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Sick and Tired of Being Sick and Tired: Putting an End to Separate and Unequal Health Care in the United States 50 Years After the Civil Rights Act of 1964

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SICK AND TIRED OF BEING SICK AND TIRED: PUTTING AN END TO SEPARATE AND UNEQUAL
HEALTH CARE IN THE UNITED STATES 50 YEARS AFTER THE CIVIL RIGHTS ACT OF 1964

Ruqaiijah Yearby^{d1}

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*For three hundred years, we've given them time. And I've been tired so long, now I am sick and tired of being sick and tired, and we want a change. We want a change in this society in America because, you see, we can no longer ignore the facts.*¹

Fannie Lou Hamer

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***2 INTRODUCTION**

Since the end of the Civil War in 1865, the U.S. health care system has been structured to be racially separate and unequal.² Ninety-nine years later, the enactment of Title VI of the Civil Rights Act of 1964 (Title VI) was supposed to put an end to this racially separate and unequal health care system by mandating equal access to health care for all races.³ However, fifty years later, African Americans continue to receive separate and unequal treatment compared to Caucasians, in hospitals, nursing homes, and physician offices.⁴ As a result, racial disparities in health status and access to health care persist. Consequently, since 1964, research studies estimate that 4.2 million African Americans have died unnecessarily because of health disparities.⁵ Beyond the costs of lost lives, the fiscal costs of racial disparities in health care from 2009 through 2018 is estimated to be approximately \$337 billion, including \$220 billion for *3 Medicare, \$27 billion for Medicaid, and \$90 billion for private insurers and individual's out-of-pocket costs.⁶

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These racial disparities in health status and access to health care are due to racial bias.⁷ Dr. Camara Phyllis Jones defines racial bias as “a system of structuring opportunity and assigning value based on the social interpretation of how we look (which is what we call ‘race’), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources.”⁸ Research has shown a link between experiencing racial bias and an increased likelihood of experiencing cardiovascular disease, infant mortality, and the onset of hypertension.⁹ Moreover, racial bias prevents African Americans from obtaining the same educational, employment, and housing opportunities as Caucasians, thus limiting *4 African Americans' ability to access health care.¹⁰ Over three decades of empirical research studies show that racial bias prevents African Americans from receiving quality education, obtaining jobs, and accessing housing in safe, diverse, and environmentally-friendly neighborhoods.¹¹ Due to racial bias, African Americans attend *5 substandard schools, are more likely to be unemployed or employed with no health insurance, and reside in houses with environmental hazards (that contain, for example, lead, vermin, or are situated near toxic waste dumps) located in unsafe neighborhoods. As a result of these hazards and because many lack health insurance, African Americans are left with little or no access to health care, resulting in reduced health care options.

African Americans' access to health care is further limited by racial bias within the health care system, which operates on three levels: structural, institutional, and interpersonal. As a result of structural racial bias, health care services in the United States are delivered based on ability to pay, leaving those who cannot pay (predominately minorities) without access to health care.¹² Institutional racial biases contribute to the accumulation of health care facilities and physicians in wealthy, Caucasian neighborhoods, leaving those in poor, minority communities with no access to quality health care.¹³ Finally, interpersonal racial biases in the form of explicit and implicit racial bias result in some health care providers failing to *6 give African American patients the same life-saving treatment that is provided to Caucasians.¹⁴

To save African American lives and decrease the billions of dollars spent as a result of racial disparities in health status and access to health care, the U.S. government must stop funding and supporting racial bias. The 2014 Case Western Reserve University School of Law, Law-Medicine Symposium represents the first of many steps in this battle to eradicate racial bias in the U.S. health care system. The purpose of this interdisciplinary conference was to commemorate the fiftieth anniversary of Title VI by challenging the continuation of racial bias in the U.S health care system, which limits African Americans' access to health care and causes their unnecessary morbidity and mortality. This introduction summarizes not only the symposium articles contained in this issue, but also the key presentations given at the symposium.

Section I provides a brief history of how the U.S. health care system has been separate and unequal since the Civil War because of racial bias and remains so in spite of the passage of the Patient Protection and Affordable Care Act (ACA). Section II examines the effects of structural and institutional racial bias on African Americans' health status and access to quality health care, while Section III discusses the effects of interpersonal racial bias on African Americans' health status. Finally, Section IV provides solutions to put a definitive end to racial bias within the U.S. health care system.

I. SEPARATE AND UNEQUAL: GOVERNMENT SPONSORED AND SUPPORTED RACIAL BIAS WITHIN THE U.S. HEALTH CARE SYSTEM

At the end of the Civil War, Congress debated creating a universal health care system that would cover all U.S. citizens.¹⁵ The *7 proposal was emphatically vetoed based on arguments that the system would cover newly freed blacks.¹⁶ The development of private health insurance ensured the defeat of racially integrated government health insurance, and the development of private hospitals guaranteed the racial segregation of patients.¹⁷ Thus, Caucasians who could afford private health insurance were

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provided the best health care in private hospitals, while African Americans who could afford private health insurance and pay to stay in the same health care facilities as Caucasians were treated in separate and unequal health care facilities.¹⁸ The influence of racial bias in the development of the U.S. health care system was so pervasive that the federal government not only funded, but also explicitly and implicitly supported separate and unequal health care services, in contravention of the laws prohibiting racial bias.¹⁹

For example, the Hospital Survey and Construction Act of 1946, better known as the Hill-Burton Act, allotted funding for the construction of hospitals and nursing homes and granted states the authority to regulate this construction. Hospitals used this funding to construct among other things, hospital buildings, nursing homes, and freestanding geriatric hospitals.²⁰ The Hill-Burton Act also provided assurances that adequate health care facilities be made available to all state residents without discrimination of color.²¹ According to Dr. David Barton Smith's article, "The 'Golden Rules' for Eliminating Disparities: Title VI, Medicare, and the Implementation of the Affordable Care Act," these assurances were not worth the paper they were written on because "there was no procedure for checking on the validity of the 'assurances,' nor was there any authorized course of *8 action for violations."²² This nondiscrimination rule was further negated by section 622(f), which stated:

[S]uch hospital or addition to a hospital will be made available to all persons ... but *an exception shall be made in cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group.*²³

Federal support and funding of separate and unequal health care facilities ensured that African Americans' tax money in at least fourteen states was used for the construction of health care facilities from which they were barred.²⁴

The passage of Title VI was supposed to put an end to federally supported and funded racial bias within the health care system. However, Dr. Smith noted that in the first year and half year after the passage of Title VI, the government had not allocated any staff to enforce the law, nor were there any investigative tools (reporting requirements, subpoena powers, etc.) or the ability to impose credible sanctions, and it was unclear what constituted noncompliance.²⁵ Things changed with the passage of the Medicare and Medicaid Acts.

By linking Title VI to Medicare and Medicaid, the federal government was able to leverage the influx of cash to hospitals and convince them to integrate almost overnight.²⁶ The government also harnessed the power of the civil rights movement by using local civil rights groups and activists, many of them health care or government workers, to conduct Title VI inspections in hospitals that refused to integrate even with the promise of cash, or those hospitals that took the cash but did not integrate.²⁷ Many, but not all hospitals' certification in Medicare and Medicaid was guaranteed by local civil rights groups and activists after finding that the hospitals were compliant with Title VI.²⁸ Unfortunately, this was the extent of the victory under Title VI.

