MED. CARE 592, 600, 603 (1987) (suggesting that nonwhite pneumonic patients receive fewer services, especially with regards to intesive care).

\textsuperscript{180} \textit{Black-White Disparities}, supra note 173, at 2345; John Yergan et al., supra note 179.

\textsuperscript{181} Id.; See also, R.H. de Regt et al., \textit{Relation of Private or Clinic Care to the Cesarean Birth Rate}, 315 NEW ENG. J. MED. 619, 619-24 (1986).

\textsuperscript{182} \textit{Black-White Disparities}, supra note 173, at 2344; de Regt et al., supra note 181.
care from a physician should be able to be assured of the most appropriate medical treatment available. Irrespective of race, each of us should be assured that the physician will act in our best interest. Every person should be assured that the physician will not let personal prejudice or medical prejudice influence our medical treatment. As the situation exists, an African-American does not have those assurances.

C. Summary

Race affects access to care independent of socioeconomic class. Race also affects medical treatment independent of socioeconomic class. While the disparities in treatment decisions reflect clinical characteristics, income, medical or biological differences, they also reflect racial bias.\(^{183}\) To improve the health of African-Americans, it is not sufficient merely to remove barriers to access based on socioeconomic class. Health care institutions must rid themselves of institutional racism.

Medicine has found cures and controls for many afflictions, improving the health of all Americans—African-Americans, Asian-Americans, Hispanic-Americans, Native-Americans and European-Americans.\(^{184}\) However, the health institutions have failed to extend the same magnitude of improvement in health among European-Americans to African-Americans and other minority populations.\(^{185}\) Health institutions have failed to eliminate the racial distribution of health care.\(^{186}\) They also continue to perpetuate distinctions. Such a situation is intolerable. Of all the influences on African-Americans health, the influence of health care institutions, though relatively small, should nevertheless be free of racial prejudice and discrimination.

IV. HEALTH POLICY AND ELIMINATING THE HEALTH DISPARITY

This the American black man knows: his fight here is a fight to the finish. Either he dies or wins. If he wins, it will be by no subterfuge or evasion of amalgamation. He will enter modern civilization here in America as black man on terms of perfect and unlimited equality with any white man, or he will enter not at all. Either exterminate root and branch, or absolute equality. There

\(^{183}\) Black-White Disparities, supra note 173.  
\(^{184}\) KNOWLES & PREWITT, supra note 15, at 99.  
\(^{185}\) See Id. at 98 (implicating health institutions for the failure to carry on medical advances and treatment to the black community).  
\(^{186}\) Id. at 99.
can be no compromise. This is the last great battle of the West. 187

Institutional racism is a term that describes practices in the United States nearly as old as the nation itself. Institutional racism comprises those policies, practices, and activities which injure or damage an individual or group based on race. Like individual racism, the effects of institutional racism can derive from intentional or unintentional conduct. For African-Americans who face disproportionate morbidity and mortality, whether the conduct was intentional or not is irrelevant. When medical institutions’ behavior sets up racial barriers to access and provides racially disparate treatment of African-Americans, and thereby injures those the institutions purport to help, the institutions are institutionally racist.

African-Americans have not profited as much as European-Americans by the early advances of health care. In fact, the gap between African-American health and European-American health has widened over the last ten years. 188 Racism has adversely affected African-American health independently of other factors contributing to excess African-American morbidity and mortality. We have much to lose by its persistence.

In 1992, the presence of institutional racism in a system dedicated to improving the life of all Americans is a powerful indictment of a system that offers part of its population what some consider the best health care in the world. 189 Despite having ultimate responsibility for providing health care for all Americans, de-

189. Scott, Lawmakers Differ on Measures to Reform Health care, MEMPHIS BUS. J., June 1, 1992, 41 (stating that lawmakers agree America has the best health care service in the world); Storer H. Rowley, Prescription from Canada: Would Universal Health Care Work in the Country?, CHI. TRIB., May 31, 1992 (reporting that “[m]any Americans still boast that they have the best health care money can buy and that it's there on demand, without Canada's occasionally lengthy waiting lines”); Joel Havemann, A Safety Net Snags on Its Cost: Western Europe's Prized Welfare Programs Follow Citizens From Cradle to Grave. But Tax Rates are Astronomical by U.S. Standards, and Critics Are Gingerly Making Changes, Los Angeles Times, April 21, 1992, at A1 (reporting that “[t]he U.S. medical profession insists that it delivers the best health care in the world, that most medical breakthroughs bear a Made-in-the-USA label”); John Lucadamo, Porter, Sullivan Clash at Debate Over Everything But Pensions, CHI. TRIB., March 10, 1992 (reporting that “Porter said the United States has the best health care in the world ‘for those in the system’); George Will, Revision of Our Health-Care System Should be High on Nation's Agenda, ATLANTA J. & Const., Mar. 9, 1992 (stating that “America can provide the world’s best health care - if you can afford it”); President George Bush, Remarks of President Bush to the San Diego Rotary Club (Feb. 7, 1992) FED. NEWS SERV., (reporting that “[t]his country has the best health care system in the world — the best. And the quality of health care in America is unrivaled”).
spite a belief in this country that all persons have certain rights to life, liberty and health, the American health care institution has contributed to and perpetuated racism.

What white Americans have never fully understood — but what the Negro can never forget — is that white society is deeply racist. White institutions created it, white institutions maintained it and white societies condone it.  

For health care institutions to remove the blemish of racism, they must develop specific solutions. To bring African-American health on par with European-American health, we must design and implement a delivery system to effectively address the health issues of African-Americans. There are four policy/legislative positions that can be adopted (singly or in some combination).

First, the health care system, legislature or court can do nothing. The legislature (and courts) could continue to rely on the present system without specifically addressing issues relevant to African-American health. This position denies that the health care system perpetuates disparity among African-Americans and European-Americans. However, this position does provide a base measure against which other policy alternatives can be evaluated. Second, insurance coverage could be expanded. Expanding insurance coverage would theoretically remove economic barriers to health care. Third, based on those facts that suggest severe treatment disparity between African-Americans and European-Americans, special health services could be targeted to African-Americans. Finally, Title VI of the Civil Rights Act could be used to eliminate racist practices in health care delivery systems.

Policy options are neither right nor wrong and can only be evaluated in the context of how well the policy satisfies other criteria. These policy alternatives can be evaluated using seven criteria: horizontal equity, vertical equity, economic efficiency, preference satisfaction, privacy, avoidance of stigma, and political feasibility. Horizontal equity seeks to treat equals as equals. For example, a policy proposal that targets services to all diabetic patients residing in the United States satisfies the criterion of horizontal equity, whereas a policy targeting all African-American diabetic patients does not. Vertical equity is unequal treatment of unequals, trying

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192. Duncan MacRae, Jr. & Ron Haskins, Combining the Roles of Scholar and Citizen, in
to make them more equal. Vertical equity suggests that a good policy proposal is one that favors the have-nots over the haves in the distribution of benefits. Economic efficiency is the use of resources to produce the maximum benefit for the smallest expenditure. Preference satisfaction requires that a policy produce the most happiness for the greatest number of people, usually by creating options and allowing individuals to maximize their own preferences. Therefore, in selecting between alternate policy options, the policy which is consistent with people's preferences is favored. One problem with preference measurement is that human preferences do change as a result of education and advertising. Therefore, weight given to preference satisfaction should be considered against the likelihood of the preference being changed. The privacy criterion stipulates that a policy should not allow intrusion into the life of the individual. Avoidance of stigma means that individuals are not negatively labeled as different from other citizens not affected by the policy. Political feasibility is the possibility that the particular alternatives have a chance of being adopted and implemented by the courts and legislature.

A. "Do Nothing" Policy Option

Horizontal Equity. In evaluating the different policy options, the "do nothing" option serves as a baseline. The existent system does not provide African-Americans who are ill with the same ac-

<table>
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<tr>
<th>Horizontal Equity</th>
<th>Vertical Equity</th>
<th>Economic Efficiency</th>
<th>Preference Satisfaction</th>
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<th>Stigma</th>
<th>Political Feasibility</th>
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cess as sick European-Americans; nor do African-Americans receive the same treatment once in the health care system. Consequently, sick African-Americans are not treated the same as sick European-Americans. The current system lacks horizontal equity.

**Vertical Equity.** Doing nothing maintains the status quo and does not attempt to improve access or treatment services for African-Americans. African-American communities have fewer providers and medical institutions. African-Americans have disproportionate morbidity and mortality. Doing nothing does not address the unique needs of African-Americans. Doing nothing does not close the gap in health between African-Americans and European-Americans. Given the unequal access and unequal medical treatment, doing nothing makes no changes which, by treating African-Americans differently, would lead to equal health care. Therefore, vertical equity does not exist.

