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# The "Golden Rules" for Eliminating Disparities: Title VI, Medicare, and the Implementation of the Affordable Care Act

David Barton Smith

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# THE “GOLDEN RULES” FOR ELIMINATING DISPARITIES: TITLE VI, MEDICARE, AND THE IMPLEMENTATION OF THE AFFORDABLE CARE ACT

*David Barton Smith*<sup>†</sup>

## ABSTRACT

Addressing health care disparities rarely focuses on how the “gold” (meaning the federal dollars flowing into the nation’s health system) has, at different times, both widened and narrowed health care disparities. This paper describes (1) the early attempts to use the power of the federal purse to address disparities that led to the enactment of Title VI of the 1964 Civil Rights Act; (2) how Title VI, as applied in the implementation of Medicare, reduced disparities; and (3) the lessons that this story offers for similar opportunities in the implementation of the Affordable Care Act (ACA). Reducing disparities with the implementation of the ACA will require (1) rekindling the spirit of the grass roots movement that captured the Title VI enforcement process with the implementation of Medicare; (2) exposing adversaries through data disclosure and taking advantage of the “invisible army” that supports these goals; (3) using the power of both the economic and ethical versions of the Golden Rule; and (4) creating the political insulation and urgency necessary to reduce health care disparities.

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<sup>†</sup> Emeritus Professor, Risk, Insurance and Health Care Management, Temple University; Ph.D. Health Management and Policy, University of Michigan. This paper was developed from the keynote presentation at the Law-Medicine Symposium celebrating the 50th Anniversary of Title VI at Case Western Reserve University School of Law in Cleveland, Ohio on March 27, 2014.

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## INTRODUCTION

Most approaches to addressing racial disparities in health care in the United States do not look “outside the box.” They focus on incremental, palliative changes leaving the basic system for financing care untouched.<sup>1</sup> Yet, health care has always been shaped by the economic version of the Golden Rule—*those with the gold, rule*. Health care providers respond to financial incentives and those incentives, for most of our history, have contributed to disparities.

Indeed, many argue that race has always been a concealed part of the logic of health care financing in the United States. Race is a part of the “American exceptionalism” that has made the financing of the U.S. health system so different from that of other developed nations.<sup>2</sup> Race has contributed to making the United States the only remaining industrialized nation lacking some form of universal health insurance coverage for its citizens. Race is hidden in the U.S. health system’s compromise patchwork of solutions: the expansion of private insurance, the creation of producer cooperative solutions in the form of voluntary Blue Cross plans, the creation of its dominant, voluntary hospitals sector, the ideology of individualism, and the opposition to public solutions in favor of the promotion of free market solutions. All of these “solutions” have a disparate impact on blacks and other disadvantaged minority groups, mocking the now universally

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1. *See generally* ALISON MACK, ET AL., INST. OF MED., SUPPORTING A MOVEMENT FOR HEALTH AND HEALTH EQUITY: WORKSHOP SUMMARY (2014).

2. *See* BEATRIX HOFFMAN, HEALTH CARE FOR SOME: RIGHTS AND RATIONING IN THE UNITED STATES SINCE 1930 *at* x, xi (2012); JAMES MORONE, HELLFIRE NATION: THE POLITICS OF SIN IN AMERICAN HISTORY 181-82 (2003); JAAP KOOLJMAN, . . . AND THE PURSUIT OF NATIONAL HEALTH: THE INCREMENTAL STRATEGY TOWARD NATIONAL HEALTH INSURANCE IN THE UNITED STATES OF AMERICA 15-17 (1999); JILL QUADAGNO, THE COLOR OF WELFARE: HOW RACISM UNDERMINED THE WAR ON POVERTY 4 (1994).

embraced national goal of the elimination of health care disparities that have remained unchanged for more than thirty years.

Yet, also concealed in the evolution of the U.S. health system is a more hopeful story. At times, the flow of federal funding has been directed to combat racial and social class distinctions that have been used to divide and fragment the U.S. health system. The most significant example of this took place a half century ago with the introduction of Medicare. For the first time, the federal government used the requirements of Title VI of the Civil Rights Act of 1964 to control the flow of federal funds to hospitals. This Article tells the story of that struggle. In Part I, I describe the early attempts to use the power of the federal purse to address disparities that led to the enactment of Title VI. In Part II, I discuss how Title VI was enforced in the implementation of Medicare. Finally, in Part III, I discuss the lessons that this story offers for similar opportunities in the implementation of the Affordable Care Act (ACA).

## I. EARLY FEDERAL USE OF THE POWER OF THE PURSE

### A. *Health Care Before the Civil Rights Movement*

Despite fading memories and a peculiar rebirth of nostalgia about the pre-Medicare and Medicaid days, health care in the United States at the end of World War II was markedly different than it is now. Indeed, it was appalling. Those without insurance or the ability to pay were relegated to the charity wards and the indigent clinics of public hospitals and medical schools. Blacks were at the bottom of this caste system of care. In the South, blacks were either excluded altogether from community hospitals, or they were relegated to separate and typically inferior accommodations in basement wards or separate buildings. The result was a much higher rate of riskier home deliveries and a higher death rate from automobile accidents because of more restricted access to hospital emergency care.<sup>3</sup> Many blacks had to rely on those white physicians who would accept them as patients, often in segregated waiting rooms where they would wait until all of the white patients had been seen.<sup>4</sup> Similar discrimination took place in public hospital and medical school clinics. In northern cities, segregation of hospital and medical care was often almost as complete as in the South, only in the North, the segregation of hospitals and medical care was shaped by residential segregation and

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3. Albert Dent, *Hospital Services and Facilities Available to Negroes in the United States*, 18 J. NEGRO EDU. 326, 327 (1949); Hoffman, *supra* note 2, at 63-64, 81-85.

4. Interview with Mattie Gadson (1996) (recording available in the Temple University Library).

the informal practice patterns of physicians and hospitals. For example, Chicago hospitals in 1960 came close to matching the segregation patterns of hospitals in the Deep South in spite of laws passed prohibiting hospital discrimination in admission practices.<sup>5</sup>

If one could not access a service, one could not use it. Rates of use of all forms of inpatient or outpatient care were substantially lower for blacks as opposed to whites. Usage rates for services of all kinds were also directly related to income. However, usage rates were still lower for blacks regardless of income.<sup>6</sup> The degree of morbidity and thus the need for services was greater in the black population as well as in low income populations regardless of race. From the beginning of modern medicine in the United States (circa 1910), the harsh economic version of the Golden Rule (those with the gold, rule), as opposed to its ethical version (do unto others as you would have done unto you), ruled. Consequently, the use of medical services was directly related to income and inversely related to need.