*9 The U.S. Department of Health and Human Services (HHS), the agency responsible for enforcing Title VI, allowed hospitals to move out of predominately African American neighborhoods to predominately Caucasian neighborhoods. HHS ruled that physicians were not required to comply with Title VI,²⁹ and it permitted nursing homes to racially discriminate in admission decisions and also in the provision of quality nursing care.³⁰

Empirical evidence shows that since the passage of Title VI, racial bias remains rampant in every facet of health care. In the 1970s, some hospitals remained racially segregated by floor, room, and staff.³¹ In the 1980s, African Americans were denied

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admission to nursing homes that provided excellent quality care.³² In the 1990s, studies found that some health care providers believed African American patients were unintelligent, which kept providers from recommending medically necessary cardiac catheterization, curative surgery for early-stage lung cancer, and antibiotics to treat pneumonia, thereby increasing death rates for African Americans.³³ In the 2000s, research showed that race *10 was a significant factor in the decision to close hospitals between 1937 and 2003.³⁴ In the 2010s, physician surveys showed that some pediatricians' racial bias prevented them from prescribing pain medication for African American children following surgery.³⁵ Nothing has changed with the enactment of the ACA because it did not fix any of the problems with Title VI.³⁶

Furthermore, although one of the main goals of the ACA is to put an end to racial disparities in health care by increasing insurance coverage, research, data collection, and quality improvement measures,³⁷ this has not been enough to put an end to racially separate and unequal hospital, nursing home, and physician care.³⁸ Dr. Smith suggests that the ACA can still be used to reduce racial disparities in health care. However, the implementation of the ACA must include “(1) rekindling the spirit of the grass roots movement that captured the Title VI enforcement process with the implementation of the Medicare program, (2) exposing adversaries through data disclosure and taking advantage of the ‘invisible army’ that supports these goals, (3) using the power of both the economic and ethical versions of the golden rule (those with the gold, rule) and (4) creating the political insulation and urgency necessary to make it possible.”³⁹ In addition to the suggestions proposed by Dr. Smith, the government must begin to dismantle the structural, institutional, and interpersonal racial biases that perpetuate the United States' separate and unequal health care system.

***11 II. RACIAL DISPARITIES IN ACCESS TO HEALTH CARE: STRUCTURAL AND INSTITUTIONAL RACIAL BIAS**

African Americans' access to health care is limited by structural and institutional racial bias. Structural racial bias operates at the societal level, privileging Caucasians, while denying African Americans many important resources.⁴⁰ This racial bias affects African Americans' length and quality of life.⁴¹ It also restricts African Americans' educational, housing, and economic opportunities.⁴² Often relegated to racially segregated neighborhoods, African Americans attend low-quality schools, keeping them unemployed, underemployed, or in jobs without health insurance.⁴³

Structural racial bias within the health care system, which provides health care based on ability to pay, not need, denies many African Americans without money or insurance access to medically necessary health care. This is compounded by institutional racial bias which operates through organizational structures within institutions *12 which “establish separate and independent barriers”⁴⁴ to health care services.⁴⁵ Institutional racial bias within the health care system is best demonstrated by hospital closures in African American communities,⁴⁶ which leaves predominately African American neighborhoods without access to quality health care services.⁴⁷

A. Structural Racial Bias

1. Racial Bias in the United States

Racial bias persists in the United States,⁴⁸ resulting in increased stress for African Americans that impairs their health status.⁴⁹ The *13 effect of this racial bias on health is captured by the “constrained choice theory,” which describes the ways that inequity within institutions and social structures affects an individual's biology and shapes his or her health status as well

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as opportunities to pursue healthy choices.⁵⁰ In their article, "Understanding and Addressing the Common Roots of Racial Disparities: The Case of Cardiovascular Disease & HIV/AIDS in African Americans," Drs. Martha E. Lang and Chloe E. Bird use the constrained choice theory to explain how racial bias affects African Americans' health.

*14 Studies have shown that both U.S. born and foreign born African American women who have experienced racial bias were more likely to have hypertension or hypertension events.⁵¹ In fact, African American women who had experienced racial bias and had chosen not to object to it were 4.4 times more likely to have hypertension than those who stated that they took action or talked to somebody about it.⁵² Moreover, research suggests that there is a higher positive correlation between perceived racial prejudice and increased cigarette and alcohol use among African Americans as compared to Caucasians.⁵³ The increased stress from perceived racial bias also affects birth outcomes by increasing African Americans' rates of infant mortality.⁵⁴ Finally, research has shown that experiencing racial bias accelerates the biological aging of African American men, which may lead to their lower life expectancy.⁵⁵

In addition to the biological effects of racial bias, Drs. Lang and Bird note that racial bias limits African Americans' opportunities to pursue health. For instance, because American cities are nearly as hypersegregated as apartheid era South African metropolitan areas⁵⁶ *15 and have only made slight gains towards desegregation in the past twenty years,⁵⁷ African Americans have higher rates of disability and death.⁵⁸ In particular, racially hypersegregated neighborhoods usually have less economic investment,⁵⁹ and thus they have fewer resources such as healthy food,⁶⁰ places to exercise or play,⁶¹ and health care, but they have more stressors such as pollution, noise, overcrowded housing stock, and high rates of crime.⁶² This translates into poorer health for African Americans.

Indeed, researchers have found that the presence of one or more health clubs as well as lower crime rates were both directly associated with lower cardiovascular disease risk for the African American women in their study.⁶³ Furthermore, in racially hypersegregated neighborhoods, "residents do not have access to healthy food due to a lack of supermarkets and a preponderance of convenience stores and fast food restaurants as the primary food outlets,"⁶⁴ all of which have been shown to lead to obesity, a risk factor for cancer and cardiovascular disease.⁶⁵

Racial segregation also affects the place that African Americans receive care. In highly racially segregated areas, African Americans are more likely to undergo surgery in low-quality hospitals, whereas in *16 areas with low degrees of racial segregation, African Americans and Caucasians are likely to undergo surgery at low quality hospitals at the same rate.⁶⁶ This is significant because among Medicare patients, most of the racial disparities in risk-adjusted death rates for major surgery are a result of the site of care.⁶⁷

Wealth inequality also directly affects health by leaving African Americans without the money they need to pay for medically necessary health services. Following the same households for over twenty-five years (1984-2009), researchers found that the total wealth gap between Caucasian and African American families nearly tripled, increasing from \$85,000 in 1984 to \$236,500 in 2009, a difference of \$152,000.⁶⁸ For instance, a 2009 survey showed that the median wealth of white families was \$113,149 compared with \$5,677 for African American families, a difference of almost \$108,000.⁶⁹ Researchers found that approximately 66 percent of the wealth gap between African Americans and Caucasians was a result of racial bias which caused racial inequalities in homeownership, income, employment, education, and inheritance.⁷⁰

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During his symposium presentation, Dr. David Miller noted that, “as of February 2014, 12.9% of African American men were unemployed compared to 5.5% of Caucasian men.”⁷¹ A college education does not equalize employment; indeed, in 2009, the Bureau of Labor Statistics showed that the unemployment rate for African American male college graduates was 8.4 percent compared to 4.4 percent for Caucasian college graduates.⁷² Studies show that African *17 Americans seeking employment have a harder time obtaining employment because non-African American managers tend to hire more Caucasians. Also, African Americans with non-Caucasian names received 50 percent less callbacks than African Americans with Caucasian sounding names.⁷³ Thus, racial bias in the United States results not only in African Americans' poorer health status, but it also prevents African Americans from being able to access health care.

