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Breaking the Cycle of “Unequal Treatment” with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias

RUQAIJJAH YEARBY

Since the Civil War access to health care in the United States has been racially unequal. This racially unequal access to health care remains even after the passage of Title VI of the Civil Rights Act of 1964 (“Title VI”) and the election of an African-American President. Both of these events held the promise of equality, yet the promise has never been fulfilled. Now, many hail the passage of the Patient Protection and Affordable Health Care Act (“ACA”) as the biggest governmental step in equalizing access to health care because it has the potential to increase minority access to health insurance. However, access to health insurance means little when physicians continue to exhibit conscious and/or unconscious racial prejudice keeping them from adequately treating African-Americans (interpersonal racial bias); health care entities close and relocate leaving minority neighborhoods without medical facilities (institutional racial bias); and the health care system is based on ability to pay, not need, leaving those with poor health and no money, usually minorities, without access to health care (structural racial bias). Thus, in order to equalize access to health care, the government must acknowledge that racial bias (interpersonal, institutional, and structural) is the central cause of racial disparities in the United States, and implement institutional and structural changes to address racial bias in health care, such as integrating quality improvement programs and civil rights enforcement. Then, and only then, will the cycle of unequal treatment be broken.

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Breaking the Cycle of “Unequal Treatment” with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias

RUQAIJJAH YEARBY*

I. INTRODUCTION

The election of President Obama prompted many Americans to declare that the United States had entered into a “post-racial” era in which racial bias no longer existed and African-Americans are treated equally. However, racial bias did not cease before or after the election of an African-American president. In fact, empirical evidence shows that African-Americans continue to be treated unequally because of racial bias in decisions regarding bankruptcy, residential zoning, mortgage lending, apartment rental, and housing rental.¹ One of the most poignant examples of the continuation of racial bias in a “post-racial” era was a Cincinnati landlord’s posting of a “White Only” sign by a pool in the summer of

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¹ Tara Siegel Bernard, *Blacks Face Bias In Bankruptcy, Study Suggests*, N.Y. TIMES, Jan. 21, 2012, at A1; Hannah Dreier, *Bias Against Blacks Prevalent in Richmond Housing*, CONTRA COSTA TIMES, Oct. 28, 2011 (My Town); Lisa Prevost, *Housing Lawsuit Alleges Bias*, N.Y. TIMES, Dec. 11, 2011, at RE4; Press Release, Dep’t of Justice, Justice Department Reaches \$335 Million Settlement to Resolve Allegations of Lending Discrimination by Countrywide Financial Corporation (Dec. 21, 2011); Ben Feldheim, *Anti-Black Rental Bias Costs Orland Park Landowner \$35,000*, ORLANDPARKPATCH (Jan. 19, 2011), <http://orlandpark.patch.com/articles/anti-black-rental-bias-costs-orland-park-landowner-35000> (consent decree on file with author); Alain Sherter, *Why the Feds’ Countrywide Settlement Settles Nothing*, CBS NEWS (Dec. 22, 2011), http://www.cbsnews.com/8301-505123_162-57347259/why-the-feds-countrywide-settlement-settles-nothing/; Lou Young, *Feds: Glitzy Riverdale Apartment Building Discriminated Against Black Renters*, CBS N.Y. (Sept. 27, 2011), <http://newyork.cbslocal.com/2011/09/27/feds-glitzy-riverdale-apartment-building-discriminated-against-black-renters/>.

2011.² The persistence of racial bias in a “post-racial” era is also evident in the health care system, where the unequal treatment of African-Americans because of their race is the main cause of the continuation of racial disparities in health care.³ However, unequal treatment of African-Americans in health care is nothing new.

In 2002, the groundbreaking Institute of Medicine Study, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* (“IOM study”), noted that some health care providers, such as physicians, were influenced by a patient’s race, which, in turn, created a barrier to African-Americans’ access to health care.⁴ Not only did this racial bias prevent African-Americans from accessing health care services, it caused African-Americans to have poor health outcomes.⁵ The IOM study also found evidence of poorer quality of care for minority patients in studies of cancer treatment, treatment of cardiovascular disease, and rates of referral for clinical tests, diabetes management, pain management, and other areas of care.⁶ Ten years after the publication of this sweeping study, racial bias continues to drive racial disparities in health care, and as a result, access to

² Associated Press, *Ruling Stands in ‘White Only’ Pool Sign Case*, BOS. GLOBE, Jan. 13, 2012, (National), at 2.

³ DOROTHY ROBERTS, *FATAL INVENTION: HOW SCIENCE, POLITICS, AND BIG BUSINESS RECREATE RACE IN THE TWENTY-FIRST CENTURY* 96–97, 127–33, 135–36, 198 (2011); Ruqaiijah Yearby, *African Americans Can’t Win, Break Even, or Get Out of the System: The Persistence of “Unequal Treatment” in Nursing Home Care*, 82 TEMP. L. REV. 1177, 1177–79 (2010) [hereinafter *African Americans Can’t Win*] (arguing that the issue of accessibility of quality nursing home care to African Americans is the result of socioeconomic status and residential segregation, with racial bias playing a significant role); Ruqaiijah Yearby, *Does Twenty-Five Years Make a Difference in “Unequal Treatment”? The Persistence of Racial Disparities in Health Care Then and Now*, 19 ANNALS HEALTH L. 57, 57–60 (2010) [hereinafter Yearby, *Twenty-Five Years*] (discussing the successes and failures of federal programs aimed at elimination of racial discrimination in health care and emphasizing the critical role that scholars, researchers, and federal officials will play in the adoption of new approach aimed at eradicating racial disparities).

⁴ INST. OF MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* (Brian D. Smedley et al. eds., 2003) [hereinafter *UNEQUAL TREATMENT*]. The study describes in great detail the various ways health care providers and services are influenced by a patient’s race, including appropriate levels of clinical care, the general organization and financing of the health care system, geographic distribution of clinics and pharmacies, clinical uncertainty influenced by pre-conceived notions of racial health issues, and the patient’s ability to respond comfortably and honestly to a health care provider. *Id.* at 5–9, 11–12.

⁵ See, e.g., *id.* at 38–9, 42–44 (discussing differences in cardiovascular care, and noting that over six hundred articles and surveys have been published in the last three decades that address the disparity in health care experienced by whites and minorities, with the majority of these studies finding that even after controlling for a host of factors, clear “racial and ethical disparities in cardiovascular care remain”).

⁶ E.g., *id.* at 53–55, 57–59, 60–64 (describing the poor quality of care experienced by minorities in cancer care in terms of treatment, post-surgical surveillance and pain management; in cerebrovascular disease care in terms of diagnostic and therapeutic procedures; in renal failure care in terms of treatment and position on transplant waiting lists; in HIV/AIDS care in terms of specific treatments for the disease and for the symptoms; in asthma care in terms of treatment and access to asthma specialists; and diabetes care in terms of treatment, testing and patient education).

health care remains unequal.⁷ Racial bias in health care operates on three different levels: interpersonal, institutional, and structural.⁸

Interpersonal bias is the conscious (explicit) and/or unconscious (implicit) use of prejudice in interactions between individuals.⁹ Interpersonal bias is best illustrated by physicians' treatment decisions based on racial prejudice, which results in the unequal treatment of African-Americans. According to René Bowser's seminal article, *Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities*, these racial disparities in treatment often lead to racial disparities in mortality rates between African-Americans and Caucasians.¹⁰

⁷ Neil S. Calman, *Out of the Shadow: A White Inner-City Doctor Wrestles with Racial Prejudice*, HEALTH AFF., Jan. 2000, at 170, 172–74 (describing the main types of prejudice in health professionals and exploring how they impact and limit patients' health care opportunities); Thomas E. Perez, *The Civil Rights Dimension of Racial and Ethnic Disparities in Health Status*, in UNEQUAL TREATMENT, *supra* note 2, at 626, 628, 633, 636–37 (discussing the nature of the subtle but ongoing racial discrimination in health care); Vernellia R. Randall, *Eliminating Racial Discrimination in Health Care: A Call for State Health Care Anti-Discrimination Law*, 10 DEPAUL J. HEALTH CARE L. 1, 8–9 (2006) (explaining that based on the Supreme Court's holding in *Alexander v. Choate*, Title VI's prohibition on discrimination only extends to intentional discrimination, and does not extend to unconscious discrimination, which is especially prevalent in the health care sector); Kevin A. Schulman et al., *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*, 340 NEW ENG. J. MED. 618, 623 (1999) ("We found that the race and sex of the patient affected the physicians' decisions about whether to refer patients with chest pain for cardiac catheterization, even after we adjusted for symptoms, the physicians' estimates of the probability of coronary disease, and clinical characteristics."); David R. Williams, *Race, Socioeconomic Status, and Health: The Added Effects of Racism and Discrimination*, ANNALS N.Y. ACAD. SCI. Dec. 1999, at 173, 177–80 (explaining that residential segregation continues to have pervasive adverse effects on the health of African-Americans by negatively impacting education and employment, which in turn influence access to health care); David R. Williams & Chiquita Collins, *Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health*, 116 PUB. HEALTH REP. 404, 405–07 (2001) (arguing that residential segregation and institutional discrimination have negatively impacted the socioeconomic status of a majority of African-Americans, which consequently accounts for much of the racial differences in health and health care); Yearby, *African Americans Can't Win*, *supra* note 3, at 1177–79 (arguing that the issue of accessibility of quality nursing home care to African Americans is the result of socioeconomic status and residential segregation, with racial bias playing a significant role); 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, 462 (2007) [hereinafter Yearby, *Striving for Equality*] ("Innumerable reasons have been offered to explain the continuation of these health inequities, including cultural differences, geographic racial segregation, socioeconomic status, and racial discrimination. . . . [T]aken together, [these reasons] have caused racial inequities in accessing quality health care services. However, when each factor is controlled the biggest predictor of lack of access to quality health care is race."); Yearby, *Twenty-Five Years*, *supra* note 3, at 57–60 (discussing the successes and failures of federal programs aimed at elimination of racial discrimination in health care and emphasizing the critical role that scholars, researchers, and federal officials will play in the adoption of new approach aimed at eradicating racial disparities).

⁸ Yearby, *African Americans Can't Win*, *supra* note 3, at 1180.

⁹ Leith Mullings & Amy Schulz, *Intersectionality and Health: An Introduction*, in GENDER, RACE, CLASS, AND HEALTH 3, 12 (2006) (examining the different forms of racism present in health status issues); Yearby, *African Americans Can't Win*, *supra* note 3, at 1180.

¹⁰ René Bowser, *Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities*, 7 MICH. J. RACE & L. 79, 90–91 (2001) ("The disparities in medical treatment between

Institutional bias operates through organizational structures within institutions, which “establish separate and independent barriers”¹¹ to health care services.¹² According to Brietta Clark, institutional bias is best demonstrated by hospital closures in African-American communities.¹³ Finally, operating at a societal level, structural bias exists in the organizational structure of society, which “privile[ges] some groups . . . [while] denying others access to the resources of society,” including health care.¹⁴ An example of structural bias is the provision of health care based primarily on ability to pay, rather than on the needs of the patient.

Unfortunately, the government often ignores the significance of racial bias in causing racial disparities in health care, and by extension, overall health, even though such biases are among the causes identified in numerous government reports, initiatives, and empirical research studies conducted over the past decade.¹⁵ The Patient Protection and Affordable Care Act (“ACA”) exemplifies the government’s failure to acknowledge the interconnectedness of racial bias and racial disparities.¹⁶ Although the

Blacks and Whites have been estimated to result in at least 60,000 excess deaths in the Black population annually.”).

¹¹ Vernellia R. Randall, *Eliminating the “Black Health Deficit” of African Descendants in the Americas and Europe by Assuring Access to Quality Health Care*, OHCHR, available at www2.ohchr.org/...African_Descent/.../Black_Health_Deficit-VR_Randall.doc.

¹² *Id.*; see also VERNELLIA R. RANDALL, RACE, HEALTH CARE AND THE LAW REGULATING RACIAL DISCRIMINATION IN HEALTH CARE 6 (2001), available at [http://www.unrisd.org/80256B3C005BCCF9/\(httpAuxPages\)/603AC6BDD4C6AF8F80256B6D005788BD/\\$file/drall.pdf](http://www.unrisd.org/80256B3C005BCCF9/(httpAuxPages)/603AC6BDD4C6AF8F80256B6D005788BD/$file/drall.pdf) (“The institutional/structural racism that exists in the United States hospitals and health care institutions manifests itself in (1) the adoption, administration, and implementation of policies that restrict admission; (2) the closure, relocation or privatization of hospitals that primarily serve “racially disadvantaged” communities; and (3) the continued transfer of unwanted patients (known as “patient dumping”) by hospitals and institutions to underfunded and over burdened public care facilities. Such practices have a disproportionate effect on “racially disadvantaged” groups; banishing them to distinctly substandard institutions or to no care at all.”).

¹³ See Brietta R. Clark, *Hospital Flight From Minority Communities: How Our Existing Civil Rights Framework Fosters Racial Inequality in Healthcare*, 9 DEPAUL J. HEALTH CARE L. 1023, 1029 (2005) (describing the local governments’ closure of public hospitals in minority communities as an attempt to conserve resources, and highlighting the trend of private hospitals leaving minority communities and relocating to more affluent, predominately white communities).

¹⁴ Mullings & Schulz, *supra* note 9, at 12.

¹⁵ See, e.g., U.S. Dep’t of Health & Human Servs., *Healthy People 2020: Disparities*, HEALTHYPEOPLE.GOV (Dec. 29, 2010), <http://healthypeople.gov/2020/about/DisparitiesAbout.aspx>. (noting that in order to gain the understanding it currently lacks, “[t]hroughout the next decade, Healthy People 2020 will assess health disparities in the U.S. population by tracking rates of illness, death, chronic conditions, behaviors, and other types of outcomes in relation to demographic factors including: Race and ethnicity; Gender; Sexual identity and orientation; Disability status or special health care needs; [and] Geographic location (rural and urban)”).

¹⁶ Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119, amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 §§ 2713, 2716, 2717 (codified as amended in scattered sections of 26 and 42 U.S.C.) (demonstrating that the clear and demonstrated racial health disparities are not addressed in the Act; for example, women and children are specifically mentioned as protected classes, but racial minorities are

Patient Protection Act explicitly mentions disparities in health care and provides several mandates to address these disparities, it fails to acknowledge or target the root causes of racial disparities—racial bias. Therefore, this Article argues that the ACA will not fully equalize access to health care for minorities. In fact, the Act may exacerbate the existing problem of racial disparities because it proposes individual and community based solutions that will not put an end to interpersonal, institutional, and structural racial bias, which cause racial disparities in health care.

The debate surrounding the ACA has rarely focused on issues related to racial disparities. This Article begins to fill this void.¹⁷ Part II provides a brief historical context for the ACA by discussing previous legislation that addressed racial disparities in health care and governmental action to measure and eradicate racial disparities. Part III then reviews the root cause of racial disparities—racial bias—as evidenced by empirical data. Next, Part IV examines specific sections of the ACA, which address racial disparities, and discusses the strengths and weakness of the Act. Finally, Part V suggests some solutions.

