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WHEN IS A CHANGE GOING TO COME?: SEPARATE AND UNEQUAL TREATMENT IN
HEALTH CARE FIFTY YEARS AFTER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

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“Our urgent responsibility is to assure adequate health care to all Americans I think that none would deny that consideration of race or color has no place with regard to the ailing body or the healing hand.”

--Anthony J. Celebrezze, Secretary of Health, Education, and Welfare (March 9, 1964)¹

I. INTRODUCTION

ON June 19, 1963, when the Civil Rights Act was first introduced, President John F. Kennedy said in a message to Congress:

Events of recent weeks have again underlined how deeply our Negro citizens resent the injustice of being arbitrarily denied equal access to those facilities and accommodations, which are otherwise open to the general public. That is a daily insult, which has no place in a country proud of its heritage-- the heritage of the melting pot, of equal rights, of one nation and one people. No one has been barred on account of his race from fighting or dying for America--there are no ‘white’ or ‘colored’ signs on the foxholes or graveyards of battle. Surely, in 1963, 100 years after emancipation, it should not be necessary for any American citizen to demonstrate in the streets for the opportunity to stop at a hotel, or to eat at a lunch counter in the very *288 department store in which he is shopping, or to enter a motion picture house, on the same terms as any other customer.²

Enacted in memorial to President Kennedy, the passage of the Civil Rights Act of 1964 was a monumental feat.³ Title VI of the Civil Rights Act of 1964 was the vehicle used by Congress to put an end to racial bias in health care, education, and other areas.⁴ One member of Congress noted that Title VI “represented the moral sense of the Nation that there should be racial equality in Federal assistance programs.”⁵ In health care, Title VI prohibits health care facilities in receipt of government funding from using racial bias to determine who receives quality health care.⁶ It provides both a private right of action and mandates for government enforcement. Section 601 provides private parties with the right to sue health care facilities that use racial bias to prevent their participation or access to benefits under programs funded by federal financial assistance, such as

Medicare or Medicaid payments.⁷ Section 602 requires the federal government to undertake measures to ensure that health care facilities receiving federal financial assistance do not prevent participation or access to health care benefits based on race.⁸ Unfortunately, fifty years after the passage of Title VI, health care in the United States continues to be racially separate and unequal.⁹ Thus, one must ask: when is a change going to come?

***289** Prior to the passage of Title VI, hospitals and nursing homes funded by the federal government were racially segregated. The hospitals and nursing homes with the best quality care served Caucasians, while African Americans were treated in substandard facilities. Since the passage of Title VI, many hospitals and nursing homes that receive federal funding have continued to be racially segregated, and those that serve African Americans are still substandard.¹⁰ This separate and unequal health care system in the United States is caused by racial bias prohibited by Title VI.¹¹ This situation can no longer be ignored. Hence, in this article I undertake ***290** a critical analysis of the failure of Title VI to put an end to racial bias in health care in the United States, discuss how racial bias causes racial disparities in African Americans' access to quality health care and health status, and provide suggestions on how to put an end to racial bias in health care.

Using nursing homes and hospitals as case studies, Section II compares the state of health care in the United States prior to and after the passage of Title VI to show that there have been little to no gains made in eradicating racial bias. In fact, David Barton Smith's research has shown that nursing homes have never achieved full racial integration or actively sought African American patients.¹² The only change in nursing homes after Title VI was the removal of blatant discriminatory advertising.¹³ Nursing homes are not the only culprits. Empirical evidence shows that racial bias remains rampant in every facet of health care. In the 1970s, some hospitals remained racially segregated by floor, room, and staff.¹⁴ In the 1980s, African Americans were denied admission to nursing homes that provided excellent quality of care.¹⁵ In the 1990s, studies found that some physicians believed minority patients were unintelligent, which kept physicians from recommending medically appropriate cardiac catheterization, curative surgery for early-stage lung cancer, and antibiotics to treat pneumonia, thereby increasing mortality rates of African Americans.¹⁶ In the 2000s, research showed that race was a significant factor in the decision to close hospitals between 1937 and 2003.¹⁷ In the 2010s, ***291** physician surveys showed that some pediatricians' racial bias prevented them from prescribing medically necessary pain medication for African American children following surgery.¹⁸ Thus, because racial bias persists in health care, it comes as no surprise that health care remains racially separate and unequal.

Section III discusses how each branch of the federal government has not only failed to put an end to racial bias in health care as mandated by Title VI, but also it has often further exacerbated the problem by eliminating private rights to challenge the continuation of racial bias and ignoring the existence of racial bias. The U.S. Department of Health and Human Services (HHS), the executive branch agency in charge of enforcing Title VI in health care,¹⁹ has failed to racially integrate and equalize the care provided by hospitals, ignored the use of racial bias in nursing home admissions, and exempted physicians from compliance with Title VI.²⁰ The judicial branch has not only eviscerated the protections under Title VI by limiting private parties' right to sue for disparate impact bias, but it has also allowed HHS to neglect its duties to enforce Title VI.²¹ Even though congressional reports and congressionally ordered reports by the U.S. Commission on Civil Rights (USCCR) and the Institute of Medicine (IOM) have noted the continuation of racial bias in health care and the government's failure to enforce Title VI, the legislative branch did not mention racial bias or fix the problems with Title VI when it passed the Patient Protection and Affordable Care Act (ACA).²² With limited options to challenge racial bias in health care, African Americans continue to be denied equal access to quality health care because of racial ***292** bias.²³

Reviewing decades of empirical research studies, Section IV shows how the continuation of interpersonal and institutional racial bias has led to racial disparities in access to quality health care and health status.²⁴ *293 Interpersonal racial bias is the conscious (explicit) or unconscious (implicit) *294 use of racial prejudice in interactions between individuals.²⁵ Interpersonal racial bias in health care is best illustrated by physicians' treatment decisions based on their racial prejudice that results in the unequal treatment of African Americans.²⁶ This often leads to racial disparities in mortality rates compared to Caucasians.²⁷ Institutional racial bias operates through organizational structures within institutions and "establish[es] separate and independent barriers"²⁸ to health care services.²⁹ According to Brietta Clark, institutional racial bias in health care is best demonstrated by hospital closures in African American communities,³⁰ which leaves minority neighborhoods without access to medical services.³¹ Due to these biases, African Americans are prevented from accessing quality health care, which leads to African Americans' increased *295 disability and mortality.³² Unfortunately, when passing the ACA, the government ignored the significance of racial bias in causing racial disparities in access to quality health care, and by extension, health status; instead it focused on research, data collection, and quality improvement programs that do not take into account racial bias.³³

Section V critiques the ACA's programs designed to address racial disparities in health care, discusses new HHS plans and programs to address racial disparities, and provides solutions to put an end to racial bias in health care and eliminate racial disparities in access to health care and health status. In response to the passage of the ACA, HHS issued an Action Plan to Reduce Racial and Ethnic Health Disparities (Action Plan),³⁴ developed the National Stakeholder Strategy for Achieving Health Equity in order to ensure that racial and ethnic minorities reach their full health potential,³⁵ and partnered with the National Consortium for Multicultural Education for Health Professionals to create a medical school course concerning civil rights law and health disparities.³⁶ These programs are a move in the right direction; however, additional steps are needed.

In order to address interpersonal bias, the government should educate health care providers about their racial bias that affects medical treatment decisions and apply Title VI to physicians. To put an end to institutional racial bias, initiatives to put an end to racial disparities in health care need to be integrated with Title VI enforcement and Medicare and Medicaid quality regulations. For example, the collection of racial data that evidences racial disparities in health care should be shared with those prosecuting racial bias under Title VI and those who enforce Medicare and Medicaid to regulate the quality of health care provided by health care facilities. Additionally, both state and federal regulators should require all government-funded health care facilities to conduct strategic diversity planning, which includes increasing the diversity of health care providers and patients within the health care facility. Finally, regulators must require any health care entity planning to close quality health care facilities in predominately minority neighborhoods to submit a racial impact statement that assesses the harm to the minority neighborhood. Many of these solutions, such as provider education and racial impact *296 statements, can be implemented under the current laws and regulations, while others such as applying Title VI to physicians, will require changes in the rules. Nevertheless, without these changes, racial bias in health care will continue making Title VI's promise of equal access to health care a lie.

II. THE MORE THINGS CHANGE, THE MORE THEY STAY THE SAME: SEPARATE AND UNEQUAL HEALTH CARE FIFTY YEARS LATER

Throughout the development, regulation, and funding of hospitals and nursing homes in the United States, some form of racial bias has always been present. In fact, the influence of racial bias in the development of the United States' health care system was so pervasive that the federal government provided funding to ensure that nursing homes and hospitals remained racially separate and unequal.³⁷ During the 1960s, African Americans waged national and international battles to obtain the rights of full citizenship in the United States.³⁸ With the passage of the Civil Rights Act of 1964, the United States promised African Americans equality of rights in every public area of life, including the right to quality health care. In particular, Title VI was

supposed to put an end to all racially “discriminatory activities, including denial of services [and] differences in quality, quantity, or manner of services”³⁹ within the health care system. Unfortunately, the more things change, the more things stay the same. Racial bias is still present in the health care system, and thus discriminatory activities in health care, such as denial of services and differences in quality, quantity, or manner of services based on race, continue.

A. SEPARATE AND UNEQUAL BEFORE TITLE VI

In the 1800s, the nursing home system was segregated based on class because African Americans were not admitted. Rich whites were housed in private charitable facilities, while poor whites were housed in county or public general hospitals, psychiatric hospitals, poor houses, and poor farms.⁴⁰ African Americans received their care from families regardless of whether they were slaves or not. They were not even allowed to take part in this system until approximately 135 years later, when they were provided care by public institutions.⁴¹

With the passage of the Social Security Act of 1935 (SSA), the federal government established federal funding for the elderly under the Old *297 Age Assistance Program⁴² but prohibited public institutions from receiving Old Age Assistance payments.⁴³ Hence, only private institutions housing the elderly, i.e., nursing homes, could receive payment under this program. This prohibition was particularly significant because in the 1930s the health care system was racially separated based on whether the institution was public or private.⁴⁴ Most African Americans received their care at public institutions, while Caucasians received their care at private institutions.⁴⁵ Because public institutions were prohibited from receiving Old Age Assistance payments, the passage of the SSA served as a means to foster the segregation of races in nursing homes.⁴⁶ With the influx of cash, private nursing homes developed acute care or geriatric wings in private hospitals for rich whites and private boarding houses for poor and disabled whites.⁴⁷ Racial segregation in nursing homes was further exacerbated by the enactment of the Hospital Survey and Construction Act of 1946, better known as the Hill-Burton Act.⁴⁸

The Hill-Burton Act allotted funding for the construction of hospitals and granted states the authority to regulate this construction.⁴⁹ Hospitals used this funding to construct, among other things, nursing home wards and freestanding geriatric hospitals to care for the elderly, the precursors to current day nursing homes.⁵⁰ The Act also provided that adequate healthcare facilities be made available to all state residents without discrimination of color.⁵¹ This language seemingly granted adequate funding without discrimination, but Section 622(f) negated this promise. Section 622(f) of the Hill-Burton Act 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 group⁵²

Consequently, the Act was designed to induce the states through financial support to supervise, regulate, and maintain the placement of adequate racially segregated hospitals and nursing home facilities throughout their *298 territory.⁵³ To accomplish this goal, the states had to review all applications for funding and submit a detailed plan to the Surgeon General for authorization of funding.⁵⁴ Under Section 622(f) of the Hill-Burton Act, states could opt to participate in the federal program based on a “separate but equal” plan.⁵⁵ Fourteen states submitted “separate but equal” applications to the Surgeon General, who then reviewed the states’ plans to ensure that there was equitable distribution of funding.⁵⁶ The Surgeon General accomplished the goal of keeping health care institutions segregated, but the equitable distribution of funding was never realized.⁵⁷ Instead, it

was commonplace under the Hill-Burton Act to underfund African American health care institutions and use the rest of African Americans' tax money for the construction of health care facilities from which they were barred.