Black physicians were also excluded from privileges and training opportunities at most historically white medical schools and hospitals. As many as 500 black hospitals, often under-resourced, had been created to serve black patients and physicians.<sup>7</sup> Even in the white facilities that accepted black patients (though, often in segregated accommodations), their white medical staffs typically refused staff privileges to black physicians, thus preserving the economic monopoly such exclusion assured the white medical staffs. Indeed, the first successful effort in eliminating racial discrimination in hospital privileges involved an anti-trust case rather than a civil rights challenge. In February of 1961, ten black Chicago physicians filed a suit in U.S. District Court against multiple defendants including the state of Illinois, various local hospital and medical associations, and fifty-six Chicago hospitals.<sup>8</sup> A verdict in favor of the plaintiffs could have imposed substantial sanctions on the hospitals (*e.g.*, treble damages for the perhaps lifetime earnings of more than 300 black Chicago physicians or possibly more than a billion dollars). This threat, along with pressure from Mayor Daley, resulted in the creation of a special committee of hospital leaders and an out-of-court

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5. Interview with Dr. Quentin Young (June 14, 1997) (recording available in the Temple University Library).
  6. See DAVID B. SMITH, *HEALTH CARE DIVIDED: RACE AND HEALING A NATION* 200-03 (1999).
  7. See generally NATHANIEL WESLEY, *BLACK HOSPITALS IN AMERICA: HISTORY, CONTRIBUTIONS AND DEMISE* (2010).
  8. *Chicago Physicians Sue for Admission to Hospital Staffs*, 53 J. NAT'L MED. ASS'N 198 (1961).

accommodation that assured privileges for about 120 black physicians admitting them at one of the historically white hospitals in Chicago.<sup>9</sup>

*B. The Integration of the Veteran’s Administration Hospitals*

Beginning with the Truman Administration, the executive branch had achieved small victories in battles desegregating hospitals even in well-entrenched bastions of segregation by threatening to withhold federal funding. The federal power of the purse was first applied in eliminating segregation in Veteran’s Administration (VA) facilities, then to medical schools seeking National Institutes of Health (NIH) funding, and, finally in an important legal precedent, to voluntary hospitals receiving funds under the Hill-Burton Act of 1946. These accomplishments went largely unnoticed but they still played an important role in setting the stage for the struggle to force desegregation of all hospitals with the implementation of Medicare.

In 1948, President Harry S. Truman ordered both an end to segregation in the armed services and discrimination in federal employment.<sup>10</sup> These orders forced the eventual desegregation of all of the nation’s VA hospitals. The battle over the construction of a new VA hospital in Jackson, Mississippi in 1956 demonstrated how accommodations were worked out even in one of the most rigidly enforced Jim Crow communities in the nation. The old, now desegregated VA hospital in Jackson, was overcrowded and in need of replacement. At the behest of veterans’ groups, the Mississippi legislature passed a bill in 1954 donating state land for the new VA hospital. The federal government had approved approximately \$15 million (\$133 million in 2014 dollars) for the project.<sup>11</sup> When the Jackson White Citizens Council discovered that the new facility located on donated state land would be racially integrated, they persuaded a Mississippi legislator to submit a bill to rescind the state land offer. Veterans’ groups objected. As one veteran noted, “the integration controversy has unfortunately overshadowed the real question and that is whether or not our state, by cooperating on this project, is going to give its veterans like ourselves a chance to get adequate treatment without having to go so far from home that our families could never visit.”<sup>12</sup> Besides, this spokesman argued, it is not “real” integration because “the wards are so constructed as to provide each patient his own room or cubicle, which is completely enclosed

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9. Interview with Dr. Quentin Young (June 14, 1997) (recording available in the Temple University Library); Smith, *supra* note 6, at 50-53.

10. See Exec. Order No. 9980 & 9981, 3 C.F.R. § 145 (1949).

11. David Barton Smith, *The Politics of Disparities: Desegregating the Hospitals in Jackson, Mississippi*, 83 MILBANK Q. 247, 255 (2005).

12. *Id.*

and affords him as much privacy as he could expect in any hospital.”<sup>13</sup> In the end, the dollars and the benefits to veterans and Jackson as a whole trumped abstract principles about a “southern way of life.” The cornerstone for a fully integrated new hospital was laid in 1960 on the donated state land. Consequently, in many southern communities such as Jackson, VA hospitals became small islands of integration in otherwise rigidly enforced Jim Crow environments. Local officials looked the other way in order to ensure access to health care for veterans and to receive the economic benefits that such facilities provided to communities.

*C. The Integration of the Medical School Hospitals*

Kennedy, using Truman’s executive orders as a model, promised during his 1960 presidential campaign to end discrimination in federally supported housing “with the stroke of a pen.”<sup>14</sup> Kennedy, however, delayed for almost two years signing such an order. As he soon discovered, ending any federal support of discrimination was a politically hazardous undertaking. In winning the 1960 presidential election, Kennedy had assembled a coalition of blacks and southern whites. He won the election with 49.7 percent to Nixon’s 49.5 percent, the narrowest margin of victory in U.S. history up to that time. Had Kennedy not secured the black vote, Nixon would have won 52 percent of the popular vote, carried both Illinois and Michigan, and won the election. Equally essential to Kennedy’s election was the support of the largely Democratic “solid South.” Thus, southern Democratic legislators’ resistance to integration made the passage of his promised civil rights legislation in Congress impossible.

Nor could Kennedy easily extend desegregation by executive order to states and other nonfederal entities receiving federal funding as Truman had done for federal agencies. Any executive order blocking the use of federal funds to entities that were discriminatory would be challenged and Kennedy would lose the Southern voters he needed for reelection. No federal laws prohibited the distribution of federal funding to private and state segregated hospitals. Indeed, the Hill-Burton Act of 1946 providing construction funding for private hospitals specifically permitted the funding of segregated facilities.<sup>15</sup>

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13. *Id.*

14. TAYLOR BRANCH, PARTY WITH WATERS: AMERICA IN THE KING YEARS 1954-1963, at 587-588 (1988).

15. Hospital Survey and Reconstruction Act (Hill-Burton), Pub. L. No. 79-725, § 622(f), 60 Stat. 1040, 1043 (providing an exception to the nondiscrimination requirement “in cases where separate hospital facilities are provided for separate population groups, if the [state] plan makes equitable provision on the basis of need for facilities and services

Since the late 1940s, Adam Clayton Powell, a Congressman from Harlem, had tried to undo the Hill-Burton precedent by submitting the “Powell Amendment,” prohibiting, in whatever bill was being considered, funding to any entity that discriminated.<sup>16</sup> These amendments were routinely defeated and, as a result, only served to add further legitimacy to the Hill-Burton precedent.

Thus, discretion became the better part of valor and the introduction of Kennedy’s promised civil rights bill was delayed for more than two years. During this period, the Kennedy Administration sought to placate the civil rights activists by subtler and more indirect means; still, the pressure on Kennedy increased. A widely circulated report by the Civil Rights Leadership Conference documented the “pervasiveness of the American tax payers’ subsidization of racial injustice . . . . With few exceptions, there is no federal policy or machinery to assure that these funds, paid for by all taxpayers alike, will be used in a non-discriminatory manner. On the contrary, it would be hard to overestimate the significance of these funds as support for the continuation of segregation and discrimination.”<sup>17</sup> The report estimated that \$8 billion (\$62 billion in 2014 dollars) in grants in aid would flow to state and local governments in 1962 and more than \$3 billion (\$23 billion in 2014 dollars) would flow in the form of scholarships, fellowships, and grants to hospitals, universities, and research institutions.<sup>18</sup> Federal grants in aid accounted for more than 21 percent of all funds expended by the states of Alabama and Mississippi.<sup>19</sup> The report further noted, “it is ironic that tax payers for those states where the national policy of non-discrimination is observed make a disproportionately larger per capita financial contribution to these federal programs; tax payers in states where the national policy of non-discrimination is flouted receive a disproportionately larger per capita share of the benefits.”<sup>20</sup>

An interagency task force set up to study the problem acknowledged the validity of the civil rights group’s criticism. A Department of Health and Welfare (DHEW) staff study completed in January of 1961 tried to identify possible opportunities for executive

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of like quality for each such group”), *invalidated by* *Simkins v. Cone*, 323 F.2d 959 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964).