II. BRIEF HISTORICAL CONTEXT

The U.S. Department of Health and Human Services ("HHS") defines health disparities as the differences in health between groups of people who have systematically experienced greater obstacles to health care services based on their racial group, socioeconomic status, or other characteristics historically linked to discrimination or exclusion.¹⁸ The largest disparity in accessing quality health care and health status in the United States remains between African-Americans and Caucasians.¹⁹ With

not, nor do the wellness prevention programs address the problem of health disparities among racial minorities).

¹⁷ I am currently working on a book entitled, "Health Care Reform in a "Post-Racial" Era: The Paradox of Fixing Racial Disparities Without Addressing Race," which will fully discuss the evolution of racial bias in health care after the Civil Rights Movement, why racial bias is the central cause of racial disparities, and how to put an end to racial disparities in a "post racial" era, using health care reform.

¹⁸ Nat'l P'ship for Action to End Health Disparities, *Health Equity & Disparities*, HHS.GOV (last modified Mar. 4, 2011, 9:15AM), <http://www.minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=34> (defining health disparities as health differences that "adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation; geographic location; or other characteristics historically linked to discrimination or exclusion"); see also David Satcher et al., *What If We Were Equal? A Comparison Of The Black-White Mortality Gap In 1960 and 2000*, 24 HEALTH AFF. 459, 459 (2005) ("Health disparities are observed across a broad range of racial, ethnic, socioeconomic, and geographic subgroups in America, but the history of African Americans, rooted in slavery and postslavery segregation, motivates our focused analysis of black-white health disparities.").

¹⁹ Satcher et al., *supra* note 18, at 459. Data regarding health disparities is often limited to a comparison between African-Americans and Caucasians. Therefore, the disparity between African-

the enactment of Title VI of the Civil Rights Act of 1964 ("Title VI"), the right to equal enjoyment and access to health care became the subject of federal government regulation.²⁰ Title VI prohibits health care entities receiving government funding from using racial bias to determine who receives quality health care.²¹ Using its spending power, Congress made compliance with Title VI mandatory before a health care provider, such as a hospital or nursing home, could become eligible to receive Medicare²² or Medicaid²³ funding.²⁴ Decades of government reports and research studies have shown that forty-seven years after the enactment of Title VI, access to health care still remains unequal and as a result racial disparities in health care persist.²⁵

A. *The Civil Rights Era: The Promise of Equal Treatment*

Throughout the 1960s, African-Americans waged national and international battles to obtain the rights of full citizenship in the United States.²⁶ The civil rights movement focused on equality of rights in every area of life, including the right to quality health care. The disenfranchisement of African-Americans seeking health care did not change until African-Americans forced the government to comply with the Constitutional mandates of the Equal Protection Clause of the Fourteenth Amendment.²⁷ In 1962, a group of African American physicians, dentists

American and Caucasians is the major focus of this Article. However, where data is readily available about disparities in health for other minorities this information is included as well.

²⁰ See Civil Rights Act of 1964, 42 U.S.C. §§ 2000d to 2000d-4a (2006).

²¹ Medicaid is a state and federally funded program to pay for medical assistance for the poor. See Social Security Act, 42 U.S.C. § 1396. The States administer this program. *Id.*

²² Medicare is a federal entitlement program to pay for health insurance for the elderly and disabled. See Social Security Act, 42 U.S.C. § 1395.

²³ Medicaid is a state and federally funded program to pay for medical assistance for the poor. The States administer this program. See Social Security Act, 42 U.S.C. § 1396.

²⁴ DAVID BARTON SMITH, *HEALTH CARE DIVIDED: RACE AND HEALING A NATION* 159–61 (1999).

²⁵ Satcher et al., *supra* note 18, at 459; Yearby, *African Americans Can't Win*, *supra* note *, at 1177–79 (arguing that the issue of accessibility of quality nursing home care to African Americans is the result of socioeconomic status and residential segregation, with racial bias playing a significant role); Yearby, *Striving for Equality*, *supra* note *, at 462 ("Innumerable reasons have been offered to explain the continuation of these health inequities, including cultural differences, geographic racial segregation, socioeconomic status, and racial discrimination. . . . [T]aken together, [these reasons] have caused racial inequities in accessing quality health care services. However, when each factor is controlled the biggest predictor of lack of access to quality health care is race."); Yearby, *Twenty-Five Years*, *supra* note 3, at 57–60 (discussing the successes and failures of federal programs aimed at elimination of racial discrimination in health care and emphasizing the critical role that scholars, researchers, and federal officials will play in the adoption of new approach aimed at eradicating racial disparities).

²⁶ See generally Derrick A. Bell, Jr., *Brown v. Board of Education and the Interest-Convergence Dilemma*, 93 HARV. L. REV. 518 (1980).

²⁷ See generally SMITH, *supra* note 24, at 29.

and patients filed a lawsuit against two hospitals in North Carolina receiving federal funding because the hospitals denied admission to African-Americans because of race.²⁸ Not only did the federal government intervene on behalf of the plaintiffs, but it also enacted Title VI of the Civil Rights Act of 1964 to put an end to 'separate, but equal' access to health care.²⁹

Title VI provides both a private right of action and mandates for government enforcement. The private right of action is found in section 601,³⁰ which reads: "No person in the United States shall, on the ground of race, color, or national origin, *be excluded from participation in, be denied the benefits of, or be subjected to discrimination* under any program or activity receiving Federal financial assistance."³¹

The mandates of enforcement for the government are found in section 602, which states:

Each Federal department and agency which is empowered to extend Federal financial assistance to any program or activity, by way of grant, loan, or contract other than a contract of insurance or guaranty, is authorized and directed to effectuate the provisions of section 2000d [Section 601] of this title with respect to such program or activity by issuing rules, regulations, or orders of general applicability which shall be consistent with achievement of the objectives of the statute authorizing the financial assistance in connection with which the action is taken.³²

Under Section 601, private parties have a right to sue health care facilities for disparate treatment, i.e., race conscious actions that prevent participation or the access of benefits under federally funded health care programs.³³ Section 602 requires the U.S. Department of Health and Human Services, Office for Civil Rights ("OCR") to undertake measures to ensure that health care entities receiving federal funding do not discriminate either through disparate treatment or disparate impact, i.e.

²⁸ *Simkins v. Moses H. Cone Mem'l Hosp.*, 323 F.2d 959, 960–61 (4th Cir. 1963).

²⁹ SMITH, *supra* note 24, at 115–16.

³⁰ See *Cannon v. Univ. of Chicago*, 441 U.S. 677, 694 (1979) (holding that there was a private right of action under Title IX of the Educational Amendment of 1972 because Title IX was patterned after Title VI of the Civil Rights Act). The Court "embraced the existence of a private right to enforce Title VI[.]" *Alexander v. Sandoval*, 532 U.S. 275, 280 (2001).

³¹ 42 U.S.C. § 2000d (2006) (emphasis added).

³² *Id.* § 2000d-1.

³³ *Sandoval*, 532 U.S. at 280.

race-neutral actions that have a disproportionate effect on minorities.³⁴

When Title VI was enacted federal funding to health care entities was limited. However, the enactment of Medicare and Medicaid in 1965 significantly increased federal funding to all health care entities, including hospitals and nursing homes.³⁵ In fact, Congress made compliance with Title VI “mandatory” before health care entities could receive any Medicare and Medicaid funding.³⁶ OCR focused its initial efforts on hospitals.³⁷ Because hospitals relied on federal funding, the federal government was able to force hospitals to integrate without much resistance from the hospital industry.³⁸ Faced with the loss of a substantial source of revenue stream, most hospitals integrated overnight, putting an end to “separate but equal” hospital care.³⁹

Unfortunately, this was the main victory of Title VI. Physicians were not required to comply with Title VI⁴⁰ and other health care entities, such as nursing homes, were allowed to ignore the requirements of Title VI.⁴¹ Specifically, physicians receiving payments under Medicare were exempted from compliance with Title VI because these payments were not defined as federal financial assistance.⁴² Moreover, nursing homes were not interested in participating in Medicare and Medicaid initially, and the government was not dedicated to forcing racial integration in nursing homes.⁴³ In fact, David Barton Smith’s research has shown that nursing

³⁴ The Court ruled that 45 C.F.R. § 80.3 forbids health care entities from using ‘race-neutral’ policies that have the effect of subjecting African Americans to racial bias or impairing their ability to access quality health care. *Id.* Because the regulation only applies to HHS, there is no private right of action for disparate impact. *Id.*

³⁵ SMITH, *supra* note 24, at 159–61.

³⁶ *Id.* at 100–02.

³⁷ *Id.* at 191–95.

³⁸ *Id.*

³⁹ *Id.* at 143–59.

⁴⁰ Physicians receiving payments under Medicare Part B are exempted from compliance with Title VI because these payments are not defined as federal financial assistance. SMITH, *supra* note 24, at 164. Thus, physicians can continue to discriminate based on race. *Id.* Although not discussed in this article, the governmental funding of physicians that racially discriminate is a violation of domestic and international law. For a detailed discussion, see generally Vernellia R. Randall, *Racial Discrimination in Health Care in the United States as a Violation of the International Convention on the Elimination of All Forms of Racial Discrimination*, 14 U. FLA. J.L. & PUB. POL’Y 45, 47–65 (2002).

⁴¹ President Lyndon B. Johnson championed the Civil Rights Act, which was enacted in memorial to President Kennedy. SMITH, *supra* note 24, at 100. Although leading the charge for the enactment of the Civil Rights Act, President Johnson did not fully support all enforcement actions. For instance, during the passage of Title VI, Congress and the President noted that unlike hospitals, nursing homes were more than simple treatment centers. *Id.* at 159–63, 236–52. Nursing homes were viewed as private residences funded by the government. *Id.* at 236–38. In the 1960s, Congress and the President were unwilling to wage a massive attack to integrate these “homes.” *Id.* at 159–60. Consequently, Title VI enforcement fell apart at the start because nursing homes were viewed as private homes of citizens. *Id.* at 159.

⁴² See *infra* Section III.B.

⁴³ SMITH, *supra* note 24, at 159–63, 236–52.

homes never fully racially integrated or actively sought African American patients.⁴⁴ The only change in nursing homes after Title VI was the removal of blatant discriminatory advertising.⁴⁵ Thus, because the promise of equal health care never became a reality, it comes as no surprise that government reports and research studies conducted after the passage of Title VI show that there are racial disparities in health care access and health status between African-Americans and Caucasians.

B. After Title VI: Evidence of Racial Disparities

Twenty-one years after the passage of Title VI, the government issued the first report on African-American health outcomes. In 1985, the Secretary of HHS issued a landmark report—the *Heckler Report*—exposing and detailing the existence of racial disparities between African-Americans and Caucasians in the U.S. health care system.⁴⁶ Seventeen years later, in the IOM study, the government acknowledged the continuation of racial disparities in health status and in access to health care because of racial bias, and provided suggestions for the elimination of these disparities.⁴⁷ Finally, in 2007 the National Healthcare Disparities Report (“NHDR”) noted that racial disparities in health status and in access to quality health care between African-Americans and Caucasians were not decreasing; instead the gaps persisted.⁴⁸

In response to these reports, the federal government issued several initiatives to put an end to racial disparities in access to health care and health status. In 1990, HHS issued the first national health initiative, which provides ten years of science-based national objectives for

⁴⁴ *Id.* at 236–75.

⁴⁵ See generally *id.*

⁴⁶ Yearby, *Twenty-Five Years*, *supra* note 3, at 57; see also Office of the Dir., Ctr. for Disease Control and Prevention, *Perspectives in Disease Prevention and Health Promotion Report of the Secretary's Task Force on Black and Minority Health*, 35 MORBIDITY & MORTALITY WKLY. REP. 109, 109–12 (1986) (“A comprehensive study was carried out to investigate the long-standing disparities between the health status of U.S. blacks, Hispanics, Asian/Pacific Islanders, and Native Americans compared to that of whites.”); Stephen B. Thomas et al., *Historical and Current Policy Efforts to Eliminate Racial and Ethnic Health Disparities in the United States: Future Opportunities for Public Health Education Research*, 7 HEALTH PROMOTION PRAC. 324, 325 (2006) (noting that “[t]hirty-four years after closing of the Office of Negro Health Works, Margaret Heckler, Secretary of U.S. Department of Health and Human Services (DHHS; 1985) released the Secretary’s Task Force Report on Black and Minority Health[, a] 10-volume landmark report [that] documented ‘excess’ deaths from seven disease conditions” that were experienced by minority populations).

⁴⁷ Yearby, *African Americans Can’t Win*, *supra* note 3, at 1203; see also UNEQUAL TREATMENT, *supra* note 4, at 5, 13–23.

⁴⁸ U.S. DEP’T OF HEALTH & HUMAN SERVS., AGENCY FOR HEALTHCARE RESEARCH & QUALITY, NATIONAL HEALTHCARE DISPARITIES REPORT 2007 1–2 (2008), available at <http://archive.ahrq.gov/qual/nhdr07/nhdr07.pdf>.

improving the health of all Americans.⁴⁹ In the first national health initiative, called *Healthy People 2000*, one of the main objectives was to reduce health disparities among all Americans, and particularly among racial and ethnic minority populations.⁵⁰ To wit, “[i]n 1998, President Bill Clinton announced the *Initiative to Eliminate Racial and Ethnic Disparities in Health Care*[, which] was supposed to eliminate racial and ethnic health disparities in six key areas of health status, including infant mortality, by the year 2010.”⁵¹ In 2000, the *Healthy People 2010* initiative was issued with an objective of eliminating racial disparities in health care.⁵² In 2010, the *Healthy People 2020* initiative expanded these goals of eliminating racial disparities in health care to include achieving health equity and improving the health of all groups.⁵³

These disparities are also illustrated by empirical evidence. Research studies have shown that in 1950, before the end of legalized racial segregation, the life expectancy rates of 65-year-old male African-Americans and Caucasians were the same.⁵⁴ By 1995, African-American mortality rates—when compared to Caucasians for cancer, diabetes, suicide, cirrhosis of the liver and homicide—were higher than they were in 1950.⁵⁵ As of 1985, 60,000 excess deaths were occurring annually in African-American and minority populations.⁵⁶ By 2002, an estimated 83,570 African-Americans had died each year that would not have died if African-American death rates were equivalent to those of Caucasians.⁵⁷ “In fact, ‘there has been no sustained decrease in black-white disparities in age-adjusted mortality (death) or life expectancy at birth at the national

⁴⁹ U.S. DEP’T OF HEALTH & HUMAN SERVS., *HEALTHY PEOPLE 2000 FINAL REVIEW 1* (2001), available at <http://www.cdc.gov/nchs/data/hp2000/hp2k01.pdf>.

⁵⁰ See *id.* at 8–11 (discussing the *Healthy People 2000* study goal of reducing health disparities among the American population).