2. Structural Racial Bias: Rationing Health Care Based on Ability to Pay

Health care in the United States is rationed on ability to pay, and although this seems race neutral, it is not.⁷⁴ As the wealth inequities discussed above show, because of structural racial bias, African Americans do not have equal wealth compared to Caucasians, and thus they are often unable to pay for health care.⁷⁵ Specifically, African Americans and Hispanics are more likely than Caucasians to work in low-wage jobs, and they tend to have reduced access to employer-sponsored health care coverage relative to their higher-wage counterparts.⁷⁶ Consequently, minorities are more likely than Caucasians to be uninsured or be covered by Medicaid. In fact, of the 45.7 million non-elderly Americans who were uninsured in 2008, more than half (55 percent) were minorities and, as of 2009, 23 percent of African Americans were uninsured.⁷⁷

In addition to health insurance, minorities disproportionately live in poverty. In 2007, the U.S. Census Bureau reported that 24.5 percent of African Americans were living at the poverty level compared to 8.2 percent of Caucasians.⁷⁸ By 2008, over 50 percent of *18 African Americans were poor or near poor compared with 27 percent of Caucasians.⁷⁹ As a result of their lack of employer-sponsored health care insurance and poverty, minorities are disproportionately unable to afford insurance or to pay for health care, which results in racial disparities in access to health care.

Professor Rene Bowser discusses the disproportionately harmful effects of rationing on African Americans in his article “Race and Rationing.”⁸⁰ Uninsured and unable to afford health care, African Americans “lack a usual source of care, have substantially higher unmet health needs, and have higher out of pocket costs.”⁸¹ In 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.”⁸² This racial difference in physician visits is not new. In 1986, a national survey of the use of health care services found that “even 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 [sic] lower mean number of annual ambulatory [walk-in] visits and are less likely to have seen a physician in a year.”⁸³ Thus, African Americans often forgo care leading to diagnosis at more advanced stages of disease.⁸⁴ Indeed, government data shows that African American women were 10 percent less likely to have been diagnosed with breast cancer; however, they were 34 percent more likely to die from breast cancer, as compared to Caucasian women.⁸⁵

Professor Bowser also notes that the U.S. health care system is rationed based on physician status and power, which determines who gets to see a renowned specialist or added to an organ transplant waiting list.⁸⁶ While Caucasian “patients cared for by ‘high status’ *19 physicians have privileged access to health care services and can more easily push their patients to the head of the queue,” African Americans are often treated by African American physicians who “report greater difficulties accessing high-

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quality specialists, diagnostic imaging, and nonemergency admission of their patients to the hospital than physicians serving predominantly nonminority patients.”⁸⁷

An example of the deadly effects of rationing based on physician status and power was shown in a 2013 study on surgery mortality.⁸⁸ The study showed that African Americans patients were more likely than Caucasian patients to die from coronary artery bypass grafting, abdominal aortic aneurysm repair, and resection for lung cancer.⁸⁹ This disparity in survival rates was due to African Americans' separate and unequal access to quality hospitals. Even though African Americans live closer to high quality hospitals than Caucasians, they were more likely to undergo surgery at low-quality hospitals.⁹⁰ A plethora of “decisions about where to go for major surgery [such as coronary artery bypass grafting, abdominal aortic aneurysm repair, and resection for lung cancer] are made by referring physicians, not by patients and their families,” and studies show that physicians serving African American patients have reduced access to specialists, suggesting that these patients will have trouble seeing and being treated by surgeons at high-quality hospitals.⁹¹ Thus, regardless of whether care is rationed based on ability to pay or physician status and power, African Americans are denied equal access to health care, which results in unnecessary morbidity and mortality for African Americans.

B. Institutional Racial Bias: Hospital Closures

In 1949, African Americans were either excluded from or were given restricted access to emergency care in hospitals, which resulted in higher death rates for African Americans from auto accidents in particular.⁹² In 2008, research showed that African Americans still had a higher death rate for trauma injuries, including those from auto accidents, because of “treatment delays, different care due to receipt *20 of fewer diagnostic tests, and decreased health literacy.”⁹³ In fact, almost forty years of studies have shown that African Americans are still excluded from hospitals because of institutional racial bias.⁹⁴

Shortly after the passage of Title VI, hospitals in African American communities closed and relocated to affluent Caucasian neighborhoods.⁹⁵ Similarly, in 1992, a report of 190 urban community hospitals between 1980 and 1987 found that the percentage of African American residents in the neighborhood was the most significant factor in hospital closures.⁹⁶ As the percentage of African American residents increased in the neighborhood, hospital closures increased.⁹⁷ 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 1997.⁹⁸

In fact, while speaking at the symposium, Dr. Sager showed that 45 percent of hospitals open in 1970 had closed by 2010, and of these hospitals, 60 percent were in neighborhoods that were predominately African American.⁹⁹ St. Louis and Detroit are poignant examples of these race-based hospital closures. St. Louis had eighteen hospitals in predominately African American neighborhoods. By 2010, all but one had closed.¹⁰⁰ In 1960, Detroit had forty-two hospitals open in predominately African American neighborhoods; by 2010 only four were open.¹⁰¹

*21 This reduction of hospital beds in African American communities, which generally have the greatest need for care, further compromises African Americans' health by decreasing their access to health care, thereby increasing health care costs.¹⁰² As hospitals leave predominately African American neighborhoods, the remaining hospitals are left to fill the void.¹⁰³ This often strains the remaining hospitals' resources and their ability to provide quality care.¹⁰⁴ Consequently, the hospitals that do remain to provide care to African Americans gradually deteriorate and provide substandard care.¹⁰⁵

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Not only is access to health care diminished because of a reduction of hospital services, but care also suffers because of physician departures.¹⁰⁶ 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 health care services in predominately African American neighborhoods.¹⁰⁷ Evidence shows that primary care physicians often leave after the closure of a neighborhood hospital because the hospital provides a critical base for their practice.¹⁰⁸ This disruption in care is significant because many predominately African American neighborhoods already suffer from physician shortages prior to hospital closures and physician flight.¹⁰⁹ Additionally, 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.¹¹⁰ Thus, even if African Americans are granted access to hospitals, they still receive less than the *22 medically necessary care, which is compounded by interpersonal racial bias against African Americans.