16. CHARLES V. HAMILTON & ADAM CLAYTON POWELL, JR., *THE POLITICAL BIOGRAPHY OF AN AMERICAN DILEMMA* 226 (1991).
17. C.R. LEADERSHIP CONF., *The Wikinson-Aaronson Report: Proposal for Executive Action to End Federally Supported Segregation and Other Forms of Discrimination* 8 (August 20, 1961).
18. *Id.*
19. *Id.*
20. *Id.* at 9.

action. However, the exercise was attacked as hopelessly flawed by DHEW’s general counsel who argued that DHEW had no authority whatsoever to withhold funds on the basis of discrimination without explicit authorization in the legislation or explicit rejection of the constitutionality of parts of legislation that permitted “separate but equal” use of federal funds.<sup>21</sup>

Yet, both medicine and hospitals had benefited from a post-war boom in federal funding. The Hill-Burton Act of 1946 provided approximately \$22 billion (2014 dollars) in federal funds over the next twenty years for hospital construction.<sup>22</sup> Local and state matching funds increased the total to \$70 billion for more than 8,300 projects providing more than 353,500 hospital and nursing home beds.<sup>23</sup> The National Institutes of Health (NIH) appropriations for medical research expanded rapidly during this same period from \$43 million in 1947 to more than \$7.3 billion in 1966.<sup>24</sup> These were fondly remembered as “the golden years” of NIH expansion and the vast majority of these funds flowed to medical schools and medical school hospitals. The expanding health-related flow of federal funds became a focus of attention of the emerging civil rights movement.

NIH funding offered a relatively easy, surreptitious way to put pressure on medical schools and their hospitals to desegregate. The growing flow of NIH funding ceded control over their allocation to the review processes of the scientific community.<sup>25</sup> As a result, research grant peer review committees, through a combination of subtle guidance, selection, and predilections, made it clear to medical schools that they had to choose between Jim Crow practices and federal research funding.

This choice put university medical centers in states with local Jim Crow laws in an awkward bind. The solution for many was to integrate but not tell anybody about it. This was apparently the case for the University of North Carolina Hospital System that, along with

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21. Memorandum from James Quigley, Assistant Sec’y of Health, Welfare, and Educ., to Harris Wofford, Legal Assistant to President John Kennedy (July 6, 1961) (noting that “[t]he language of [the Hill-Burton Act] makes it clear that Congress intended to allow Federal monies to be spent in ways which would condone discrimination on the basis of race.”).
  22. *Highlights of the Hill Burton Program*, 81 PUB. HEALTH REP. 684 (1966).
  23. *Id.*
  24. NAT’L INST. OF HEALTH, A SHORT HISTORY OF THE NATIONAL INSTITUTES OF HEALTH (2014), available at [http://history.nih.gov/exhibits/history/docs/page\\_06.html](http://history.nih.gov/exhibits/history/docs/page_06.html).
  25. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 343 (1982).

local civil rights groups, quietly arranged to integrate in order to avoid the possible loss of federal funding support. According to Dr. Charles Watts, a key black medical leader in the state:

We filed a suit against the University of North Carolina when I was President of the Old North State Medical Society (ONSMS). We got a student at A&T and two others admitted to the psychiatric unit at UNC. A state senator over the weekend had gotten drunk, had the DTs and was admitted to the desegregated unit. When he woke up he demanded that the hospital get [the black patients] out. So the University told them they would have to leave. Two had to be sent to West Virginia for care. The state Civil Rights Commission was having a hearing in 1961. I represented the ONSMS at the hearing and I described the situation. The head UNC psychiatrist said it had nothing to do with race, they had just found that they couldn't treat black and white patients in the same setting. I said, 'Well, we're going to let the courts decide.' The chairman of the Commission called me after the meeting. He asked if I thought it would be satisfactory for ONSMS to withdraw the complaint, if the medical center just quietly integrated. He said it would hurt the University and hurt them in getting grants if we made a big public to-do about it or published the fact that we had made the University change its policies. I said, 'we're not out to hurt the University, and it will cost us more in legal fees. If you send me a letter to that effect, I will present it to my committee.' That's what they did; they sent us a letter saying that racial discrimination would no longer be allowed in the University Hospital System. They didn't relate it to our suit at all. Floyd McKissick was our lawyer. He advised us to accept it and keep the University Hospital System under observation. We filed the letter. If anybody came up with a complaint, we could trot it out. I think it cost us \$200 to integrate the whole hospital system. This took place in 1962. Our purpose was to get change, not to stir up controversy.<sup>26</sup>

Dr. Charles Johnson, who would later serve as President of the NMA from 1990-91, went to Duke in 1964 for a fellowship in endocrinology, just as the school was beginning to integrate. He faced a similar confrontation over NIH funding at the division level and quietly prevailed.

I was told by the division chief that he didn't want me going on the private side because some of the physicians

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26. Interview with Dr. Charles Watts (1996) (recording available in the Temple University Library).

were concerned about the reaction of their patients. I felt I was signed on under false pretenses. It turned out that the Division was trying to get a Biometrics Lab funded by NIH. Dr. Fine from the University of Michigan and two others were on the site visit. They questioned the endocrine fellows. We were all sitting at the table, all nine. At the end of the session, Dr. Fine asked, ‘Are any of you unhappy about the training you have received?’ I said, ‘Yes I am. I have been told that I can’t rotate on the private side because of my color.’ He said, ‘What did you say?’ I said, ‘I have been told that I can’t rotate on the private side because of my color.’ He said, ‘Well, we’ll see about that!’ The other fellows came to my support. I hadn’t known what they felt before. Any ways, the senior faculty and chief of the division followed the fellows. The first question asked the chief of the division was, ‘Why can’t Dr. Johnson rotate on the private side of the hospital?’ No answer. I never heard the inner working of what did and didn’t get said after that but I’m certain a lot of money got tied up in the discussion. Ed Horton who was doing research related to transplanting diabetics and who is now at Harvard called me and said, ‘I think you better stay away from here until the dust settles.’ Finally, the chief, met with me. He had lost his voice by the way, he could not talk for several days—race relations is always a touchy question and if it’s the first question it creates a state of shock. The man really lost his voice. He says, ‘Dr. Johnson, do you really want to rotate on the private service?’ . . . . I rotated. Clearly they accepted the money and me too. Otherwise, they would have lost a large sum of government money. It wasn’t that they wanted me so bad, they wanted the money more. They needed a big stick waved over their heads.<sup>27</sup>

Even the well-funded state enforcer of segregation, the Mississippi Sovereignty Commission, had to concede in a chess game that began to be played out in the 1960s over the future of the University of the Mississippi Medical Center in Jackson.<sup>28</sup> Dr. Robert Marston, a former Rhodes Scholar who later served as NIH director, was director and dean of the Medical Center at this time. Marston and other recruits had little sympathy with the Sovereignty Commission’s mission.