Hence, the federal government's funding of public institutions through the Hill-Burton Act did not equalize the separate and unequal health care system developed under the SSA, particularly in nursing homes and hospitals. In the South, "a separate system of hospitals existed to serve black communities and as a place where [African American] physicians could be trained and practice."⁵⁸ In the North, training opportunities and staff privileges for Caucasian hospitals were limited to Caucasian physicians, resulting in "an almost equivalent degree of [racially] separate and unequal health care."⁵⁹ In fact, at the start of the Great Depression, African Americans' health conditions in the South were similar to their conditions during the slavery era, in part because of their lack of access to quality health care.⁶⁰ The federal government's racially unequal funding of health care institutions under the Hill-Burton Act caused these conditions and led to a civil rights lawsuit that precipitated the passage of Title VI.

Seven years after the Supreme Court's landmark decision in *Brown v. Board of Education*⁶¹ ended racial segregation in public schools, a group of African American physicians, dentists, and patients filed a federal suit styled as *Simkins v. Moses H. Cone Memorial Hospital*.⁶² Filed in the *299 state where the most racially segregated hospitals were located,⁶³ the case challenged the legality of two North Carolina hospitals' receipt of Hill-Burton funding to construct hospitals that provided racially discriminatory care. Using the Equal Protection Clause of the Fourteenth Amendment as a basis, the plaintiffs challenged the constitutionality of Section 622(f) of the Hill-Burton Act that authorized racial bias and won.⁶⁵

The judicial opinion in this case is noteworthy for two reasons. First, the court ruled that the hospitals were state actors and thus violated the Equal Protection Clause of the Fourteenth Amendment when denying access to care by race.⁶⁶ The court based its decision on the fact that the hospitals received millions of dollars worth of federal funding to construct hospitals.⁶⁷ Moreover, the court held that the "hospitals operate as integral parts of comprehensive joint or intermeshing state and federal plans or programs designed to effect a proper allocation of available medical and hospital resources for the best possible promotion and maintenance of public health."⁶⁸ Hence, health care facilities receiving Hill-Burton Act funding were deemed to be state actors or public institutions subject to government regulation. As state actors, the health care facilities were prohibited by the Equal Protection Clause of the Fourteenth Amendment from racially discriminating against African Americans.

Second, the court ruled that the "separate but equal" language in the Hill-Burton Act, which authorized the use of federal funds to construct racially separate health care facilities was unconstitutional.⁶⁹ The court's finding was in part due to the intervention of U.S. Attorney General Robert F. Kennedy on behalf of the African American parties. The Attorney General argued that the government, both state and federal, had authorized and sanctioned the hospitals' racial bias perpetrated against *300 the plaintiffs with the passage of Section 622(f) of the Hill-Burton Act.⁷⁰ The court made a point of noting the persuasiveness of this argument in its invalidation of the "separate but equal" language.⁷¹ The hospitals appealed the case to the Supreme Court, which denied certiorari.

The *Simkins* case was important to the civil rights movement because it provided a broad definition of state actors, which included those regulated by and receiving funding from the government. Additionally, it was significant that the court ruled it was unconstitutional for the government to fund a "separate but equal" health care system. Not only did the government incorporate these rules of law into federal civil rights legislation, but it also referred specifically to the *Simkins* case as it debated the passage of Title VI of the Civil Rights Act of 1964.⁷² Notwithstanding these efforts and the passage of Title VI, racial bias in health care persists in hospitals and nursing homes.

B. SEPARATE AND UNEQUAL AFTER TITLE VI

Research studies show that nursing homes and hospitals remain racially segregated and unequal. Although the “Colored” and “Whites Only” signs have been removed, research studies show that African American patients seeking care are often steered by physicians, nurses, and hospital discharge staff to poor-quality health care institutions because of their race, just as they were prior to the passage of Title VI.⁷³ Furthermore, in 1980, Dr. Alan Sager found that between 1937 and 1977, hospital closures and relocations were directly connected to race.⁷⁴ When more than 50% of the neighborhood population was African American, “almost half of the hospitals either closed or relocated.”⁷⁵ The closure and relocation of hospitals has left African Americans with limited access to hospital care.

Notwithstanding this fact, even when African Americans live closer to high-quality hospitals than Caucasians, they are more likely to undergo surgery at low-quality hospitals.⁷⁶ As a result, African Americans are more likely to die from coronary artery bypass grafting, abdominal aortic aneurysm repair, and resection for lung cancer than Caucasian patients.⁷⁷ This surgery-mortality disparity is in part due to physician referral patterns based on race.⁷⁸ 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 *301 physicians, not by patients and their families,”⁷⁹ and studies show that the provision of primary care is racially separate and unequal, which determines where patients have surgery.⁸⁰ Even when African American patients receive care in the same hospitals as Caucasians, they receive less care. Research shows that African American Medicare beneficiaries with diabetes receive less than the medically necessary treatment compared to Caucasians.⁸¹

Nursing homes also remain racially separate and unequal. Two decades of empirical studies found that African Americans faced longer delays in transfer to nursing homes and are often denied admission to quality nursing homes, relegating elderly African Americans to poor quality nursing homes.⁸² The majority of elderly patients are transferred to a nursing home after a hospital stay.⁸³ The decision to transfer a patient from a hospital to a nursing home is controlled by the patient's physician and the hospital's discharge staff.⁸⁴ A transfer normally occurs once a physician determines that a patient is well enough to be released from the hospital but not well enough to go home.⁸⁵ A member of the hospital discharge staff contacts the nursing home when seeking to transfer a patient.⁸⁶ A delay in transfer is “the time elapsed between when a patient was medically ready for discharge to another form of care and when he or she actually was discharged.”⁸⁷ Delays in transfers to nursing homes have a direct impact on the patient's well being by denying the patient access to medically necessary rehabilitative care, which hospitals are not equipped *302 to provide.⁸⁸

Since the 1980s, studies have shown that African Americans are delayed by at least ten days in a transfer from the hospital to a nursing home.⁸⁹ In 1988, doctors William Weissert and Cynthia Cready found that there was a significant delay in transfer of African Americans from hospitals to nursing homes in North Carolina.⁹⁰ This delay was caused by Caucasian nursing home residents wanting to room with those of the same race.⁹¹ To comply with this request, nursing homes intentionally kept rooms and their facilities segregated by denying admittance to African Americans.⁹² Additional research studies found that because there are fewer African Americans in nursing homes than Caucasians,⁹³ African Americans patients are delayed transfer to nursing homes until they can be placed in the same room with other African Americans or can be transferred to predominately African American nursing homes, which disproportionately provide poor quality care.⁹⁴

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Finally, a study conducted in 2004 found that Caucasian patients with dementia were placed in nursing homes 2.5 times the rate of African American patients even after controlling for socioeconomic status, age, total number of memory and behavioral problems, and caregiver factors.⁹⁵ The study found that race was a primary factor in time to nursing home placement.⁹⁶ As a result of delays in transfer and denial of admission, elderly African Americans are on average two times more likely to reside in poor quality nursing homes than Caucasians.⁹⁷

For instance, in 1984, a study of New York nursing homes showed that nursing homes that provided excellent quality of care demonstrated a pattern of admitting Caucasians over African Americans.⁹⁸ The study was based on civil rights documents submitted by nursing homes to the New York State Health Department.⁹⁹ According to the study, Caucasian patients were admitted to quality nursing homes and those in racial minority *303 groups were relegated to substandard¹⁰⁰ nursing homes.¹⁰¹ Similar to the real estate industry, this inequity was attributed to “a combination of discrimination by nursing homes and steering by hospital discharge planners.”¹⁰² In 1992, the New York State Advisory Committee (Advisory Committee) to the USCCR reviewed nursing home admission practices in New York and found that there were still significant racial inequities in admission between African Americans and Caucasians.¹⁰³ The Advisory Committee's findings showed that Caucasian patients were three times more likely to get into a quality nursing home than minority patients.¹⁰⁴ Of the characteristics used to decide whether to admit a patient, race remained the chief factor, even in nursing homes sponsored by religious organizations, which were more likely to admit those of a different religious background than those of a different race.¹⁰⁵ Based on this evidence, the Advisory Committee found “discrimination on the basis of race plays a role in the rejection of at least some minorities by the nursing homes to which they apply for long-term care.”¹⁰⁶ Although these studies were conducted in the 1980s and 1990s, there is no evidence that nursing homes' race-based admission decisions have stopped.¹⁰⁷

*304 In fact, elderly African Americans brought a lawsuit in *Linton ex rel. Arnold v. Commissioner of Health & Environment* against the government regarding nursing homes' use of Medicaid¹⁰⁸ to discriminate against African Americans.¹⁰⁹ The plaintiffs in this lawsuit asserted that the states' policies for Medicaid bed certification allowed nursing homes to racially discriminate.¹¹⁰ Specifically, some nursing homes would deny African American Medicaid patients admission because the nursing home did not have any Medicaid beds, but then if a Caucasian Medicaid patient sought admission at the same nursing home a Medicaid bed would be certified on the spot.¹¹¹ Thus, in violation of Title VI, nursing homes used Medicaid as a proxy to deny African Americans admission because of their race based on race ‘neutral’ policies.¹¹² Although this suit was successful in changing the disparate impact admission practices of nursing homes in Tennessee, it was not the only state with the problem. For example, African Americans in Pennsylvania were denied access to quality nursing homes because of their race,¹¹³ and, in Ohio, a nursing home allegedly denied admission to African Americans because of their race.¹¹⁴ Notwithstanding these cases and research studies, the federal and state governments have given nursing homes full discretion in determining what patients to admit,¹¹⁵ allowing some to implement policies that deny admission to African Americans.¹¹⁶ Federal and state governments have also given hospitals discretion in deciding where to locate facilities, and as a result many hospitals have closed hospitals in predominately African American neighborhoods.¹¹⁷ Unsurprisingly, hospitals and nursing homes continue to be racially separate and unequal, in part because the government has failed to enforce Title VI.¹¹⁸