⁵¹ Yearby, *Twenty-Five Years*, *supra* note 3, at 58; see also Said A. Ibrahim et al., *Achieving Health Equity: An Incremental Journey*, 93 AM. J. PUB. HEALTH 1619, 1620 (2003) (“On February 21, 1998, President Bill Clinton announced a new initiative that set a national goal of eliminating longstanding racial/ethnic disparities in health status by 2010.”).

⁵² See U.S. DEP’T OF HEALTH & HUMAN SERVS., *HEALTHY PEOPLE 2010 FINAL REVIEW ES-22* (2000), available at http://www.cdc.gov/nchs/data/hpdata2010/hp2010_final_review.pdf (discussing the *Healthy People 2010* study goal to “eliminate health disparities that occurred by race and ethnicity, gender, education, income, geographical location, disability status, or sexual orientation”).

⁵³ SEC’Y ADVISORY COMM. HEALTH PROMOTION & DISEASE PREVENTION OBJECTIVES FOR 2020, PHASE I REPORT 5–6 (2008); see also *Disparities*, HEALTHYPEOPLE.GOV (Dec. 29, 2010), <http://www.healthypeople.gov/2020/about/disparitiesAbout.aspx> (discussing the definition of “disparities” and presenting the goals for *Healthy People 2020*).

⁵⁴ Barney Cohen, *Introduction to CRITICAL PERSPECTIVES ON RACE AND ETHNIC DIFFERENCES IN HEALTH CARE IN LATE LIFE* 1, 3 (Norman Anderson et al. eds., 2004).

⁵⁵ David R. Williams, *Race, Socioeconomic Status, and Health: The Added Effects of Racism and Discrimination*, 896 ANNALS N.Y. ACAD. SCI. 173, 175–76 (1999).

⁵⁶ Satcher et al., *supra* note 18, at 459; Yearby, *Twenty-Five Years*, *supra* note 3, at 57.

⁵⁷ Satcher et al., *supra* note 18, at 460; Yearby, *Twenty-Five Years*, *supra* note 3, at 57.

level since 1945.”⁵⁸ These disparities in mortality are a result of disparities in medical treatment.

In 1996, the *New England Journal of Medicine* published a study regarding racial disparities in the provision of Medicare services.⁵⁹ Even after controlling for income, the study showed that physicians treated African-American Medicare patients less aggressively than Caucasians, who were more likely to be hospitalized for ischemic heart disease, have a mammography, and undergo coronary-artery bypass surgery, coronary angioplasty, and hip-fracture repair.⁶⁰ Likewise, a 1998 study found that African-Americans were less likely than Caucasians to receive curative surgery for early-stage lung cancer, which is linked to increased mortality rates of African-Americans.⁶¹ In fact, the study showed that if African-American patients underwent surgery at a rate equal to Caucasians, their survival rate would approach that of Caucasian patients.⁶²

According to a study conducted that same year by Harvard researchers, African-American Medicare patients received poorer basic care than Caucasians who were treated for the same illnesses.⁶³ The study showed that only thirty-two percent of African-American pneumonia patients with Medicare were given antibiotics within six hours of admission, compared with fifty-three percent of other pneumonia patients with Medicare.⁶⁴ Also, African-Americans with pneumonia were less likely to have blood cultures done during the first two days of hospitalization.⁶⁵ The researchers noted that other studies had associated prompt administration of antibiotics and collection of blood cultures with lower death rates.⁶⁶ In

⁵⁸ Yearby, *Twenty-Five Years*, *supra* note 3, at 58 (quoting Robert S. Levine et al., *Black-White Inequalities in Mortality and Life Expectancy, 1933–1999: Implications for Healthy People 2010*, 116 PUB. HEALTH REP. 474, 475 (2001)); *see also* Levine, *supra* at 480–82 (discussing the U.S. Census data from 1940 to 1998 on the estimated excess deaths in black population compared to white population, and finding that “[n]o matter how much racial equality in access is introduced into such a system, black people can be expected to continue to have higher mortality rates than white people, because the higher occurrence of preventable risk among blacks will continue to produce higher risks of becoming ill or injured in the first place”).

⁵⁹ Marian E. Gornick et al., *Effects of Race and Income on Mortality and Use of Services Among Medicare Beneficiaries*, 335 NEW ENG. J. MED. 791, 791–92 (1996) (using data from the U.S. Census to analyze the effects of race and socioeconomic status on the use of services among Medicare beneficiaries).

⁶⁰ *Id.* at 793–94.

⁶¹ Peter B. Bach et al., *Racial Differences in the Treatment of Early-Stage Lung Cancer*, 341 NEW ENG. J. MED. 1198, 1198, 1198–1202 (1999).

⁶² *Id.* at 1202.

⁶³ John Z. Ayanian et al., *Quality of Care by Race and Gender for Congestive Heart Failure and Pneumonia*, 37 MED. CARE 1260, 1260–61, 1265 (1999).

⁶⁴ *Id.* at 1265.

⁶⁵ *Id.*

⁶⁶ *Id.*; *see also* Manreet Kanwar et al., *Misdiagnosis of Community-Acquired Pneumonia and Inappropriate Utilization of Antibiotics: Side Effects of the 4-h Antibiotic Administration Rule*, 131 CHEST 1865, 1865 (2007) (discussing the association between timely antibiotic therapy and improved

spite of all the government reports, initiatives, and research studies, health care disparities persist and, in some cases, have even worsened.⁶⁷

Innumerable reasons have been offered to explain the continuation of racial disparities in health care, including insurance status, education levels, and socioeconomic status.⁶⁸ Yet, research studies show that “even when all these factors are controlled[,] racial disparities in health care persist, leaving race as the only plausible answer for the continuation of disparities.”⁶⁹ The logical question, then, is why race?

III. RACIAL BIAS: THE CENTRAL CAUSE OF RACIAL DISPARITIES

Some argue that biological difference between racial groups is the cause of racial disparities in health.⁷⁰ However, leading academics have discredited this claim.⁷¹ For example, in her landmark book, *Fatal Invention: How Science, Politics, and Big Business Re-Crete Race in the Twenty-First Century*, Dorothy Roberts states that “genetic explanations for health disparities are basically implausible.”⁷² As noted by Nancy Krieger, the biological theory is based on three flawed assumptions: “that ‘race’ is a valid biological category; that the genes which determine ‘race’ are linked to the genes which affect health; and that the health of any community is mainly the consequence of the genetic constitutions of the individuals of which it is composed.”⁷³ Thus, if race plays a role in racial disparities, it is because race “is a powerful determinant of the location and

health outcomes in patients with community-acquired pneumonia); Mark L. Metersky et al., *Predicting Bacteremia in Patients with Community-Acquired Pneumonia*, 169 AM. J. RESPIRATORY & CRITICAL CARE MED. 342, 342 (2004) (“[P]erformance of blood cultures on Medicare patients hospitalized with pneumonia has been associated with a lower mortality rate.”).

⁶⁷ U.S. Dep’t of Health & Human Servs., *Call to the Nation*, 15 PREVENTION REP. 1, 1 (2001).

⁶⁸ See Ralph B. Everett, *Preface to RONALD DAVID, JOINT CTR. FOR POLITICAL & ECON. STUDIES HEALTH POLICY INST., INEQUALITY MATTERS: INFANT MORTALITY IN THE GLOBAL VILLAGE* v (2007) (“[M]aternal characteristics, such as marital or employment status, do not alter disparities; nor do education or income levels.”); Yearby, *Twenty-Five Years*, *supra* note 3, at 58.

⁶⁹ Yearby, *Twenty-Five Years*, *supra* note 3, at 58.

⁷⁰ Kenneth M. Weiss & Brian W. Lambert, *Does History Matter?*, 19 EVOLUTIONARY ANTHROPOLOGY 92 (2010); Nicholas Wade, *Gene Study Identifies 5 Main Human Populations, Linking Them to Geography*, N.Y. TIMES, Dec. 20, 2002, at A1.

⁷¹ See, e.g., ROBERTS, *supra* note 3, at 112–13; Jonathan Kahn, *A Call To Reform the Presentation of Forensic DNA Evidence in Criminal Trials*, 74 BROOK. L. REV. 325 (2009); Jonathan Kahn, *Race-ing Patents/Patenting Race: An Emerging Political Geography of Intellectual Property in Biotechnology*, 92 IOWA L. REV. 353 (2007); see also Mary Bassett & Nancy Krieger, *The Health of Black Folk: Disease, Class, and Ideology in Science*, MONTHLY REV., July–August 1986, at 74, 75–79; Troy Duster, *Race and Reification in Science*, 307 SCIENCE 1050 (2005); Jonathan Kahn, *Misreading Race and Genomics After BiDil*, 37 NATURE GENETICS 655, 655 (2005); Jonathan Kahn, *How a Drug Becomes “Ethnic”: Law, Commerce, and the Production of Racial Categories in Medicine*, 4 YALE J. HEALTH POL’Y, L. & ETHICS 1 (2004).

⁷² ROBERTS, *supra* note 3, at 116.

⁷³ Bassett & Krieger, *supra* note 71, at 76.

life-destinies of individuals within the class structure of the U.S. society.”⁷⁴

More specifically, society has defined racial groups based on physical traits, such as skin color, which determine the distribution of resources, such as health care.⁷⁵ As David Williams and Pamela Jackson noted, “[r]ace is a marker for differential exposure to multiple disease-producing social factors. Thus, racial disparities in health should be understood not only in terms of individual characteristics but also in light of patterned racial inequalities in exposure to societal risks and resources.”⁷⁶ Unfortunately, the significance of societal factors, such as racial bias in causing racial disparities in health care, is often ignored. Credible and robust research studies have suggested, however, that racial bias, which leads to unequal treatment, may be the chief factor in the continuation of racial disparities in health care.⁷⁷ Specifically, social psychologists, medical researchers, and legal scholars have suggested that interpersonal, institutional, and structural racial biases are the chief causes of racial disparities.⁷⁸ This Article next briefly discusses each type of racial bias

⁷⁴ *Id.*

⁷⁵ ROBERTS, *supra* note 3, at 116–22, 156; Ian F. Haney Lopez, *The Social Construction of Race: Some Observations on Illusion, Fabrication, and Choice*, 29 HARV. C.R.-C.L. L. REV. 1, 6–7, 11–17 (1994).

⁷⁶ David R. Williams & Pamela Braboy Jackson, *Social Sources of Racial Disparities in Health*, 24 HEALTH AFF. 325, 325 (2005).

⁷⁷ Yearby, *Twenty-Five Years*, *supra* note 3, at 59–60 & nn.10–15 (discussing and collecting studies on racial discrimination in the health care system).

⁷⁸ See Calman, *supra* note 7, at 173–74 (discussing a personal memory of a black patient being treated differently from white patients and recognizing importance of overcoming bias in healthcare); James Collins, Jr. et al., *Very Low Birthweight in African American Infants: The Role of Maternal Exposure to Interpersonal Racial Discrimination*, 94 AM. J. PUB. HEALTH 2132, 2135–37 (2004) (discussing study results and finding that interpersonal racial discrimination experiences has an effect on pregnancy outcomes of African American women); H. Jack Geiger, *Health Disparities: What Do We Know? What Do We Need to Know? What Should We Do?*, in GENDER, RACE, CLASS, AND HEALTH, *supra* note 6, at 261, 261–88 (“Numerous studies and a long stream of recent books offer evidence that the United States has been in a decades-long period of rebounding individual and institutional racism.”); Mullings & Schulz, *supra* note 9, at 3, 12 (“Studies in medicine, epidemiology, and public health, interrogating the role of racism in producing health risks, seek to identify the pathways through which racism has an impact on health status. These include structural racism that operates at the societal level, privileging some groups and denying others access to the resources of society; institutional racism, which operates through organizational structures; and interpersonal racism, expressed in individual interactions.”); Janice Sabin et al., *Physicians’ Implicit and Explicit Attitudes About Race by MD Race, Ethnicity, and Gender*, 20 J. HEALTH CARE POOR & UNDERSERVED 896, 907 (2009) (“Experiences of discrimination in health care lead to delay in seeking care, an interruption in continuity of care, non-adherence, mistrust, reduced health status, and avoidance of the health care system.”); Schulman et al., *supra* note 7, at 623 (“We found that the race and sex of the patient affected the physicians’ decisions about whether to refer patients with chest pain for cardiac catheterization, even after we adjusted for symptoms, the physicians’ estimates of the probability of coronary disease, and clinical characteristics.”); Michelle van Ryn & Jane Burke, *The Effect of Patient Race and Socio-Economic Status on Physicians’ Perception of Patients*, 50 SOC. SCI. & MED. 813, 813–14 (2000) (discussing how “[p]hysicians’ perceptions of patients may vary by patient race, socio-

and why it causes racial disparities in access to health and health status.⁷⁹

A. *Interpersonal Bias*

Interpersonal bias is the conscious (explicit) and/or unconscious (implicit) use of prejudice in interactions between individuals.⁸⁰ Prejudice is a negative *pre-judgment* against a person or group.⁸¹ An action based on racial prejudice is *racial bias*, while *racism* is racial bias plus power.⁸² Interpersonal racial bias can be defined as a conscious (explicit) prejudicial action or comment by a racist individual, which harms another person. Charles Lawrence notes, however, that such a definition fails to recognize the harm caused by an individual who, although unconscious of his or her prejudice, acts as a racist.⁸³

The full harm caused by interpersonal racial bias is best captured by social psychology research, which acknowledges both conscious (explicit) and unconscious (implicit) racial prejudice. According to psychiatrist Joel Kovel, there are two types of people who exhibit interpersonal racial bias: dominative and aversive racists.⁸⁴ A “dominative racist” is a person who is conscious of his or her prejudice that members of one racial group (such as Caucasians) are superior and acts based on these beliefs, while an “aversive racist” believes that everyone is equal but harbors contradicting, often unconscious, prejudice that minorities (such as African-Americans) are inferior.⁸⁵

Over four decades of social psychology research suggests aversive racism has become the dominant form of interpersonal racial bias between African-Americans and Caucasians in the United States.⁸⁶ More recently,

economic status, or other demographic characteristics” and that “these differences in perceptions may explain some of the variance in physician behavior toward and treatment of patients”).

⁷⁹ This discussion concerning the three types of racial bias is adapted from Ruqaiyah Yearby, *Racial Disparities in Health Care and Health*, in *DEBATES ON U.S. HEALTH CARE* (Jennie Jacobs Kronenfeld et al. eds., 2012).

⁸⁰ See Andrew Grant-Thomas & John A. Powell, *Toward a Structural Racism Framework*, *POVERTY & RACE*, Nov./Dec. 2006, at 3, 3–6 (defining “structural racism” as looking at the social and inter-institutional dynamics when analyzing and understanding racism).

⁸¹ Jay Newman, *Prejudice as Prejudgment*, 90 *ETHICS* 47, 47–49 (1979).

⁸² Beverley Daniels Tatum, *Defining Racism: “Can We Talk?”*, in *RACE, CLASS, AND GENDER IN THE UNITED STATES* 124, 127 (Paula S. Rothenberg ed., 2004).