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27. Interview with Dr. Charles Johnson (1996) (recording available in the Temple University Library).

28. David B. Smith, *The Politics of Racial Disparities: Desegregating the Hospitals in Jackson, Mississippi*, MILBANK Q. 256-260 (2005).

Instead, they were concerned with building the reputation of the medical school and hospital. Following its usual procedures, the Sovereignty Commission sent detectives to investigate complaints made by whites regarding integration efforts. For example, in 1960, a nurse had complained that a personnel director and nurses in charge were all from the North and that these nurses had compelled white nurses to work on “colored” floors and black nurses to work on white floors. Additionally, the nurse alleged that the elevator operators were now all black and were allowing black visitors to ride the same elevators as white visitors. Another informant complained that one of the doctors at the center had been lecturing at medical schools around the world and that some of the students from these schools that had visited the medical center in Jackson were black. In 1964 a Sovereignty Commission detective had reported that segregation at the medical center was on the verge of collapse. The parking lots were integrated and the white and colored patients used the same waiting room in the X-ray department. “Since there is only one cobalt machine and all the X-rays are adjacent to the waiting room. I do not know how the hospital authorities can remedy this congestion of the mixing of Negroes and Whites, except through expansion.”<sup>29</sup>

The obstetrics and pediatric service at the Mississippi Medical Center were a particular source of concern to the investigator. There was one labor room with eight beds used for both black and white women, and they all used the same four delivery rooms. After their deliveries, the black mothers were placed on a separate floor, but their babies remained on the same floor in a segregated nursery next to the nursery for white babies and near where the white mothers were placed. On the pediatric floor, children of both races shared a common area and playroom. The black and white patients were not supposed to use the playroom at the same time, although staff admitted that this rule was seldom enforced. The investigator aptly summarized the dilemma that the Medical Center posed for the protection of Mississippi’s “sovereignty”:

The University Hospital is a very fine institution and composed of some of the best doctors and instructors in the Nation and is a credit to the State of Mississippi. Mississippi people are proud of the University Hospital, but there are no doubts in my mind but that improvements can be brought about at the University to improve on the creeping integration which is in evidence out there. I am sure it will cost the state extra money, but

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29. *Id.* at 257.

Mississippi should by all means provide the extra cash needed to maintain proper segregation at University Hospital.<sup>30</sup>

In other words, if the state was really committed to preserving segregation, it should pay for it. In early 1964, the U.S. Army Medical Research and Development Commission had advised the University that it would have to comply with the federal executive orders banning segregation. Dean Marston made clear to the Director of the Sovereignty Commission that this would be just the beginning of similar compliance orders from other federal agencies that would involve the loss of at least \$5.3 million in federal support (\$41 million in 2014 dollars).<sup>31</sup> In its report to the governor, the Sovereignty Commission outlined the options that might be considered:

Since it is inconceivable at this time that the State Legislature would be in a position to supplement the appropriations for the Medical Center and replace the federal funds flowing to the Center or in the available future . . . . In a way this leaves us in a somewhat untenable position. We can yield and assure continuance of the funds, which would be against our policies, we could advise the army [that] we cannot comply with the request and lose the army research grant; we could continue the present segregated facility policies and take the chance that many months or years would transpire before each of the various agencies served similar notice about the facilities; or we could write off all the federal funds for the Medical Center and seek some method of replacing these funds with either state or private money or both.<sup>32</sup>

The state of Mississippi opted to take the money. The Sovereignty Commission suggested some convoluted ways to eliminate visible symbols of segregation while possibly preserving “voluntary” segregation. These suggestions appear to have been ignored by the Medical Center.

The desegregation of medical school hospitals followed a pattern that would later be repeated for the health system as a whole. The first targets of desegregation in medical school hospitals were the units most medicalized and insulated from public scrutiny—the newly created intensive care units. These units were set up in medical school hospitals in the early 1960s in order to provide better care for critically ill patients. At the University of North Carolina Medical Center, an early special care unit had one room with three beds while

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30. *Id.* at 258.

31. *Id.* at 259.

32. *Id.*

another room had four beds. Nurses were supposed to move the patients from one room to the other to keep the races separate. This meant extra work for the nurses and would sometimes compromise care. Cookie Wilson, a nurse who had a long career at the medical center, recalled in 2002: “I was just a rotating staff nurse at the time, but I got tired of that. It was ridiculous. So, I did not move them. I integrated the unit.” No family complaints and no hospital reprimand followed. “Nobody opened their mouth.”<sup>33</sup>

Dr. Chris Hansen, a white physician in Mississippi and a participant in the civil rights movement, served on a Hospital Compliance Committee and offered a similar story about the University of Mississippi Medical Center. Hansen met with its director, Dr. Robert Marston. Marston assured him that the Medical Center was making slow but steady progress. Marston said, “I know it is slow, but [I] want to tell you as a measure of our good faith that we have our first integrated ward and I’m going to take you up and show it to you.” He took them upstairs and showed them and, there indeed, was a four-bed male ward with four patients: two African Americans, a white man, and a Native American. All four of them were unconscious. They had achieved their first step at integration with four people in a coma.<sup>34</sup> Neither the comatose ICU patients nor their families, focused as they were on the survival of their loved one, were going to pay much attention to who was in the bed next to them. In addition, from the hospital’s standpoint, the cost of creating two separate ICUs, no matter its racial views, was hard to justify.

#### *D. Using Federal Funds to Integrate All Hospitals*

By the end of 1965 most the medical school hospitals in the Jim Crow South were well on the way toward being fully integrated. In most cases, this had been done secretly with many denying any change in policies. While the changes had been facilitated by supportive medical school deans and university administrators, it was the threat of the loss of federal funding and the budget crisis it presented to the universities and states that ultimately silenced the segregationist opposition. Yet, medical school hospitals represented only a small fraction of the nation’s hospitals and federal research dollars offered little leverage over the rest.

Federal Hill-Burton funding, however, offered potential leverage over these other hospitals. It also was the key to unlocking federal

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33. Dick Broom, *The First ICU: The Earliest Critically Ill Patients Found Intensive Care at UNC*, UNIV. N. C. (2002) (published as part of a press packet for the fiftieth anniversary celebration of the North Carolina Memorial Hospital) (on file with the author).

34. Interview by Barbara Berney with Jack Geiger (2013) (notes on file with the author).

power to block the flow of federal funding to all discriminatory programs and institutions. Inserted in the 1946 Hill-Burton Act by Senator Lister Hill (Democrat from Alabama) was the requirement that hospitals receiving Hill-Burton funding provide “assurances” that their facility would be

made available to all persons resident in the territorial area of the applicant without discrimination on account of race, creed or color, but an *exception* shall be made in cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group.<sup>35</sup>

This exception is the only acknowledgment of federal financial support of segregation (*i.e.* separate but equal) in federal laws enacted in the twentieth century. As such, Hill-Burton effectively barred the executive branch from withholding federal funds to private institutions and programs that discriminated.