III. RACIAL DISPARITIES IN HEALTH STATUS: INTERPERSONAL RACIAL BIAS

Health care providers' explicit and implicit racial biases favoring Caucasians over African Americans illustrates interpersonal racial bias. According to presenter Dr. Michelle van Ryn, there is evidence that a patient's race can affect physicians' "question-asking in clinical interview, diagnostic decision-making, referral to specialty care, symptom management, and treatment recommendations."¹¹¹ For example, contrary to evidence showing that African Americans are intelligent and compliant, some health care providers believe that African Americans are unable to adhere to treatment regimens, and thus providers give less than the medically recommended health care services to African Americans.¹¹² As a result, many African Americans die unnecessarily.¹¹³

For instance, a study conducted by Harvard researchers found that African American Medicare patients received poorer basic care than Caucasians who were treated for the same illnesses.¹¹⁴ Specifically, the study showed that only 32 percent of African American pneumonia patients with Medicare were given antibiotics within six hours of admission, compared with 53 percent of other *23 pneumonia patients with Medicare.¹¹⁵ Also, African Americans with pneumonia were less likely to have blood cultures performed during the first two days of hospitalization.¹¹⁶ The researchers noted that other studies had associated prompt administration of antibiotics and collection of blood cultures with lower death rates.¹¹⁷ Nevertheless, almost twenty years of research shows that this disparate treatment is caused by health care providers' implicit racial bias against African American patients.

Empirical evidence of health care providers' implicit racial bias was first published in 1999 in the Schulman study. That 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.¹¹⁸ 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.

That same year, researchers found that African Americans were less likely than Caucasians to be evaluated for renal transplantation, and that African Americans were less likely to be placed on a waiting list for transplantation after controlling for patient preferences, socioeconomic status, the type of dialysis facility patients used, perceptions of care, health status, the cause of renal failure, and the presence or absence of coexisting illnesses.¹¹⁹

In 2000, 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.¹²⁰

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That same *24 year, Drs. van Ryn and Burke conducted a survey of physicians' perceptions of patients.¹²¹ 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.¹²² Physicians' perceptions of African Americans were negative even when there was individual evidence that contradicted the physician's prejudicial beliefs.

In 2006, Dr. van Ryn repeated this study using candidates for coronary bypass surgery. Again, the physicians that were surveyed exhibited prejudicial beliefs about African Americans' intelligence and ability to comply with medical advice.¹²³ 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.

More recently, a 2008 study found that physicians subconsciously favor Caucasian patients over African American patients.¹²⁴ In this study, physicians' racial attitudes and stereotypes were assessed and then physicians were presented with descriptions of hypothetical cardiology patients differing only in race. Although physicians reported not being explicitly racially biased, most physicians *regardless of race or ethnicity* held implicit negative attitudes about African Americans, and thus were aversive racists.¹²⁵ This is significant because research has shown that the stronger the implicit bias, the less likely the physician was to recommend the appropriate medical treatment for heart attacks for African American patients.¹²⁶ Therefore, in order to address racial bias within health care, there must be a transformative change within the United States that addresses all the forms of racial bias.

IV. SOLUTIONS

In her article, "Toward a Structural Theory of Implicit Racial and Ethnic Bias in Health Care," Professor Dayna Bowen Matthew notes that the existence of racial disparities in health care is a structural problem and therefore racial biases that contribute to disparities must *25 be structurally dismantled.¹²⁷ For example, it is not enough to simply reeducate health care providers who have an explicit or implicit racial bias if African Americans still cannot afford health care and there are no health care facilities in their neighborhoods.

Hence, in order to put an end to racial bias within the health care system, Professor Matthew suggests the use of a new theory that she has created called "structurally derived discrimination."¹²⁸ The structurally derived discrimination theory takes into consideration all forms of racial bias that affect African Americans' health status and access to health care, and it acknowledges the interconnectedness of health, wealth, and power.¹²⁹ This means that solutions that focus on putting an end to health care providers' explicit and implicit racial bias against African Americans must be linked with solutions that change the structural racial bias in health care in order to provide care based on need rather than on the ability to pay or physician status and power. Without connecting the solutions to the elimination of interpersonal, institutional, and structural racial bias, Professor Matthew argues that little will change. Recognizing this need to address all forms of racial bias, the solutions discussed below address the structural problems of racial bias and the interconnectedness of interpersonal, institutional, and structural racial bias within the health care system that cause racial disparities in health status and access to health care.

First and foremost, the government must equalize Africans Americans' opportunities to quality education, employment, and housing. Second, instead of focusing on individual responsibility solutions, such as patient health education, which is the prevailing approach under the ACA, the government must acknowledge that "many of the decisions that shape an individual's opportunity to pursue health are outside the control of the individual."¹³⁰ According to Drs. Lang and Bird, a better approach is "to identify the relevant stakeholders whose decisions shape or constrain individual opportunity to pursue health and assign

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responsibility accordingly.”¹³¹ Therefore, policy makers, legislators, and regulators must hold all parties accountable, not just the patients who are powerless to change *26 the racial bias within the health care system that allows physicians to provide African American patients with less than the necessary care; hospitals and nursing homes to provide them substandard care; and health care services to be delivered to them based on ability to pay rather than need.

Specifically, the government must expand individual responsibility solutions to include corporations, specifically health care corporations, who are viewed as individuals under the law.¹³² Using the power of the purse, the government needs to prohibit health care corporations such as hospitals that receive state and federal tax-exempt status from bringing wage garnishment lawsuits against patients who are poor and qualify for hospital debt relief.¹³³ Not only does this waste taxpayer dollars that could be used for better schools or Medicaid expansion, but it also has a chilling effect on those seeking medically necessary care that they cannot afford. If these health care corporations will not voluntarily stop, then the government needs to revoke their tax-exempt status. Furthermore, the government should not only stop paying hospitals and nursing homes for substandard health care provided to Medicare and Medicaid patients, but it should also follow the lead of New Mexico's Attorney General and sue hospitals and nursing homes to recoup Medicare and Medicaid payments made to hospitals and nursing homes providing substandard care.¹³⁴

Third, in order to put an end to separate and unequal health care, the federal government must stop funding and supporting racial bias within the health care system. The government must hold everyone responsible for racial bias in the health care system. This means that everyone receiving federal funding under the Medicare and Medicaid Acts must comply with Title VI, and if they do not, then the government must impose penalties on them such as fines. *27 Furthermore, compliance with Title VI cannot be based on statements from those that are violating Title VI; the government must conduct its own Title VI investigations and not simply rely on private complaints.

Fourth, because racial bias is linked to hospital closures, the government needs to put an end to racially-based hospital closures by using Title VI. Specifically, both state and federal regulators must review institutional plans to close or relocate quality health care facilities for the disproportionate harm such plans have on African American communities. This review will force hospitals 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 to care. By instituting this review, the racial link will become clearer, and owners will have to mitigate the harmful effects of closing, relocating, and over-concentrating quality facilities in predominately Caucasian neighborhoods.