*305 III. THE PROMISE OF EQUALITY DENIED

With the passage of Title VI, the United States promised to eradicate racial bias against African Americans in health care and equalize access to health care in the United States.¹¹⁹ Although the language of Title VI clearly prohibits racial bias in health

care by those receiving federal funding assistance, the enforcement scheme as written is ineffectual for two reasons. First, under Title VI, the only remedy available to the government is termination from participation in government health programs, such as Medicare and Medicaid.¹²⁰ The USCCR determined that when termination is the only government sanction, the trend has been for the government to try to avoid imposing termination by allowing health care facilities to voluntarily comply with the applicable regulations.¹²¹ In fact, the regulations governing Title VI enforcement state that HHS is “to the fullest extent practicable seek the cooperation of recipients in obtaining compliance . . . and shall provide assistance and guidance to recipients to help them comply voluntarily”¹²² Thus, HHS has tried to obtain compliance with Title VI through assurances and voluntary cooperation.¹²³

Second, even if termination was an option in a particular case, it becomes effective only after the agency submits a full written report to both the House and the Senate committees responsible for the funding.¹²⁴ No other termination process from government programs, including the termination process of nursing homes from participation in the Medicare program because of poor quality, requires submission to Congress before becoming final.¹²⁵

In addition to these enforcement gaps in Title VI, each branch of the United States government, during both Democratic and Republican administrations, has reneged on Title VI's promise to equalize access to health care and prevent racial bias in health care.¹²⁶ The executive branch *306 has exempted physicians from compliance with Title VI and neglected to investigate complaints of racial bias in nursing homes and hospitals. The judicial branch eviscerated patients' private rights of action under Title VI and supported HHS in its decision not to collect racial data as part of its Title VI enforcement. The legislative branch has failed to fix any of these problems when passing health care legislation. Thus, fifty years after the enactment of Title VI, racial bias in health care persists almost unfettered and has led to racial disparities in access to quality health care and health status.

A. EXECUTIVE BRANCH FAILURES

Section 602 of Title VI requires HHS to undertake measures to ensure that health care providers receiving federal financial assistance do not prevent participation or access to health care benefits based on race.¹²⁷ Congress made compliance with Title VI mandatory before health care facilities could receive any federal financial assistance, such as Medicare and Medicaid payments.¹²⁸ Because most hospitals applied to participate in Medicare and Medicaid in order to receive federal financial assistance, HHS was able to force many, but not all, hospitals to integrate.¹²⁹ However, hospital care remained racially separate and unequal because some hospitals “integrated” by creating separate and unequal floors and rooms, while other hospitals moved to predominately Caucasian neighborhoods.¹³⁰ In some “integrated” hospitals, Caucasians were placed on Caucasian-only floors, while African Americans had separate entrances and were placed on floors that were overcrowded, leaving some patients in the hallways.¹³¹ Unfortunately, this limited progress was HHS's main victory under Title VI. Physicians were not required to comply with Title VI¹³² and nursing homes were allowed to ignore the requirements of Title VI.¹³³

*307 Specifically, physicians receiving payments under Medicare were exempted from compliance with Title VI because these payments were not classified as “federal financial assistance.”¹³⁴ The failure to apply Title VI to physicians has allowed them to treat African Americans differently than Caucasians without repercussion while receiving federal funding. This practice continues today. For example, in 2000, Dr. Calman, a Caucasian family practice 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.¹³⁵ He stated that:

I have often contemplated whether, as a physician, I can rise above the attitudes of the society in which I was born and live and the city in which I practice. Can I learn to see through the faces of the people I treat and deliver to every one of them the highest-quality care I have been trained to provide? Can I assist my patients in negotiating the racial prejudice that lines the road between my office and the rest of the health care system?

I cannot provide Mr. North [my African American male patient] with all that New York's great health care institutions have to offer. He knows that. He has often tried to teach me that, and just as often is amazed that I am unable to accept it. It comes up time and time again when I send him for specialty consults, diagnostic tests, or even prescription refills. The same considerations my family or I would receive are rarely given to him. The cardiology specialist who helped so much in planning a treatment regimen for his heart failure never thought of referring him to a heart transplant center for evaluation. It took three separate suggestions from me before a consultation was arranged . . . There is absolutely no doubt that Mr. North is treated differently than my white, middleclass patients are treated.¹³⁶

Due to HHS's decision not to apply Title VI to health care providers, some physicians continue to racially discriminate against African Americans.¹³⁷ Evidence of physicians' racial bias and its effect on African Americans access to health care and health status is discussed in greater detail in Section IV.A.

Additionally, some nursing homes continue to discriminate against African Americans because they were not initially interested in receiving Medicare and Medicaid funding, and once they began receiving Medicare and Medicaid funding, the government was not dedicated to putting an end to racial bias in nursing homes.¹³⁸ During the 1960s and 1970s, the low reimbursement rates of Medicaid did not provide steady income for nursing homes, and the time and eligibility requirements of Medicare *308 caused many nursing homes to forego participation in the programs.¹³⁹ Instead, nursing homes sought private paying patients.¹⁴⁰ Furthermore, the government was reluctant to force Caucasians and African Americans to live together in nursing homes.¹⁴¹ In 1967, when nursing home enrollment in Medicare began, most homes were still "owner-operated converted houses" and viewed more as private residences than health care facilities.¹⁴² As a result, the government viewed nursing homes as private residences, as compared to hospitals, and thus did not actively enforce racial integration.¹⁴³ According to Professor David Barton Smith, "[t]he nursing-home industry concluded that so long as discriminatory practices were not flaunted, there would be no intervention by federal officials."¹⁴⁴ Hence, as long as nursing homes made a "good faith effort" by marketing with nondiscriminatory language and submitting written assurances of nondiscrimination, the government allowed nursing homes to participate in Medicare and Medicaid in spite of their continued use of racially discriminatory practices to bar admission of African Americans.¹⁴⁵ In fact, HHS refused to collect racial or admission flow data, regulate nursing homes' admissions practices, or survey the racial makeup of nursing homes to ensure that nursing homes were racially integrated.¹⁴⁶ In the 1970s, the USCCR noted that because most nursing homes' Title VI compliance was never assessed, their Title VI compliance was a matter of "conjecture."¹⁴⁷

Even though HHS created the Office for Civil Rights (OCR) in 1967 to be the primary civil rights office to enforce Title VI,¹⁴⁸ most of OCR's Title VI efforts were initially devoted to education desegregation, while "only 4 percent of OCR's compliance efforts were devoted to health and social services."¹⁴⁹ In a 1980 oral and written statement to the USCCR, the Director of the OCR, Roma Stewart, highlighted the lack of OCR's *309 commitment to ending racial bias in health care.¹⁵⁰

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Since its creation, OCR had focused primarily on putting an end to racial bias in education; however, with the creation of the DOE, she stated that OCR would focus exclusively on putting an end to racial bias in health care and promised to devote resources to that goal. Director Stewart promised that OCR resources and staff would be dedicated to eradicating racial bias in health care.¹⁵¹ In particular, she planned to use OCR's "resources on system-wide compliance reviews, where patterns of discrimination can be found and corrected in ways that benefit larger numbers of people than are helped by individual case resolutions."¹⁵² This aspect of monitoring through systemic compliance reviews would enable OCR to "achieve more far-reaching results than can be obtained by investigation of an individual complaint" because it would produce more significant outcomes.¹⁵³ Director Stewart pledged to "have a full-fledged operation that [could] concentrate exclusively on an increased investigative effort, development of policy, immediate and long-range planning, and the development of a data collection program."¹⁵⁴

This full-fledged operation was to address "some specific areas in which past investigations [had] revealed frequent problems," including "admission practices of hospitals and long term care facilities [and] . . . the failure of State Medicaid agencies to monitor hospitals and other providers to ensure that they do not discriminate . . ."¹⁵⁵ She also identified several problems with bias in nursing homes that included "nursing homes that limit Medicaid admissions to a set percentage of total numbers of patients; nursing homes that segregate minorities once they have been admitted; [and] fraternally owned nursing homes that explicitly refuse to admit people of a particular race or origin."¹⁵⁶

According to Director Stewart, racial bias generally barred African Americans from nursing homes and they were often forced to "live in unlicensed and substandard boarding homes where they cannot receive Medicaid benefits, and where the quality of care is inferior. Although most of these problems relate to accessibility, they also raise questions about the quality of care in hospitals and nursing homes."¹⁵⁷ Director Stewart promised to take steps to address these problems by issuing regulations and providing guidance.¹⁵⁸ These regulations were supposed to *310 propose new sanctions to be used against perpetrators because "the agency admittedly did not like to impose termination from participation in government programs," the only remedy available to OCR.¹⁵⁹ Unfortunately, thirty-four years later, Director Stewart's assurances of government enforcement of Title VI have never fully materialized.¹⁶⁰ OCR never established the guidelines or implemented any of the new sanctions that Director Stewart promised.¹⁶¹ Consequently, numerous hospitals and nursing homes have been found to be out of compliance with Title VI, but because of the enforcement limitations of Title VI, OCR has only required statements of commitment to stop discriminating against African Americans. Those statements have also not been enforced.¹⁶²

In fact, critics have noted that HHS and OCR have "permitted formal assurances of compliance [by hospitals and nursing homes] 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."¹⁶³ In its 2002 report, the USCCR noted that OCR's civil rights system was rudimentary.¹⁶⁴ Even though the USCCR found that HHS had established civil rights enforcement programs, the USCCR concluded that these programs were unsatisfactory.¹⁶⁵ The USCCR "found [OCR's] efforts to develop policy and conduct civil rights enforcement activities to be halfhearted."¹⁶⁶ 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."¹⁶⁷

*311 Furthermore, the USCCR 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.”¹⁶⁸ 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.”¹⁶⁹ As a result of HHS's failure to fulfill the mandates of Section 602 of Title VI, racial bias in health care remains. The executive branch's failure to enforce Title VI has been compounded by the judicial branch.¹⁷⁰

B. JUDICIAL BRANCH FAILURES

In 1996, in the case styled *Madison-Hughes v. Shalala*, patients sued Donna Shalala, the Secretary of HHS, for failing to enforce Section 602 of Title VI.¹⁷¹ Specifically, the patients challenged the Secretary's failure to collect racial data and information, arguing that data collection was needed to prove the continuation of racial bias in health care.¹⁷² The Court of Appeals for the Sixth Circuit ruled that this duty was discretionary because HHS's only duty was to obtain Title VI compliance reports from health care facilities with as much information as necessary.¹⁷³ According to the court, the extent to which HHS monitored and enforced Title VI was under HHS's own discretion.¹⁷⁴ Therefore, although the language of Title VI says that the federal government must enforce Title VI, it does not say how.¹⁷⁵ The “how” is under the discretion of the Secretary.¹⁷⁶ According to the court, as long as the government was investigating complaints and seeking voluntary compliance, it was enforcing Title VI.¹⁷⁷ However, as discussed in subsection A, HHS was not effectively enforcing Title VI at the time of the lawsuit and, to date, has not effectively enforced Title VI.¹⁷⁸ Consequently, the burden of solving this problem has been left to African Americans and their advocates, who have *312 sought judicial relief in an attempt to put an end to racial bias in health care by filing lawsuits to assert violations of Section 601 of Title VI.¹⁷⁹ Often, little direct evidence is available in the health care system showing disparate treatment because of race. Therefore, most cases have centered on the theory of disparate impact.¹⁸⁰ With its decision in *Alexander v. Sandoval* to limit private parties' right to sue for disparate impact under Title VI, the judicial branch has made HHS, whose enforcement of Title VI has been woefully inadequate, the primary enforcer of Title VI.