⁸³ See Charles R. Lawrence III, *The Id, the Ego, and Equal Protection: Reckoning with Unconscious Racism*, 39 *STAN. L. REV.* 317, 323 (1987) (arguing that “requiring proof of conscious or intentional motivation as a prerequisite to constitutional recognition that a decision is race-dependent ignores much of what we understand about how the human mind works”).

⁸⁴ JOE KOVEL, *WHITE RACISM: A PSYCHOHISTORY* 31–32 (1970).

⁸⁵ See *id.* at 32 (“[T]he dominative type has been marked by heat and the aversive type by coldness. . . . The dominative racist, when threatened . . . , resorts to direct violence; the aversive racist, in the same situation, turns away and walls himself off.”).

⁸⁶ See Samuel L. Gaertner & John F. Dovidio, *Understanding and Addressing Contemporary Racism: From Aversive Racism to the Common Ingroup Identity Model*, 61 *J. SOC. ISSUES* 615, 618,

medical research studies have begun to study aversive racism in health care by measuring physicians' unconscious prejudicial beliefs about African-Americans and the effect of these beliefs on physicians' treatment decisions.⁸⁷ These studies show that instead of relying on individual factors and scientific facts, physicians rely on their conscious and unconscious prejudicial beliefs. This reliance results in the unequal treatment of African-Americans, leads to racial disparities in medical treatment, and causes inequalities in mortality rates between African-Americans and Caucasians.⁸⁸

Empirical evidence of physician's prejudicial beliefs was first published in 1999 in the Schulman study. The study investigated primary care physicians' perceptions of patients and found that a patient's race and sex affected the physician's decision to recommend medically appropriate cardiac catheterization.⁸⁹ Specifically, African-Americans were less likely to be referred for cardiac catheterizations than Caucasians, while African-American women were significantly less likely to be referred for treatment compared to Caucasian males.⁹⁰ One year later, Dr. Calman, a Caucasian physician serving African-American patients in New York, wrote about his battle to overcome his own and his colleagues' racial prejudices, which often prevented African-Americans from accessing quality health care.⁹¹

In 2000, van Ryn and Burke conducted a survey of physicians' perceptions of patients.⁹² The survey results showed that physicians rated African-American patients as less intelligent, less educated, and more likely to fail to comply with physicians' medical advice.⁹³ Physicians' perceptions of African-Americans were negative even when there was

621, 623 (2005) (discussing the nature, prevalence and consequences of aversive racism in the United States).

⁸⁷ See Sabin et al., *supra* note 78, at 897–98, 906–07 (comparing implicit and explicit racial preferences among doctors); van Ryn & Burke, *supra* note 78, at 813–14 (examining the degree to which race and socioeconomic status affect physicians' perceptions of patients).

⁸⁸ See Sabin et al., *supra* note 78, at 907 (discussing the quality of care effects of discrimination in healthcare); Yearby, *Twenty-Five Years*, *supra* note 3, at 59 (discussing studies of physicians' implicit and explicit attitudes about race and their effect on patients' access to quality healthcare).

⁸⁹ Schulman et al., *supra* note 7, at 622–24, 624 tbl.4 (showing the treatment referral rates according to race and gender of study participants); see also Yearby, *Twenty-Five Years*, *supra* note 3, at 59.

⁹⁰ Schulman et al., *supra* note 7, at 623–24, 624 tbl.4; see also Yearby, *Twenty-Five Years*, *supra* note 3, at 59.

⁹¹ Calman, *supra* note 7, at 172–74; see also Yearby, *Twenty-Five Years*, *supra* note 3, at 59.

⁹² van Ryn & Burke, *supra* note 78, at 814 ("This paper utilizes survey data provided by physicians on 618 post-angiogram physician-patient encounters to examine the way physician beliefs about patient personal and psychosocial characteristics, behavior and likely role demands are affected by patient race and socio-economic status.") (footnote omitted).

⁹³ *Id.* at 821.

individual evidence that contradicted the physician's prejudicial beliefs.⁹⁴ In 2006, van Ryn repeated this study using candidates for coronary bypass surgery.⁹⁵ Again, the physicians that were surveyed exhibited prejudicial beliefs about African-Americans' intelligence and ability to comply with medical advice.⁹⁶ The physicians acted upon these prejudicial beliefs by recommending medically necessary coronary bypass surgery for male African-Americans less often than compared to male Caucasians.⁹⁷

In 2002 and 2006, research showed that African-American patients, when compared to Caucasian patients, were less likely to receive encouragement to participate in medical decision-making and less likely to receive sufficient information from their physicians about their medical condition.⁹⁸ Most recently, a 2008 study found that physicians subconsciously favor Caucasian patients over African-American patients.⁹⁹ In this study, physicians' racial attitudes and stereotypes were assessed and then physicians were presented with descriptions of hypothetical cardiology patients differing in race.¹⁰⁰ Although physicians reported not being explicitly racially biased, they held implicit negative attitudes about African-Americans,¹⁰¹ and thus were aversive racists. The study further showed that Caucasian male physicians tend to exhibit higher levels of aversive racism compared to Caucasian female, African-American female and African-American male physicians.¹⁰² This is significant because seventy-five percent of African-Americans medical interactions are with physicians who are not African-American.¹⁰³ Studies further found that medical interactions between racially different patients and physicians are "characterized by less patient trust, less positive affect, fewer attempts at

⁹⁴ See *id.* at 822–23 (suggesting that physicians apply general race differences to their impressions of patients and fail to incorporate "disconfirming individual information").

⁹⁵ Michelle van Ryn et al., *Physicians' Perceptions of Patients' Social and Behavioral Characteristics and Race Disparities in Treatment Recommendations for Men with Coronary Artery Disease*, 96 AM. J. PUB. HEALTH 351, 351–52 (2006).

⁹⁶ See *id.* at 354 (finding that physicians rated black patients more negatively than their white counterparts in terms of education level, intelligence, and likelihood of failure to comply with medical advice).

⁹⁷ *Id.* at 351, 353, 355.

⁹⁸ John F. Dovidio et al., *Disparities and Distrust: The Implications of Psychological Processes for Understanding Racial Disparities in Health and Health Care*, 67 SOC. SCI. & MED. 478, 481–82 (2008).

⁹⁹ Alexander R. Green et al., *Implicit Bias Among Physicians and Its Prediction of Thrombolysis Decisions for Black and White Patients*, 22 J. GEN. INTERNAL MED. 1231, 1235–36 (2007).

¹⁰⁰ *Id.* at 1232.

¹⁰¹ *Id.* at 1235–36.

¹⁰² *Id.* at 1234 tbl.1.

¹⁰³ Louis A. Penner et al., *Aversive Racism and Medical Interactions with Black Patients: A Field Study*, J. EXPERIMENTAL SOC. PSYCHOL., March 2010, at 436, 436.

relationship building, and less joint decision-making."¹⁰⁴ Finally, the stronger the implicit bias, the less likely the physician was to recommend the appropriate medical treatment for African-American patients.¹⁰⁵

For example, even though African-Americans, in general, have a higher rate of stroke and cerebrovascular death than Caucasians, African-American patients have a lower rate for carotid endarterectomy, a procedure that would greatly reduce fatalities from these conditions.¹⁰⁶ Furthermore, in a study conducted in 1999, researchers evaluated the medical records of patients who underwent a coronary angiography during hospitalization to ascertain "whether there were differences by race and gender in the underutilization of [coronary artery bypass] surgery among patients for whom [this procedure] is the appropriate intervention."¹⁰⁷ There were significant racial differences:¹⁰⁸ after controlling for disease status, income level, and educational attainment, African-American patients were only sixty-four percent as likely as Caucasians to receive surgery.¹⁰⁹ This study, and a majority of these studies discussed in Section II.B, controlled for socioeconomic status, disease status, and education level, suggesting that race, specifically racial bias in the form of implicit (unconscious) racial bias, is the central cause of disparities in medical treatment.¹¹⁰ In addition to the harm caused by unequal treatment due to implicit racial bias, research shows that African-Americans perceive this implicit bias and respond negatively.¹¹¹

Data show that African-Americans reacted most negatively to physicians who were aversive racists (those individuals who exhibited low explicit, or conscious, prejudice, but high implicit, or unconscious, prejudice), compared to physicians who were not racist (those that possessed low explicit and implicit bias) or were 'dominative racists'

¹⁰⁴ *Id.* at 436 (citations omitted); see also John F. Dovidio et al., *Disparities and Distrust: The Implications of Psychological Processes for Understanding Racial Disparities in Health and Health Care*, 67 SOC. SCI. & MED. 478, 480–82 (2008).

¹⁰⁵ Green et al., *supra* note 99, at 1235.

¹⁰⁶ Elizabeth A. Mort et al., *Physician Discretion and Racial Variation in the Use of Surgical Procedures*, 154 ARCHIVES INTERNAL MED. 761, 762–63, 765 (1994); see also Allison Halliday et al., *10-Year Stroke Prevention After Successful Carotid Endarterectomy for Asymptomatic Stenosis (ACST-1): A Multicentre Randomised Trial*, 376 LANCET 1074, 1082 (2010) (finding that carotid endarterectomy reduces the ten year stroke risk in patients seventy-five and under).

¹⁰⁷ Edward L. Hannan et al., *Access to Coronary Artery Bypass Surgery by Race/Ethnicity and Gender Among Patients Who Are Appropriate for Surgery*, 37 MED. CARE 68, 69 (1999).

¹⁰⁸ *Id.* at 69, 75.

¹⁰⁹ *Id.* at 73.

¹¹⁰ See Irene V. Blair et al., *Unconscious (Implicit) Bias and Health Disparities: Where Do We Go From Here?*, 15 PERMANENTE J. 71, 72–74 (2011) (reviewing current research on the presence and consequences of implicit bias in healthcare); Michelle van Ryn & Somnath Saha, *Exploring Unconscious Bias in Disparities Research and Medical Education*, 306 J. AM. MED. ASS'N 995, 995–96 (2011) (discussing how implicit bias may contribute to unequal healthcare).

¹¹¹ Penner et al., *supra* note 103, at 438.

(those who exhibited either high explicit or conscious prejudice, or high implicit or unconscious prejudice).¹¹² Patients perceived aversive racists as deceitful compared to dominative racists, who were clear and honest about their prejudicial beliefs.¹¹³ African-Americans' perception of racial prejudice outside the health care system also results in negative health outcomes.¹¹⁴

Empirical evidence shows that perception of racial prejudice results in increased stress that negatively affects health status.¹¹⁵ In fact, perceived racial prejudice has been associated with poorer health status for African Americans.¹¹⁶ Several studies suggest that there is a higher positive correlation between perceived racial prejudice and increased cigarette and alcohol use among African-Americans as compared to Caucasians.¹¹⁷ The increased stress from perceived racial prejudice may also affect birth outcomes by increasing rates of infant mortality.¹¹⁸

During the last century, infant mortality rates in the United States decreased.¹¹⁹ Nevertheless, the ratio of disparity of infant mortality rates between African-Americans and Caucasians has continued, regardless of socioeconomic status, education level, or health insurance status.¹²⁰ Based on geographic area, the infant mortality ratio of African-Americans is 1.4

¹¹² *Id.* at 436–38.

¹¹³ *Id.* at 437.

¹¹⁴ *Id.*

¹¹⁵ See *id.* (“[P]erception of being discriminated against personally is directly related to psychological distress.”).

¹¹⁶ See Alex L. Pieterse et al., *Perceived Racism and Mental Health Among Black American Adults: A Meta-Analytic Review*, 59 J. COUNSELING PSYCHOL. 1, 6 (2012) (citing findings that suggest that exposure to racism adversely impacts African-American’s general and mental health).

¹¹⁷ See David R. Williams et al., *Racial/Ethnic Discrimination and Health: Findings from Community Studies*, 93 AM. J. PUB. HEALTH 200, 201 (2003) (citing three studies that found a positive correlation between discrimination and cigarette smoking, two studies that reported a similar correlation between discrimination and alcohol use, and two studies that showed that perceptions of discrimination made an “incremental contribution” to differences in health between blacks and whites).

¹¹⁸ See James W. Collins, Jr. et al., *Very Low Birthweight in African American Infants: The Role of Maternal Exposure to Interpersonal Racial Discrimination*, 94 AM. J. PUB. HEALTH 2132, 2132, 2135 (2004) (stating that African American mothers who delivered preterm infants of “very low birth weight” (VLBW), which “accounts for more than half of the neonatal deaths and 63% of the Black–White gap in infant mortality in the United States,” were more likely to report interpersonal racial discrimination during their lifetime than were African-American mothers who delivered infants at term).

¹¹⁹ Bernard Guyer et al., *Annual Summary of Vital Statistics: Trends in the Health of Americans During the 20th Century*, 106 PEDIATRICS 1307, 1312 (2000) (“The infant mortality rate ([IMR], deaths in the first year of life per 1000 live births) has shown an exponential decline during the 20th century.”).

¹²⁰ See Ralph B. Everett, *Preface* to RONALD DAVID, *INEQUALITY MATTERS: INFANT MORTALITY IN THE GLOBAL VILLAGE* v (Joint Ctr. for Political & Econ. Studies Health Policy Inst. ed., 2007) (“African Americans have higher infant mortality rates in every age category . . . regardless of their socioeconomic status, native-born African American women fare worse in birth outcomes compared to white women at every income and education level.”).

to 4.8 times the rate of Caucasians.¹²¹ Nationally, between 2000 and 2003, the African-American to Caucasian infant mortality ratio underwent only a slight increase from 2.3 to 2.4, while the absolute gap declined from 8.0 to 6.5 deaths per 1000.¹²² The main causes of death for African-American infants are preterm birth and low birth weight, which, according to Richard David and James Collins Jr., is caused in part by racial bias.¹²³

David and Collins' study compared the birth weights of three groups of women: African Americans, Caucasians, and Africans who had moved to Illinois.¹²⁴ The birth weights of Caucasian and African infants were almost identical, whereas the birth weights of African-American infants were substantially lower.¹²⁵ Researchers suggested that one reason African-American mothers have babies who weigh less at birth is that they are subject to stress caused by perceived interpersonal racial bias.¹²⁶

Between African-American women who had babies with normal weights at birth ("NLBW") and African-American women whose babies' birth weight was very low ("VLBW")—under three pounds—interpersonal racial bias played a significant role.¹²⁷ Specifically, "African American mothers who delivered VLBW preterm infants were more likely to report experiencing interpersonal racial discrimination during their lifetime than were African American mothers who delivered NLBW infants at term."¹²⁸ Hence, the perception of racial prejudice can negatively affect African-American health status at birth and throughout adulthood.¹²⁹

B. Institutional Bias

Institutional bias operates through organizational structures and establishes "separate and independent" barriers through the neutral denial of access to quality health care that results from the normal operations of

¹²¹ Vera Haynatzka et al., *Racial and Ethnic Disparities in Infant Mortality Rates—60 Largest U.S. Cities, 1995–1998*, 51 MORBIDITY & MORTALITY WKLY. REP. 329, 330 (2002).