**Economic Efficiency.** To the extent that the United States is already spending enough to bring every citizen high quality, high-technology care, economic efficiency is not met. Of the $817 billion that is spent each year on health care, it is estimated that $200 billion is spent on unnecessary medical care, overpriced procedures and inefficient administration.\(^\text{200}\) Apparently, the current system is not economically efficient. Reforming the health care system to

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\(^{200}\) *Wasted Health Care Dollars, 57(7) CONSUMERS REPS 435 (1992); See generally, George Lundberg, *National Health Care Reform: The Aura of Inevitability Intensifies*, 267 JAMA 2521-24 (1992) (The costs of malpractice coverage and defensive medicine are unknown but very large — perhaps in excess of $20 billion per year. Defensive medicine probably benefits no one except these with the health care jobs that are generated. . . The current system is rife with administrative waste, inefficiency, and a ubiquitous "hassle factor." ); D.U. Himmelstein & S. Woolhandler, *Cost Without Benefit: Administrative Waste in U.S. Health Care*, 314 NEW ENG. J. MED. 441-45 (1986) ("With the institution of a national health plan, $30 billion in administrative costs could be saved."); Jasjit Ahluwalis, *Health Care in the United States: Our Dynamic Jigsaw Puzzle*, 150 ARCHIVES INTERNAL MED. 256, 256-258 (1990) ("Up to 20% of every dollar spent on the administrative aspects of health care is wasted. If the system were streamlined, then $15 billion of the $78 billion spent in administration could be saved."); Eli Ginzberg, *Commentary: US Health Policy — Expectations and Realities*, 260 JAMA 3647, 3647-3650 (1988) ("The 'waste' in the system of medical care exemplified in physicians' doing too much and, worse still, often performing diagnostic and therapeutic procedures that are contraindicated"); cf., State of North Carolina ex rel Rufus L. Edmisten v. P.I.A. Asheville, Inc, 740 F.2d 274 (1984) (indicating that the legislative histories of both the National Health Planning and Resource Development Act of 1974 and of the 1979 amendments and North Carolina's certificate of need legislation show that Congress and the North Carolina legislature were concerned about "the unrelenting rise in the cost of health care, and about wasteful, duplicative major acquisitions by health care providers"); Alabama Renal Stone Institute, Inc. v. State Health Planning Agency, 594 So. 2d 106 (Ala. Civ. App. 1991) (explaining that to allow the hospitals to use the Medstone device to perform kidney lithotripsy without first obtaining a certificate of need would be contrary to
meet the needs of African-Americans will not be any more economically inefficient than the current system. On the other hand, failure to reform the system will mean continued costs in African-American lives. This cost is one which will not only affect individual lives and the African-American community, but also the general society in lost productivity and additional health care expenses.

Preference Satisfaction. Preference satisfaction requires that a policy produce the most happiness for the greatest number of people, usually by creating options and allowing individuals to maximize their own preferences. Whether preference satisfaction exists depends on whose perspective one considers. Certainly, for those who have access to the health care system and adequate treatment, doing nothing might allow them to maximize their own preferences. However, for African-Americans whose access to health care is limited and whose treatment is below standards, doing nothing would not create options or allow them to maximize their preferences.

Privacy. The privacy criterion stipulates that a policy does not allow intrusion into the life of the individual. The current system maximizes an individual's privacy. Theoretically, the free-choice, fee-for-service, retrospective payment system currently serving much of the population, neither limits from whom an individual can seek services nor limits the services that a provider can render. Those enjoying limitless services are not required to disclose information to receive care. In this way, doing nothing maximizes the privacy of those with access to health care services; while those without access to services have no privacy issues, because they are excluded from participation.

Stigma. Avoidance of stigma means that individuals are not negatively labeled as different from other citizens not affected by the policy. To the extent that doing nothing allows the gap in health between African-Americans and European-Americans to continue, it may cause some stigma. Individuals who believe that a major cause of illness and death is behavior may view reports of poorer

the intent of the legislature to avoid oversupply and the substantial waste that will occur); But see, Maxwell J. Mehman, Health Care Cost Containment and Medical Technology: A Critique of Waste Theory, 36 CASE W. RES. L. REV. 778 (1985/1986) (stating that the high cost of health care has led to proposals to reduce wasteful medical technology under Medicare and other payment systems. Achieving this objective is problematic because of the difficulties of defining, detecting and eliminating technology waste).

201. There is no system imaginable "that's more dysfunction[al] than the one we have now, more expensive, not doing the job with more waste." Wasted Health Care Dollars, supra note 200 (quoting Dr. Philip Caper, an internist and medical policy analyst at Dartmouth Medical School).
health among African-Americans as evidence of poor health behavior. To some extent they are correct.202 However, if European-Americans fail to acknowledge the role of the health care system, doing nothing results in a failure of the health care system to accept responsibility for its role in the health of African-Americans. It also leads to indirect blaming and negative labelling of African-Americans.

Political Feasibility. Political feasibility is the possibility that the particular alternatives have a chance of being adopted and implemented by the courts and legislature. Maintaining the status quo is generally easier than making substantial changes. The likelihood that specific actions will be taken to improve the health of African-Americans seems slim, since little attention is being given the problem.

Summary. The do nothing option allows for the social, economic, and health care disparity to continue to exist between African-Americans and European-Americans. Racial and economic barriers to access experienced by African-Americans would persist. Racial and economic barriers to entering the health care professions would remain. Doing nothing would be to insist on ignoring the racial disparities in medical treatment. This situation is untenable. The health of African-Americans clearly indicates that something needs to be done.

202. See, supra text accompanying notes 82-86; See generally, E. Richard Brown, Health USA; A National Health Program for the United States, 267 JAMA 552, 552-58 (1992) (explaining that state programs must designate funds for a prevention account, to be used for community-based disease prevention and health promotion programs targeted to population groups with the greatest unmet needs); Harold Freeman, Race, Poverty, and Cancer, 83 J. NAT'L CANCER INST. 526, 526-27 (1991) (showing that shared elements lead to common lifestyle, attitudes, and behavior. Such cultural factors deeply influence health, and any successful intervention must necessarily take these powerful cultural realities into account.); Antonia C. Novello et al., Hispanic Health: Time for Data, Time for Action, 265 JAMA 235, 253-55 (1991) (explaining that differences in health behaviors and health exist between U.S.-born and foreign-born members of the same ancestral group; in general, recent arrivals tend to be of better health.); J. Michael McGinnis, Communication for Better Health, 105 PUB. HEALTH REP. 217-18 (1990) (stating that better control of behavioral risk factors alone could prevent between 40% and 70% of premature deaths); Council on Scientific Affairs, Education for Health: A Role for Physicians and the Efficacy of Health Education Efforts, 263 JAMA 1816, 1816-19 (1990) (suggesting that many health problems are caused or exacerbated by individuals' life-styles, and that a result has been efforts to avert health problems of all kinds leading to the development of programs designed to promote healthful behavior and improve health).
B. Expanded Insurance Coverage

1. Background

The United States and South Africa are the only major industrialized nations without a universal health insurance system that guarantees access to health care for all of their citizens. What the United States has instead of universal health care is a scheme of employer-financed insurance and government programs\textsuperscript{203} that still leaves more than 37 million Americans without the financial resources to pay for health care.\textsuperscript{204}

The lack of health insurance is a particular issue for African-Americans who are less likely to have employer-financed insurance.\textsuperscript{205} While public programs, such as Medicaid and Medicare, are important sources of health care coverage for many low-income and African-Americans, they do not reach all of the uninsured poor.\textsuperscript{206} In fact, one-fourth (25\%) of African-Americans have no source of health coverage.\textsuperscript{207}

Even more disturbing is that the number of uninsured African-Americans is increasing. In 1977, only 18\% of African-Americans


Yet, Medicare's impact extends well beyond the program. For example, other institutional purchasers of health care, such as private insurers, typically follow Medicare's lead with regard to medical technology and payment schedules. OTA MEDICARE, supra note 203, at 23.

\textsuperscript{204} Pamela Short et al., Health Insurance of Minorities in the United States 1(2) J. Health Care for Poor & Underserved 9-24 (1990).

\textsuperscript{205} In 1985 only 47\% of African-Americans had employment related insurance compared to 62\% of non-African-Americans. Stephen Long, Public Versus Employment-related Health Insurance: Experience and Implications for Black and NonBlack Americans, in Health Policies and Black Americans 200-12, at 203 (David P. Willis ed., 1989); see also, Davis, supra note 170.