In *Alexander v. Sandoval*,¹⁸¹ a non-English speaking American, Sandoval, filed a federal case challenging the failure of the Alabama Department of Public Safety (Department) to provide driver's license exams in languages other than English.¹⁸² Sandoval asserted that the use of English-only exams excluded people on the basis of race, color, and national origin from obtaining a driver license.¹⁸³ Section 601 of Title VI prohibits bias based on race, color, and national origin that prevents individuals from participating in any program receiving federal funding.¹⁸⁴ Because the Department received federal funding from the U.S. Department of Justice, Sandoval alleged that exclusion of people based on race, color, and national origin was in violation of Title VI.¹⁸⁵ The Department argued that its actions did not violate Title VI because the bias was not intentional. The bias resulted from a provision of the Alabama Constitution that English was the official language of Alabama, and thus the bias was a result of disparate impact of “neutral policies.”¹⁸⁶ The Supreme Court reviewed the case solely for the purpose of determining whether private parties had a right to sue under Title VI for bias as a result of *313 disparate impact.¹⁸⁷

The Supreme Court ruled that private parties do not have a right to sue for disparate impact bias under Title VI.¹⁸⁸ The Court found that disparate impact cases could only be addressed under Section 602 of Title VI because the only prohibition against disparate impact bias was found in the regulations referring to Section 602.¹⁸⁹ The Court reasoned that because the language of Section 601 of Title VI only grants a private right of action for intentional bias, the regulations that prohibit disparate impact do not apply to Section 601.¹⁹⁰ The Supreme Court ruled that its precedent dictated that there was no private right of action for disparate impact racial bias under Section 601 because a private plaintiff cannot bring a suit based on acts not prohibited by

the statute.¹⁹¹ Thus, the Supreme Court held that the Title VI regulations do not provide a private right of action for disparate impact because private parties do not have a private right of action under Section 602 of Title VI to sue for disparate impact.¹⁹²

The Court made this decision that Section 601 of Title VI did not address disparate impact, even though when Section 601 of Title VI was passed in 1964, the artificial court-created distinction between disparate impact (allowable racial bias) and disparate treatment (illegal racial bias) did not exist.¹⁹³ This distinction was not created until 1971.¹⁹⁴ Justice Stevens noted in his dissent in *Sandoval* that from 1971--when the Supreme Court devised this distinction between disparate treatment and disparate impact-- until 2001, private plaintiffs had a private right of action to challenge disparate impact bias under Title VI.¹⁹⁵ Although nothing had changed in the language of the Title VI statute or regulations, the majority negated this precedence by barring victims' access to the courts.¹⁹⁶ Moreover, the majority's decision to bar private parties' access to the federal courts under Title VI is contrary to the intent of Congress.¹⁹⁷

When enacting Title VI, members of Congress specifically discussed the *Simkins* case, a case by private parties challenging racial bias, using it as an example of the rights granted under Title VI.¹⁹⁸ Because Congress enacted Title VI before the distinction between disparate treatment and *314 disparate impact, the legislature did not address whether the distinction affects private rights of action.¹⁹⁹ Notwithstanding this fact, when passing Title VI, Congress noted the significance of private rights of action to enforce Title VI separate from the government's authority to enforce Title VI.²⁰⁰ As a result of the *Sandoval* ruling, many of the lawsuits brought by African Americans to challenge the continuation of racial bias in health care have been dismissed.²⁰¹

C. LEGISLATIVE FAILURES

Although aware of the enforcement gaps in Title VI, HHS's failure to enforce Title VI, and the *Sandoval* case, Congress has exacerbated the problem of racial bias in health care with funding cuts and disregarded the problem when passing the ACA.

By the 1980s, the majority of hospitals and nursing homes were certified to participate in Medicaid and Medicare, and any hope of putting an end to racial bias in hospitals and nursing homes based on the lure of federal funding was obliterated by government cutbacks in response to rising healthcare costs.²⁰² Congress initiated Medicare and Medicaid cutbacks even though studies showed that in order to achieve a racially integrated and equal health care system, the government needed to increase reimbursement rates for Medicare and Medicaid.²⁰³ As a result of these cuts, many African Americans are relegated to substandard health care facilities.²⁰⁴

In addition to funding cuts, Congress has ignored decades of reports noting that racial bias persists in health care. For example, as early as 1987, the United States House of Representatives Committee on Government Operations found "that OCR unnecessarily delayed case processing, allowed [racial] bias 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."²⁰⁵ The same committee "criticized *315 OCR's reluctance to sanction noncompliant recipients and recommended that OCR pursue investigations of complaints as well as compliance reviews in more systematic ways."²⁰⁶ In addition to these findings, the USCCR and the Institute of Medicine (IOM) have issued several congressionally mandated reports concerning the government's failure to enforce Title VI and the continuation of racial bias in health care.

Created by Congress in 1957, the USCCR is charged with informing the development of national civil rights policy and enhancing enforcement of federal civil rights laws through investigations and reports.²⁰⁷ As mandated by Congress, the USCCR reviewed the progress of HHS's Title VI enforcement in 1974, 1996, 1999, and 2002.²⁰⁸ Each time the USCCR found that HHS and OCR were not fulfilling the mandates of Title VI and that racial bias in health care remained.²⁰⁹ Furthermore, in response to growing racial disparities in health care, Congress asked the IOM to investigate the causes of racial disparities in health care. In 2003, the IOM issued its findings in its report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* (IOM study). The 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 access to health care.²¹⁰ Not only did racial bias prevent African Americans from accessing health care services, but it also caused African Americans to have poor health outcomes.²¹¹ Specifically, the study found evidence of poorer quality of care for minority patients in studies of cancer treatment, treatments of cardiovascular disease, rates of referral for clinical tests, diabetes management, pain management, and other areas of care.²¹² According to the *316 study, racial disparities in health care existed in part because of the unfilled potential of Title VI due to OCR's failure to enforce the law and allowing physicians to be exempt.²¹³ The IOM also made very specific recommendations regarding racial bias in health care and civil rights enforcement by OCR.²¹⁴

In particular, the IOM study suggested that Congress provide greater resources for OCR so that it could enforce civil rights laws and expand OCR's ability to address civil rights complaints and carry out its oversight responsibilities.²¹⁵ Additionally, it was suggested that OCR "resume the practice of periodic, proactive investigation, both to collect data on the extent of civil rights violations and to provide a deterrent to would-be lawbreakers."²¹⁶ Dr. Thomas Perez, one of the authors of the IOM study, argued that, among other things, Congress should require OCR to (1) collect racial data to show whether health care facilities are still racially discriminating, (2) strengthen the federal, state, and private civil rights infrastructure in health care through increased funding and provider education, and (3) restore the private right of action for disparate impact eviscerated by Sandoval.²¹⁷ Finally, the study urged Congress to fund more research on the connection between racial bias and racial disparities.²¹⁸

Nine years after the publication of the IOM study, Congress enacted the ACA to regulate the health insurance industry, increase access to health insurance for the uninsured, and address health disparities.²¹⁹ Many 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,"²²⁰ 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."²²¹ However, the ACA fails to implement any of the IOM study's suggestions concerning racial bias and civil rights enforcement by OCR. The ACA addresses health disparities by increasing the stature of the HHS's Office of Minority Health, requiring data collection, and applying Title VI to the new law. Nevertheless, the ACA fails to address the shortcomings of OCR, fix the problems with Title VI, or address racial bias in health care.

*317 The ACA reorganizes HHS by reauthorizing and increasing the authority and stature of the Office of Minority Health (OMH), a part of the Office of the Secretary.²²² 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 the Secretary, one of the central decision-making agencies in HHS. The ACA 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.²²³ Finally, the ACA creates the National Institute on Minority Health and Health Disparities, an institute under the

National Institutes of Health. However, the ACA leaves OCR as it is--powerless and ineffective. Therefore, while increasing the power of OMH and creating new offices of minority health to track racial disparities in health care, Congress has left OCR, the agency responsible for putting an end to racial bias and racial disparities, powerless.

Section 1557 of the ACA notes that the requirements of nondiscrimination apply to the ACA.²²⁴ Specifically, the Act states that civil rights laws, such as Title VI, which govern health care, apply to the Act and remain unchanged. Unfortunately, Congress' decision to keep the status quo means that racial bias will continue almost unfettered in the health care system because, as noted above, Title VI has several enforcement gaps, the executive branch has not aggressively enforced Title VI to put an end to racial bias in health care, and the judicial branch has eviscerated the private right of action granted under Title VI.

Finally, the ACA fails to address racial bias in its efforts to put an end to health disparities through data collection. Even though three decades of USCCR's reports,²²⁵ empirical research studies, and the IOM study all, show that racial bias is the most significant cause of racial disparities in access to quality health care and health status, the ACA does not mention racial bias or ways to address its effects on access to health care. 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, yet racial bias is not mentioned.²²⁶ Furthermore, after fighting against having to collect racial data in the Madison-Hughes case,²²⁷ HHS is now required to collect racial data, standardize all racial data collection, and make it a significant priority in combating health disparities, yet the data will not be used for Title VI enforcement.