Moreover, Dr. Sager suggested in his presentation at the symposium that states need to identify hospitals that are needed to protect the public's health that are likely to close in time to intervene.¹³⁵ Then, the state must make the public aware of the risk of the hospitals closure. To prevent the closure of the hospital, states should allow “officials or citizens to petition a court to take control of a hospital and stabilize its finances under state receivership law or urge the governor to declare that closing the hospital constitutes a ‘public health emergency,’ allowing the State to seize control of [a] needed hospital and stabilize it.”¹³⁶ For permanent protection, “states can use short-term financial relief through a state trust fund financed by 0.25 percent of each hospital's revenue, which is about \$500 million yearly.”¹³⁷

Fifth, after ensuring that hospitals remain open, the government needs to mandate that hospitals adopt policies and practices that make the elimination of racial bias a priority. According to Dr. van Ryn, current studies suggest widespread medical care organizational climates that are racist or subtly tolerant of racism.¹³⁸ These informal organizational norms are supportive of racial bias and encourage the expression of implicit and explicit racial bias by health care providers within these health care organizations. In fact, a recent national *28 survey showed that “over 70% of Black physicians report experiencing racial discrimination in their workplace. In another study, 62% of physicians reported that they had witnessed a patient receive poor

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quality health care because of the patient's race or ethnicity.”¹³⁹ Thus, in order to put an end to institutional racial bias, both state and federal regulators should require health care facilities to conduct strategic diversity planning.¹⁴⁰ The planning should include mandatory diversity courses for all hospital staff--including senior management staff--in which the policies and practices of the health care institution are reviewed for structural, institutional, and interpersonal racial bias. It should also require the adoption of policies that have a zero tolerance for racial bias including an automatic punishment for any infraction of the policy regardless of accidental mistakes, ignorance, or extenuating circumstances.

Sixth, interpersonal racial bias (explicit and implicit) is malleable and can be changed through re-education.¹⁴¹ During her presentation, Dr. van Ryn proposed several re-education practices that can reduce the use of explicit and implicit racial bias by physicians, such as self-awareness, intergroup contact, seeking counter-stereotypic images and imagery, emotional regulation skills by increasing positive emotions, empathy, and partnership building skills.¹⁴²

*29 Furthermore, according to Dr. Sana Loue, a presenter at the symposium, this re-education must include changing cultural competency training to cultural humility training.¹⁴³ Currently, HHS' Office of Minority Health has created voluntary national culturally and linguistically appropriate services (CLAS) standards that are intended to provide health equity and eliminate health care disparities.¹⁴⁴ The CLAS standards are achieved through cultural competency training, which includes equitable governance, diverse leadership and health care workforce, communication and language assistance programs, engagement by health care facilities, and accountability. However, according to Dr. Loue this cultural competency approach has several problems, including but not limited to the fact that:

1. It often assumes that the ‘problem’ of cultural incompetence results from individual ignorance or prejudice, and fails to consider systemic issues;
2. Its promise of mastery is a false promise;
3. It reifies culture without taking into consideration changes in culture and subcultures over time;
4. It fails to consider interaction and mutual evolution of majority and minority groups and culture;
5. It results in stereotypes and responses to stereotypes, such as viewing individuals as members of groups rather than just individuals;
6. It assumes that diversity is a challenge only when a person who is Caucasian encounters a minority;
7. It often fails to consider all salient factors of an individual, such as age, class, economic circumstances, and politics; and

*30 8. It assumes that a person of an identified group is ‘culturally competent’ about that group, *i.e.* an African American person knows everything about all African Americans.¹⁴⁵

Thus, instead of teaching cultural competency, health care providers should be taught cultural humility. The basic assumption of cultural humility training is that in each and every interaction with a patient, there is something that health care providers neither know nor understand which cannot be answered through stereotyping. It can only be answered by expressing humility in each and every encounter with a patient to learn about that specific patient's needs and desires. Additionally, the explicit and implicit negative attitudes and behaviors that health care providers hold against African Americans can only be addressed through a development of critical consciousness which requires “lifelong self-reflection, self-critique, and learning.”¹⁴⁶ Rather

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than being a promise of mastery like cultural competency, cultural humility training tries to transform health care providers into enlightened change agents who are actively engaged in trying to put aside their biases to do the best for their patient. No longer would training emphasize difference between individuals and ignore the similarities; instead, it would train health care providers to view all patients as unique individuals, both similar and different from themselves.

Health care providers should also be trained about Title VI, which prohibits the use of racial bias in the health care system. According to Celeste Davis, a presenter at the symposium, the HHS Office of Civil Rights has partnered with the National Consortium for Multicultural Education for Health Professionals since 2009 to create a medical school course to help develop a health professional curriculum that addresses racial disparities in health and Title VI training.¹⁴⁷ The curriculum “is scenario-based and uses role-playing and discussion to teach students about illegal racial discriminatory actions and their *31 impact on health disparities, and to appreciate the leadership role health professionals can play in the broader public policy arena” regarding health care disparities and discrimination.¹⁴⁸ The curriculum has been used at member schools including Stanford, Emory, and University of Colorado.

Thus, to put an end to interpersonal racial bias within health care, all health care provider training, including but not limited to state continuing medical education, medical school education, residency training, nursing school education, social worker education, hospital administrator education, master of business administration in health care, and pre-medical education, must include implicit and explicit racial bias re-education practices, cultural humility training, and Title VI training. The training must be mandatory.

Finally, if institutions and health care providers are unwilling to make changes, Professor Vernellia Randall, in her presentation at the symposium, proposed adopting a new anti-discrimination law that would hold institutions and health care providers responsible for intentional, reckless, and negligent racial bias that affects African Americans' access to health care.¹⁴⁹ The law would authorize and fund the use of medical testers and provide a private right of action both for individuals who are victims of racial bias and for organizations that represent these individuals.¹⁵⁰ The law would also require the establishment of an Equity Health Care Council by HHS that would be responsible for data collection and reporting concerning racial bias in health care.¹⁵¹ Furthermore, each health care institution and health care provider would be responsible for submitting a racial equity report card that would be available online and in print to patients seeking care.¹⁵² If a health care institution or a health care provider was sued and found guilty for violating the law, then that person or entity would be fined, subject to punitive damages, and have to pay attorneys fees.¹⁵³

Adopting all of the solutions discussed above would not only put an end to racial bias within the health care system, but it would also *32 ensure that African Americans would have equal access to quality health care, decrease racial disparities in morbidity and mortality, and save at least 835,700 African American lives¹⁵⁴ and \$337 billion over the next ten years.¹⁵⁵

CONCLUSION

One hundred forty-nine years after the end of slavery, the time has come for African Americans to be treated equally in every sphere of U.S. society, including health care. Fifty years ago, African Americans were promised equal access to health care with the passage of Title VI. That promise was a lie, and as a result, African Americans are more disabled and die more often than Caucasians. Lacking access to quality health care, African Americans are sick and tired of being sick and tired. In order to finally equalize a health care system that has been separate and unequal since the Civil War, the government must act. The time has come to put an end to racial bias in health care by treating all patients as human beings who deserve the right to equal access to quality health care regardless of race, so that the promise of equality in health care will finally be a reality.