\textsuperscript{206} Only 28\% of African-Americans had public insurance.; Long, supra note 205, at 203; see also Davis, supra note 63, at 1.

\textsuperscript{207} Short et al., supra, note 204; See also, Long, supra note 205, at 203; Davis, supra note 170, at 1.
had no health coverage. Furthermore, the gap between African-American uninsured and European-American uninsured is widening. For instance, while the proportion of uninsured non-elderly European-Americans increased only 3 percent from 1977 to 1987 (from 12% to 15%), the proportion of uninsured non-elderly African-Americans increased 7% (from 18% to 25%) during the same period.

Since private health insurance coverage is linked to employment, racial barriers to employment are one explanation for the significant difference in insurance coverage. For example, in 1990 the African-American unemployment rate was 240% more than the European-American unemployment rate. Even where employed, the African-American is more likely to be in a lower paying job which does not provide employer-based health insurance. Another factor affecting insurance coverage is the higher percentage of African-American families with only one adult. Families with two working adults are more likely to have at least one adult with employer-based insurance.

However, while the absence of health insurance is much more likely with lower income, race is an independent factor affecting whether an individual will be insured. In fact, the racial difference in proportion of uninsured is most marked at higher incomes. For example, poor/low income African-Americans are uninsured at about the same rate as poor/low income European-Americans; however, middle/high income African-Americans are almost twice as likely to be uninsured than higher income European-Americans.

208. Short et al., supra note 204.
209. Id.; Davis, supra note 170, at 3-6.
210. Davis, supra note 170, at 5.
211. Id. (reporting that as of 1988, the mean earnings for European-American males was 36% higher than African-American males).
212. In 1990, 61% of African-American families with children under the age of 18 were single caregivers, (i.e. single parent, single foster parent, single relative, single grandparent) compared to 23% of similar European-American families. Davis, supra note 170, at 5.
213. Id. at 6.
214. Davis, supra note 170, at 28; Short et al., supra note 204.
215. Short et al., supra note 204; Davis, supra, note 170, at 28. Of poor individuals, 36% of European-Americans are uninsured compared to 35% of African-Americans. Of low-income individuals, 31% of European-Americans are uninsured compared to 30% of African-Americans. Finally, of middle/high income individuals, 9% of European-Americans are uninsured compared to 16% of African-Americans. Id.

African-Americans are more likely to be uninsured because they are more likely to be unemployed or employed in low paying positions which do not provide health care benefits. For instance, in 1989, 30.7 percent of African-Americans were poor, compared with 12.8
Expanding insurance coverage so that everyone will have either employer-based or government-based insurance is one proposal for addressing the inequities in the health care system.\textsuperscript{216} During the 102nd Congress, more than thirty proposals were introduced to expand insurance coverage and reform the health care system.\textsuperscript{217} The proposals under consideration fell into five major categories: market-reform, employer mandate plus Medicaid, employer choice of Medicare or private, Medicare for all, comprehensive public plan. See, Table 11 below.

- \textit{Market-reform}. Small group health insurance reform is a targeted approach to extend insurance to the working uninsured.\textsuperscript{218} It proposes reforming the small group market to make coverage affordable and easier to purchase and to then sell private health insurance to small firms.\textsuperscript{219} The reforms include: requiring private insurers to make coverage available to all firms, employees and dependents in the group, limiting pre-existing condition waiting periods for coverage, limiting variation of premiums based on group risk, limiting the extent to which premiums could be increased.\textsuperscript{220}

- \textit{Employer-Mandated Basic Coverage plus Medicaid}. Similar to market-reform, this proposal would require employers to offer coverage and to contribute at least 75 to 80 percent toward the premium cost.\textsuperscript{221} In addition, Medicaid would be expanded to cover all poor persons not encompassed under an employer policy.\textsuperscript{222}

- \textit{Employer Choice of Medicare or Private}. The “play or pay” option would provide employers the alternative of acquiring private health insurance coverage for employees and dependents or contributing toward their coverage under a public percent of European-Americans. In 1990, the African-American unemployment rate (11.3 percent) was 140\% more than European-Americans (4.7 percent). Finally, the mean earnings of European-American males was 36 percent higher than African-American males. U.S. House of Representatives, Committee on Ways and Means, 1991. \textit{Green Book, Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means}, Washington, D.C.: U.S. Government Printing Office, May 7 (1991).

\textsuperscript{216} Numerous policy responses has been suggested for increasing insurance coverage. The three main proposals are employer mandate coverage which require all employers to provide health insurance, expansion of Medicaid coverage or a combination of employer mandated and expansion of Medicaid. Long, \textit{supra} note 168, at 200-12. It is estimated that even with a combined employer mandate and medicaid expansion some 2.1 million African-Americans will remain uninsured. \textit{Id. at 211.} Thus, a fourth proposal, universal health insurance, has been suggested.

\textsuperscript{217} \textit{This Week with David Brinkley}, (ABC television broadcast, Feb. 2, 1992).

\textsuperscript{218} Davis, \textit{supra} note 170, at 11-12.

\textsuperscript{219} \textit{Id.} at 11.

\textsuperscript{220} \textit{Id.} at 11-13.

\textsuperscript{221} \textit{Id.} at 13.

\textsuperscript{222} \textit{Id.}
plan similar to Medicare. If a person is not covered under a private insurance plan, he or she would automatically be covered under the public plan and assessed a premium based on income.

- **Medicare for All.** This alternative would broaden the present Medicare program to the whole population. Employers would be required to contribute financially toward the coverage of their employees. States would also be required to contribute current Medicaid funding for acute care benefits to the poor.

- **Comprehensive Public Plan.** This option provides comprehensive health benefits to the entire United States population through a single public plan. This plan would replace all private health insurance.

### TABLE 11

<table>
<thead>
<tr>
<th>EXPANDED HEALTH INSURANCE OPTIONS</th>
<th>Market Reform</th>
<th>Employer Mandate Plus Medicaid</th>
<th>Employer Choice of Medicare or Private</th>
<th>Medicare for All</th>
<th>Comprehensive Public Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage</td>
<td>20-23 million</td>
<td>6 million</td>
<td>Universal</td>
<td>Universal</td>
<td>Universal</td>
</tr>
<tr>
<td>Benefits</td>
<td>Limited</td>
<td>Basic</td>
<td>Medicare</td>
<td>Medicare</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Private Insurance</td>
<td>170 million</td>
<td>200 million</td>
<td>180 million</td>
<td>Supplemental</td>
<td>None</td>
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<tr>
<td>Cost Containment</td>
<td>None</td>
<td>Managed Care</td>
<td>All Payer</td>
<td>Single payer</td>
<td>Global Budget</td>
</tr>
<tr>
<td>Financing</td>
<td>Individual Premiums</td>
<td>Employer Premiums Contributions</td>
<td>Employer Premium Contributions or Payroll</td>
<td>Payroll Tax Income Tax</td>
<td>Payroll Tax Other</td>
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2. Policy Analysis

*Horizontal Equity.* To the extent that expanded insurance coverage would provide economic access for all uninsured, it has hori-

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223. *Id.* at 15-18.

224. *Id.* Acute benefits for low income families would no longer be covered under Medicaid. Instead, states would contribute toward the new public plan coverage of acute care benefits. *Id.* However, Medicaid would continue to provide supplemental benefits and long-term care. *Id.*

225. *Id.* at 18-20.

226. *Id.* at 20-21.

227. *Id.*

228. *Id.* app. (chart 2).

229. The chart below is a visual representation of how well “Expanding Insurance Coverage” meets the various criteria. A minus sign (−) means that the criteria is not met. A plus sign (+) means that the criteria is met. A question mark (?) means that it is uncertain as to how well the criteria will be met.
RACIST HEALTH CARE

Horizontal equity. In essence, expanded insurance coverage treats equals (the uninsured) as equals. Therefore, options such as employer choice of Medicare or private insurance, Medicare for all, and comprehensive public plan, have horizontal equity.

However, market-reform and employer-mandated plus Medicaid do not provide for coverage for all uninsured. For instance, market-reform options do not require the employer to contribute toward the premiums. Without employer contributions, many employees in low-paying jobs will not be able to afford the premiums. Furthermore, premiums may increase because of availability of coverage to high-risk, sick individuals who had been previously excluded by underwriting practices. Therefore, under the market-reform option almost 40 millions persons will still be uninsured.

Similarly, employer mandate only covers two-thirds of the uninsured who are in families with a working adult. It excludes from coverage almost 7 million uninsured, such as part-time workers and older adults who are disabled or retire early and are not eligible for Medicare. The groups (including those in low-paying jobs and/or part-time employment) that market-reform and employer mandate plus Medicaid will not cover would include high numbers of African-Americans.