The “assurances” required that hospitals receiving Hill-Burton funding be open to all people regardless of race; however, black medical civil rights activists soon discovered that these “assurances” were worth less than the paper they were written on. Dr. Brenda Armstrong, now on the faculty of Duke University’s medical school, recalled the experiences of her father, Dr. Wiley T. Armstrong, a physician in Rocky Mount, North Carolina during this period and his struggle to overcome the indifference to discrimination on the part of the federal government:

My first memory of medical practice was going with Dad to deliver a baby in someone’s home. He took me to help him stay awake. My sister and I were born at home. The hospital would not accept black patients. We had a birthing room in my house. My brother was born in 1956 with CP because he was too big and needed a C-section. Although my mother was the wife of a physician, she could not be admitted to the hospital, even though my father pleaded with them. It was too late and risky to transport her all the way to the “Colored Ward” at Duke. As a result he was born at home vaginally, had a stroke and CP because of it. He could have been the brightest and most accomplished of us all.<sup>36</sup>

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35. Hospital Survey and Construction Act, Pub. L. No. 79-725, § 622(e), 60 Stat. 1040, 1043 (1946) (codified as amended at 42 U.S.C. § 291c(e) (2014)) (emphasis added).

36. See Smith, *supra* note 6, at 32; Duke University Medical School, *Part 2: Trailblazer*, YOUTUBE (Apr. 22, 2013), <https://www.youtube.com/watch?v=gd-ih66t574>.

Dr. Wiley Armstrong, along with two other key North Carolina civil rights medical activists, Drs. Eaton and Watts, traveled to Washington, D.C. in November of 1961. As representatives of North Carolina’s black medical society, they sought federal intervention to assure that the “assurances” provided by hospitals receiving Hill-Burton funding were honored. The U.S. attorney general’s office had previously declined to offer an opinion on the provision. The visit with the DHEW officials was equally discouraging. The “assurances” of nondiscrimination on the part of applicants for these funds “had never been questioned. There was no procedure for checking on the validity of the ‘assurances,’ nor was there any authorized course of action for violations. It did not appear that the Department considered it in its province to know what went on in hospitals after grants had been made nor was it anxious to become involved in this area.”<sup>37</sup>

Dr. Armstrong and his colleagues, however, did get a reminder of the importance of their mission to Washington. On their arrival at National Airport, they managed to hail down a cab. After they climbed in, the black female cab driver turned around, smiled and said,

“How you, Dr. Armstrong!”

“Sugar, you know me?” Armstrong answered in surprise.

“Yeah,” the cabby answered. “I’m from Rocky Mount. You delivered me.”<sup>38</sup>

In May of 1962, the pressure brought by the North Carolina civil rights activists in concert with a national campaign finally began to bear fruit. Two white only hospitals in Greensboro, North Carolina had received substantial Hill-Burton funds. Private hospitals had been considered immune from the *Brown v. Board of Education* decision since they were not public institutions. However hospitals that received Hill-Burton funds also participated in a state plan for allocating those funds. And as the plaintiffs in the *Simkins v. Moses Cone Hospital* case had argued, these hospitals were “an arm of the state” thus triggering the *Brown* decision prohibiting public institutions from engaging in so called separate but equal treatment.<sup>39</sup>

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37. Integration Battlefront, *Executive Procedure Without Effect in Hospital Area*, 54 J. NAT’L MED. ASS’N 256, 259 (1962).

38. Interview with Dr. Charles Watts (1996) (recording available in the Temple University Library).

39. See generally *Simkins v. Moses H. Cone Hosp.*, 211 F.Supp. 628, 640 (M.D.N.C. 1962).

Using this argument, Dr. George Simkins joined a group of local black physicians and, with the assistance of the NAACP Legal Defense Fund, challenged the constitutionality of the Hill-Burton provision and thus the right of the two hospitals to exclude black admissions.<sup>40</sup> While they lost the case in the District Court of North Carolina, they gained the intervention of the Justice Department on their behalf in on appeal.<sup>41</sup> In a telegram to Dr. Montague Cobb, the convener of what would end up being the last conference organized (May 1962) to press for action in desegregating the nation’s hospitals, President Kennedy noted:

I am sure you are aware that the attorney general has intervened in a federal court case, arguing that the clause sanctioning segregation in the Hill-Burton Act is unconstitutional. I am hopeful, as I know you are, that this action will speed the day when we will recognize that we cannot afford to squander our resources on the practice of racial discrimination and that the availability of hospital services will not depend on the race, color or creed of the patient.<sup>42</sup>

The Fourth Circuit ruled in favor of the plaintiffs but the hospitals appealed the decision to the Supreme Court.<sup>43</sup> In February of 1964, the Supreme Court promptly declined to review the decision leaving intact the Fourth Circuit’s ruling.

The timing of all of this was fortuitous but hardly coincidental. In June of 1963, Kennedy, forced by the violent reactions to civil rights protests, finally introduced his civil rights bill. Echoing the arguments made two years earlier by the Civil Rights Leadership Council and shadowing the intervention of the U.S. attorney general in the *Simkins* case more than a year earlier, Kennedy argued, “Simple justice requires that public funds, to which all taxpayers of all races contribute, not be spent in any fashion which encourages, entrenches, subsidizes or results in racial discrimination.”<sup>44</sup> The *New York Times* noted that the prompt decision by the Supreme Court not to review *Simkins*

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40. *Id.* at 629.

41. *Id.*

42. Integration Battlefront, *supra* note 37, at 501.

43. *Simkins v. Cone*, 323 F.2d 959 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964).

44. John F. Kennedy, *Special Message to Congress on Civil Rights and Job Opportunities, June 19, 1963*, in PUBLIC PAPERS OF THE PRESIDENTS OF THE UNITED STATES: JOHN F. KENNEDY, 1963, at 248 (1964).

was made while the whole issue that was partly involved in the lower court decision was pending in the Administration’s equal rights bill on which the Senate had not even begun to debate . . . . It must be concluded that the Court was fully aware that its timing in the case would cut the ground away from the effort in the Senate to maintain in Title VI the exemptions authorized in the Hill Burton Act . . . . In sum, the Court departed from the usual by ruling, not that a statute passed by Congress was unconstitutional, but that a proposal about to be taken up would be if legislated.<sup>45</sup>

The Civil Rights Act passed in June of 1964 after the longest filibuster in Senate history. Title VI survived without the Hill-Burton exemptions, but it left much in doubt about how or even if this section of the law would ever be implemented.

In the first year and a half after its enactment, the prospects for Title VI did not seem promising. What constituted noncompliance was vague and ill defined. No staff was allocated to enforce it. No investigative tools (reporting requirements, subpoena powers, etc.) were available and no credible sanctions could be imposed. Even though civil rights groups had submitted hundreds of complaints against hospitals receiving Hill-Burton funding that federal officials acknowledged were legitimate, nothing happened. DHEW focused most of its efforts on trying to get voluntary compliance, but it was not working.

## II. ENFORCING TITLE VI IN MEDICARE AND MEDICAID

The enactment of Medicare and Medicaid in July of 1965 altered the federal government’s leverage. Participating hospitals could now collect from these new federal programs cost plus reimbursement for patients that they had often received no payment from before. Care to the elderly and the indigent that had threatened their solvency now guaranteed it. In 1967, the first full year of operation, 32 percent of participating hospital revenues would flow from Medicare and Medicaid. This would soon rise to over 50 percent. In the first full year of operation, hospitals received \$5.6 billion from Medicare and Medicaid (the total amount that hospitals receive from these two public sources now exceeds \$500 billion). Few hospitals could afford to refuse to be part of this immense new funding stream. For most, it was a choice between new affluence and bankruptcy. By participating

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45. Arthur Krock, *A Court Ruling Extended to Pending Legislation*, N.Y. TIMES, Mar. 4, 1964, at 32.

in Medicare and Medicaid, private hospitals that once had been insulated from pressure to desegregate were now insulated from state and local political pressures opposed to desegregation. Indeed, their private boards had a fiduciary responsibility for protecting their charitable assets. Those with the new gold, it would seem, were free to extract whatever concessions they demanded.