Footnotes

- d1 Professor of Law, Case Western Reserve University, School of Law, B.S. (Honors Biology), University of Michigan, 1996; J.D., Georgetown University Law Center, 2000; M.P.H., Johns Hopkins School of Public Health, 2000. I would like to thank Ayesha Hardaway for her insightful comments. My gratitude extends to Ayanna Yearby and Irene F. Robinson for their assistance and support. Many thanks to all the speakers who participated in the 2014 Case Western Reserve University, School of Law, Law-Medicine Symposium entitled "Sick and Tired of Being Sick and Tired: Putting an End to Separate and Unequal Health Care in the United States 50 Years After the Civil Rights Act of 1964." Finally, thank you to the student editors of Health Matrix for their diligent work in publishing Volume 25.
- 1 THE SPEECHES OF FANNIE LOU HAMER: TO TELL IT LIKE IT IS 62 (2011) (Maegan Parker Brooks & Davis W. Houck eds., 2011) (quoting a speech given by Hamer at Williams Institutional CME Church in Harlem, New York on December 20, 1964).
- 2 See DAVID BARTON SMITH, HEALTH CARE DIVIDED: RACE AND HEALING A NATION 11 (1999). Moreover, a universal health care system would mean that poor whites would have the same access to health care as rich whites. As a result of this desire to keep not only the races separate, but also to keep the classes separate, the U.S. health care system was structured by linking ability to pay to delivery of care. See *id.* at 28-30.
- 3 U.S. COMM'N ON CIVIL RIGHTS, FEDERAL TITLE VI ENFORCEMENT TO ENSURE NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS 24 (1996). (hereinafter U.S. COMM'N ON CIVIL RIGHTS, FEDERAL TITLE VI ENFORCEMENT (1996)); see Civil Rights Act of 1964, 42 U.S.C.A. §§ Fd-2000d-1 (West 2004). Title VI also prohibits denial of health care based on national origin and color. *Id.*
- 4 See generally INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC INEQUITIES IN HEALTH CARE (2002).
- 5 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) (estimating that 83,570 African Americans die annually from health disparities, which although "observed across a broad range of racial, ethnic, socioeconomic, and geographic subgroups in America, ... the history of African Americans, rooted in slavery and post-slavery segregation, motivates our focused analysis of black-white health disparities.").
- 6 TIMOTHY WAIDMANN, URBAN INST., ESTIMATING THE COST OF RACIAL AND ETHNIC HEALTH DISPARITIES 1, 6, 11, 12 (2009). This study compared the changing of age-specific prevalence rates for diabetes, hypertension, stroke, renal disease, and fair/poor health between African Americans, Hispanics, and non-Hispanic Caucasians and found health disparities between the races. Using these health disparities, the researchers found that "the two largest public sector health insurers, Medicare and Medicaid, do experience excess costs for both African Americans--more than \$12 billion annually in combined costs--and Hispanics--nearly \$5 billion." *Id.* African American/Caucasian health disparities resulted in estimated substantial excess costs for private insurers of \$4.9 billion annually and \$233 million for Hispanic/Caucasian disparities. *Id.* "Finally, considering payments made to providers directly by individuals, we estimated that excess disease prevalence among African Americans results in more than \$2 billion per year in out-of-pocket costs for African American patients. For Hispanics, there were no excess out-of-pocket costs, but rather a small reduction caused by disparities." *Id.* (emphasis added).
- 7 See Ruqaiijah Yearby, *When is a Change Going to Come?: Separate and Unequal Treatment in Health Care Fifty Years After Title VI of the Civil Right Act of 1964*, 67 SMU L. REV. 287, 289 (2014).
- 8 Camara Phyllis Jones, *Confronting Institutionalized Racism*, 50 PHYLON 7, 9 (2002). "Racism" and "racial bias" are used interchangeably in the health care disparities literature and they are used exclusively in the health law literature. For clarity, I have chosen to use racial bias to prevent confusion.

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- 9 See Elizabeth A. Pascoe & Laura Smart Richman, *Perceived Discrimination and Health: A Meta-Analytic Review*, 135 PSYCHOL. BULL. 531, 532 (2009); 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, 2132 (2004).
- 10 Historically, race, ethnicity, national origin, class, gender, age, sexual orientation, religion, and disability, have all have all been statuses or identities that have disadvantaged groups in the United States while unfairly advantaging others. See Richard Delgado, *Two Ways to Think About Race: Reflections on the Id, the Ego, and Other Reformist Theories of Equal Protection*, 89 GEO. L. J. 2279, 2280 (2001); Andrew Grant-Thomas & John A. Powell, *Toward Structural Racism Framework*, 15 POVERTY & RACE, Nov-Dec. 2006, at 3, 4; 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); Charles R. Lawrence III, *The Id, the Ego, and Equal Protection: Reckoning with Unconscious Racism*, 39 STAN. L. REV. 317, 329 (1989); Kimberle Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Policies*, U. CHI. LEGAL F. 139, 140 (1989). These disadvantages affect the health of those that are disadvantaged. See Paula Braveman, *Socioeconomic Disparities in Health in the United States: What the Patterns Tell Us*, 100 AM. J. PUB. HEALTH S186, S186-88 (2010); Leith Mullings & Amy Schulz, *Intersectionality and Health: An Introduction*, in GENDER, RACE, CLASS, AND HEALTH 3, 12 (2006) (examining the different forms of isms that affect individuals health status); Pamela Braboy Jackson & David R. Williams, *The Intersection of Race, Gender and SES: Health Paradoxes*, in GENDER, RACE, CLASS, AND HEALTH 131, 131 (Amy J. Schulz & Leith Mullings eds., 2006) (examining the effects of different statuses on health disparities); Ruthe E. Zambrana & Bonnie Thorton Dill, *Disparities in Latina Health: An Intersectional Analysis*, in GENDER, RACE, CLASS, AND HEALTH 192, 202 (Amy J. Schulz & Leith Mullings eds. 2006) (examining the effects of different statuses on health disparities); Peter Franks et al., *The Burden of Disease Associated with Being African-American in the United States and the Contribution of Socio-Economic Status*, 62 SOC. SCI. & MED. 2469, 2469-72 (2006). The largest disparity in accessing quality health care and health status in the United States is between African Americans and Caucasians. Satcher et al., *supra* note 5, at 459. Data regarding health disparities is often limited to a comparison between African Americans and Caucasians. Therefore, the disparity between African 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.
- 11 See Jacqueline L. Angel & Ronald J. Angel, Commentary, *Minority Group Status and Healthful Aging: Social Structure Still Matters*, 96 AM. J. PUB. HEALTH 1152, 1154 (2006); Steven P. Wallace, *The Political Economy of Health Care for Elderly Blacks*, 20 INT'L J. HEALTH SERVS. 665, 674 (1990); David R. Williams, *Race, Socioeconomic Status, and Health: The Added Effects of Racism and Discrimination*, 896 ANNALS N.Y. ACAD. SCI. 173, 177-179 (1999); David R. Williams & Chiquita Collins, *Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health*, 116 PUB. HEALTH REP. 404, 405-07 (2001). Their research shows that residential segregation and socioeconomic status are inextricably linked to the continuation of racial bias. Wallace, *supra* at 674; Williams, *supra* at 177-179; Williams & Collins, *supra* at 407. In fact, Steven Wallace and David Williams believe that the cause of geographic racial segregation and socioeconomic status is linked to racial discrimination. See Wallace, *supra* at 673-78; Williams & Collins, *supra* at 405-406; Furthermore, recently released nursing home data on race suggests that, although residential segregation is a significant factor in racial inequities in nursing home care, this residential segregation is caused by racial discrimination such as redlining neighborhoods and denying admission to African Americans. David Barton Smith et al., *Separate and Unequal: Racial Segregation and Disparities in Quality Across U.S. Nursing Homes*, 26 HEALTH AFF. 1448, 1456 (2007). Thus, even neutral reasons are not separate from racial bias. See Ruqaiijah 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, 462-70 (2007) (discussing how racial discrimination plays a part in geographical racial segregation and socioeconomic status).
- 12 Rene Bowser, *Race and Rationing*, 25 HEALTH MATRIX (2015); A. Mort et al., *Physician Discretion and Racial Variation in the Use of Surgical Procedures*, 154 ARCHIVES INTERNAL MED. 761, 761 (1994).
- 13 ALAN SAGER & DEBORAH SOCOLAR, CLOSING HOSPITALS IN NEW YORK STATE WON'T SAVE MONEY BUT WILL HARM ACCESSTO 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%2020Nov06.pdf)
- 14 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); Michelle van Ryn et al., *Physicians' Perceptions of Patients' Social and*