Vertical Equity. A system of universal insurance regardless of coverage fails to resolve the racial difference in access between African-Americans and European-Americans that is not related to insurance coverage. For example, European-Americans have better access to health care even when the insurance coverage is similar. Expanding insurance would not increase community availability of

<table>
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<tr>
<td>?</td>
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<td>?</td>
<td>?</td>
<td>+</td>
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230. Id. at 12; See generally Paul Cotton, Insurance Loss Threatens Medical Gain, 266 JAMA 2185 (1991) (explaining that healthy people are increasingly unable to get what health care they do need due to severe medical underwriting practices by health insurance companies); Limits on Medical Coverage May Affect 1 of 3 under 65, ATLANTA J. & CONST., June 19, 1991, at B3 (detailing how an underwriting guide from an insurer contained 84 conditions - from acne to varicose veins - that it permanently excluded from health insurance coverage); Private System Places Millions at Risk, Citizen Action Report Says, 18 Pens. Rep. (BNA) 1048 (June 24, 1991) (discussing how private health insurance policies have lifetime limits on coverage, routinely deny coverage for any treatment or device that they do not recognize as accepted medical practice, exclude from underwriting such conditions as allergies or mild headaches be permanently excluded and deny coverage for pregnancy and cancer).

231. Davis, supra note 170, at 12.

232. Id. at 13-14.

233. See supra notes 183-186 and accompanying text.
either European-American institutions and providers or African-American institutions and providers. Nor does expanding insurance coverage address the issues of racially disparate treatment. In short, expanding insurance coverage does not address the issue of institutional racism. Consequently, expanding insurance coverage does not provide for vertical equity.

**Economic Efficiency.** Whether expanding insurance coverage is economically efficient is highly debatable. Without cost controls, expanding insurance coverage could increase health care costs drastically. Historically, the existence of health insurance has played a significant role in increased health care costs. This is so because the insurer’s method of reimbursing providers introduced into the health care system a “complex of irrational economic incentives”\(^\text{234}\).

In particular, the “fee-for-service basis”\(^\text{235}\) system euphemistically called “the free lunch system,” has delivered medical care without regard to cost containment, and sometimes without regard to medical necessity. Under fee-for-service, third-party payers pay health care providers for each discrete item of service. In 1980, 50% of active physicians were compensated by fee-for-service; approximately 20% were salaried and the other 30% received a mixed form of compensation.\(^\text{236}\) Similarly, government programs (Medicaid and Medicare) reimbursed providers for most of their costs or charges incurred in treating covered patients.\(^\text{237}\) Both reimbursement forms created powerful incentives to over-utilize the health care system.\(^\text{238}\) In fact, no one had a rational incentive to

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236. *Id.*

237. *See supra* text and notes accompanying footnote 200.

238. Capron, *supra* note 234, at 708. In particular, the payors’ methods of calculating fees to be paid further complicated the picture. The practice of covering “usual, customary and reasonable (UCR) cost” allowed the provider to charge whatever the market would bear — and they usually did.

When the maximum payments available under usual and customary became public knowledge, there was a natural tendency on the part of physicians . . . to move to the maximum available. . . . Once that was done, the whole concept of usual and customary, based on physicians’ pricing as an independent entity unaffected by their peers or others in the community, was gone. The whole program changed its nature both as to Medicare and as to private, usual and customary. . . . Prices rose dramatically. . . . The doctor could find [the maximum UCR] out very readily by simply testing the system by raising his fees until he hit the upper limit, and they did.

Sylvia A. Law & Barry Ensminger, *Negotiating Physicians’ Fees: Individual Patients or Soci-
For example, a patient contracted for insurance through the employer for 80% of the usual, customary, and reasonable (UCR) cost of "medically necessary care." Therefore, the patient lacked the incentive to economize because no matter the charges, the patient only paid 20% of the cost.\(^\text{239}\) Because the insurance premium was shared with the employer, the patient generally was not directly concerned with future premium increases. Even so, her individual health care choices did not directly influence her insurance premium, since insurers did not typically base health care insurance premiums on "experience rating." In this way the patient did not realize the full financial impact of her health care treatment decisions.

Nor were hospitals and physicians motivated to economize. Because most third-party payors guaranteed providers 80% of their customary charges, fee-for-service or cost-based charges had an opposite and "perverse influence" on health service delivery.\(^\text{240}\) Under both reimbursement systems, providers made more when they treated more.\(^\text{241}\) This phenomenon had two effects. First, physicians and hospitals tended to de-emphasize preventive care, which was not as lucrative as treatment services. Second, providers tended to place excessive reliance on the use of medical technology because third-party payors paid for discrete procedures, not time spent with patients.\(^\text{242}\)

From the patient's point of view, insurance removed the need to ration health care dollars, creating a "moral hazard problem."\(^\text{243}\) And, from the insurer's point of view, a payment system that had worked well for auto and life insurance seemed to make sense. In these ways, health care insurance was designed and implemented on the basis of faulty assumptions by all parties.\(^\text{244}\)

Extending health care insurance to greater numbers of persons...
could result in over-utilization unless serious cost containment measures, such as utilization review and financial risk-shifting, are introduced into the health care system.

Neither the market-reform option nor the employer-mandated option is likely to contain substantial cost containment provisions. Small firms and private plans do not typically offer managed care products which provide the mechanism for serious cost containment. While some larger employers may offer managed care products, they represent a relatively small proportion of the newly insured since most larger employers are already covering their employees. There is potential for cost containment with the expansion of Medicaid, since it would extend its tight provider payment limits to a larger number of persons. However, those same payment limits might also act as a deterrent to provider participation which would then limit the actual availability of service. Therefore, expanding insurance is only efficient if the health care system is reformed to eliminate unnecessary medical care, reduce overpriced procedures, and improve administration.

**Stigma.** While expanding insurance coverage will not necessar-

245. Utilization review is the process by which an organization determines if medical services are appropriate and necessary. In the managed care product, this involves examining providers' authorization and furnishing services to detect variations from the norm that may point to unnecessary or inappropriate care. Pamela S. Bouey, *Peer Review In Managed Care Setting, in COM. LAW AND PRAC. COURSE AND HANDBOOK SERIES, MANAGED CARE 1988: LEGAL AND OPERATIONAL HEALTH CLASSES* (1988). When the third-party payer detects variation, either it does not pay the claim [retrospective utilization management programs analyze data on hospital admissions, patterns of treatment and utilization of certain procedures or refuses to authorize the provision of the service (concurrent and prospective)]. Under a prospective review system, most non-emergency hospital admissions must receive prior approval and an initial approved length of stay is assigned. Richard Hinden & Douglas Elden, *Liability Issues for Managed Care Entities*, 14 SETON HALL LEGIS. J. 1, 52 (1990).

246. If payers did not combine utilization review with financial risk shifting, the review process alone would have limited effectiveness in controlling costs. Consequently, payers use various financial risk-shifting mechanisms. These mechanisms cause the provider (physician) to change his or her pattern of practice from over-utilization to "appropriate utilization" at best and "under-utilization" at worst.

Financial risk shifting can arise in a variety of arrangements: ownership interest, joint-venture, or a "bonus" arrangement in which the third-party payer shares the surplus from "cost-effective" care with the physician. *See generally*, Paul M. Elwood, Jr., *When MDs Meet DRGs*, 57 HOSP., Dec. 16, 1983, at 62-63; E. Haavie Morreim, *The MD and the DRG*, 15 HASTINGS CTR. REP., June 1985, at 30, 34-35; Capron, *supra* note 234, at 725-29. While the form may vary, the penalties have similar effects. For instance, payers indirectly penalize physicians by giving them less profits or directly penalize them by reducing capitation payments each time they make "inappropriate referrals." However, not all risk shifting mechanisms have the same impact. Some have a greater potential than others for causing the physician to act in a way that is not consistent with the patient's best interests. For instance, because mechanisms, like physician diagnostic-related groups and capitation, require the physicians to bear individual loss, they have the greatest risk.
ily stigmatize, actions taken to make it workable, that is, cost containment efforts, might lead to stigmatization. The stigmatization may be a result of individuals being treated differently based on the type and amount of coverage they have. Historically, the type and extent of coverage varies among individuals and groups, based on whether it is government or employer-based insurance.

Even among employers, insurance varied among large employers with unions (such as General Motors) and smaller employers without unions. Further, regardless of size of employer, individuals employed in minimum-wage positions often have no coverage or minimal coverage with large deductible amounts.