***318** Specifically, the ACA requires the Secretary of HHS to collect data to track health disparities under Medicaid and Medicare.²²⁸ The Secretary of HHS is also required 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."²²⁹ Finally, the Secretary of HHS is required to analyze the data to detect and monitor trends in health disparities and report it to the OMH, the National Center on Minority Health and Health Disparities, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, the Centers for Medicare & Medicaid Services, 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. OCR is not one of the agencies identified by the ACA for data sharing or data collection. Therefore, the data collection will not be used to address the continuation of racial bias in health care--the central cause of racial disparities in access to quality health care and health status. Hence, because the executive, judicial and the legislative branch have done little to put an end to racial bias in health care that causes racial disparities in access to health care and health status, it is not surprising that these disparities continue to worsen.

IV. RACIAL DISPARITIES IN ACCESSING QUALITY HEALTH CARE AND HEALTH STATUS

The largest disparity in accessing quality health care and health status in the United States is between African Americans and Caucasians.²³⁰ Health disparities are defined 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 bias or exclusion.²³¹ Scholars have defined access to health care "as those dimensions which describe the potential ***319** and actual entry of a given population group to the health care delivery system."²³² Disparity in access to "health care manifests itself in many ways, affecting both the quality and longevity of life."²³³

In 1996, the New England Journal of Medicine published a study regarding racial disparities in the provision of Medicare services.²³⁴ Even after controlling for income, the study showed that physicians treated African American Medicare patients

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less aggressively than Caucasians, who were more likely to be hospitalized for ischemic heart disease, have a mammogram, or undergo coronary-artery bypass surgery, coronary angioplasty, or hip-fracture repair.²³⁵ 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.²³⁶ 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.²³⁷

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.²³⁸ The study showed that only 32% of African American pneumonia patients with Medicare were given antibiotics within six hours of admission, compared with 53% of other pneumonia patients with Medicare.²³⁹ African Americans with pneumonia were also less likely to have blood cultures done during the first two days of hospitalization.²⁴⁰ The researchers noted that other studies had associated prompt administration of antibiotics and collection of blood cultures with lower death rates.²⁴¹ This unequal treatment leads to *320 health care disparities in access to health care and health status.²⁴² Although these studies showed that African Americans received unequal treatment compared to Caucasians, which caused racial disparities in health status, the government did not “officially” link racial bias and racial disparities in health care until the groundbreaking IOM study.

As discussed in Section III.C., the IOM study was issued in response to the federal government's concern about the continuation of racial disparities in health care. According to the IOM study, African Americans' unequal access to quality health care was in part caused by the pervasive nature of racial bias in health care, beginning “at the point of entry and continu[ing] throughout the secondary and tertiary pathways of the system.”²⁴³ Since the publication of the IOM study, interpersonal and institutional racial biases continue to drive racial disparities in health care, and, as a result, access to health care remains separate and unequal.²⁴⁴

A. INTERPERSONAL RACIAL BIAS AND RACIAL DISPARITIES

Interpersonal bias is the conscious (explicit) or unconscious (implicit) use of prejudice in interactions between individuals.²⁴⁵ PREJUDICE IS A NEGATIVE *321 PRE-JUDGMENT AGAINST A PERSON OR GROUP.²⁴⁶ AN ACTION BASED ON RACIAL PREJUDICE IS RACIAL BIAS, WHILE RACISM IS RACIAL BIAS PLUS POWER.²⁴⁷ INTERPERSONAL RACIAL BIAS CAN BE DEFINED AS A CONSCIOUS (EXPLICIT) PREJUDICIAL ACTION OR COMMENT BY A RACIST INDIVIDUAL THAT 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.²⁴⁸

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.²⁴⁹ 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.²⁵⁰

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.²⁵¹ More recently, 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.²⁵² These studies show that instead of relying on individual factors and scientific facts, physicians rely on their 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.²⁵³

*322 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.²⁵⁴ 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.²⁵⁵ That same year, researchers found that African Americans were less likely than Caucasians to be evaluated for renal transplantation and placed on a waiting list for transplantation after taking into consideration 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.²⁵⁶

In 1999, researchers also 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."²⁵⁷ There were significant racial differences.²⁵⁸ After controlling for disease status, income level, and educational attainment, African American patients were only 64% as likely as Caucasians to receive surgery.²⁵⁹

In 2000, van Ryn and Burke conducted a survey of physicians' perceptions of patients.²⁶⁰ 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.²⁶¹ Physicians' perceptions of African Americans were negative even when there was individual evidence that contradicted the physician's prejudicial beliefs.²⁶² In 2006, van Ryn repeated this study using candidates for coronary bypass surgery. *323 ²⁶³ Again, the physicians surveyed exhibited prejudicial beliefs about African Americans' intelligence and ability to comply with medical advice.²⁶⁴ 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.²⁶⁵

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.²⁶⁶ More recently, a 2008 study found that physicians subconsciously favor Caucasian patients over African American patients.²⁶⁷ In this study, physicians' racial attitudes and stereotypes were assessed, and then physicians were presented with descriptions of hypothetical cardiology patients differing in race.²⁶⁸ Although most physicians reported not being explicitly racially biased, they held implicit negative attitudes about African Americans,²⁶⁹ and thus were aversive racists. The study further showed that although physicians of all races held implicit negative attitudes about African American patients, Caucasian male physicians tend to exhibit higher levels of aversive racism compared to Caucasian female, African American female, and African American male physicians.²⁷⁰ This is significant because 75% of African Americans' medical interactions are with physicians who are not African American.²⁷¹ Studies further found that medical interactions between racially different patients and physicians are "characterized by less patient trust, less positive effect, fewer attempts at relationship building, and less joint decision-making."²⁷² Finally, the study showed the stronger the implicit bias, the less likely the physician was to recommend the appropriate medical treatment for African American patients for heart attacks.²⁷³

In 2010, research showed that even though African Americans, in general, have a higher rate of stroke and cerebrovascular death than Caucasians, *324 African American patients have a lower rate for carotid endarterectomy, a procedure that would greatly reduce fatalities from these conditions.²⁷⁴ This study, and a majority of the studies discussed infra, controlled for socioeconomic status, disease status, and education level, suggesting that race, specifically racial bias in the form of implicit racial bias, is the central cause of disparities in medical treatment.²⁷⁵ In addition to the direct harm caused by unequal treatment due to implicit racial bias, research shows that African Americans perceive this implicit bias and respond negatively.²⁷⁶

Data show that African Americans reacted most negatively to physicians who were aversive racists (those individuals who exhibited low explicit racial bias, but high implicit racial bias), compared to physicians who were not racist (those that possessed low explicit and implicit racial bias) or were dominative racists (those who exhibited high explicit racial bias and high implicit racial bias).²⁷⁷ Patients perceived aversive racists as deceitful compared to dominative racists, who were clear and honest about their prejudicial beliefs.²⁷⁸ This perception may explain why African Americans are less compliant with treatment recommendations made by physicians who they feel are aversive racists.²⁷⁹ The negative health effects of interpersonal racial bias exhibited by some physicians is compounded by the lack of quality health care facilities and physicians available in predominately African American areas, which is due to institutional racial bias.

B. INSTITUTIONAL RACIAL BIAS AND RACIAL DISPARITIES

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 the institutions in a society.²⁸⁰ Not all institutional actions that disproportionately affect minorities are racially biased. According to Professor Rene Bowser, in order to constitute institutional racial bias, an action must reinforce the racial hierarchy of the inferiority of minorities and *325 impose substantial harm on minorities.²⁸¹ Once this occurs, the institution's actions constitute institutional racial bias, even if the actions are seemingly race-neutral.²⁸² The most poignant examples of institutional racial bias in health care are the closure of hospitals in predominately African American communities²⁸³ and the placement of African Americans in substandard quality nursing homes. These decisions may seem race neutral, however, they reinforce the racial hierarchy of the inferiority of minorities and cause substantial harm to minorities.

1. Institutional Racial Bias and Hospital Closures

According to Professor Brietta Clark, hospital closures reinforce the racial hierarchy in health care, showing that African Americans' health does not matter compared to the health of Caucasians.²⁸⁴ Clark also argues that hospital closures have resulted in significant harm, including increased mortality rates of minorities.²⁸⁵ In order to control costs, state and federal regulators have allowed hospitals to close facilities in predominately African American neighborhoods without balancing the needs of African American communities.²⁸⁶ Unfortunately, not only have closures failed to control costs, but they have also caused racial disparities in access to health care and health status.²⁸⁷

In the late 1970s, the American Hospital Association published a study surveying hospital administrators to determine the primary reasons for hospital closures or relocations.²⁸⁸ According to the survey:

Of the 231 hospitals, the reasons for closure or relocation were broken down as follows: 27% [of hospitals] reported financial reasons for closure or relocation, 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.²⁸⁹

Due to repeated assertions made by hospital administrators, administrators' fiscal justifications created the perception that hospital closures were *326 beneficial for society and race-neutral; thus, state and federal regulators routinely approved closures and relocations.²⁹⁰ However, that is simply not the case: hospital closures increase costs, decrease access to health care, and are significantly linked to race.²⁹¹

The perception that hospital closures reduce costs by getting rid of 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.²⁹² Thus, the number of beds stays the same, and so do the costs. 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, thereby increasing health care costs.²⁹³ For, as these hospitals leave predominately African American neighborhoods, the remaining hospitals are left to fill the void.²⁹⁴ This often strains the remaining hospitals' resources and ability to provide quality care.²⁹⁵ Consequently, the hospitals that remain to provide care to African Americans gradually deteriorate and provide substandard care.²⁹⁶

Not only is access to health care diminished because of a reduction of hospital services, but it is also diminished by physician departures.²⁹⁷ Once a hospital has closed or relocated, the physicians practicing in the predominately African American neighborhood often follow the hospital to Caucasian neighborhoods, thereby further disrupting the primary care services in predominately African American neighborhoods.²⁹⁸ 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.²⁹⁹ This disruption in care is significant because many predominately African American neighborhoods already suffer from physician *327 shortages prior to hospital closures and physician flight.³⁰⁰ 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.³⁰¹ Lack of access to health services is not the only harm from hospital closures: patients and minority communities also experience humiliation, frustration, and a sense of helplessness.³⁰²

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.³⁰³ As a result, patients have been unable to obtain timely and medically necessary health care.³⁰⁴ 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.³⁰⁵ 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.³⁰⁶ 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.³⁰⁷ Thus, these hospital closures appear to reinforce a racial hierarchy that African Americans' lives are less valued than Caucasians' lives.