¹²² Ashley H. Schempf et al., *The Contribution of Preterm Birth to the Black-White Infant Mortality Gap, 1990 and 2000*, 97 AM. J. PUB. HEALTH 1255, 1257 (2007); *What's Killing You?*, CENTRAL FLORIDA PARTNERSHIP ON HEALTH DISPARITIES, <http://www.cfphd.org/africanamericans.html> (last visited Feb. 7, 2012).

¹²³ Collins, Jr. et al., *supra* note 118, at 2132, 2137.

¹²⁴ Richard J. David & James W. Collins, Jr., *Differing Birth Weight Among Infants of U.S.-Born Blacks, Africa-Born Blacks, and U.S.-Born Whites*, 337 NEW ENG. J. MED. 1209, 1210 (1997).

¹²⁵ See *id.* at 1211–12 (stating that the risks for lower birth weight were significantly higher among infants of U.S.-born blacks than among infants of African-born blacks).

¹²⁶ Sarah Mustillo, *Self-Reported Experiences of Racial Discrimination and Black-White Differences in Preterm and Low-Birthweight Deliveries: The CARDIA Study*, 94 AM. J. PUB. HEALTH 2125, 2129 (2004).

¹²⁷ Yearby, *Twenty-Five Years*, *supra* note 3, at 60.

¹²⁸ *Id.* (quoting Collins, Jr. et al., *supra* note 118, at 2135).

¹²⁹ *Id.* at 2 ("As a result of both studies, researchers suggested that one reason African American mothers have babies who weigh less at birth is that they are subject to stress caused by perceived racial discrimination.").

the institutions in a society.¹³⁰ Not all institutional actions that disproportionately affect minorities are racially biased. In order to constitute institutional racial bias, an action must reinforce the racial hierarchy of the inferiority of minorities and impose substantial harm on minorities.¹³¹ Once this occurs, the institution's actions constitute institutional racial bias, even if the actions are seemingly race-neutral.¹³²

The most poignant example of institutional racial bias in health care is the closure of hospitals in predominately African-American communities.¹³³ These decisions may seem race neutral. According to Brietta Clark, however, hospital closures reinforce the racial hierarchy in health care that holds that African-Americans' health does not matter compared to the health of Caucasians.¹³⁴ Clark also argued that hospital closures have resulted in significant harm, including increased mortality rates of minorities.¹³⁵ In order to control costs, state and federal regulators have allowed hospitals to make this decision without balancing the needs of African-American communities.¹³⁶ Unfortunately, not only have closures failed to control costs, but they have also caused racial disparities in access to health care and health status.

In the late 1970s, the American Hospital Association published a study surveying hospital administrators to determine the primary reasons for hospital closures or relocations.¹³⁷ According to the survey,

[o]f the 231 hospitals, the reasons for closure or relocation were broken down as follows: 27% [of hospitals] reported financial reasons for closure, 23% were replaced by a new facility; 14% closed due to low occupancy rate; 13% closed because they were outdated facilities; and 10% closed due to inadequate supply of physicians.¹³⁸

¹³⁰ Mullings & Schulz, *supra* note 9, at 12.

¹³¹ Bowser, *supra* note 10, at 102.

¹³² *See id.* ("Such [racially biased] institutional practices impose substantial injuries on minorities, even if they do so in a quiet, unconsidered manner.").

¹³³ *See* Clark, *supra* note 13, at 1029 (describing the local governments' closure of public hospitals in minority communities as an attempt to conserve resources, and highlighting the trend of private hospitals leaving minority communities and relocating to more affluent, predominately white communities).

¹³⁴ *See id.* at 1029.

¹³⁵ *See id.* at 1031 (stating that the increased travel time and distance to medical health care facilities is often a matter of "the difference between life and death" in minority communities, especially given the extraordinarily high rates of violence crimes in such areas).

¹³⁶ *See id.* at 1040 (stating that local governments often relocate hospitals on a fiscal basis, thus leading to a greater loss of hospital services among minority communities that generally have a higher need for medical services).

¹³⁷ *Id.* at 1039.

¹³⁸ *Id.*

Due to the repeated assertions made by hospital administrators and this survey, administrators' fiscal justifications created the perception that hospital closures were beneficial for society and race-neutral; thus state and federal regulators routinely approved closures and relocations.¹³⁹ However, that is simply not the case: hospital closures increase costs, decrease access to health care, and are significantly linked to race.¹⁴⁰

The perception that hospital closures reduce excess hospital bed capacity, improve quality care and help save scarce public resources is false. Research shows that the anticipated benefits from hospital closures never materialize because as hospitals decrease the number of beds available in African-American communities, they simultaneously increase the number of hospital beds in predominately Caucasian neighborhoods.¹⁴¹ Thus, the number of beds stays the same. Additionally, this reduction of beds in minority communities, which generally have the greatest need for care, further compromises African-Americans' health by decreasing their access to health care, and thereby increasing health care costs.¹⁴²

As these hospitals leave predominately African-American neighborhoods, the remaining hospitals are left to fill the void.¹⁴³ This often strains the remaining hospitals' resources and ability to provide quality care.¹⁴⁴ Consequently, the hospitals that remain to provide care to African-Americans gradually deteriorate and provide substandard care.¹⁴⁵ Not only is access to health care diminished because of a reduction of hospital services, but also because of physician departures.¹⁴⁶

Once a hospital has closed or relocated, the physicians practicing in the area often follow the hospital to more affluent neighborhoods, thereby further disrupting the primary care services in predominately African-American neighborhoods.¹⁴⁷ Evidence shows that primary care physicians often leave after the closure of a neighborhood hospital because the

¹³⁹ See *id.* at 1040 (stating that the perceived benefits of hospital closures are based on the assumption that "such closures actually reduce excess bed capacity, improve quality of care, and help save scarce public resources that will benefit society at large"); see also Yearby, *Striving for Equality*, *supra* note 7, at 476 ("No longer do nursing homes advertise or admit that their facilities are 'white only.' Instead, a plethora of research studies show that some nursing homes simply deny admission and quality care to African Americans based on race, using 'neutral policies' . . .").

¹⁴⁰ *Id.*

¹⁴¹ See *id.* at 1033–34 (describing how physicians followed white patients who moved to the suburbs during the 1970s and 1980s).

¹⁴² See *id.* at 1035 ("Hospital closures set into motion a chain of events that threaten minority communities' immediate and long term access to primary care, emergency and nonemergency hospital care.").

¹⁴³ *Id.* at 1034.

¹⁴⁴ *Id.*

¹⁴⁵ *Id.* at 1034–35.

¹⁴⁶ See *id.* at 1035 (highlighting the importance of understanding "physician flight" as an important consequence of disruptions in primary care services, and particularly hospital closures).

¹⁴⁷ *Id.*

hospital provides a critical base for the their practice.¹⁴⁸ This disruption in care is significant because many predominately African-American neighborhoods already suffer from physician shortages prior to hospital closures and physician flight.¹⁴⁹ Moreover, as the number of primary care physicians decreases, African-Americans are forced to seek care in emergency rooms and public hospitals, which are often understaffed and not adequately maintained.¹⁵⁰ Lack of access to health services is not the only harm from hospital closures; patients and minority communities experience humiliation, frustration, and a sense of helplessness.¹⁵¹

The effect of these closures and physician departures on the surrounding community is best illustrated by California's health care crisis in the 1990s. Since 1990, more than seventy hospital emergency rooms and trauma centers have closed in California alone.¹⁵² As a result, patients have been unable to obtain timely and medically necessary health care. For instance, an emergency room physician in California noted that a woman who had a miscarriage was forced to wait in a hospital waiting room for hours with her fetus in a Tupperware dish before she could be seen, while a boy with serious head trauma went without medically necessary services.¹⁵³ These two patients, and many more, were not able to access medically necessary health care because of a shortage of physicians and overburdened emergency rooms, as a result of private hospital closures.¹⁵⁴

Most predominately Caucasian neighborhoods are full of health care services, while many African-American neighborhoods are left without health care services and often suffer unnecessary disability and deaths as a result of the absence of these services.¹⁵⁵ Moreover, the closures often exacerbate physician shortages and further overburden emergency rooms, leaving African-Americans humiliated, frustrated and feeling helpless. Thus, these hospital closures appear to re-enforce a racial hierarchy that African-Americans' lives are less valued than Caucasians' lives.

Additionally, hospital placement, closures, and removal of services has

¹⁴⁸ *Id.* at 1034.

¹⁴⁹ See Gwendolyn Roberts Majette, *Access to Health Care: What a Difference Shades of Color Make*, 12 ANNALS HEALTH L. 121, 130 (2003).

¹⁵⁰ See Clark, *supra* note 13, at 1034–35 (describing the “ghettoization” of hospitals that remain in areas serving minority communities).

¹⁵¹ *Id.* at 1039.

¹⁵² *Id.* at 1038.

¹⁵³ *Id.*

¹⁵⁴ *Id.* at 1039.

¹⁵⁵ See *id.* at 1037 (“[N]ewer facilities in affluent areas will be given priority in the allocation of scarce resources. This sends a clear message to minority communities that they are less valuable and less deserving of certain resources than the white communities.”).

been linked to race since 1937.¹⁵⁶ In 2006, Alan Sager reported that as the African-American population in a neighborhood increased, the closure and relocation of hospital services increased for every period between 1980 to 2003, except between 1990 and 1997.¹⁵⁷ In the Jim Crow era, these hospital closures were overtly linked to race. Since the passage of Title VI, hospitals have justified closures and relocations based on financial concerns; however, hospital closures and relocations are still significantly correlated with race.¹⁵⁸

Those closing a hospital often fail to consider the importance of equal distribution of health care entities among all communities, and instead leave predominately African-Americans neighborhoods deprived of health care services by relocating services to over-served, predominately Caucasian areas.¹⁵⁹ This institutional decision to close a hospital may seem race neutral; however, research shows that irrespective of financial concerns, hospital closures still remain linked to race and re-enforce a racial hierarchy in health.¹⁶⁰

C. Structural Bias

Structural racial bias operates at the societal level, denying some groups access to the resources of society, while privileging other groups.¹⁶¹ While seemingly similar, there is a significant difference between institutional and interpersonal bias on the one hand, and structural bias on the other. Both interpersonal and institutional biases focus on the direct racial effects of individual or institutional actions, whereas structural bias measures how non-race based factors, such as economic inequalities, indirectly affect racial minorities.¹⁶² Structural racial bias is a result of power relationships between racial groups, where one dominant group holds power over the other group and uses that power to secure material

¹⁵⁶ ALAN SAGER & DEBORAH SOCOLAR, HEALTH REFORM PROGRAM, CLOSING HOSPITALS IN NEW YORK STATE WON'T SAVE MONEY BUT WILL HARM ACCESS TO CARE 29–31 (2006), available at [http://dcc2.bumc.bu.edu/hs/Sager Hospital Closings Short Report 20Nov06.pdf](http://dcc2.bumc.bu.edu/hs/Sager%20Hospital%20Closings%20Short%20Report%20Nov06.pdf).

¹⁵⁷ *Id.* at 42.

¹⁵⁸ Clark, *supra* note 13, at 1072–74.

¹⁵⁹ *Id.* at 1032.

¹⁶⁰ See *id.* at 1029 (describing studies that showed a correlation between race and hospital closures). In fact, many courts have accepted these “race-neutral” economic arguments allowing closures despite the introduction of evidence in Title VI challenges that showed that before the closure of an inner city hospital, the surrounding hospitals could not treat the patients left by the hospital’s planned closure. See Majette, *supra* note 149, at 130.

¹⁶¹ Mullings & Schulz, *supra* note 9, at 12.

¹⁶² See Grant-Thomas & Powell, *supra* note 80, at 4 (“Whereas both the individual and institutional racism frameworks emphasize dynamics triggered immediately by race, racism and racial inequality often originate in treatment inspired by non-race factors (e.g., class status, religious belief, language) that interact with race in patterned ways. This kind of secondary racism, a function of inter-institutional relations, forms the leading edge of structural racism.”).

and social resources—such as health care.¹⁶³ The dominant group remains in power because its position in society enables it to retain power despite the will or aims of the groups it has power over.

Specifically, structural bias allows those with privilege, such as wealthy Caucasians, to obtain the best quality health care available. The privileged obtain access because they are able to afford health insurance or pay for health care not covered by insurance. Those without privilege, such as minorities, who are disproportionately poor, have limited access to health care because they do not have health insurance and cannot afford to pay for it.¹⁶⁴ Adding insult to injury, the wealthy, who predominantly have health insurance, receive discounts on the cost of health care, negotiated by their insurers, while indigent minorities, who do not generally have health insurance, are charged more for the health care services they receive and are increasingly required to pay upfront for the care they receive.¹⁶⁵ Unable to afford the full cost of or pay upfront for health care, minorities often forego treatment until it is too late, resulting in racial disparities in mortality.¹⁶⁶

For example, a 2012 *New York Times* article noted that affluent patients who pay in cash can stay in elite hospital wings that offer marble baths, butler service, and bed linens by “Frette, Italian purveyors of high-thread-count sheets [sold] to popes and princes.”¹⁶⁷ Yet, the Article noted that one patient who could not afford the elite rooms was left in pain, on a gurney, without a bed pan.¹⁶⁸ The effect of this structural bias is also evidenced by empirical data of the health status and mortality rates of uninsured minorities.¹⁶⁹ Compared to the privately insured, the uninsured tend to be in worse health.¹⁷⁰ In fact, “[e]leven percent of the uninsured are in fair or poor health, compared to [five percent] of those [covered by private health insurance].”¹⁷¹ Moreover, nineteen years of data show that

¹⁶³ See *id.* at 5–6 (linking social opportunity to inter-institutional dynamics).

¹⁶⁴ See Ruqaiyah Yearby, *Racial Inequities in Mortality and Access to Health Care: The Untold Peril of Rationing Health Care in the United States*, 32 J. LEGAL MED. 77, 83 (2011) (describing racial inequalities in access to health care).

¹⁶⁵ *Id.*

¹⁶⁶ See *id.* at 84–86 (describing studies which show a higher mortality rate among minorities).

¹⁶⁷ Nina Bernstein, *Chefs, Butlers, Marble Baths: Hospitals Vie for the Affluent*, N.Y. TIMES, Jan. 22, 2012, at A1.

¹⁶⁸ See *id.*

¹⁶⁹ See STAN DORN, URBAN INSTITUTE, UNINSURED AND DYING BECAUSE OF IT 2 (2008) (“In 2002, the Institute of Medicine (IOM) estimated that 18,000 Americans died in 2000 because they were uninsured. Since then, the number of uninsured has grown. Based on IOM’s methodology and subsequent Census Bureau estimates of insurance coverage, 137,000 people died from 2000 through 2006 because they lacked health insurance . . .”).

¹⁷⁰ CATHERINE HOFFMAN ET AL., KAISER COMM’N ON MEDICAID & THE UNINSURED: A PRIMER 6 (2007).