Government programs (such as Medicaid and Medicare) have had lower provider payment schedules and treatment guidelines, which discourage provider participation. In fact, many providers have refused to accept payment from policies that either do not make full restitution or that place restriction on their practices. Individuals who have these policies are likely to be labeled negatively by providers and institutions. Given that many African-Americans are employed in minimum-wage positions (or are covered by government insurance) they are likely to be stigmatized more by providers' refusal to accept certain policies.

Preference Satisfaction. There is no indication that a generalized insurance program will allow for preference satisfaction for all participants. Preference satisfaction implies the ability to exercise choice in providers and treatment. To make expanded insurance coverage workable, patient choice might be limited to control cost. For example, many employers may adopt managed care plans as a mechanism of controlling cost. Managed care plans control cost

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247. With the stabilization of HMOs as a cost control mechanism, payers were pushed to find more efficient cost control methods or plans. The push resulted in the proliferation of other managed care arrangements, most notably preferred provider organizations (PPOs). PPOs contract directly with an employer through its health benefits department or indirectly through an insurance carrier. Typically, while the choice of providers is limited, the overall expense to the patient is lower than with traditional insurance. Physicians contracting with PPOs agree to accept both utilization review controls and financial risk-shifting structures. Payers give consumers economic incentives to use the PPOs' physicians. National Health Lawyers Association, Introduction To Alternative Delivery Mechanisms: HMOs, PPOs & CMPs 11 (Jeanie M. Johnson ed., 1986). Greg de Lissvoy, et. al., Preferred Provider Organizations: Today's Models and Tomorrow's Prospects, 23 INQUIRY 7, 7-8 (1986).

Monetary incentives focused on the patient effectively obviate freedom of choice. If a patient is unable to pay the difference, he or she will have no choice but to utilize the preferred provider. Approximately 20 states have attempted to resolve this issue by passing laws which limit the reimbursement differential between PPO and non-PPO utilization. It is unclear whether such limitations protect "freedom of choice" since to do so would limit the effectiveness of managed care products. Daniel Forbes, Cut Health Care Costs, Get Sued?
by having physicians act as “gatekeepers”, limiting a person's access to certain treatment and to specialist physicians. While expanding insurance coverage in itself will not limit preference satisfaction, the gatekeeping aspects of cost containment programs will. These attempts to have the physician become the gatekeeper to medical care will ultimately change the entire structure of the American health care system and not necessarily for the better. The least articulate, least educated, least financially well-off person will have the most limits imposed by cost containment efforts. If cost containment efforts result in injuries, the poor and minorities will have to bear the cost of restricted access to services. The cost containment efforts that will be associated with expanding insurance coverage could potentially result in greater health disparity be-

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248. Current cost-containment efforts shift the risk of financial loss for health care in whole or in part to the providers of that care. Galen D. Powers, Allocation of Risk in Managed Care Programs, in Managed Health Care: Legal and Operational Issues Facing Providers, Insurers, and Employers 279 (1986) [hereinafter Allocation of Risk]. Physicians are offered economic incentives to act as the third-party payer's agent—the “gatekeeper” to health care services. Carolyn M. Clancy & Bruce E. Hillner, Physicians as Gatekeepers: the Impact of Financial Incentives, 149 ARCHIVES INTERNAL MED. 917, 917-20 (1989). This change shifts the focus of the health care system from the doctor-patient relationship to the doctor-payer relationship. Ultimately, the doctor and payer will determine the quality of care received by the patient and the patient's access to that care. The gatekeeping role is not new to physicians. They have used their position in several ways. For instance, physicians have used their authority as health care gatekeepers to resist hospitals' and insurers' efforts to influence medical treatment. Furthermore, they have generally used their role to obtain more services for the patient, not less. Now, however, they use their position to “save” money for third party payers by ordering fewer services. See, Robert Scheier, Twin City MDs Fight IPA Hospital Contracts, AM. MED. NEWS, Feb. 28, 1986.

249. No matter how one looks at gatekeeping schemes they will eventually alter the perceptions and expectations of society, physicians, patients and third-party payers. How these parties will feel about what is owed to whom, what treatments are appropriate in what circumstances, and even what qualifies as a disease will be altered. Capron, supra note 234, at 730-33. These changes run the risk of injuring individuals merely because they cannot get access to the treatment that they need. When this failure to obtain appropriate medical care is due to cost containment efforts, who shall bear the cost? If cost containment is an important societal goal, then the cost of injuries should be spread throughout the society. Soon payers will routinely withhold (or decline to pay for) certain interventions that might benefit certain patients but that simply cost too much because it is the collective societal attitude not to “check on physicians’ temptation to place their own interest ahead of their patient's interests. Instead society [attents] to use physicians' selfish motivation to restrain full pursuit of patients' interest.” Capron, supra note 234, at 749. “By asserting incentives that result in the physicians’ having their own finances at risk, the new methods of physician reimbursement turn physicians into gatekeepers for [third-party payers]. Their decisions would no longer be based on medical criteria alone (i.e., does this medicine have something to offer this patient?) but would take into account the financial risk if they admit patients into the system whose care costs more than insurance will pay.” Capron, supra note 234, at 753.
tween African-Americans and European-Americans. This is especially true given physicians' propensity to treat patients differently based on race.

Privacy. Expanded insurance coverage does not necessarily affect privacy. However, as in preference satisfaction, steps taken to implement the option may negatively affect a person's privacy. In order for governments and third-party payers to carry out utilization review and financial risk-shifting, they must scrutinize the treatment of individual patients. In particular, utilization review examines appropriateness of medical services to detect variations from the norm that point to unnecessary or inappropriate care. When the third-party payer detects variation, either it does not pay the claim (retrospective\(^2\)) or refuses to authorize the provision of the service (concurrent and prospective\(^2\)). Each form\(^2\) requires varying degrees of information about the individual. The plan which will most invade an individual's privacy is the one that employs prospective or concurrent utilization review because it re-

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251. "Retrospective utilization management programs analyze data on hospital admissions, patterns of treatment and utilization of certain procedures." Hinden & Elden, supra note 245, at 52.
252. "Under a prospective review system, most non-emergency hospital admissions must receive prior approval and an initial approved length of stay is assigned." Hinden & Elden, supra note 245, at 52.
253. Utilization review may take several forms:

   Pre-admission review for scheduled hospitalization which determines the medical necessity of a scheduled inpatient admission, of expensive procedures, or of outpatient procedures. Initial determination is made by a nurse review coordinator using established criteria. Almost all managed care products use pre-admission certifications. Bouey, supra note 207, at 11. A registered nurse usually conducts off-site pre-admission certification. If there is a scheduled admission prior to hospitalization, the patient's physician completes a review form. She describes the patient's medical condition, and the treatment plan, and forwards the form to the nurse review coordinator. The nurse notifies the physician, patient and hospital of the decision regarding the appropriateness of admission and length of stay. Harold Bischoff, Utilization Review and Health Maintenance Organizations, 13-14 (1989) (fellowship thesis, American Hospital Association). There is, of course, an appeal process that is conducted by a physician.

   Admission review for unscheduled hospitalization determines the medical necessity of unscheduled in-patient admissions or other admissions not covered by pre-admission review. Most managed care products use concurrent review. The primary exception is hospitals that are paid based upon diagnostic-related groups. Bouey, supra note 245, at 11.

   Second opinions for elective surgery. Bouey, supra note 245 at 11;

   Concurrent review (or, length of stay ["LOS"] certification) determines the medical necessity of a continued hospital stay. When the LOS certificate expires either the patient or the provider may request extension. Bouey, supra note 245, at 12; Hinden & Elden, supra note 245, at 52. A concurrent review is conducted by a nurse reviewing the patient's treatment plan. The nurse conducts the review at the hospital using established medical criteria. If the nurse judges the treatment plan to be appropriate, s/he approves the stay until the next review cycle or the patient is discharged. If s/he does not approve the treatment plan, the
quires information about a current illness for the purpose of denying care.

**Political Feasibility.** Almost certainly, within the next four years some bill will be passed expanding insurance coverage. The only real question is what shape the reform will take. As noted above, the 102nd Congress introduced more than thirty proposals which include market-reform, employer mandate plus Medicaid, employer choice of Medicare or private, Medicare for all, comprehensive public plan. Given the extensive insurance lobby, it is not likely that a comprehensive public plan or a Medicare-for-all plan will be adopted since both those options would nearly eliminate the role of private insurance. The market-reform option, while the least intrusive into the current system, would also leave many individuals uncovered. Given the pain and agony that many are undergoing to change the system, leaving large numbers uncovered would be political suicide. The most likely reform is some combination of employer mandate plus Medicaid and/or employer choice of Medicare and/or private. While this would leave some individuals uncovered, it would provide the most extensive coverage without radically changing the health care system.