It was, of course, not that simple. Many questions regarding enforcement remained. For instance, what constituted compliance with Title VI? Discrimination was not defined in the Civil Rights Act. Would the lack of a definition of discrimination liken the Civil Rights Act to the vague and meaningless “assurances” inserted in the Hill-Burton Act? There were no reporting requirements on the part of recipients of federal funding and no federal resources allocated for staffing enforcement. Aggrieved parties could submit complaints to DHEW but how could they know that they had actually been discriminated against? Furthermore, what could DHEW do about these complaints? The Office of Equal Health Opportunity (OEHO), the agency responsible for ensuring Title VI compliance in Medicare, had been established just four months before the implementation of Medicare. It had a staff of six. Indeed, some of the same southern Senators that had filibustered Title VI had assured that its enforcement would be toothless and that OEHO would remain without a budget.

Those in the Social Security Administration responsible for implementing Medicare were unlikely civil rights heroes. They needed the trust and collaboration of hospitals and physicians. Using Medicare to enforce Title VI had never been part of their game plan.<sup>46</sup> The American Medical Association (AMA) and many state and local medical societies had fought against its passage and the hospital associations and their leaders had been late and reluctant supporters. In addition, there had been no discussion of Title VI by anyone during the drafting of the Medicare and Medicaid Acts or in the debate over their passage in Congress. Everyone—including southern legislative supporters of Medicare and Medicaid—assumed that an accommodation would be made similar to the “assurances” in the Hill-Burton Act.

Such a conclusion was supported by the decision early in the implementation process to exempt Medicare Part B—the part that paid for physician services through a voluntary, federally subsidized plan—by defining Part B of Medicare as a “contract of insurance” with its subscribers rather than a direct grant of public funds. Indeed, contracts of insurance were specifically exempted from Title VI

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46. Telephone Interview with Ted Marmor, Professor, Yale University School of Management (Apr. 13, 2014).

requirements.<sup>47</sup> As a result, a hospital could pass Title VI certification and, through the racially exclusionary admission practices of its medical staff, remain segregated. This offered a loophole equivalent to the Hill-Burton Act “assurances.”

In addition, an early use of Title VI to withhold funding from the Chicago public schools in the Fall of 1965 suggested that the Johnson Administration would not have the stomach for an all out battle over Title VI compliance in Medicare. In Chicago, civil rights leaders had demanded that DHEW block the allocation of \$32 million in new federal funds for Chicago’s public schools on Title VI grounds. Secretary Gardner, following the usual procedure, had delayed the release of this funding pending an investigation of these complaints. Mayor Daley protested directly to President Johnson. Johnson sent Under Secretary Wilbur Cohen to Chicago the next day to immediately release the funds while getting “assurances” that the public school officials would “look into the complaints.”<sup>48</sup> Cohen was one of the central figures involved in the implementation of Medicare.

Given Johnson’s reluctance to fight in the Chicago schools’ Title VI dispute, no one could have anticipated the dramatic change that occurred in hospitals across the United States after the passage of Medicare and Medicaid. In less than four months, OEHO inspectors visited approximately three thousand hospitals. Two thousand hospitals changed their policies in anticipation of these inspections and another thousand were brought into compliance with Title VI after subsequent follow-ups. Compliance went far beyond simply signing a form professing good intentions or simply removing the white and colored signs as had happened with the Chicago schools. No self-segregation was permitted, either in the assignment of patients to multiple occupancy rooms or in outpatient and emergency waiting rooms. The actual behavior of staff and patients could not reflect racial preferences. If self-segregation was taking place in waiting

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47. Civil Rights Act of 1964, Pub. L. No. 88-352, § 605, 78 Stat. 241, 253. This exclusion in the law was designed to allay the fears of some senators from the South that Title VI, because of the federal insurance of bank deposits, might be used to block mortgages for housing that was racially discriminatory. The Fair Housing Act of 1968 rendered this concession irrelevant. *See generally* Fair Housing Act of 1968, 42 U.S.C. §§ 3601-3631 (1970). Whatever rationale existed at that time for the use of the Title VI exemption for a contract of insurance, it has long since evaporated as hospitals have acquired physician practices, as Medicare has provided combined payments to managed care plans, and as state Medicaid plans have acquired Part B coverage for their beneficiaries.

48. EDWARD D. BERKOWITZ, MR. SOCIAL SECURITY: THE LIFE OF WILBUR J. COHEN 248-49 (1995); JOSEPH A. CALIFANO, GOVERNING AMERICA: AN INSIDER’S REPORT FROM THE WHITE HOUSE AND THE CABINET 221-23 (1981).

rooms or other parts of the hospital, the hospital was required to redesign these spaces to prevent it. In less than four months, private hospitals in the United States went from the nation’s most segregated private institutions to its most integrated.

The longer-term impact was equally dramatic. Within a decade, most of the usage rate patterns turned upside down with use becoming *inversely* related to income and blacks using *more* rather than *less* hospital services than whites. For the first time, usage rates began to reflect the medical needs of patients.<sup>49</sup> Furthermore, for the first twenty years after the implementation of Medicare, racial disparities in health outcomes decreased.<sup>50</sup> The physical structure of care also changed. The charity wards disappeared and indigent clinics became indistinguishable from private medical offices. Most of the black hospitals and public charity hospitals were closed or converted to other purposes.

In the current national political gridlock, it is hard to imagine such a profound transformation taking place so quickly. Indeed, at least in terms of civil rights issues, the political gridlock that existed at the time of the implementation of Medicare was more than a match for the current one. It had existed for almost a century. A more detailed description of the sequence of events is provided elsewhere.<sup>51</sup> The events, however, do not explain *why* it happened. Explanations that attribute it all to the qualities of leadership of the major actors or to just fortuitous accidents are not very convincing either. I argue that four necessary conditions made it possible: (1) a grassroots movement, (2) visible adversaries and an invisible army of supporters, (3) both versions of the Golden Rule, and (4) multiple barriers to political interference.

#### A. A Grassroots Movement

Nothing would have happened without a grassroots movement. As the civil rights movement demonstrated, powerlessness exists only through the consent of the powerless. People can always vote with

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49. See Smith, *supra* note 6, at 203.

50. Nancy Krieger et al., *The Fall and Rise of US Inequalities in Premature Mortality 1960-2002*, 5 PLOS MED. 227, 235 (2008); Douglas V. Almond et al., *Civil Rights, the War on Poverty, and Black-White Convergence in Infant Mortality in the Rural South and Mississippi* 11 (M.I.T. Dep’t of Econ. Working Paper No. 07-04, 2006); Haochi Zheng & Chao Zhou, *The Impact of Civil Rights Acts and Hospital Integration on Black-White Differences in Mortality: A Case Study of Motor Vehicle Accident Death Rates 1* (unpublished working paper) (December 2008).