Finally, contrary to 'race-neutral' claims, hospital placement, closures, and removal of services have been linked to race since 1937.³⁰⁸ In 1980, Dr. Alan Sager found that between 1937 and 1977, hospital closures and relocations were directly connected to race.³⁰⁹ 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 *328 significant factor in hospital closures.³¹⁰ As the percentage of African Americans residents increased in the neighborhood, hospital closures increased.³¹¹ In 2006, Dr. 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 1997.³¹² In the Jim Crow era, these hospital closures were overtly linked to race,³¹³ now the closures are a result of institutional racial bias.³¹⁴

2. Institutional Racial Bias and Nursing Home Quality

A plethora of research studies have noted that there are racial disparities in the provision of quality nursing home care.³¹⁵ Like hospitals, nursing homes explain this racial disparity through 'race-neutral' reasons. Specifically, nursing home owners assert they deny admission to African Americans to stay in business and that low government reimbursement rates limit the resources available to provide African Americans with quality nursing home care.³¹⁶ This reinforces the racial hierarchy that African Americans' need for health care is outweighed by Caucasians' wants to room with only Caucasians and relegated African Americans to substandard nursing homes. Furthermore, when nursing homes do admit African Americans, they provide less care and poorer quality care to African Americans than Caucasians, even when the payor status is the same, which harms African Americans.³¹⁷

A study using statistical analysis of data regarding the transfer of patients from the hospital to nursing homes showed that African Americans' failure to find prompt nursing home placements did not correlate with the patient's payment source, physical condition, demographic attributes, family cooperativeness, or behavioral issues.³¹⁸ Instead, racial *329 bias was the central factor in the timing of the transfer.³¹⁹ Caucasian patients did not want to room with African Americans, and nursing home complied with this request.³²⁰ According to the authors of the study, racial bias took three different forms, all of which were institutionalized and have an adverse disparate impact on African Americans.³²¹ The first form of racial bias is "passive discrimination," which "refers to the practice of acceding to others' discriminatory preferences."³²² The second form of racial bias is "entrepreneurial discrimination," which is based on the preferences of residents or reactions of the market. The third form is "cultural distinctiveness discrimination," which is based on the misconception that racial groups prefer to be with people of their own kind.³²³ The authors found that nursing home owners used the need to satisfy Caucasian patients' racial bias in order to stay in business as a means to explain the untenable practice of using one or all three forms of racial bias to deny African Americans admission to nursing homes.³²⁴ This reasoning, however, reinforces the racial hierarchy of the inferiority of minorities because it shows that African Americans' right to equal access to quality nursing home care does not matter when compared to Caucasians' preferences to not room with African Americans. Furthermore, this leads to significant harm because African Americans are barred admission to quality nursing homes.³²⁵

The quality of Medicare or Medicaid certified nursing homes is evaluated by state health agencies conducting annual recertification inspections of each nursing home.³²⁶ This recertification process is called "survey and certification."³²⁷ Under the current survey and certification system, once a nursing home is certified to participate in Medicare or Medicaid, the home is visited every nine to fifteen months³²⁸ by a state health agency survey team comprised of, among others, nurses, nutritionists, social workers, and physical therapists.³²⁹ The team assesses whether the nursing home continues to be in compliance with the

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Medicare or Medicaid conditions of participation.³³⁰ If the survey team finds the nursing home out of compliance with the conditions of participation, it cites the facility for a deficiency³³¹ and assigns a scope and severity level to the deficiency based on the egregiousness of the offense.³³² The scope refers to the number of residents affected, and the severity level refers to the seriousness of the harm.³³³ The severity level includes actual harm and serious actual harm posing a risk of death (immediate jeopardy).³³⁴ This means that the more egregious the deficiency, the poorer the quality of the nursing home. If a nursing home is significantly out of compliance with the conditions of participation, then it can be deemed substandard.³³⁵ Substandard care is defined as a significant deficiency in care that caused actual or serious actual harm to one or more nursing home residents.³³⁶ Substandard care often results from the failure to provide care to residents, such as the failure to prevent pressure sores or falls.

African Americans tend to reside in substandard nursing homes in part because of 'neutral' decisions that reinforce the racial hierarchy of the inferiority of minorities and impose substantial harm on minorities.³³⁷ However, as with hospitals, research shows that these decisions are not always race neutral. For instance, national data compiled from Medicare forms showed that African Americans reside in nursing homes with "lower ratings of cleanliness/maintenance and lighting" compared to nursing homes serving Caucasians, even when the payor status is the same.³³⁸ Another study of several states, including New York, Kansas, Mississippi, and Ohio, found that the quality of care provided to Caucasians and African Americans is different, even when they reside in the same nursing home.³³⁹ Furthermore, the resident assessment instrument (RAI),³⁴⁰ which includes racial data, showed that late-stage pressure sores are more common to African Americans, while early-stage pressure sores are more common to Caucasians.³⁴¹ According to the researchers, the higher rates of late-stage pressure sores in African Americans occur because they are commonly underdiagnosed.³⁴² Hence, Caucasians received treatment before the pressure sore became too severe, while African Americans and other minorities suffer without treatment until the pressure sore became irreparable.³⁴³

Additionally, a 2009 investigation of Illinois nursing homes by the Chicago Reporter showed that African Americans residing in nursing homes received poor quality care compared to Caucasians.³⁴⁴ Specifically, it found that the staff at Illinois' black nursing homes spent less time daily with residents than staff at facilities where a majority of the residents are white. Of that time, black residents got a smaller percentage of time with more-skilled registered nurses than facilities where the residents were white.³⁴⁵

In fact, Caucasian "seniors had qualitatively better nursing home options than black seniors--in some cases, even when facilities had the same owner."³⁴⁶

In particular, there was one owner of thirty for-profit nursing homes throughout Illinois, which included three predominately African American nursing homes and sixteen predominately Caucasian nursing homes.³⁴⁷ All three of the predominately African American nursing homes received the lowest quality ranking by the federal government, whereas fewer than half of the sixteen predominately Caucasian facilities received that same rating.³⁴⁸ In fact, the two nursing homes that had received the highest quality ratings were predominately Caucasian.³⁴⁹ One of the three-predominately African American nursing homes, Alden Wentworth, had "the worst rating a nursing home can get--three times the number of lawsuits of half of Chicago nursing homes--". . . [where the] residents [had] less than half the time each day with staff than residents at a predominantly white facility in Evanston operated by the same owner."³⁵⁰

The investigation by the Chicago Reporter also found that “[a] quarter of white homes received an excellent rating, compared with none of the black homes. More than half of the black homes received the worst rating [a one on a five-point scale], while 8 percent of white homes earned the same score.”³⁵¹ Four years later, the Chicago Tribune found that “Illinois leads the nation in the number of poorly rated,” predominately African American nursing homes.³⁵² In fact, twenty-six out of the fifty (52%) predominately African American nursing homes in Illinois have received a one-star quality rating from Nursing Home Compare, compared to 110 out of the 640 (17%) of the predominately Caucasian nursing homes that received that rating.³⁵³ Facilities with one star are considered to have “quality much below average.”³⁵⁴ Even if African Americans gained access to quality nursing homes, national studies show that African American “nursing home residents [were] less likely to receive medically appropriate treatments, ranging from cardiovascular disease medication to pain medication to antidiabetes drugs” than Caucasians residing in the same nursing home.³⁵⁵ Manifested in many different ways and forms, poor-quality care often translates into poor health outcomes for African Americans as compared to Caucasians. For example, a 2008 study consisting of data from 8,997 nursing homes located in urban cities throughout the continental United States³⁵⁶ found that African American nursing home residents were more likely than Caucasian residents to be hospitalized for “dehydration, poor nutrition, bedsores, and other ailments because of a gap in the quality of in-house [nursing home] medical care.”³⁵⁷ These ailments arise when residents are not receiving proper care.

Overall, a review of the empirical data suggests that access to quality nursing home care is limited because of institutional racial bias. Specifically, nursing homes make ‘neutral’ decisions to provide less resources and staff to predominately African American nursing homes and African Americans residing in nursing homes with Caucasians even when the payor source is the same. These ‘neutral’ decisions reinforce the racial *333 hierarchy that African Americans' health does not matter and, as discussed above, cause more disability and mortality in African Americans.

These are just a few examples of the well-documented racial disparities in access to health care due to interpersonal and institutional racial bias, which have resulted in serious harm. In order to put an end to racial disparities, the federal government must first acknowledge the fact that racial bias remains in the health care system and causes racial disparities in access to quality health care and health status. Otherwise, the separate and unequal health care system in the United States will continue for another fifty years, causing unnecessary disability and death for African Americans.

V. RECOMMENDATIONS

For the last fifty years, the government has ignored the continuation of racial bias in health care and failed to enforce Title VI, causing racial disparities in health care and, by extension, overall health status. With the enactment of the ACA, the government has provided a health insurance mandate, increased the authority and stature of OMH, and funded health disparities research, patient education programs, and racial data collection programs.³⁵⁸ However, these actions are meaningless in putting an end to African Americans' separate and unequal access to health care if racial bias in health care is allowed to continue.

For example, access to health insurance or increased government funding for research means nothing when some physicians provide care based on race, not insurance status (interpersonal racial bias), and when patients do not have a health care facility located in their neighborhood (institutional racial bias). Furthermore, increasing the authority and stature of OMH to collect racial disparity data is pointless if that information is not shared with OCR in order to prosecute those violating Title VI, which causes racial disparities. However, it is noteworthy that the ACA has led to several executive branch racial disparities initiatives. Yet, there is more work to be done.

A. HHS PROGRAMS

Since the passage of the ACA, HHS issued an Action Plan to Reduce Racial and Ethnic Health Disparities (“Action Plan”), the first federal strategic racial disparities plan, and established the National Partnership for Action to End Health Disparities (“NPA”).³⁵⁹ The Action Plan and the NPA build on the ACA's focus on putting an end to racial disparities. The NPA is governed by the findings in the Action Plan. The Action Plan has five goals: 1) transform health care; 2) strengthen the Nation's health and human services infrastructure and workforce; 3) advance the health, safety, and well-being of the American people; 4) advance scientific innovation; *334 and 5) increase efficiency, transparency, and accountability of HHS programs. Furthermore, the Secretary of HHS noted in the Action Plan that, “[i]t is time to refocus, reinforce, and repeat the message that health disparities exist and that health equity benefits everyone.”³⁶⁰

HHS has also developed the National Stakeholder Strategy for Achieving Health Equity (“Strategy”).³⁶¹ The Strategy includes a set of common goals and objectives for the public and private sector to use in order to ensure that racial and ethnic minorities reach their full health potential. Finally, HHS' Office of Civil Rights has partnered with the National Consortium for Multicultural Education for Health Professionals to create a medical school course concerning civil rights laws and racial disparities.³⁶² In this course, providers are educated about unequal access to health care, racial disparities in health outcomes, and the legal ramifications for racial bias in health care.