**Summary.** The lack of health insurance explains a significant part of the difference in the use of health care services between African-Americans and European-Americans. Expanding insurance coverage is certain to help to increase the use of health care services. For example, in 1977 uninsured African-Americans in the South saw physicians an average of 1.5 times, while insured African-Americans saw physicians an average of 2.8 times. However, it is important to note that, while African-Americans' physician visits almost doubled for those with insurance, the racial differential between African-Americans and European-Americans remained

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nurse refers the case to a physician advisor who either confirms the need for continued treatment or suggests alternate treatment. Bischoff, *supra* note 253, at 11.

*Gate-keeping by primary physician* determines, in a variety of ways, whether or not a patient should be seen. Bouey, *supra* note 245, at 14.

*Retrospective claims review* disallows payments of claims for utilization abuses. Since it is not as effective as prospective or concurrent review, use of retrospective claims review is declining. Bouey, *supra* note 245, at 14. However, it is useful as a tool to research provider claims. For example, it would be useful in determining whether the objective laboratory data (biopsy) and subjective data (surgeon notes) coincide with the length of stay or the length of surgery. Bischoff, *supra* note 253, at 15. Consequently, retrospective review can be a very important tool in a managed care agency such as an HMO.

That is, uninsured European-Americans had 150% more visits per year than uninsured African-Americans; insured European-Americans had 132% more visits per year than insured African-Americans.\footnote{255}{Davis, \textit{supra} note 170, at 9.} \footnote{256}{\textit{Id.}}

It seems that expanded insurance coverage is a policy option which will remove major economic barriers to health care. However, this option is not a satisfactory replacement for removing race-related problems with access to health care. Furthermore, it increases access at the risk of increasing health care cost, decreasing preference satisfaction and interfering with an individual's privacy—all of which are areas in which African-Americans will be affected in greater proportion than European-Americans.

Ultimately, the most significant problem with expanding insurance coverage, from the African-American perspective, is that expanding insurance coverage does little more than provide individuals with a piece of paper that says, in effect, that they may obtain health care, \textit{if} they can find someone to accept the coverage. Expanding coverage does nothing to ensure that a provider in the community will furnish health care nor does it address the issues of disparate medical treatment.

C. Targeting Health Care Services to African-Americans

1. Background

Targeting health care services to African-Americans would focus resources on the specific health problems confronting them. In particular, funds could be allocated to establish community clinics in African-American communities. Such targeting services to specific population groups is not new and has been implemented in other areas: Maternal-Child health, Family Planning and Handicapped Children. Community clinics have been used to serve low income communities.

Congress passed the Disadvantaged Minority Health Improvement Act [hereinafter DMHIA], which was passed to improve the health status of individuals from disadvantaged backgrounds, including racial and ethnic minorities, and to increase the numbers of minorities in the health professions. This was to be accomplished by establishing within the Department of Health and Human Services an Office of Minority Health and by giving the office grant au-
The DMIHA also established a program of primary health care services to residents of public housing. It revived and extended the program of Centers for Excellence in Health Professions Education for Minorities. The Act established programs of loans, scholarships, and loan repayment for individuals from disadvantaged backgrounds who are pursuing a degree in a health profession. It revised and extended the authority for the National Center for Health Statistics, and it created a new program of grants for data studies on the health of ethnic and racial minorities. The DMHIA established a new program of grants for assisting communities in educating minorities to serve as health professionals in those communities. It revised and extended the programs of Community and Migrant Health Centers and created a program of grants for improving the health status of Pacific Islanders. Furthermore, the Congress appropriated funding specifically directed to issues relevant to improving African-American health.

States could take steps to target services toward African-Americans. In 1991-92, only nineteen states had minority health entities. Seven states established the minority health entities by statute, four states established the minority health entities by executive order, and eight states established the entities by the appointed health officer. However, the budgets for these entities indicate that they may be little more than "advisors" on minority health.

257. See Disadvantaged Minority Health Improvement Act of 1990, Pub. L. No. 101-527, 104 Stat. 2311. The establishment of the Office of Minority Health within the Office of the Assistant Secretary for Health in the Department of Health & Human Services was codified in Title XVII of the Public Health Service Act. The Disadvantaged Minority Health Improvement Act [hereinafter DMHIA] provided for a broad range of activities relating to improving the health status of African-Americans and other minorities. For instance, the Office of Minority Health [hereinafter OMH] is required to establish objectives and to coordinate all activities within the Department of Health & Human Services related to minority health, including disease prevention, health promotion, service delivery, and research. Furthermore, OMH is required to enter into interagency agreements with public health service agencies to increase the participation of minorities in the service and its promotion programs.

258. Id. at § 3.
259. Id. at § 4.
260. Id. at § 5.
261. Id. at § 6.
262. Id. at § 8.
263. Id. at § 9.
264. Id. at § 10.
266. Delaware, Michigan, Mississippi and New Jersey. Id.
267. Alabama, Georgia, Hawaii, Indiana, Massachusetts, Oregon, South Carolina and Virginia. Id.
rather than service providers. In 1991-1992, only three states had budgets which exceeded $500,000\textsuperscript{268} and eleven states had less than $100,000.\textsuperscript{269}

2. Policy Analysis\textsuperscript{270}

*Horizontal equity.* Targeting health care services to African-Americans requires treating African-Americans differently than European-Americans even when both have similar health problems. Thus, this proposal fails to promote horizontal equity.

*Vertical Equity.* To the extent that African-Americans and European-Americans are affected differently by health disorders, it does provide vertical equity. For instance, more African-Americans are affected by diabetes than European-Americans. Consequently, targeting services toward African-Americans would be treating unequal groups unequally to promote equality.

*Stigma.* The very act of targeting African-Americans can result in significant stigma. Singling out African-Americans would lead to labeling the beneficiaries of the programs as different. This process could increase racial polarization. Providing greater services to African-Americans could arouse opposition from other groups who perceive their needs as great as African-Americans.

*Preference Satisfaction.* Whether there would be preference satisfaction depends on how the services are delivered. If the services are delivered through private providers, then certainly there would be no more problems with preference satisfaction than any of the other insurance programs. On the other hand, if the services are delivered through programs that employ a specific staff, there would be limited preference satisfaction since the choice of providers for African-Americans using the services would be limited.

*Economic Efficiency.* As in expanding insurance coverage, the cost of targeting services to African-Americans is significant. The government would need to allocate additional funds for the prov-

\textsuperscript{268} Michigan ($900,000), New Jersey ($500,000), Ohio ($1,600,000) and Oregon ($1,838,241).

\textsuperscript{269} Id.

\textsuperscript{270} The chart below is a visual representation of how well "Targeting Services" meets the various criteria. A minus sign (–) means that the criteria is not met. A plus sign (+) means that the criteria is met. A question mark (?) means that it is uncertain as to how well the criteria will be met.

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sion of the services. However, to the extent that targeting services to specific population attacks the problem directly, targeting services could be more efficient (and less costly) than a broader approach (i.e. primary care for all).

**Privacy.** To the extent that African-Americans would need to be identified as having specific health issues in order to have their health care problems addressed, issues of privacy exist. Problems also exist if programs would need information from African-Americans to monitor the community health.

**Political Feasibility.** This choice has limited political feasibility. Given the current deficit, Congress may have difficulty in justifying spending limited health care resources on a narrow population group. Other groups who view themselves as having similar or significant health problems could be angered if their population was not given similar treatment. In this age of racial tension and discord, in-fighting over limited resources is undesirable.

**Summary.** Targeting services to African-Americans would address some access issues and treatment disparity problems since it would require availability of services in the African-American community. The treatment disparity between African-Americans and European-Americans is more likely to be addressed in this environment. However, a major drawback to targeting service is that it does not necessarily effect change in the overall system. Assuming that such an approach would be short term, the problems of racial barriers to access and racially disparate treatment would continue. Furthermore, African-Americans not served by the special programs could continue to face those same problems. Other major drawbacks are the significant stigma that might be associated with such programs and the political unpopularity of targeting health care services for a specific ethnic population group.

**D. Using Title VI to Eliminate Institutional Racism**

1. **Background**

The Civil Rights Act of 1964 provides the legal force for desegregation efforts in health care. Specifically, section 601 of Title VI provides:

No person in the United States, shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any
program or activity receiving Federal financial assistance.\textsuperscript{271}

In short, Title VI prohibits discrimination on the basis of race, color, or national origin. The Office of Civil Rights (OCR) is delegated the responsibility of enforcing Title VI and the Department of Health Education and Welfare [now Department of Health and Human Services (DHHS) and Department of Education] issued the first interpretive regulations.\textsuperscript{272} Those regulations provide that:

A recipient . . . may not . . . utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination of their race, color or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color, or national origin.\textsuperscript{273}

A recipient is any public or private entity or individual that receives federal financial assistance.\textsuperscript{274} Federal financial assistance includes federal money awarded through grant, loan, or contract.\textsuperscript{275}

In light of these two definitions, Title VI, has the potential of having a broad range effect. Once a program\textsuperscript{276} has been determined to violate Title VI, the program “must take affirmative action to over-


\textsuperscript{273} 45 C.F.R. § 80.3(b)(2) (1991) (emphasis added).