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Behavioral Characteristics and Race Disparities in Treatment Recommendations for Men with Coronary Artery Disease, 96 AM. J. PUB. HEALTH 351, 351-54 (2006); 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); Kevin A. Schulman et al., *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catherization*, 340 NEJM 618, 622-24 (1999); John Ayanian, *The Effect of Patients' Preferences on Racial Differences in Access to Renal Transplantation*, 341 NEJM 1661, 1661,1663 (1999).

15 See SMITH, *supra* note 2, at 29; see also David Barton Smith, *The "Golden Rules" for Eliminating Disparities: Title VI, Medicare and the Implementation of the Affordable Care Act*, 25 HEALTH MATRIX (2015).

16 See SMITH, *supra* note 2, at 28.

17 *Id.* at 29-30. Blue Cross Blue Shield was the nation's first private insurer. See *id.*

18 See *id.* Those who were poor and African American were left totally out of the system. *Id.*

19 Both the Hill-Burton Act and Title VI of the Civil Rights Act of 1964 prohibit the denial of health care based on race; however, the government has failed to prosecute entities and individuals responsible for racial bias, instead allowing voluntary compliance with the law that has resulted in the continuation of separate and unequal health care due to racial bias. Yearby, *supra* note 7, at 288, 297.

20 See Hospital Survey and Construction Act, 42 U.S.C. § 291e(f) (2006).

21 See *id.*

22 Smith, *supra* note 15.

23 Hospital Survey and Construction Act, Pub. L. No. 79-725, § 622(f)(1), 60 Stat. 1041 (1946) (Emphasis added).

24 Yearby, *supra* note 11, at 435. See *id.* at 463, n. 76.

25 Smith, *supra* note 15.

26 *Id.*

27 *Id.*

28 *Id.*

29 Physicians receiving payments under Medicare Part B are exempt from compliance with Title VI because these payments are not defined as federal financial assistance. See SMITH, *supra* note 2, at 161-64. 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, 46-65 (2002).

30 SMITH, *supra* note 2, at 159-63.

31 *Id.* at 145-59, 174-6, 246-50.

32 William G. Weissert & Cynthia Matthews Cready, *Determinants of Hospital-to-Nursing Home Placement Delays: A Pilot Study*, 23 HEALTH SERVS. RES. 619, 642, 645 (1988); Ronald Sullivan, *Study Charges Bias in Admission to Nursing Homes*, N.Y. TIMES, Jan. 28, 1984, <http://www.nytimes.com/1984/01/28/nyregion/study-charges-bias-in-admissions-to-nursing-homes.html>; Ronald Sullivan, *New Rules Sought on Nursing Homes*, N.Y. TIMES, May 5, 1985, <http://www.nytimes.com/1985/05/05/nyregion/new-rules-sought-on-nursing-homes.html>.

33 See Peter B. Bach et al., *Racial Differences in the Treatment of Early-Stage Lung Cancer*, 341(16) NEJM 1198, 1204 (1999); see John Z. Ayanian et al., *Quality of Care by Race and Gender for Congestive Heart Failure and Pneumonia*, 37 MED. CARE 1260, 1260-61,

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1265 (1999); Schulman et al., *supra* note 14, at 622-624 (“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.”); *see also* 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, 58 (2010) (discussing the successes and failures of federal programs aimed at elimination of racial bias 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).

34 SAGER & SOCOLAR, *supra* note 13, at 27-31.

35 Janice Sabin & Anthony Greenwald, *The Influence of Implicit Bias on Treatment Recommendations for 4 Common Pediatric Conditions: Pain, Urinary Tract Infection, Attention Deficit Hyperactivity Disorder, and Asthma*, 102 AM. J. PUB. HEALTH 988, 992 (2012).

36 Ruqaiijah Yearby, *Breaking the Cycle of “Unequal Treatment” with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias*, 44 CONN. L. REV. 1281, 1288 (2012).

37 *Id.* at 1310-1316.

38 *Id.* at 1316.

39 Smith, *supra* note 15.

40 Mullings & Schulz, *supra* note 10, at 12.

41 *See* Vickie M. Mays et al., *Race, Race-Based Discrimination, and Health Outcomes Among African Americans*, 58 ANN. REV. PSYCHOL. 201 (2007); Arline T. Geronimus et al., “*Weathering*” and Age Patterns of Allostatic Load Scores Among Blacks and Whites in the United States, 96 AM. J. PUB. HEALTH 830, 830 (2006).

42 Although education, employment, and housing opportunities are not within the control of the health care system, they have such a significant effect on the health of individuals that they have been designated as social determinants of health. Defined by the World Health Organization, social determinants of health are defined as social structures and economic systems, shaped by the distribution of money, power, and resources throughout local communities, nations, and the world, including education, employment, and housing. *See* Comm’n on Social Determinants of Health (CSDH), *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health*. WHO: GENEVA (2008), available at http://www.who.int/social_determinants/sdh_definition/en/.

43 *See* Timothy Waidmann, *Estimating the Cost of Racial and Ethnic Health Disparities*, URBAN INST. (Sept. 2009); EDUARDO BONILLA-SILVA, *RACISM WITHOUT RACISTS: COLOR BLIND RACISMANDTHE PERSISTENCE OF RACIAL INEQUALITYINTHE UNITED STATES* (Rowman & Little-field Publishers, Inc., 2d ed. 2006); Linda Darling-Hammond, *Unequal Opportunity: Race and Education*, BROOKINGS INST. (Spring 1998), <http://www.brookings.edu/research/articles/1998/03/spring-education-darling-hammond>; ROBERT BLAUNER, *RACIAL OPPRESSIONIN AMERICA* (1972).

44 Vernellia R. Randall, *Eliminating the “Black Health Deficit” of African Descendants in the Americas and Europe by Assuring Access to Quality Health Care*, U.N. HUMAN RIGHTS, OFFICE OF THE HIGH COMM’R FOR HUMAN RIGHTS, http://www2.ohchr.org/english/events/itypad2011/documents/Working_Group_on_African_Descent/2008_WGPAD_Session/Black_Health_Deficit-VR_Randall.doc (last downloaded on Apr. 2, 2015).