All of these initiatives are admirable and are a step in the right direction; however, more needs to be done. For example, similar to the ACA, the Action Plan fails to mention the significance of racial bias in the continuation of health disparities. In fact, although the Action Plan mentions the IOM study, it does not acknowledge the study's findings that racial bias is one of the root causes of racial disparities in health care. The Strategy also fails to address racial bias--more specifically, providers' implicit racial bias. For example, one objective of the Strategy is to increase the number of racial and ethnic minority physicians treating minorities. Nevertheless, as discussed in Section IV.A., research shows that physicians of all races and ethnicities are aversive racists who hold negative implicit racial bias against African-American patients. Thus, health equity must also include training to overcome physicians' implicit racial bias. Below, I discuss the next steps in putting an end to racial bias that causes racial disparities.

B. SOLUTIONS FOR INTERPERSONAL BIAS

Racial disparities in lack of access to quality health care and health status is caused in part because health care providers do not provide the same care to African Americans. In order to address this problem, health care providers and patients need to be educated about racial bias. In particular, physicians should be educated about interpersonal racial bias and how it impacts their treatment of patients. Research suggests that making physicians aware of how their unconscious racial bias can influence outcomes of medical encounters and can help motivate them to correct their bias.³⁶³ For example, Drs. Dasgupta and Greenwald tested subjects' pro- *335 white implicit bias before and after showing the subjects images of ten famous and highly regarded African-Americans, such as Dr. Rev. Martin Luther King, Jr., and ten images of infamous white Americans, such as Charles Manson. They found that viewing the images weakened the subjects' pro-white implicit bias.³⁶⁴ This re-education should be integrated into current educational programs for health care providers, such as Continuing Medical Education (CME) and national culturally and linguistically appropriate services (CLAS).

In order to maintain a license to practice medicine, many states require health care providers to take CME courses. CME is required to ensure that health care providers maintain competency in their field and learn about new, developing areas in their field of practice. Each state has different CME requirements.³⁶⁵ Additionally, OMH has created CLAS standards that are

intended to provide health equity and eliminate health care disparities.³⁶⁶ The CLAS standards are achieved through cultural competency training, which includes education about: 1) equitable governance, diverse leadership and health care workforce; 2) communication and language assistance programs; and 3) engagement by health care facilities, continuous improvement and accountability.

No state CME mentions a requirement to take classes to lessen implicit racial bias. Furthermore, although the CLAS standards provide important information and training, it fails to address providers' implicit racial bias. Thus, training on how to combat implicit racial bias should be added to each state's CME and the CLAS standards in order to educate health care providers about implicit racial bias. Specifically, the training must discuss three things. First, it must teach health care providers how racial biases affect treatment recommendations and cause poor patient outcomes. Second, it must show health care providers how bias affects patients' interaction with the medical system. Third, it must include re-education exercises to change health care providers' use of implicit racial bias in the health care setting. In order to ensure that all physicians undergo this training, the federal government needs to make the training a mandatory requirement in order for physicians to receive Medicare and Medicaid payments or staff privileges at a Medicare and/or Medicaid-certified health care facility. This can be accomplished by changing the rules regarding physician payments under Medicare and Medicaid.

If health care professionals are unwilling to change their behavior after being educated about their bias, they need to be targeted for civil rights ***336** violations. Data shows that some providers continue to use race to determine treatment decisions in violation of Title VI.³⁶⁷ This problem can be changed by including physicians in the definition of "health care entities" or by classifying their payments as federal financial assistance. In fact, under the ACA, physicians and all health care professionals are defined as health care entities as they relate to assisted suicide.³⁶⁸ Thus, Title VI regulations can define physicians as a health care entity in accordance with the ACA. In the alternative, their payments can be defined as federal financial assistance.

C. SOLUTIONS FOR INSTITUTIONAL BIAS

In order to put an end to institutional racial bias, both state and federal regulators should require hospitals and nursing homes to conduct strategic diversity planning.³⁶⁹ The planning should include mandatory diversity courses for the senior management staff, in which the policies and practices of the health care institution are reviewed for institutional racial bias.

Additionally, both state and federal regulators must review institutional plans to close health care facilities in predominately African American communities to determine any disproportionate harm such plans may have on African American communities. This review will force hospitals and nursing homes to balance the benefits of relocating and over-concentrating quality facilities in predominately Caucasian neighborhoods against the detrimental effects on African American communities from the loss of access to health care facilities. By instituting this review, the racial link will become clearer, and owners will have to consciously mitigate the harmful effects of closing health care facilities in predominately African American neighborhoods to relocate them in over-concentrated, predominately Caucasian neighborhoods.

Finally, civil rights enforcement in health care, Medicare and Medicaid regulations, and racial disparities programs need to be integrated. For example, those in charge of running racial disparities programs should collaborate with civil rights enforcement by sharing the data collected and research conducted with OCR so that OCR can use the information as the basis of administrative action for disparate impact racial bias cases. Those managing racial disparities programs should also integrate the data collected and research conducted with Medicare and Medicaid regulations by using the information to support violations of Medicare and Medicaid quality regulations. Finally, civil rights enforcement and Medicare and Medicaid regulations should be integrated by linking the survey and certification to Title VI enforcement.

*337 While surveyors would review the care provided in nursing homes for compliance with the Medicare or Medicaid conditions of participation as discussed in Section IV.B.2, they would also collect racial data to see if African American residents received less care than the Caucasian residents. Furthermore, surveyors would review admissions data to see if African Americans were being denied admission to nursing homes.³⁷⁰ If African Americans receive less care or are denied admission, the surveyors should fine the nursing homes.

Integrating these systems would provide significant benefits. The burden of investigating racial disparities would fall on those actually regulating the nursing home enforcement system instead of on the under-funded and under-staffed civil rights offices of HHS and the states. The administrative burden on those regulating the nursing home enforcement system would be minimal because they already collect racial data.³⁷¹ Moreover, integration would allow for the imposition of sanctions that are used in the nursing home enforcement system, such as fines, rather than termination of the Medicare or Medicaid provider agreement, which HHS rarely imposes in any situation.

As Professors Sara Rosenbaum and Joel Teitelbaum note, “it no longer makes sense to divide the world of enforcement when the overall goal is the systemic improvement of program performance.”³⁷² 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.”³⁷³ This is further supported by the IOM study,³⁷⁴ which stated “[b]y establishing both racial equality and program quality improvement as two inextricably linked goals . . . the federal government would immeasurably strengthen its hand in the setting of prospective standards of conduct.”³⁷⁵

These recommendations for putting an end to racial bias in health care are just the beginning. All of the recommendations of the IOM study and USCCR reports regarding racial bias and racial disparities, such as increased funding for Medicaid, must be implemented immediately. However, none of these recommendations will fix the problem until the government explicitly acknowledges that the United States health care system remains separate and unequal because of racial bias. Then, and only then, will the United States begin to break the cycle of unequal treatment in health care.

*338 V. CONCLUSION

“Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane.”

--Dr. Martin Luther King, Jr.³⁷⁶

Fifty years after the enactment of Title VI, which prohibits the denial of health care services and benefits based on race, decades of medical research studies and government reports show that racial bias still prevents African Americans from accessing quality health care. Consequently, the health care system remains separate and unequal, and racial disparities in health care persist. Due to the continuation of this separate and unequal health care system, an estimated 4.2 million African Americans have died unnecessarily since the 1960s.³⁷⁷ The time has come to stop racial bias in health care before more African Americans die unnecessarily.

Footnotes

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- 1 U.S. COMM'N ON CIVIL RIGHTS, 89th Cong., Rep. on Equal Opportunity in Hospitals and Health Care Facilities 6 (1965).
- 2 S. Rep. No. 88-872 at 7 (1964), reprinted in 1964 U.S.C.C.A.N. 2355, 2363 (emphasis added).
- 3 DAVID BARTON SMITH, HEALTH CARE DIVIDED: RACE AND HEALING A NATION 00 (1999).
- 4 FREDERICK D. ISLER ET AL., 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. §§ 2000d-2000d-1 (2012). Title VI also prohibits denial of health care based on national origin and color. Id.
- 5 U.S. COMM'N ON CIVIL RIGHTS, FEDERAL TITLE VI ENFORCEMENT (1996), supra note 4, at 25 (emphasis added).
- 6 See 42 U.S.C. §§ 2000d-2000d-4a (2012).
- 7 See *Cannon v. Univ. of Chi.*, 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).
- 8 See 42 U.S.C. § 2000d-1 (2012).
- 9 DOROTHY ROBERTS, FATAL INVENTION: HOW SCIENCE, POLITICS, AND BIG BUSINESS Re-create Race in The Twenty-First Century 96-97, 127-33, 135-36, 198 (2011); Ruqaijah 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 Yearby, *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); Ruqaijah 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 the elimination of racial discrimination in health care and emphasizing the critical role that scholars, researchers, and federal officials will play in the adoption of a new approach aimed at eradicating racial disparities).
- 10 SMITH, supra note 3, at 145-59, 247-49; David Falcone & Robert Broyles, *Access to Long-Term Care: Race as a Barrier*, 19 J. HEALTH POL. POL'Y & L. 583, 588-91 (1994); Mary L. Fennell et al., *Facility Effects on Racial Differences in Nursing Home Quality of Care*, 15 AM. J. MED. QUALITY 174, 174-76 (2000); David Barton Smith, *The Racial Integration of Health Facilities*, 18 J. HEALTH POL. POL'Y & L. 851, 862-64, 866 (1993); William G. Weissert & Cynthia Matthews Cready, *Determinants of Hospital-to-Nursing Home Placement Delays: A Pilot Study*, 23 HEALTH SERVS. RES. 619, 632, 642 (1988); Yearby, *African Americans Can't Win*, supra note 9, 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); Ruqaijah 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) ("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 9, at 57-60 (discussing the successes and failures of federal programs aimed at the elimination of racial discrimination in health care and emphasizing the critical role that scholars, researchers, and federal officials will play in the adoption of a new approach aimed at eradicating racial disparities).