\textsuperscript{274} 45 C.F.R. § 80.13(i) (1991). DHHS provides federal assistance “to more than 6,800 hospitals, 13,700 out-patient and primary care facilities, various state and local public health agencies, 8,000 day care centers and 37,000 local services agencies. . . . [T]here are more than 43,000 DHHS recipients serving more than 93 million beneficiaries.” Rice and Jones, supra note 236, at 100.


come the effects of prior discrimination.\textsuperscript{277}

While the statute does not specifically define discrimination, it specifically requires HEW to define discrimination.\textsuperscript{278} In particular, Title VI regulations prohibit:

- criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin;\textsuperscript{279}
- criteria or methods of administration which have the effect of defeating or substantially impairing accomplishment of the objectives of the program with respect to individuals of a particular race, color, or national origin;\textsuperscript{280}
- Difference in quality of services because of the individual's race, color, or national origin;\textsuperscript{281}
- Differences in quantity or the manner in which the benefit is provided because of the individual's race, color, or national origin;\textsuperscript{282} and,
- Locating services with the purpose or effect of excluding individuals because of the individual's race, color, or national origin from the benefits of the program.\textsuperscript{283}

Title VI could be used to improve access of African-Americans to health care services. Title VI regulations clearly prohibit policies and practices which result in segregation within and between institutions.\textsuperscript{284} Hospitals and nursing homes which engage in restrictive admission practices face discontinuation of their federal funds.\textsuperscript{285} Communities can use Title VI to resist major changes in health care delivery that disadvantage African-Americans. For example, the closing of a predominantly African-American inner-city hospital and the expansion of another hospital serving primarily European-Americans could be attacked under Title VI.\textsuperscript{286} Similarly, Medicaid and Medicare cutbacks which primarily affect African-Ameri-

\textsuperscript{277} 45 C.F.R. § 80.3(b) (6) (i) (1991).
\textsuperscript{282} 45 C.F.R. § 80.3(b)(1)-(3) (1991).
\textsuperscript{283} Id.
\textsuperscript{284} For example, referral of white mental patients to individual counseling and blacks to group counseling; or the dumping of indigent emergency room patients from private, largely “white” hospitals to public hospitals would be prohibited under Title VI. Dorn et al., supra note 100, at 440-41.
\textsuperscript{285} Restricted admission practices which have a discriminatory effect include: not having physicians on staff or otherwise available who accept Medicaid patients; or requiring pre-admission deposits as a condition of obtaining care. Dorn et al., supra note 100, at 441.
\textsuperscript{286} Id.
cians also violate Title VI. Thus, Title VI has the potential of forcing health care institutions to evaluate their policies and practices which have a disparate impact on African-Americans.

Title VI can also be used to correct problems of racially disparate health care. Under Title VI, institutions must assure that the quality and quantity of health care services offered to African-Americans are proportionate to their need.

2. Policy Analysis

**Horizontal Equity.** Title VI focuses on assuring that African-Americans who have been treated differently than European-Americans are assured the same access and health care treatment. Using Title VI as a way to eliminate institutional racism would achieve horizontal equity since it would treat equals (sick individuals) as equals.

**Vertical Equity.** Meeting vertical equity will depend largely on the types of policies and practices an institution adopts as part of Title VI compliance. Using Title VI to eliminate institutional racism in health care merely requires that African-Americans who are sick and in need of care be given the equal access to health care and be given appropriate medical treatment. However, to the extent that African-Americans now have less access and different treatment, it would require institutions to adopt policies and practices that would assure African-Americans increased access and better treatment. Those policies and practices might treat African-Americans and European-Americans differently. If so, vertical equity would be met.

**Stigma.** Using Title VI may not remove the problem of stigma. Whether stigma persists will depend on how the institutions respond to the Title VI challenges and how the community responds to health care policy changes and costs necessitated by Title VI compliance. Individuals using any targeted services would certainly risk labeling. Title VI could generally raise racial hostility among

287. *Id.*

288. The chart below is a visual representation of how well the “Eliminating Discrimination” meets the various criteria. A minus sign (−) means that the criteria is not met. A plus sign (+) means that the criteria is met. A question mark (?) means that it is uncertain as to how well the criteria will be met.

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289. Although, Title VI does have affirmative action provisions and rules.
the European-Americans (and other groups) that are experiencing different types of access problems. Such hostility could result in additional stigma on African-Americans. However, to the extent that Title VI compliance assures that no group is discriminated against based on race, Title VI compliance would improve access and treatment for other ethnic groups similarly situated to African-Americans.

Preference Satisfaction. Unlike "targeting services," Title VI could have the advantage of allowing for preference satisfaction. As institutions do away with discriminatory practices which limit access and treatment options, individuals will have increased choice. On the other hand, unless existing facilities are made sufficiently attractive to competent providers, preference satisfaction still may be lacking. To some extent, it is a program's responsibility to expend the resources necessary to assure quality of services to the African-American community. Realistically, the courts are likely to allow programs to balance this goal against other goals.

Economic Efficiency. If the current system is the most efficient for a significant segment of the population, efficiency may be lost if health care institutions reconsider their administrative policies and their evaluations of physicians to decide the disparate impact that their institution and policies will have on African-Americans. However, evidence indicates that this system is not the most economically efficient. More than $200 billion are wasted each year in unnecessary care and inefficient administration. That $200 billion is enough to assure adequate health care and changes in the health care system to eliminate institutional racism.

Privacy. While the other options raised issues of patient privacy, this option raises issues of provider privacy. Title VI compliance will require evaluation of physician behavior. For example, treatment decisions must be scrutinized by health care institutions and licensing boards to identify and explain any racial disparity in treatment. Provider attitudinal study may require identification of patients themselves. Even if this latter step is eliminated, individual physician treatment choices and institutional records will be scrutinized in ways not presently undertaken. Thus, privacy criteria are not met.

Political Feasibility. Title VI can be enforced through the administrative complaint process or through a private legal action. The political feasibility of using Title VI to eliminate racism depends in part on the forum chosen.

a. Administrative Complaint Process. The administrative com-
RACIST HEALTH CARE

Compliance mechanism authorizes the federal agencies that award federal financial assistance to take action against programs which violate Title VI. The administrative process presents several problems. First, the victim of discrimination must file a complaint with the Office of Civil Rights within 180 days of the challenged discrimination. A short time period is a particular handicap among the sick and individuals who may not be aware of their rights. Unawareness of rights encompasses both ignorance of the statute and ignorance of medical procedures appropriate for treatment of a disease. This leaves the individual unaware both that a treatment did not meet the standard of care and that this difference was the result of racial discrimination. Thus, it becomes difficult to use Title VI if attorneys merely wait for the patient to complain, since the patient may be completely unaware of the injury and the remedy.

Second, the lack of formal participation of complainants in the administrative process leaves the victims with little control over the remedies to be tailored. Third, the process can be unusually long. It is not unusual for the entire process to take over a year. Finally, if the patient later decides to sue, there is the potential that the administrative complaint process will hold up the process of litigation.

Despite these problems, an administrative complaint presents several advantages. First, it can provide important leverage in negotiations with health facilities. Second, the Office of Civil Rights (hereinafter OCR) can command institutions to retain race-coded statistics which will be crucial to proving discrimination.

290. Agencies may refuse to grant funds or terminate funding to any recipient found in violation of the Title VI regulations. The termination is limited to the particular program or part of program. While no court order is necessary, judicial review is available at the request of the fund recipient. See 45 C.F.R. § 80.8 (1991); See generally Dorn et al., supra note 100, at 442-44.

291. 45 C.F.R. § 80.7(b) (1991).

292. One solution to the issue of ignorance of rights may be to require hospitals to give notice to patients that they have the right to file a complaint with Office of Civil Rights if they feel that they have been denied services or that the quality of services has been affected because of race.


294. Dorn et al., supra note 100, at 444.

295. See Cheyney State College Faculty v. Hufstedler, 703 F.2d 732, 738 (1983) (holding that a study of action was appropriate as some of the problems could be more readily obtained through flexibility of the ongoing administrative process); see generally Dorn et al., supra note 100, at 444.