¹⁷¹ *Id.*; see also DORN, *supra* note 169, at 2 (explaining a study that revealed the high mortality rate among the uninsured); INST. OF MED., CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE 1

African-Americans have a higher death-rate from coronary disease, breast cancer, and diabetes than Caucasians.¹⁷²

Between 2005 and 2006, "[t]he largest difference in doctor visits between insured and uninsured populations was seen among African-Americans and individuals of two or more races."¹⁷³ This racial difference in physician visits is not new; in 1986, for example, a national survey of the use of health care services found that "[e]ven after taking into account persons' income, health status, age, sex, and whether they had one or more chronic or serious illnesses, blacks have a statistically significantly lower mean number of annual ambulatory [walk-in] visits and are less likely to have seen a physician in a year."¹⁷⁴ Due to their inability to pay for a doctor or health care in general, many African Americans often forgo care, leading to unnecessary deaths.¹⁷⁵ These are just a few examples of the well-documented racial disparities in access to health care due to structural racial bias, which have resulted in serious harm.

The continuation of racial disparities is a complex issue, which cannot be solved by solely addressing institutional, interpersonal, or structural bias. In order to put an end to decades of racial disparities, policy makers must develop a variety of programs to address all three forms of bias in health care. Arguably, the ACA is the first step towards eradicating racial disparities; it provides health insurance to a large majority of the uninsured, who are largely minorities, and provides funding for disparity research. However, there is still much work to be done.

IV. HEALTH CARE REFORM: INSURANCE FOR EVERYONE

In the United States, some 49.1 million people do not have health insurance.¹⁷⁶ Naturally, there are severe health consequences for adults without health insurance.¹⁷⁷ In fact, studies show that "uninsured women with breast cancer . . . have their disease diagnosed later during its

(2002) (stating that "working-age Americans without health insurance are more likely to . . . [b]e sicker and die sooner").

¹⁷² Robin M. Weinick et al., *Racial and Ethnic Differences in Access to and Use of Health Care Services, 1977 to 1996*, 57 MED. CARE RES. & REV. 36, 37 (2000).

¹⁷³ MEGAN THOMAS & CARA JAMES, KAISER FAM. FOUND., *THE ROLE OF HEALTH COVERAGE FOR COMMUNITIES OF COLOR 6* (2009), available at <http://www.kff.org/healthreform/upload/8017.pdf>.

¹⁷⁴ Robert Blendon et al., *Access to Medical Care for Black and White Americans*, 261 JAMA 278, 279 (1989).

¹⁷⁵ THOMAS & JAMES, *supra* note 173, at 7 ("Lacking health coverage can also translate to poorer health outcomes relative to those with insurance. . . . Blacks and Hispanics compared to Whites are more likely to report experiencing these problems. . . . [A]bout 1 in 3 Blacks and Hispanics reported not filling a prescription in the past year due to cost compared to about 1 in 4 Whites.").

¹⁷⁶ See THOMAS & JAMES, *supra* note 173, at 1.

¹⁷⁷ KAISER FAM. FOUND., *THE UNINSURED: A PRIMER* (2011), available at <http://www.kff.org/uninsured/upload/7451-07.pdf>.

development, when treatment is less effective.”¹⁷⁸ Furthermore, “[u]ninsured men with hypertension are more likely to go without screenings and prescribed medication and to skip recommended doctor visits, increasing the likelihood of serious harm.”¹⁷⁹ Thus, there was, and clearly remains, a need for the ACA, which increases access to health insurance through an individual mandate, state health insurance exchanges, expansion of Medicaid, and employer requirements for certain levels of employee health insurance coverage.¹⁸⁰

Although the ACA addresses some issues related to structural bias by improving minorities’ access to insurance, it does not address institutional and interpersonal bias, and this oversight may actually exacerbate the pre-existing racial disparities in health care. Section IV.A briefly discusses the need for the ACA. Next, Section IV.B summarizes sections of the Act that increase access to insurance, address racial disparities, and prohibits discrimination. Finally, Section IV.C discusses the strengths, while Section IV.D discusses the weaknesses of the Act.

A. *The Need*

Unfortunately, those most affected by a lack of insurance are racial minorities, who are disproportionately uninsured. “[O]f the 45.7 million non elderly Americans who were uninsured in 2008, more than half (55%) [were minorities].”¹⁸¹ Specifically, thirty-two percent of Latinos are uninsured, twenty-eight percent of Native Americans are uninsured, and twenty-one percent of African-Americans are uninsured, compared to thirteen percent of Caucasians.¹⁸² Additionally, public health care programs like Medicaid disproportionately serve minorities.¹⁸³ “African Americans and [Latinos] are more likely than [Caucasians] to work in low-wage jobs, and tend to have reduced access to employer-sponsored coverage relative to their higher-wage counterparts.”¹⁸⁴ Consequently, low-income minority workers are more likely than Caucasians to be uninsured or covered by Medicaid.¹⁸⁵ As a result of their lack of employer-sponsored health care insurance and poverty, these minority families are disproportionately unable to afford to pay for health care. Thus, compared to the insured, a larger share of the uninsured are unable to pay their

¹⁷⁸ DORN, *supra* note 169, at 2.

¹⁷⁹ *Id.*

¹⁸⁰ 26 U.S.C.A. §§ 125, 4980H, 6056 (West 2003 & Supp. 2011); 29 U.S.C.A. §§ 218A–218B (West 2003 & Supp. 2011); 42 U.S.C.A. §§ 1396w-3, 18091 (West 2003 & Supp. 2011).

¹⁸¹ THOMAS & JAMES, *supra* note 173, at 1.

¹⁸² *Id.* at 2 fig.1.

¹⁸³ *Id.* at 1.

¹⁸⁴ *Id.* at 5.

¹⁸⁵ *Id.* at 5 (“Individuals who have low-wage jobs are less likely to be offered coverage through their employers and less likely to take up coverage when offered.”).

medical bills.¹⁸⁶

Data from the Institute of Medicine's 2002 report ("IOM Report"), *Caring Without Coverage: Too Little, Too Late*, showed that the uninsured received a fraction of the health services and access to health care that privately insured patients regularly received, and that the uninsured tended to wait longer and became sicker before seeing a doctor.¹⁸⁷ Moreover, the data indicated that "the uninsured [were] less likely to receive recommended preventive and primary care services, face[d] significant barriers to care, and ultimately face[d] worse health outcomes."¹⁸⁸ In addition, the uninsured report problems procuring dental care, filling a prescription due to cost, and accessing physician care.¹⁸⁹ The empirical data show that a lack of insurance leads to the under-treatment of those that are unable to pay, such as the uninsured, which results in unnecessary deaths.

The uninsured are 1.8 times more likely to die from their injuries from auto accidents, and are 2.6 times more likely to die from gunshot wounds, as compared to privately insured patients.¹⁹⁰ Dietrich Jehle, the first author of the study, explains that "uninsured adult patients in general have a 25% greater mortality rate than insured adults for all medical conditions."¹⁹¹ In addition, several previous research studies reached similar conclusions. That is, "the uninsured have a higher death rate from trauma injuries due to treatment delays, different care due to receipt of fewer diagnostic tests, and decreased health literacy."¹⁹² The data remain similar regardless of insurance status.¹⁹³ However, "the highest adjusted odds of death were for *uninsured* Hispanic patients . . . followed by *uninsured* African American

¹⁸⁶ *Id.* at 7.

¹⁸⁷ See INST. OF MED., *supra* note 171, at 1, 3–5 (discussing how "[t]he quality and length of life are distinctly different for insured and uninsured populations" by looking at the care the insured and uninsured often receive for illnesses such as, cancer, diabetes, and cardiovascular disease); see also Yearby, *supra* note 164, at 82.

¹⁸⁸ THOMAS & JAMES, *supra* note 173, at 1.

¹⁸⁹ *Id.* at 7.

¹⁹⁰ Henry L. Davis, *Serious Injuries Worse for Uninsured*, BUFF. NEWS, July 26, 2010, at B1; see also Yearby, *supra* note 164, at 84.

¹⁹¹ *Uninsured More Likely to Die from Trauma than Patients with Insurance, Study Finds*, UNIV. BUFF. June 11, 2010, <http://www.buffalo.edu/news/11447>.

¹⁹² Yearby, *supra* note 164, at 84–85; Heather Rosen et al., *Downwardly Mobile: The Accidental Cost of Being Uninsured*, 144 ARCHIVES OF SURGERY 1006, 1010 (2009); see also Adil H. Haider et al., *Race and Insurance Status as Risk Factors for Trauma Mortality*, 143 ARCHIVES OF SURGERY 945, 948 (2008) ("Lack of medical insurance is most often associated with worse baseline health status, with increased and poorly recognized comorbidities. It is known that preexisting medical conditions are associated with poor outcomes after trauma, suggesting that an uninsured patient would do worse after traumatic injury.") (footnote omitted).

¹⁹³ Haider et al., *supra* note 193, at 947–48 (showing that African-American and Hispanic patients had higher mortality rates from trauma injuries than Caucasian patients regardless of insurance status, and concluding that "[r]ace persists as a risk factor for mortality in patients with and without insurance").

patients . . . when compared with insured white patients, suggesting that insurance status has a stronger association with mortality after trauma.”¹⁹⁴ Thus, the lack of access to health insurance is a significant factor in African-American’s access to health care, which may be addressed by the ACA.¹⁹⁵

B. *The ACA*

The central focus of the ACA is to regulate the health insurance industry and increase access to health insurance for the uninsured.¹⁹⁶ Specifically, Title I of the Act contains an individual mandate for insurance and individual subsidies to purchase insurance, while Title II of the Act provides an expansion of Medicaid. By providing insurance coverage to the uninsured through the individual mandate, Medicaid expansion, and subsidies, the Act has the potential to increase access to health care for minorities by providing them access to health insurance. The Act also provides protections for the uninsured. For example, Section 9007 limits a charitable hospital’s ability to charge uninsured patients more than the amount generally billed to insured patients for emergency and other medically necessary care.¹⁹⁷ Additionally, the Act not only provides measures for assessing health disparities in accessing health care and the provision of quality health care, but it also briefly mentions the nondiscrimination requirements of Title VI.

In fact, throughout the ACA, research, data collection, and quality improvement measures are funded in order to better understand and put an end to health disparities.¹⁹⁸ Even though the Act does include language about health disparities in several sections, these disparities are broadly discussed and not always linked to race.¹⁹⁹ Section 6301 creates a Patient-

¹⁹⁴ *Id.* at 947 (emphasis added); see also *id.* at 947–48 (asserting insurance status is not the only factor because race remains a risk factor for mortality in both insured and uninsured patients, confirming that racial disparities in trauma mortality is not explained by insurance status alone).

¹⁹⁵ *Id.* at 948.

¹⁹⁶ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1, 124 Stat. 119, 119 (2010).

¹⁹⁷ This protection exists for those eligible to receive financial assistance under the hospital’s financial assistance and emergency medical care policies required by the Act. 26 U.S.C.A. § 501 (West 2003 & Supp. 2011).

¹⁹⁸ *Id.* § 300kk.

¹⁹⁹ Compare 42 U.S.C.A. § 300u-6 (West 2003 & Supp. 2011) (stating that grants shall be given to “indigenous human resource providers in communities of color to assure improved health status of racial and ethnic minorities, and shall develop measures to evaluate the effectiveness of activities aimed at reducing health disparities and supporting the local community. Such measures shall evaluate community outreach activities, language services, workforce cultural competence, and other areas . . .”), with *id.* § 294a (noting that recipients of grants for the development of area health centers shall “[d]evelop and implement strategies to foster and provide community-based training and education to individuals seeking careers in health professions within underserved areas for the purpose of developing and maintaining a diverse health care workforce that is prepared to deliver high-quality

Centered Research Institute that is required to identify a research agenda, which includes addressing health disparities.²⁰⁰ Sections 10302 and 10303 of the ACA mandate that the Secretary of HHS develop a national strategy to improve the quality of health to reduce health disparities.²⁰¹ Section 10303 further provides for the creation of quality development measures that allow the assessment of health disparities.²⁰² Medicare providers will also receive additional payment bonuses for rectifying health disparities by increasing staffing in long-term care facilities.²⁰³

Data collection concerning health disparities is discussed in Subtitle D of Title IV, entitled "Support for Prevention and Public Health Innovation."²⁰⁴ This Subtitle notes that racial disparities exist in access to health care. Section 4302 of this Subtitle amends the Public Health Service Act and strengthens federal data collection by requiring the Secretary of HHS to collect data to track health disparities under Medicaid and Medicare.²⁰⁵ Additionally, this Subtitle requires the Secretary of HHS to evaluate approaches to collect data concerning health disparities "that allow for the ongoing, accurate, and timely collection and evaluation of data on disparities in health care services and performance on the basis of race, ethnicity, sex, primary language, and disability status."²⁰⁶ The Secretary of HHS is required to analyze the data to detect and monitor trends in health disparities and report it to, among others, the Office of Minority Health ("OMH"), the National Center on Minority Health and Health Disparities, the Agency for Healthcare Research and Quality ("AHCQR"), the Centers for Disease Control and Prevention ("CDC"), the Centers for Medicare & Medicaid Services ("CMS"), the Indian Health Service and epidemiology centers funded under the Indian Health Care Improvement Act, the Office of Rural health, and other agencies within HHS.

Section 3501 creates quality improvement programs that provide technical assistance grants to health care providers to address health disparities.²⁰⁷ The Act also suggests putting an end to disparities through the use of preventative care, health education programs, language services,

care, with an emphasis on primary care, in underserved areas or for health disparity populations"). While the first section explicitly mentions the intention to develop health resources for minority populations, the second merely mentions "underserved" populations without explicitly linking those populations to race.

²⁰⁰ *Id.* at § 1320e.

²⁰¹ *Id.* §§ 280j, 299b-31.

²⁰² *Id.* § 299b-31.

²⁰³ *See id.* § 1397m (explaining grant incentives for increasing staffing in long-term care).

²⁰⁴ *See id.* §§ 300u-15, 300kk (providing that the Secretary of HHS shall provide funding for research).

²⁰⁵ *Id.* § 300kk. This section also applies to state Children's Health Insurance Programs. *Id.*

²⁰⁶ *Id.* § 1396w-5.