45 *Id.*; *see also* Vernellia R. Randall, *Race, Health Care and the Law Regulating Racial Discrimination in Health Care*, RACISM & PUB. POL’Y 6 (2001), available at [http://www.unrisd.org/80256B3C005BCCF9/\(httpAuxPages\)/603AC6BDD4C6AF8F80256B6D005788BD/\\$file/drاندall.pdf](http://www.unrisd.org/80256B3C005BCCF9/(httpAuxPages)/603AC6BDD4C6AF8F80256B6D005788BD/$file/drاندall.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

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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.”).

46 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, 1024 (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).

47 *Id.*

48 African-Americans continue to be treated unequally because of racial bias in decisions regarding bankruptcy, residential zoning, mortgage lending, apartment rental, housing rental, and hiring. See James B. Kau et al., *Racial Discrimination and Mortgage Lending*, 45 J. REAL ESTATE FINAN. ECON. 289, 295 (2012); Tara Siegel Bernard, *Blacks Face Bias in Bankruptcy, Study Suggests*, N.Y. TIMES, Jan. 20, 2012, <http://www.nytimes.com/2012/01/21/business/blacks-face-bias-in-bankruptcy-study-suggests.html>; Hannah Dreier, *Bias Against Blacks Prevalent in Richmond Housing*, CONTRA COSTA TIMES, Oct. 28, 2011, http://www.mercurynews.com/breaking-news/ci_19217513; Lisa Prevost, *Housing Lawsuit Alleges Bias*, N.Y. TIMES, Dec. 8, 2011, <http://www.nytimes.com/2011/12/11/realestate/connecticut-in-the-region-housing-lawsuit-alleges-bias.html>; 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 (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/>; Devah Pager & Hana Shepherd, *The Sociology of Discrimination: Racial Discrimination in Employment, Housing, Credit, and Consumer Markets*, 34 ANN. REV. SOC. 181 (2008); Marianne Bertrand & Sendhil Mullainathan, *Are Emily and Greg More Employable Than Lakisha and Jamal? A Field Experiment on Labor Market Discrimination*, NAT'L BUREAU OF ECON. RES., 2003, NBER Working Paper No.: 9873. 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 2011. Assoc. Press, *Ruling Stands in “White Only” Pool Sign Case*, BOS. GLOBE, Jan. 13, 2012, http://www.boston.com/news/nation/articles/2012/01/13/ohio_panel_upholds_ruling_in_white_only_pool_sign_case/.

49 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).

50 Martha E. Lang & Chloe E. Bird, *Understanding and Addressing the Common Roots of Racial Disparities: The Case of Cardiovascular Disease & HIV/AIDS in African Americans*, 25 HEALTH MATRIX (2015).

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- 86 Bowser, *supra* note 12.
- 87 See *id.*
- 88 Dimick, *supra* note 66.
- 89 *Id.* at 1049.
- 90 *Id.* at 1048.
- 91 *Id.* at 1051.
- 92 Smith, *supra* note 15.
- 93 Adil H. Haider et al., *Race and Insurance Status as Risk Factors for Trauma Mortality*, 143 ARCHIVES SURGERY 945, 947-948 (2008) (explaining that race was a significant risk factor for insured and uninsured patients).
- 94 BEATRIX HOFFMAN, HEALTH CARE FOR SOME: RIGHTS AND RATIONING IN THE UNITED STATES SINCE 1930, at 198 (2012); SAGER & SOCOLAR, *supra* note 13, at 27-31.
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- 98 See SAGER & SOCOLAR, *supra* note 13, at 27-31.
- 99 Alan Sager, Professor of Health Policy & Mgmt., Bos. Univ. Sch. of Pub. Health, *Urban Hospital Closures: Why Care? What to Do? Policy and Financial Remedies for a Race-linked Health Problem*, Presentation at the Case Western Reserve University School of Law, Law-Medicine Symposium (Mar. 28, 2014), at 28 (presentation on file with the author).
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- 101 *Id.* at 31.
- 102 See Clark, *supra* note 46, 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.”).
- 103 *Id.* at 1034.
- 104 *Id.*
- 105 *Id.* at 1034-35.
- 106 See *id.* at 1033-34 (highlighting the importance of understanding “physician flight” as an important consequence of disruptions in primary care services, and particularly hospital closures).
- 107 *Id.*
- 108 *Id.* at 1034.
- 109 See Gwendolyn Roberts Majette, *Access to Health Care: What a Difference Shades of Color Make*, 12 ANNALS HEALTH L. 121, 130 (2003).
- 110 See Clark, *supra* note 46, at 1034-35 (describing the “ghettoization” of hospitals that remain in areas serving minority communities).
- 111 Michelle van Ryn, Professor of Health Servs. Research, Mayo Clinic Sch. of Med., *Disparities in Care and Unintended Biases in Clinical Decision-Making and Behavior*, Address at the Case Western Reserve University School of Law, Law-Medicine Symposium (Mar. 27, 2014), at 7 (presentation on file with the author). Dr. van Ryn also noted that research shows that 80% of Caucasian Americans show a significant implicit preference for Caucasians over African Americans. *Id.* at 12.
- 112 van Ryn & Burke, *supra* note 14, at 354. African Americans often sense this bias against them, which results in delays seeking care, an interruption in continuity of care, non-adherence, mistrust, reduced health status, and avoidance of the health care system. 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).
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- 120 Neil S. Calman, *Out of the Shadow: A White Inner-City Doctor Wrestles with Racial Prejudice*, 19 HEALTH AFF. 170, 172-74 (2000).
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- 124 Green, *supra* note 113.
- 125 *Id.* at 1234, tbl.1, 1235-36.
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- 136 *Id.* at 42
- 137 *Id.* at 42.

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- 141 Research suggests that making health care providers aware of their implicit racial bias and how their implicit racial bias can influence outcomes of medical encounters can help motivate health care providers to correct their implicit bias. 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).
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- 147 Celeste Davis, *Federal Initiatives to Eliminate Health Care Disparities and Develop a Culturally Robust Health Care Workforce*, Presentation at 2014 Case Western Reserve University School of Law, Law-Medicine Symposium (Mar. 28, 2014), at 14 (presentation on file with the author); see also *Stopping the Discrimination Before it Starts: The Impact of Civil Rights Laws on Health Care Disparities--A Medical School Curriculum*, U.S. DEPT OF HEALTH & HUMAN SERVS., <http://www.hhs.gov/ocr/civilrights/resources/training/pptworkshop.pdf> (last visited July 17, 2014).
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- 149 Vernellia Randall, *Dying While Black: Why The Civil Rights Act of 1964 is Inadequate for 21st Century Discrimination*, Presentation at 2014 Case Western Reserve University School of Law, Law-Medicine Symposium (Mar. 28, 2014), at 12-16 (presentation on file with the author).
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- 151 *Id.*
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- 154 Satcher et al., *supra* note 5, at 459.

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