296. Dorn et al., supra note 100, at 444.

297. Id.
Third, OCR can collect the facts saving legal services considerable time and expense.\textsuperscript{298} Finally, under the OCR guidelines, investigated institutions have the burden of persuasion in responding to a prima facie case of discrimination.\textsuperscript{299} This is a significant advantage since the OCR approach to discriminatory effect has been more pro-complainant than the courts.

b. \textit{Private Law Suit.} The other approach to enforcing Title VI is through a civil suit. No complaint with OCR is required before an individual files a private action under Title VI. An individual can sue to enforce both the statute and its implementing regulations.\textsuperscript{300} One obvious drawback to litigating Title VI is that gathering and analyzing relevant statistics can be extremely time-consuming as well as expensive. However, the biggest drawback to litigating Title VI is the lack of meaningful evidentiary burdens on the defendant.

The evidentiary burden that a defendant bears depends on the categorization of the allegations of discrimination: disparate treatment versus disproportionate adverse impact. Disparate treatment discrimination pertains to intentional discrimination. The plaintiff is charged with the burden of proving discriminatory motive. Disproportionate adverse impact involves practices which may appear racially neutral but which have a more significant negative impact on minorities. Most of the practices involved in institutional racism (admission requirements, Medicaid/Medicare cutbacks, hospital relocations, medical treatment disparity) involve disproportionate adverse impact discrimination.

Disproportionate adverse impact analysis requires (1) the plaintiff to establish a prima facie case, (2) the defendant to establish a business justification, and (3) the plaintiff rebutting the defendant's business justification by showing less discriminatory alternatives.\textsuperscript{301} The evidentiary burden placed on the defendant's establishment of a business justification is the most significant roadblock to establishing a Title VI violation.

The principal evidentiary problem with Title VI disproportion-
ate adverse impact litigations is confusion with Title VII.\textsuperscript{302} Historically, in Title VII cases, the defendant bore the burden of not only coming forth with evidence of business justification but also the burden of proof.\textsuperscript{303} In \textit{Wards Cove}, the Supreme Court eliminated the requirement that the defendant bear the burden of proof. Under \textit{Wards Cove}, a defendant need only introduce some evidence of business justification. There is no longer a requirement that the defendant prove business necessity, that the policy foster safety and efficiency, or be essential to the goal of promoting safety and efficiency.\textsuperscript{304} However, the requirement of discriminatory intent has been rejected by the Congress in its employment discrimination legislation.\textsuperscript{305} While this is an important development in employment law, it is an open question as to whether the courts will change their focus on Title VI cases.

In the few Title VI health cases which exist, the burden of proof on the defendant to justify a disproportionate adverse impact policy seems to have been lessened even further. Defendants have successfully justified a policy with disproportionate adverse impact by demonstrating that the policy is rationally related to a legitimate need.\textsuperscript{306} This standard makes it difficult to challenge racist policies and practices in the health care area. Cost containment is a legitimate goal, and courts are likely to find that any relationship between the policy or practice and cost containment will suffice.

It is through litigation that Title VI will be unhitched from Title VII.\textsuperscript{307} The federal government has every right to impose a burden on the acceptance of taxpayer monies. Allowing defendants to overcome the burden with a mere rationally related justification nullifies the purpose of Title VI. Since defendants do not have to accept federal funds they should be held to a "precise compliance with [the] spending power" of Title VI.\textsuperscript{308}

\textsuperscript{302} Watson, supra note 237 at, 971-75.
\textsuperscript{303} Id. at 959-60.
\textsuperscript{306} Bryan v. Koch, 627 F.2d 612, 619-20 (1980) (holding that Title VI does not implicitly require a recipient to consider alternatives to proposed placement of closing of a public facility); NAACP v. Medical Ctr., Inc., 657 F.2d 1322, 1334-37 (3rd Cir. 1981).
\textsuperscript{307} Watson, supra note 272, at 971-75
\textsuperscript{308} Id. at 973.
Courts have mistakenly turned to Title VII principles as the starting point for fashioning evidentiary burdens in Title VI cases involving challenges to facially neutral policies that have the effect of excluding minority patients. Title VII regulates purely private employment decisions... Title VI is a spending power statute. It does not regulate but places condition on the expenditure of federal money.\(^{309}\)

**Summary.** Hospitals, nursing homes, health care institutions, and health care providers who receive federal funds should bear the burden to justify policies which have the effect of discriminating against African-Americans. If the courts (or the legislators) can be made to see that under Title VI the government has every right to demand that its money be spent in a non-discriminating way, then Title VI has the potential of being a powerful tool to end institutional racism. Unfortunately, the combination of an increased desire to control health costs and the political climate with recent Reagan and Bush appointees to the federal court may mean that getting the courts to hold health care providers to the fire may not be politically feasible now. It remains to be seen what impact the Clinton administration will have on courts. Nevertheless, the Title VI administrative process and threatened litigation could be a powerful tool in getting health care institutions to comply voluntarily.

V. CONCLUSION

Health care institutions have a social responsibility to identify and delineate all causes of disease and disability in a population and then to mobilize the medical resources necessary to attack those causes.\(^{310}\) Since it has been shown that the health of African-Americans is markedly lower than European-American, it necessarily follows that "this situation would have to be called, in part, a racist consequence of the actions and structure of those health institutions."\(^{311}\)

Getting rid of the effects of institutional racism is a task for which European-American institutions must accept the responsibility, along with the burden of identifying effecting solutions. Doing nothing is an unacceptable option. It would allow the continuation of economic and social apartheid based on race. Reform efforts which call for expanded insurance coverage are inadequate not only

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309. *Id.* at 978.

310. See, KNOWLES & PREWITT, *supra* note 15, at 96 (placing burden of mobilizing medical resources on health institutions due to their relationship with medical community and patients).

311. *Id.*
because it is possible that only a small minority of African-Americans will continue to be uncovered; more importantly, it does nothing to relieve racial barriers to access based on the availability of culturally relevant services in the community or medical treatment disparities. While special health services could be targeted to African-Americans, fiscally and politically this alternative is very unlikely. Furthermore, it still fails to deal with the inadequacy of the system in dealing with racism. Finally, litigators could use Title VI to eliminate racist practices in health care delivery and health care education. This would do little to assure economic access. But more importantly, the courts have adopted a position which makes the use of Title VI politically difficult. However, as the courts’ composition changes over the next several years this option may become more viable.

No single approach will adequately address the multi-faceted problem of improving the health care status of African-Americans. It is also clear that the health care system is undergoing enormous changes designed to make it more just. If that reform is to include better health care for African-Americans it will need to do more than assure economic access through expanding insurance. It will need increased availability of providers through Title VI and decreased treatment disparity through Title VI. Strengthening Title VI such that it becomes politically feasible to use through both the administrative and civil process should be the quid pro quo for accepting cost containment restrictions. No system can be just so long as vestiges of racism remain. Strengthening Title VI is the only mechanism available to assure that health care in America is no longer racist.

[Racism remains a] prime cause of the unequal and racially discriminatory provision of funds for health services; of the overcrowding of the ill-equipped black hospitals and the underutilization of white hospitals; of miserable housing, gross pollution, poor sanitation, and lack of health care . . . .

[Racism] in consequence, is the underlying structure causing the dreadful burden of excess morbidity and mortality, much of it preventable, that is borne by the black population. These health-specific effects are superimposed on the more general consequences of [racism] which bars the majority of [African-american] citizens from participating in decisions on the allocation of resources for health or other needs.

We believe that the . . . [American] health care system is, in consequence, fundamentally flawed. Fragmentation and duplication of services . . . . is costly and inefficient . . . .

For the majority of the black population, the whole spectrum
of health services (but most urgently, primary care) is inadequate. Entire generations suffer through much of their lifetimes. . . .

Even if . . . [racism] ended tomorrow, their effects on health would persist for years, in part because of the health consequences of the profound poverty . . . that [racism] itself has engendered and in part because widespread attitudes that encourage racism, elitism, sexism, a colonialist mentality, and prejudice against the poor take time and commitment to change. . .

Clearly, . . . [America] has the ability to reduce markedly, if not eliminate, the serious health problems that exist among the black population. It can, if it chooses, eliminate the institutionalized system of racism and discrimination that have made the country, for decades, a symbol of human rights violations. The task facing . . . [us] is to continue to extend the process that [civil rights reforms] have begun, until profound and lasting improvements in health care . . . are a reality.312

312. This quote is taken from an article about South Africa with merely name changes from South Africa to the U.S. and Apartheid to Racism, it is equally true about the United States of America. Elena Nightingale, et al., Apartheid Medicine: Health and Human Rights in South Africa, 264 JAMA 2097, 2102 (1990).