²⁰⁷ *Id.* § 299b-33.

community outreach, and cultural competency trainings.²⁰⁸ To this end, Section 10503 of Act expanded access to primary health care by investing eleven billion dollars into the Health Research Services Administrations Community Health Center Program.²⁰⁹ Sections 4003, 4004 and 4201 provide for community-based solutions.²¹⁰ Section 4003 creates an independent Preventive Services Task Force, convened by the Director of CDC, which is required to develop community-based recommendations and interventions to address health disparities. The Secretary of HHS is also required under Section 4004 to plan and implement “a national public-private partnership for a prevention and health promotion outreach and education campaign to raise public awareness” and “describe[] the importance of utilizing preventive services to promote wellness, [and] reduce health disparities”²¹¹ To promote healthy living and reduce disparities, Section 4201 provides prevention and community transformation grants for the implementation, evaluation, and dissemination of evidence-based community preventative health activities that address health disparities.²¹²

Furthermore, the Act reorganizes OMH, making OMH a part of the Office of the Secretary, increasing the authority and stature of the office.²¹³ It further creates offices of Minority Health in the CDC, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, AHCRO, the Food and Drug Administration, and CMS. A Director, who has “documented experience and expertise in minority health services research and health disparities elimination,” heads each office.²¹⁴ Finally, the Act creates the National Institute on Minority Health and Health Disparities, an institute under the National Institutes of Health. However, the Act does not provide practical guidance on how these offices should address racial disparities, other than through health promotion programs and improving “language services, community outreach, and cultural competency training” mentioned above.²¹⁵ Thus, in respect to racial disparities, the central focus of the Act

²⁰⁸ See *id.* § 18031 (stating that language should be added to the Act giving examples of activities to implement to reduce health care disparities).

²⁰⁹ *Id.* § 254b-2.

²¹⁰ *Id.* §§ 280g-7, -8, -10, & 299b-4 (codifying PPACA § 4003); *id.* § 300u-12 (codifying PPACA § 4004); *id.* § 300u-13 (codifying PPACA § 4201).

²¹¹ *Id.* § 300u-12.

²¹² *Id.* § 300u-13.

²¹³ *Id.* § 300u-6.

²¹⁴ *Id.*

²¹⁵ *Id.* Since the passage of the Act, HHS issued an Action Plan to Reduce Racial and Ethnic Health Disparities (“Action Plan”), the first federal strategic disparities plan, and established the National Partnership for Action to End Health Disparities (“NPA”). DEP’T HEALTH & HUMAN SERVS., HHS ACTION PLAN TO REDUCE RACIAL AND ETHNIC DISPARITIES: A NATION FREE OF DISPARITIES IN HEALTH AND HEALTH CARE 17 (2011), available at <http://minorityhealth.hhs.gov/npa/files/>

is increasing insurance coverage, data collection, promoting preventative care, and funding research to determine the cause of existing health disparities in access.

In addition to implementing measures and creating new agencies to fix racial disparities, Section 1557 notes that the requirements of nondiscrimination apply to the ACA.²¹⁶ Specifically, the Act states that civil rights laws, such as Title VI, which govern health care apply to the Act and remain unchanged, keeping the status quo. There are several strengths of the Act, such as the standardization of reporting racial data. However, the Act also has several flaws, such the separation of civil rights endeavors and racial disparities research.

C. Strengths: The First Step in Eradicating Racial Disparities

Government reports and industry insiders believe that the Act not only "represents the most significant federal effort to reduce disparities in the country's history,"²¹⁷ but also "has the potential to do enormous good for the health needs of racial and ethnic minorities and more potential to reduce racial and ethnic health disparities than any other law in living memory."²¹⁸ Indeed, the Act provides several benefits.

First, it equalizes the cost of health care for the uninsured receiving health care in charitable hospitals. In the past, the insured received discounts on the cost of health care, negotiated by their insurers, while indigent minorities, who did not have health insurance, were charged more for the health care services they received and were increasingly required to pay upfront for the care they received.²¹⁹ The Act begins to address this problem by limiting a charitable hospital's ability to charge uninsured patients more than the amount generally billed to insured patients for emergency and other medically necessary care.²²⁰

Second, the Act empowers communities through funding to improve the quality of health care. This is a laudable act because it empowers communities and gives them a voice in improving the conditions within their community. Third, it increases the stature of OMH and creates new offices of minority health. Prior to the Act, OMH was merely an office in the Office of Public Health Science, now it is an office within the Office of

Plans/HHS/HHS_Plan_complete.pdf. The Action Plan and the NPA build on the Patient Protection Act. Unfortunately, similar to the Act, the Action Plan and the NPA focus mainly on individual solutions, which will never fully eradicate racial disparities because there are systemic problems with the U.S. health care system beyond access to individual actions that must be fixed.

²¹⁶ 42 U.S.C.A. § 18116.

²¹⁷ DEP'T HEALTH & HUMAN SERVS., *supra* note 215, at 35.

²¹⁸ JOHN E. McDONOUGH, INSIDE NATIONAL HEALTH REFORM 304 (2011).

²¹⁹ *Id.*

²²⁰ *See, e.g.*, 26 U.S.C.A. § 501 (West 2003 & Supp. 2011).

the Secretary, one of the central decision-making agencies in HHS. Fourth, it standardizes data collection of racial data and makes it a significant priority. Interestingly, HHS went to court in the 1990s fighting requests to collect racial data to fulfill its civil rights mandate.²²¹ With the passage of the Act, HHS not only is required to collect data, but is also required to standardize the data collection and disseminate data to the agencies within HHS.

Finally, the Act increases health insurance coverage for minorities, addressing some of the issues of structural racial bias. People of color comprise one-third of the U.S. population, but they constitute more than half of the uninsured population.²²² As a result of their lack of employer-sponsored health care insurance, minorities are less able to access health care.²²³ In fact, according to an Urban Institute report, it is projected that the Act, through the individual mandate, expansion of Medicaid coverage, and subsidies to purchase insurance, will reduce the number of nonelderly uninsured individuals by nearly half.²²⁴ Moreover, in 2009, the Medicaid program provided services to “an average of 50 million people,” which the Act could potentially expand by sixteen million by 2019.²²⁵ By reducing the number of uninsured, the government will reduce the amount it spends on uncompensated care by half.²²⁶ However, access to health insurance is not the only structural barrier to care for minorities, so too is their inability to pay for insurance because of poverty. Additionally, the significance of institutional and interpersonal bias in causing racial disparities in health is ignored in the ACA, even though these causes are listed in a plethora of empirical research studies and government reports and initiatives.²²⁷

²²¹ *Madison-Hughes v. Shalala*, 80 F.3d 1121 (6th Cir. 1996).

²²² KAISER FAM. FOUND., *HEALTH REFORM AND COMMUNITIES OF COLOR: IMPLICATIONS FOR RACIAL AND ETHNIC HEALTH DISPARITIES 1* (2010), available at <http://www.kff.org/healthreform/upload/8016-02.pdf>.

²²³ See KAISER FAM. FOUND., *THE UNINSURED: A PRIMER: KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE 5* (2007), available at <http://www.kff.org/uninsured/upload/7451-03.pdf> (stating that the disparity between the number of uninsured caucasians and uninsured minorities is likely due to “the fact that minorities are much less likely to have health insurance offered through their jobs”).

²²⁴ MATTHEW BUETTGENS & CAITLIN CARROLL, URBAN INST., *ELIMINATING THE INDIVIDUAL MANDATE: EFFECTS ON PREMIUMS, COVERAGE, AND UNCOMPENSATED CARE 3* (2012), available at <http://www.urban.org/UploadedPDF/412480-Eliminating-the-Individual-Mandate.pdf> (“[F]ull implementation of the ACA would decrease the nonelderly uninsured population by 23.9 million, from 50.3 million to 26.4 million.”).

²²⁵ DEP’T HEALTH & HUMAN SERVS., *supra* note 215, at 39.

²²⁶ BUETTGENS & CARROLL, *supra* note 224, at 5 (“Uncompensated care, paid for by federal, state, and local governments as well as health care providers, would decrease by 50 percent from \$78 billion to \$39 billion.”).

²²⁷ See, e.g., Carol M. Ashton et al., *Racial and Ethnic Disparities in the Use of Health Services: Bias, Preferences, or Poor Communication?*, 18 J. GEN. INTERNAL MED. 146, 146–47 (2003) (discussing the impact of race in doctor-patient communication leading to negative health outcomes for minority patients); Blair et al., *supra* note 110, at 72–74 (summarizing field studies evidencing the

D. Weakness: Discounting the Problem of Racial Bias

Although the Act provides many potential benefits to minorities who are uninsured, the Act has several noteworthy flaws. Most significantly, the Act ignores the significance of institutional and interpersonal racial biases in causing racial disparities and fails to discuss how Title VI, which prohibits racial bias, applies to programs that address racial disparities. If these shortcomings are not fixed, racial disparities in health care and poor health care outcomes for minorities will persist, if not get worse.

1. Ignoring Racial Bias

The Act focuses mainly on individual solutions, which, unfortunately, will never fully eradicate racial disparities because there are systemic problems with the U.S. health care system beyond access to insurance that must be fixed. The structure of the U.S. health system is based on ability to pay, not need. Health care entities make decisions on placement of facilities based on profit, while providers make treatment decisions based on worthiness that is linked to racial bias. These issues will not be addressed through research, preventative measures, or community grants.

Moreover, mere access to insurance will not necessarily equalize access to health care for African-Americans, as illustrated by the "*Douglas Cases*," the recent case argued before the U.S. Supreme Court challenging cuts in California's Medicaid reimbursement rates resulting in a threat to Medicaid beneficiaries' equal access to health care.²²⁸ The case brought by California pharmacists, hospitals, and Medicaid beneficiaries argues that state cuts to Medicaid reimbursement rates are so severe that providers will stop treating Medicaid patients, and thus significantly threaten Medicaid beneficiaries' access to care.²²⁹

Minorities' access to insurance may further be limited by ability to pay. Minorities disproportionately live in poverty. In 2007, the U.S. Census Bureau reported that 24.5% of African-Americans and 21.5% of Hispanics were living at the poverty level, compared to 8.2% of

existence of bias in minority healthcare resources); Rachel L. Johnson et al., *Racial and Ethnic Differences in Patient Perceptions of Bias and Cultural Competence in Health Care*, 19 J. GEN. INTERNAL MED. 101, 107–08 (2004) (positing that minority patients' impressions of bias affect their healthcare experiences).

²²⁸ See Sara Rosenbaum, *Equal Access for Medicaid Beneficiaries—The Supreme Court and the Douglas Cases*, 365 NEW ENG. J. MED. 2245, 2245 (2011) (discussing the *Douglas* cases, argued before the U.S. Supreme Court on October 3, 2011, and explaining that the cases "stemmed from lawsuits brought by Medicaid beneficiaries and health care providers against California for cutting Medicaid reimbursement rates"). The consolidated *Douglas* cases consist of *Douglas v. Independent Living Center of Southern California*, *Douglas v. California Pharmacists Ass'n*, and *Douglas v. Santa Rosa Memorial Hospital*. *Id.*; see also *Douglas v. Indep. Living Ctr. of S. Cal.*, 132 S. Ct. 1204 (2012).

²²⁹ Rosenbaum, *supra* note 228, at 2245.

Caucasians.²³⁰ “In 2008, over half of Hispanics, African Americans, and American Indians and Alaska Natives were poor or near poor compared with 27% of [Caucasians] and 31% of Asians”²³¹ Thus, increasing access to insurance may not solve the problem because minorities still may not be able to afford health insurance or pay for uninsured care, which is significant in a system that bases access on ability to pay rather than need. Even though the Act does try to equalize the cost the uninsured pay when visiting charitable hospitals, this policy does not apply to all hospitals or address the requirement of the uninsured having to pay up front. Thus, the Act does not fully rectify structural racial bias. Furthermore, the Act does not address interpersonal and institutional racial bias.

As discussed in Section III.A, empirical research suggests that interpersonal racial bias inside and outside the health care system results in racial disparities in medical treatment, which compromise African-Americans’ health status.²³² According to the IOM study, racial bias is widespread in health care and “begins at the point of entry and continues throughout the secondary and tertiary pathways of the system.”²³³ If health care professionals continue to harbor implicit and explicit interpersonal bias against minority patients, which prevents them from providing quality health care to these patients, simply increasing minority patients access to health insurance and, thus access to health care services, is not going to improve overall care for minority patients. Moreover, increasing access to insurance and preventative services means very little when patients do not have a health care facility located in their neighborhood—a result of institutional bias.

Focusing on solutions, such as health education programs to decrease infant mortality by eating right and seeking medical care, is not going to mitigate the detrimental effect of the stress caused by perceived racial bias, the loss of hospitals available in the area, or income inequalities that limit

²³⁰ U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2007 12 (2008), available at <http://www.census.gov/prod/2008pubs/p60-235.pdf>; see also Yearby, *supra* note 164, at 83. This poverty was in part because of low income. The average African-American family median income in 2007 was \$33,916, sixty-two percent of the median income for Caucasians, while the median income for Hispanic households was \$38,679, seventy percent of the median income for Caucasians. U.S. CENSUS BUREAU, *supra*, at 6.

²³¹ THOMAS & JAMES, *supra* note 173, at 5.

²³² Brian Englum et al., *Racial, Ethnic, and Insurance Status Disparities in Use of Posthospitalization Care After Trauma*, 213 J. AM. C. SURGEONS 699, 704–06 (2011) (explaining the results of a study demonstrating that Black and Hispanic patients utilize post-hospitalization health care services on a far lower basis than whites accounting for insurance status).

²³³ Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare System: Reinvigorating the Role of the Federal Government in the Aftermath of Alexander v. Sandoval*, 3 YALE J. HEALTH POL’Y L. & ETHICS 215, 218 (2003) (discussing the IOM study).

minorities access to health care.²³⁴ Consequently, the ACA's failure to discuss and recognize that institutional and interpersonal racial biases are the root causes of racial disparities allows for the perpetuation of racial disparities in health care, and the persistence of poor health care outcomes for minorities.

2. *Keeping the Status Quo*

Perhaps balancing the potential losses against the potential gains, the only statement made that specifically addresses civil rights in the Act says that the current civil rights laws apply with no changes, keeping the status quo. Unfortunately, not only is the status quo not preventing interpersonal racial bias, but it also is ineffective in addressing structural and institutional racial bias.

First and foremost, physicians are not covered under Title VI. Second, OCR does not collect racial data. In 1994, HHS decreed that it would not collect racial and ethnic data regarding services provided by health care entities receiving federal funding.²³⁵ In 1996, patients sued the Secretary of HHS for failing to enforce section 602 of Title VI.²³⁶ Specifically, the patients challenged the Secretary's failure to collect racial data and information needed to prove the continuation of racial bias in health care.²³⁷ The Court of Appeals for the Sixth Circuit ruled that this duty was discretionary, because HHS's only duty under Section 602 of Title VI was to obtain Title VI compliance reports from health care entities with as much information as necessary.²³⁸ According to the court, the extent to which HHS monitored and enforced Title VI was under HHS's own discretion.²³⁹ Therefore, although the language of Title VI says that the federal government must enforce Title VI, it does not say how.²⁴⁰ The court noted that the "how" is in the discretion of the Secretary; thus, as long as the government is investigating complaints and seeking voluntary compliance, it is enforcing Title VI.²⁴¹ Because OCR does not review any

²³⁴ See *supra* Section III.A (discussing how the perception of racial prejudice results can increase stress levels, that, in turn, negatively affect the individual's health).

²³⁵ FREDERICK D. ISLER ET AL., U.S. COMM'N ON CIVIL RIGHTS, FEDERAL TITLE VI ENFORCEMENT TO ENSURE NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS 233-34 (1996), available at <http://www.eric.ed.gov/PDFS/ED400365.pdf>; SMITH, *supra* note 24, at 92.