51. See generally Smith, *supra* note 6; David Barton Smith, *Civil Rights and Medicare: Historical Convergence and Continuing Legacy*, in MEDICARE AND MEDICAID AT FIFTY (Alan B. Cohen et al., eds., forthcoming 2015).

their feet. That began with the individual decisions of those in the Jim Crow South seeking a better life that produced the Great Migration.<sup>52</sup> The black migrants now concentrated in northern cities gained political power, first achieving victory at the national level in Kennedy’s election, and then again in Johnson’s election. The emerging black middle class in Southern cities, often led by black physicians and dentists insulated from retaliation by the local white power structure, began to vote with their feet with bus boycotts, lunch counter sit-ins, and lawsuits targeting segregated schools and medical facilities. By the mid-1960s, this grassroots movement had become a transformative force in every region of the country.

*B. Visible Adversaries and an Invisible Army*

Segregated hospitals were a highly visible adversary just as the imagery of the beatings of the Freedom Riders and the police dogs attacking demonstrators helped create the national consensus necessary to spur federal action against segregation. Since segregated hospitals were easy to identify, they were easy to enforce corrections against. Moreover, that enforcement effort had at its disposal an immense invisible army of supporters. DHEW Secretary Gardner called for temporary volunteers to staff the Title VI inspection process, thus transforming DHEW into a civil rights enforcement agency. About one thousand individuals volunteered for this assignment, and their salaries and travel costs were borne by their home agency.<sup>53</sup> Many of these temporary transfers were individuals already active in the civil rights movement. Fifty medical students with similar commitments were hired for summer jobs in DHEW to assist with the inspections. The inspections and enforcement were carried out quietly, even secretly, surprising congressmen and senators when their constituent hospitals brought the presence of these inspectors to their attention. Local civil rights organizations and hospital workers also participated in this invisible army. The boundaries between local civil rights activists and the volunteer staff of OEHO blurred, making it impossible for hospitals to conceal anything or shift back to segregated accommodations after the inspectors had left.

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52. ISABEL WILKERSON, *THE WARMTH OF OTHER SUNS: THE EPIC STORY OF AMERICA’S GREAT MIGRATION* 8-11 (2010).

53. Congress had not authorized the funding for this effort. Secretary Gardner just asked for “volunteers” and it operated quietly perhaps even secretly “off the books” of OEHO. Congress later imposed control over staffing of Title VI efforts but by then it was too late to undo what had been accomplished during the implementation of Medicare.

*C. Both Versions of the Golden Rule*

The OEHO inspectors insisted that the hospitals had chosen to participate in Medicare and, in the process of applying to be a provider, had agreed to provide services without regard to race. All the inspectors were doing, they argued, was to help the hospitals do what they had already promised to do. Similarly, patients were free to choose to go to a segregated hospital—Medicare simply would not pay for it. “Freedom of choice” to be in a segregated wing or clinic did not apply once one had decided to go to a participating Medicare facility. All this was doing was insisting that others be treated just as you would like to be treated yourself (*i.e.* the ethical version of the Golden Rule). It captured the notion of “social solidarity,” often used as an explanation for universal health coverage in other countries but rarely invoked in the United States.

The economic version of the Golden Rule, of course, also applied. All but about one hundred hospitals out of more than six thousand otherwise eligible applied to be Medicare providers. It was striking how responsive private hospitals could be, especially since they were not noted for responding to outside pressure from the federal government or from anyone else. For example, local civil rights activists had reported to OEHO that the Louisiana Red Cross Blood Supply was segregated into “white” and “colored” blood. The OEHO staff member receiving this report sent a telegram to the Louisiana Hospital Association director without conferring with legal counsel and in a manner that certainly exceeded the intent of Title VI as it was to be applied to hospital Medicare participation. He informed the director that none of the hospitals in Louisiana would be eligible to be Medicare providers until the blood supply was desegregated. The hospitals in Louisiana did not waste any time bringing the Louisiana Red Cross Blood Bank program into compliance. In a matter of hours the blood supply in Louisiana was desegregated.<sup>54</sup> In a classic example of the economic version of the Golden Rule, Marshal Hospital—the only one in Lady Byrd Johnson’s home county in Texas—had resisted desegregation, providing a potential embarrassment for President Johnson. Dr. Richard Smith, serving as a part-time troubleshooter for OEHO, was sent to try to persuade them to comply. Nothing would budge the hospital administrator who insisted that the hospital would never desegregate. “Fine,” Smith said finally, “but you just tossed away \$100 million in Medicare funding.”<sup>55</sup> About a week later, Smith received a call from the chairman of the hospital’s board. “The trustees have just fired the administrator and want to know what

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54. Interview with Frank Weil (1995) (recording available at the Temple University Library).

55. Mike Tidwell, *The Quiet Revolution*, 6 AMERICAN LEGACY 32 (2000).

they have to do to get the Medicare money.”<sup>56</sup> Those with the gold—now the American taxpayers—ruled.

*D. Multiple Barriers to Political Interference*

In part by accident and in part by design, the process of certifying hospitals for Medicare funding avoided the political interference that had undermined compliance with Title VI in the Chicago Public Schools. There, Mayor Daley had personally intervened and successfully demanded that President Johnson release the funds to the Chicago Public Schools blocked by Title VI challenges by civil rights groups. As recommended by Vice President Humphrey and endorsed by President Johnson in the Fall of 1965, the process of ensuring compliance with Title VI of the Civil Rights Act was reorganized and decentralized. Those most directly involved and familiar with the programs and institutions receiving funding lower down in the federal bureaucracy were to be given full authority to ensure compliance.<sup>57</sup> This resulted in Secretary Gardner assigning the responsibility for Title VI certification to the newly created Office of Equal Health Opportunity (OEHO) in the Public Health Service. Gardner quietly assigned the temporary volunteer staff that would serve as Title VI investigators to OEHO. The public face of the Medicare implementation, however, included Robert Ball and the key members of his Social Security Administration team.<sup>58</sup> The Social Security Administration was a large, experienced part of the federal bureaucracy, whose central planners were well respected by the leadership of both parties in Congress for their technical expertise. As a result, the President and Congress completely delegated authority and responsibility for the implementation of Medicare to Ball and his Social Security team. “I don’t think I can exaggerate the degree of this,” Ball would later reflect. “The thought from above was, ‘we are not going to try to, in any way, interfere with the agency’s sole responsibility to put this in effect.’”<sup>59</sup>

Ball, under Gardner’s direction, proceeded to further delegate complete authority and responsibility for Title VI certification to OEHO. This had two benefits. The Social Security team, insulated

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56. *Id.*

57. Lyndon Baines Johnson, *Memorandum on Reassignment of Civil Rights Functions* (Sept. 24, 1965), available at <http://www.presidency.ucsb.edu/ws/?pid=27275>.

58. See generally THEODORE MARMOR, *POLITICS OF MEDICARE* 25 (1973); JUDITH FEDER, *MEDICARE: THE POLITICS OF FEDERAL HOSPITAL INSURANCE* 1 (1977).

59. NAT’L ACAD. OF SOC. INS., *REFLECTIONS ON IMPLEMENTING MEDICARE*, 10-11 (Jan. 2001).

from the more messy and disagreeable business of Title VI certification, could focus on developing an essential, trusting, and collaborative partnership with the hospitals and medical associations in working out the financing and administrative details of Medicare. In turn, OEHO was free to serve its enforcement function unencumbered by orders from superiors. In essence, Social Security could play the role of the good cop while OEHO played the bad cop. The two operations were insulated from each other. Indeed, Commissioner Ball never even met the OEHO Director Robert Nash.<sup>60</sup>

OEHO provided regular reports on the Title VI certification of hospitals up the chain of command: The reports were first sent to the Surgeon General of the Public Health Service; then to Secretary John Gardner and his Special Assistant for Civil Rights, Peter Libassi; then to Marvin Watson, President Johnson’s Chief of Staff; and finally to President Johnson. The reporting was informational and, as Ball had observed, virtually unencumbered by any directives flowing down the chain of command. Authority and responsibility were almost completely decentralized. In a few rare examples, the Johnson White House requested special attention to recalcitrant hospitals in Texas that could have embarrassed the President. While higher ups in the chain of command insisted that every effort be made to gain compliance, they maintained that it be done without compromise. The acid test would be when local civil rights groups acknowledged that the hospital had complied with Title VI.

A looming and seemingly impossible deadline for the implementation of Medicare eliminated the prospect of resistance to Title VI enforcement. Higher ups in the executive branch did not have the time to second-guess the decisions of OEHO. Hospitals wanted the Medicare funds and they could not afford to be litigious. OEHO did not have time to negotiate with the hospitals even if OEHO had wanted to. Most legislators learned of the infusion of “volunteer” staffing and rigor of the enforcement effort only after it was too late.

### III. LESSONS FOR THE IMPLEMENTATION OF THE ACA

Making Title VI compliance a condition for hospitals to receive funds as a Medicare provider produced profound changes. Yet, after the implementation of Medicare, Title VI proved a flawed vehicle for eliminating disparities in health care.<sup>61</sup> Physicians were specifically

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60. Telephone Interview with Robert Ball, former Comm’r of the Soc. Security Admin. (Sep. 15, 1998).

61. See Ruqaiyah Yearby, *Striving for Equality but Settling for the Status Quo in Health Care: Is Title VI More Illusory Than Real?*, 59 RUTGERS L. REV. 429, 432-34 (2007).

exempted from compliance. Managed care plans and related private insurance arrangements for publicly financed programs did not exist at the time Medicare was implemented and consequently they were never covered. Since physicians and health plans determine what care individuals receive and where they receive it, both have far more influence on health care disparities than hospitals.

While Title VI prohibited discrimination in institutions and programs receiving federal funds, it failed to define discrimination. The guidelines developed by the Public Health Service for certifying hospitals to receive Medicare funds enumerated the obvious visible prohibitions (*e.g.*, racial exclusionary staffing, deferring to the racial preferences of patients in room accommodations, etc.). Title VI regulations eventually identified two different kinds of discrimination: disparate treatment and disparate impact.<sup>62</sup> While disparate treatment (*e.g.*, refusal to treat a patient because of their race) is visible and obvious, disparate impact accounts for most if not all discrimination in the post-Civil Rights era health care. Disparate impact is rarely visible, obvious, or even conscious. Even the most obvious and most visible forms of disparate impact—for example, the relocation of hospitals out of predominantly minority communities (the only type of disparate impact that has been challenged in court)—have generally failed to overcome the business necessity arguments of providers.<sup>63</sup>

Most disparate impacts are much subtler. Why, for example, do hospitals—the only component of the U.S. health system to be effectively desegregated—now have a length of stay and a bed capacity less than half of what existed in the early days of Medicare? Both the length of stay and the hospital bed-to-population ratios of the United States are now the lowest of any developed country in the world.<sup>64</sup> Indeed, U.S. hospitals have become almost comparable to the intensive care units first integrated in southern medical school hospitals in the early 1960s. While shorter hospital stays impact all patients regardless of race or income, minority and low-income communities typically lack the home care and other resources of more affluent communities to absorb these shorter stays. Consequently, hospital readmission rates are higher. The ACA attempts to address

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62. The national goal of eliminating racial disparities adopted in the 1990s used “disparities” rather than “differences” which had been previously used, implying that there was something unethical if not illegal about their existence and shifting responsibility for their persistence to service providers.

63. See Smith, *supra* note 6, at 181.

64. It does not make our hospital system more cost effective. U.S. hospital costs per capita are roughly twice as high as other developed countries.

the general problem of readmission rates; however, it does not address the disparate impact.

The implementation of the ACA, however, offers an opportunity equivalent to the one so successfully captured with the implementation of Medicare fifty years ago.<sup>65</sup> The ACA involves a similar infusion of new public funding and takes a similar forward-looking approach to nondiscrimination. It also attempts to address three of the major limitations of the earlier effort: transparency, full accountability, and greater universality.

#### *A. Transparency*

The ACA requires for the first time that federally funded health insurers and health care providers collect and report data about the race, ethnicity, and language of the patients they serve. Long overdue, it offers the opportunity to move away from a largely ineffectual complaint based system of enforcement. In an era where all transactions with health providers and their insurers are electronic, it involves little additional cost and certainly makes the compliance process more efficient. This data-reporting requirement can describe the degree of segregation and discrimination (or lack of it) that actually exists and lead to the development of standards and strategies for monitoring and ensuring compliance with those standards. It provides a breath of fresh air to a debate that has involved all too much posturing, finger pointing, and distrust.

#### *B. Full Accountability*

The ACA specifically extends the reach of civil rights compliance to all health plans and providers receiving federal funds. That includes private health plans and physicians historically exempted because Part B of Medicare was defined as a “contract of insurance.” It also expands and standardizes compliance related to race, ethnicity, language, disability, and sex, thus making the compliance less vague by specifically focusing on its application to health care.

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65. See, e.g., Sidney Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Care Reform, Race and Equity*, 55 HOWARD L.J. 855, 855 (2012); see also Joel Teitelbaum et al., *Translating Rights into Access: Language Access and the Affordable Care Act*, 38 AM. J.L. & MED. 348, 357 (2012). Indeed, the silence about the civil rights provisions in the ACA in the debate over the implementation of the ACA almost matches the silence over the application of Title VI in the implementation of the Medicare program.

*C. Greater Universality of Coverage*

The ACA also takes a step toward federally supported universal coverage. This greater universality makes it easier to get compliance from providers (opting out of public programs ceases to be a viable alternative). It also directs more attention toward disparities. Disparities become more important the more they affect the premiums that everyone else pays. In addition, the ACA requires that nonprofit hospitals conduct a community needs assessment every two years or face penalties. With the right community input, such a process has the potential of creating some of the sense of social solidarity in health care otherwise absent in the United States.

CONCLUSION

The challenge, of course, is to recover the strengths that the Title VI compliance process benefited from in the implementation of Medicare. That includes recapturing the spirit of the grassroots social movement that made it possible. It includes, through data and other means, exposing the adversaries that have been so well concealed in the modern health system and using all members of a willing, invisible army composed of community leaders, health professionals, and public officials that drove the earlier reforms. It means making full use of both the power of the federal purse and the sense of social solidarity that combined both the ethical and economic Golden Rules so effectively in the implementation of Medicare. It means recapturing a sense of public ownership and urgency, a sense that if we do not get it right this time, we may never get another chance.