²³⁶ *Madison-Hughes v. Shalala*, 80 F.3d 1121 (6th Cir. 1996).

²³⁷ *Id.* at 1123. Ironically, HHS, the federal agency charged with enforcing Title VI in health care, argued that it had no legal duty to collect this information, but provides thousands of dollars in grants to researchers to collect the same data, which it does nothing with other than publish in medical journals. See *id.* at 1130-31.

²³⁸ *Id.* at 1125.

²³⁹ *Id.*

²⁴⁰ *Id.* at 1127-28.

²⁴¹ *Id.* at 1128.

racial data of residents from the states²⁴² or collect any report on services provided, there is no opportunity to evaluate whether racial groups are treated disparately.²⁴³ Even though, presumably, the ACA rectifies this problem because it mandates that the Secretary collect, standardize, and disseminate health disparities data to assorted agencies in HHS, OCR is not listed among the agencies in the Act that will receive health disparities data. In the past, data regarding racial disparities in health care has not been shared with OCR and nothing in the ACA changes this policy.²⁴⁴ Thus, it is questionable whether OCR will ever obtain the data.

Finally, although the language of Title VI clearly prohibits racial bias in health care by those receiving federal funding, the remedial scheme is ineffectual. As evidenced by reports from the House of Representatives and the U.S. Commission on Civil Rights ("USCCR"), racial bias continues almost unfettered, as it did before the passage of Title VI.²⁴⁵ Hence, OCR has not fulfilled this mandate of Title VI.²⁴⁶

As mandated by law, the USCCR reviewed the progress of HHS's Title VI enforcement in 1974, 1996, and 1999.²⁴⁷ Each time the USCCR found that HHS was not fulfilling the mandates of Title VI.²⁴⁸ In fact, USCCR noted that there was ample evidence that HHS had consistently and systematically failed to enforce Title VI to prohibit racial bias in health care because of lax enforcement.²⁴⁹

Specifically, critics have noted that HHS "permitted formal assurances of compliance to substitute for verified changes in behavior, failed to collect comprehensive data or conduct affirmative compliance reviews, relied too heavily on complaints by victims of discrimination, inadequately investigated matters brought to the Department, and failed to sanction recipients for demonstrated violations."²⁵⁰ As early as 1987, the U.S. House of Representatives Committee on Government Operations

²⁴² ISLER ET AL., *supra* note 235, at 233.

²⁴³ *Id.* at 234.

²⁴⁴ *Id.* at 233–34.

²⁴⁵ See Marianne Engelman Lado, *Unfinished Agenda: The Need for Civil Rights Litigation to Address Race Discrimination and Inequalities in Health Care Delivery*, 6 TEX. F. ON C.L. & C.R. 1, 26–33 (2001) (citing House Comm. on Gov't Operations, Investigation of the Office for Civil Rights in the Department of Health and Human Services, 100th Cong., 1st Sess. (1987)); see also ISLER ET AL., *supra* note 235, at 230.

²⁴⁶ ISLER ET AL., *supra* note 235, at 227–28.

²⁴⁷ See 42 U.S.C. § 2000d-1 (2006) (stating that the federal government will enforce nondiscrimination in federally assisted programs); ISLER ET AL., *supra* note 235, at 1–2 (noting that the Commission monitored the federal agencies Title VI program periodically).

²⁴⁸ ISLER ET AL., *supra* note 235, at 1–2.

²⁴⁹ *Id.*, at 240; 1 U.S. COMM'N ON CIVIL RIGHTS, THE HEALTH CARE CHALLENGE: ACKNOWLEDGING DISPARITY, CONFRONTING DISCRIMINATION, AND ENSURING EQUALITY 1, 5–6, 8–9, 73–74 (1999) [hereinafter HEALTH CARE CHALLENGE]. The problem is also a lack of funding. See generally Yearby, *supra* note 164, at 83 (describing racial inequalities in access to health care).

²⁵⁰ Lado, *supra* note 245, at 28.

determined "that OCR unnecessarily delayed case processing, allowed discrimination to continue without federal intervention, routinely conducted superficial and inadequate investigations, failed to advise regional offices on policy and procedure for resolving cases, and abdicated its responsibility to ensure that HHS policies are consistent with civil rights law, among other things."²⁵¹ The same committee "criticized OCR's reluctance to sanction noncompliant recipients and recommended that OCR pursue investigations of complaints as well as compliance reviews in more systematic ways."²⁵² Since this report, not much has changed.

In its 2002 report, the USCCR noted that OCR's civil rights system was rudimentary.²⁵³ Although the USCCR found that HHS had established civil rights enforcement programs, the USCCR concluded that these programs were unsatisfactory.²⁵⁴ The USCCR "found [OCR's] efforts to develop policy and conduct civil rights enforcement activities to be halfhearted."²⁵⁵ Although Title VI provided the legal framework to eliminate racial bias in health care, the USCCR stated without equivocation that "HHS lacks a vigorous civil rights enforcement program, and the activities of OCR appear to have little impact on the agency as a whole."²⁵⁶ The federal government's failure to enforce Title VI, which prohibits government-funded racial bias, has led to the perpetuation of racially discriminatory practices in the health care system.

The USCCR has stated that "[i]f OCR continues to focus its enforcement on the more tangible civil rights violations, without delving into the reasons they exist in the first place, it will fail to recognize and eliminate the true sources of inequity."²⁵⁷ Consistent with this perspective, the USCCR recommended a reorganization of the entire civil rights structure to prohibit racial bias in health care. Specifically, the USCCR suggested that "OCR . . . conduct broad-based, systemic compliance reviews on a rotating basis in *all* federally funded health care facilities, at least every [three] years."²⁵⁸ Although USCCR's report was released ten years ago, none of its recommendations have been implemented and the ACA did nothing to change the status quo. Thus, the civil rights enforcement system remains completely ineffective at putting an end to government prohibited racial bias in health care. Consequently, race continues to

²⁵¹ *Id.* at 29.

²⁵² *Id.* at 29–30.

²⁵³ U.S. COMM'N ON CIVIL RIGHTS, TEN-YEAR CHECK-UP: HAVE FEDERAL AGENCIES RESPONDED TO CIVIL RIGHTS RECOMMENDATIONS? 5–6 (2003), available at <http://www.usccr.gov/pubs/10yr02/vol1/vol1.pdf>.

²⁵⁴ *Id.* at 5.

²⁵⁵ *Id.*

²⁵⁶ HEALTH CARE CHALLENGE, *supra* note 249, at 74.

²⁵⁷ *Id.* at 203.

²⁵⁸ *Id.*

matter in health care even after the passage of the ACA. To fix the shortcomings of the Act, this Article suggests several regulatory solutions because the time seemingly has passed for statutory solutions.

V. RECOMMENDATIONS

Race matters because physicians continue to exhibit conscious and unconscious racial prejudice that affects physician's treatment decisions (interpersonal), health care entities closures and relocations remain linked to race and re-enforce racial hierarchy (institutional), and the health care system is based on ability to pay not need (structural). In order to put an end to racial disparities in access to health care and health status all three forms of racial bias need to be addressed. Additionally, changes need to be made to the regulatory structure of civil rights enforcement. These recommendations have the potential to improve the entire health care delivery system.

A. Addressing Racial Bias

Recognizing and acknowledging the significance of racial bias in causing racial disparities in accessing health care and health status is the first step in addressing interpersonal racial bias. Second, physicians need to be educated about their subtle, often unconscious, racial prejudice, which affects their medical treatment decisions. Medical professionals should be educated about the three levels of racial bias and how they impact the treatment of patients. Physicians also need to be educated about how experiencing racial bias affects their patients' interaction with the medical system and their health outcomes. In fact, research suggests that making physicians aware of how their unconscious racial prejudice can influence outcomes of medical encounters and sensitizing them to their own unconscious bias can help motivate them to correct their bias.²⁵⁹ Finally, African-American patients need to be educated about the severe health consequences of failing to cope with the stress of perceived racial bias and provided with coping strategies.

In order to put an end to institutional racial bias, both state and federal regulators must review institutional plans to close or relocate quality health care facilities only in predominately Caucasian neighborhoods for the disproportionate harm such plans have on African-American communities.

²⁵⁹ John F. Dovidio, et al., *Disparities and Distrust: The Implications of Psychological Processes for Understanding Racial Disparities in Health and Health Care*, 67 SOC. SCI. & MED. 478, 483 (2008); Majette, *supra* note 149, at 140–41 (recommending that diversity training constitute an integral part of the educational and professional development of medical professionals to help expose and eradicate conscious and unconscious prejudicial and stereotypical thinking about racial and ethnic minority patients).

This review will force hospitals and nursing homes to balance the benefits of closing, relocating, and over-concentrating quality facilities in predominately Caucasian neighborhoods against the detrimental effects on African-American communities that will result because of the disruptions of care. By instituting this review, the racial link will become clearer, and owners will have to consciously mitigate the harmful effects of closing, relocating, and over-concentrating quality facilities in predominately Caucasian neighborhoods.

To improve the allocation of scarce health care resources for everyone, the underlying problem of access to basic health care services must be addressed. Health care must be delivered based on need, not ability to pay. The ACA has the potential to address these structural biases and provide access to insurance for African-Americans; however, it does not alleviate some of the problems with the allocation of health care based on ability to pay, not need.

B. Addressing Regulatory Shortfalls

To address civil rights failures the government must enforce Title VI against all health care providers, require health disparities impact statements prior to hospital closures and relocations, and integrate racial disparities research and programming with civil rights measures. These measures can be accomplished through the regulations implementing sections 10302, 10303, 1303, 1557, 1946, and 4302, which deal with programs to improve chronic disease and decrease racial disparities.

First, health care professionals need to be targeted for civil rights violations. Data show that these providers continue to use race to determine treatment decisions, which may be a violation of Title VI.²⁶⁰ This problem can be changed by including physicians in the definition of health care entities or by defining their payments as federal financial assistance. In fact, under the ACA, physicians and all health care professionals are defined as health care entities as it relates to assisted suicide.²⁶¹ Thus, Title VI regulations can define physicians as a health care entity or the regulations can simply re-classify payments to physicians as federal financial assistance.

Second, the regulations implementing the Act need to specifically spell out the requirements of civil rights enforcement, such as putting an end to institutional and structural racial bias. Thus, the regulations and/or governing policies need to include a discussion of what constitutes institutional and structural racial bias. For example, it should be noted that

²⁶⁰ As discussed in Section II.B, Title VI prohibits disparate treatment and disparate impact racial bias.

²⁶¹ 42 U.S.C.A. § 18113 (West 2003 & Supp. 2011).

decisions by health care corporations to close facilities in minority neighborhoods may be an example of institutional racial bias. OCR should also require entities to submit health disparities impact statements. Health disparities impact statements should provide reports about whether the closure or relocation would disproportionately harm African-Americans. If the closure would disproportionately harm a minority community, the hospital should be required to provide services that will limit the disparate impact by providing transportation to the new facility, coordinating care with the remaining facilities, or improving the provision of care.

There is hope that OCR is already implementing this suggestion based on the recent case against the University of Pittsburgh Medical Center ("UPMC").²⁶² Recently UPMC entered into the voluntary agreement with OCR in an effort to resolve a complaint alleging that it violated provisions of Title VI when UPMC decided to close Braddock Hospital in January 2009. The hospital was located in a predominately African-American area and the hospital relocated to a predominately Caucasian neighborhood.

Among other things, the agreement requires UPMC to provide door-to-door transportation services from Braddock and surrounding communities to its new outpatient facilities in Forest Hills, Pennsylvania, as well as to UPMC McKeesport Hospital. UPMC will also designate a patient ombudsperson to assist residents with obtaining health care and receive and address residents' complaints about access to health care. The agreement remains in effect for three years, and requires UPMC to make quarterly reports to OCR regarding compliance.

The case is one of the first cases in which OCR not only required a hospital to consider the impact on communities of color before closing, but also mandated that the hospital take steps consistent with their Title VI obligations, to ameliorate the disparate impact on minorities. Yet, this is just one case. In order to institutionalize this win, OCR must formalize the requirement of health disparity impact statements.

Finally, the regulations governing racial disparities must be linked to civil rights enforcement. This goal can be accomplished by requiring that racial disparities data obtained from programs under the ACA be transmitted to OCR. Moreover, there should be collaboration between OCR and those collecting racial disparities data under the Act in setting priorities in funding programs and drafting regulations to put an end to racial bias. Furthermore, civil rights enforcement must be integrated into every facet of regulation of health care facilities. Civil rights enforcement should be integrated with quality regulation enforcement through shared resources, personnel, and remedies. For example, when the government visits a nursing home to determine whether the nursing home is providing

²⁶² Resolution Agreement Between HHS and UMPC (2009) (on file with the author).

quality care to all of its residents, the government should also review whether there are racial disparities in access to health and health status. If there are disparities in care, and the government determines that the disparities are due to racial bias, the government should increase the remedies imposed for providing poor quality.²⁶³ As Sara Rosenbaum and Joel Teitelbaum note, "it no longer makes sense to divide the world of enforcement [from the world of civil rights] when the overall goal is the systemic improvement of program performance."²⁶⁴ By integrating these systems, the government "would make clear that a particular practice is desirable not only because it improves the racial equality of programs but also because it improves the quality of health care for persons who are the intended beneficiaries of the programs."²⁶⁵

These are just a few recommendations for fixing the Act's shortcomings and putting an end to racial disparities. Many of the recommendations, such as educating physicians and health disparity impact statements, are easy to implement. The Act already provides funding for grants for education and OCR has begun to investigate hospital closures. Yet, this is just the beginning. The government needs to immediately implement all of the recommendations of the IOM study and USCCR reports regarding racial bias and racial disparities, such as increased funding for Medicaid, prosecuting entities for using racial bias to prevent access to health care services, and training minority health care providers. Then and only, then will the United States begin to break the cycle of unequal treatment.

VI. CONCLUSION

Racial disparities persist in part because the United States continues to ignore one of the root causes of the disparities: racial bias. In order to address racial bias in health care, everyone participating in the system must speak openly and honestly about the problem. The ACA is one step in the right direction; it begins to address structural bias by increasing minorities' access to health insurance. However, it fails to address the effect of institutional and interpersonal bias. Instead, the Act focuses on individual choices and community grants. By failing to speak openly and honestly and acknowledge decades of research that show that racial disparities are caused by these biases, not individual choices, the Act may exacerbate the problem by wasting time and money on individual solutions that comprise

²⁶³ For a detailed discussion, see Ruqaiyah Yearby, *Litigation, Integration, and Transformation: Using Medicaid to Address Racial Inequities in Health Care*, 13 J. HEALTH CARE L. & POL'Y 325 (2010) (discussing the need to integrate civil rights enforcement with nursing home quality enforcement measures).

²⁶⁴ Rosenbaum & Teitelbaum, *supra* note 233, at 250.

²⁶⁵ *Id.*

only a small part of the problem. If this problem is not corrected, racial disparities will persist, lives will be lost, and costs will continue to skyrocket.