11 Several articles note the continuation of racial discrimination in health care. See Thomas E. Perez, *The Civil Rights Dimension of Racial and Ethnic Disparities in Health Status*, in INST. MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* 626, 628, 633, 636-37 (Brian D. Smedley et al. eds., 2003) (discussing how racial discrimination is subtle yet ongoing) [hereinafter *UNEQUAL TREATMENT*]; Neil S. Calman, *Out of the Shadow: A White Inner-City Doctor Wrestles with Racial Prejudice*, 19 *HEALTH AFF.*, 170, 172-74 (2000) (explaining how racial prejudices affect and limit patients' health care opportunities); Kevin A. Schulman et al., *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*, 340 *NEW ENG. J. MED.* 618, 618, 623-24 (1999) (discussing how race and sex influence physician recommendations in the treatment of cardiovascular disease). Furthermore, there have been several lawsuits that provided extensive empirical data suggesting the continuation of racial discrimination, particularly in nursing homes. See, e.g., *United States v. Lorantfy Care Ctr.*, 999 F. Supp. 1037 (N.D. Ohio 1998). For additional discussion of the continuation of racial discrimination in health care, 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, 1028-44, 1056-88 (2005) (discussing how hospital closures in poor minority communities demonstrate persistent racial discrimination in health care and how the current legal structure has not prevented such discrimination); Lisa C. Ikemoto, *In the Shadow of Race: Women of Color in Health Disparities Policy*, 39 *U.C. DAVIS L. REV.* 1023, 1046-52 (2006) (discussing how the current analysis of racial disparities in health care fails to take into account gender disparities as well, thus continuing a pattern of discrimination against women of color); Dayna Bowen Matthew, *A New Strategy to Combat Racial Inequality in American Health Care Delivery*, 9 *DEPAUL J. HEALTH CARE L.* 793, 796, 798-821 (2005) (discussing how, despite its success in desegregating hospitals, Title VI has largely been ineffective in preventing race-based discrimination with respect to quality of care); Kevin Outterson, *The End of Reparations Talk: Reparations in an Obama World*, 57 *U. KAN. L. REV.* 935, 946-48 (2009) (discussing how President Obama's focus on health reform, and not reparations, might be successful in reducing racial disparities in access to 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, 8-24 (2006) (discussing how Title VI has not prevented racial discrimination because the Supreme Court has ruled that it only includes intentional discrimination, and arguing that new federal and state anti-discrimination laws must be enacted that address unintentional discrimination and private institutions); Yearby, *Twenty-Five Years*, supra note 9, at 57-61 (discussing how current federal programs aimed at the elimination of racial discrimination in health care have not been successful, and calling “scholars, researchers, and federal officials to adopt a new approach to eradicate racial disparities”).

12 SMITH, supra note 3, at 236-75.

13 See generally id.

14 Id. at 145-59, 174-76, 247-49.

15 Weissert & Cready, supra note 10, at 642, 645. Ronald Sullivan, *Study Charges Bias in Admission to Nursing Homes*, N.Y. TIMES, Jan. 28, 1984, at 127 [hereinafter Sullivan, *Study Charges Bias*]; Ronald Sullivan, *New Rules Sought on Nursing Homes*, N.Y. TIMES, May 5, 1985, at 146 [hereinafter Sullivan, *New Rules Sought*].

16 Peter B. Bach et al., *Racial Differences in the Treatment of Early-Stage Lung Cancer*, 341 *NEW ENG. J. MED.* 1198, 1198-1202 (1999); 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); Schulman et al., supra note 11, at 622-24, 624 tbl.4 (“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 Yearby, *Twenty-Five Years*, supra note at 9 (discussing the successes and failures of federal programs aimed at the 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).

- 17 ALAN SAGER & DEBORAH SOCOLAR, HEALTH REFORM PROGRAM, CLOSING HOSPITALS in New York State Won't Save Money but Will Harm Access to Health 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).
- 18 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).
- 19 The U.S. Department of Health, Education, and Welfare was renamed the U.S. Department of Health and Human Services (HHS) in 1980. See Department of Education Organization Act of 1979, 20 U.S.C. § 3508 (2012).
- 20 SMITH, *supra* note 3, at 153-63, 174-76.
- 21 *Alexander v. Sandoval*, 532 U.S. 275 (2001); *Madison-Hughes v. Shalala*, 80 F.3d 1121 (6th Cir. 1996).
- 22 See U.S. COMM'N ON CIVIL RIGHTS, FUNDING FEDERAL CIVIL RIGHTS ENFORCEMENT: The President's 2006 Request ch. 5 & tbl.5.1 (2005), available at <http://www.usccr.gov/pubs/crfund06/crfund06.pdf> [hereinafter FUNDING FEDERAL CIVIL RIGHTS ENFORCEMENT] (determining that OCR funding decreased progressively throughout the decade when accounting for inflation); UNEQUAL TREATMENT, *supra* note 11; U.S. COMM'N ON CIVIL RIGHTS, TEN-YEAR CHECK-UP: HAVE FEDERAL AGENCIES RESPONDED TO CIVIL RIGHTS RECOMMENDATIONS? VOLUME I: A BLUEPRINT FOR CIVIL RIGHTS ENFORCEMENT, at 5-6 (2002), available at <http://www.law.umaryland.edu/marshall/usccr/documents/tenyrchekupvol1.pdf> [hereinafter TEN-YEAR CHECK-UP]; U.S. COMM'N ON CIVIL RIGHTS, THE HEALTH CARE CHALLENGE: ACKNOWLEDGING DISPARITY, CONFRONTING DISCRIMINATION, AND ENSURING EQUALITY: VOLUME I THE ROLE OF GOVERNMENTAL AND PRIVATE HEALTH CARE PROGRAMS AND INITIATIVES, at ix (1999) [hereinafter HEALTH CARE CHALLENGE] (discussing both disparate treatment and disparate impact discrimination in health care industry); U.S. COMM'N ON CIVIL RIGHTS, FEDERAL TITLE VI ENFORCEMENT (1996), *supra* note 4, at 230-31.
- 23 U.S. COMM'N ON CIVIL RIGHTS, FEDERAL TITLE VI ENFORCEMENT (1996), *supra* note 4, at 230-31.
- 24 Some argue that biological difference between racial groups is the cause of racial disparities in health. See, e.g., 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. However, leading academics have discredited this claim. See, e.g., ROBERTS, *supra* note 9, at 112-13; Jonathan Kahn, *Race, Genes, and Justice: A Call To Reform the Presentation of Forensic DNA Evidence in Criminal Trials*, 74 BROOK. L. REV. 325 (2009); Jonathan Kahn, *Racing 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, 38 MONTHLY REV. 74, 75-79 (1986); 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). For example, in her landmark book, FATAL INVENTION: HOW SCIENCE, POLITICS, AND BIG BUSINESS RE-CREATE RACE IN THE TWENTY-FIRST CENTURY, Dorothy Roberts states that "genetic explanations for health disparities are basically implausible." ROBERTS, *supra* note 9, at 116. 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." Bassett & Krieger, *supra* at 76. Thus, if race plays a role in racial disparities, it is because race "is a powerful determinant of the location and life-destinies of individuals within the class structure of the U.S. society." *Id.* 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. ROBERTS, *supra* note 9, 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). 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." David R. Williams & Pamela Braboy Jackson, Social Sources of Racial Disparities in Health, 24 HEALTH AFFAIRS 325, 325 (2005).

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. Yearby, *Twenty-Five Years*, *supra* note 9, at 59-60, nn.10-15 (discussing and collecting studies on racial discrimination in the health care system). Specifically, social psychologists, medical researchers, and legal scholars have suggested that interpersonal, institutional, and structural racial biases are the chief causes of racial disparities. See Calman, *supra* note 11, 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* 261, 261-88 (2006) (“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.”); Leith Mullings & Amy Schulz, *Intersectionality and Health: An Introduction*, in *GENDER,RACE,CLASS, AND HEALTH* 3, 12 (2006) (“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 11, 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 systematically vary by patient race, socio-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”). Others argue that these disparities are derived from socially determined factors, such as social and economic opportunities and residential segregation, which are race neutral. 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); Steven P. Wallace et al., *The Persistence of Race and Ethnicity in the Use of Long-Term Care*, 53B *J. GERONTOLOGY: PSYCHOL. SCI. & SOC. SCI.* S104, S104-06 (1998). However, over three decades of empirical research studies show that these social determinants of health are caused by racial bias. See Jacqueline L. Angel & Ronald J. Angel, *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 SERVICES* 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, 177-80 (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 discrimination. Wallace, *supra* at 674; Williams, *supra* at 177-78; 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. 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. Smith et al., *supra* at 1456. Thus, even neutral reasons are not separate from racial bias. See Yearby, *supra* note 10, at 429, 462-70 (discussing how racial discrimination plays a part in geographical racial segregation and socioeconomic status). Specifically, empirical evidence suggests that racial bias prevents African Americans from obtaining jobs (social and economic opportunities) and access to housing in safe, diverse environmentally friendly neighborhoods (residential segregation). *Id.* Consequently, African Americans are more likely to be unemployed or employed with no health insurance and reside in houses with environmental hazards (lead, vermin, toxic waste dumps) in unsafe neighborhoods. *Id.* Sicker because of neighborhood environmental hazards and without health insurance, African Americans are left with little or no access to health care, resulting in racial disparities in health. *Id.* Thus, racial bias within the health care system and greater society continues to prevent African Americans from obtaining equal access to health care. 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 inside the health care system and outside the health care system 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.

- 25 Mullings & Schulz, *supra* note 24, at 12 (examining the different forms of racism present in health status issues); Yearby, *African Americans Can't Win*, *supra* note 9, at 1180.
- 26 Sabin & Greenwald, *supra* note 18, at 907 (“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 11, 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.”); van Ryn & Burke, *supra* note 24, at 813-14 (discussing how “[p]hysicians' perceptions of patients may vary by patient race, socio-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”).
- 27 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 Blacks and Whites have been estimated to result in at least 60,000 excess deaths in the Black population annually.”).
- 28 VERNELLIA R. RANDALL, OFFICE OF THE UNITED NATIONS HIGH COMM'R FOR HUMAN RIGHTS, ELIMINATING THE “BLACK HEALTH DEFICIT” IN THE AMERICAS AND EUROPE BY ASSURING ACCESS TO QUALITY HEALTH, available at http://www2.ehcr.org/english/events/iypad2011/documents/Working_Group_on_African_Descent/2008_WGPAD_Session/Black-Health_Deficit_VR_Randall.doc (last visited Apr. 2, 2014).
- 29 *Id.*; see also VERNELLIA R. RANDALL, UNITED NATIONS RESEARCH INST. FOR SOC. DEV., RACE, HEALTH CARE AND THE LAW: REGULATING RACIAL DISCRIMINATION IN HEALTH CARE, 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 overburdened 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.”).
- 30 See Clark, *supra* note 11, at 1029 (describing 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).
- 31 See SAGER & SOCOLAR, *supra* note 17; Clark, *supra* note 11, at 1029; SMITH, *supra* note 3, at 199-200 (1999).
- 32 Ruqaijah Yearby, [Breaking the Cycle of “Unequal Treatment” with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias](#), 44 *CONN. L. REV.* 1281 (2012) [hereinafter Yearby, *Breaking the Cycle*].
- 33 Patient Protection and Affordable Care Act, 42 *U.S.C.* § 300kk (2012).
- 34 DEPT HEALTH & HUMAN SERVS., HHS ACTION PLAN TO REDUCE RACIAL AND ETHNIC HEALTH DISPARITIES (2011), available at http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf [hereinafter HHS ACTION PLAN].
- 35 NATIONAL PARTNERSHIP FOR ACTION TO END HEALTH DISPARITIES (2011), available at <http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286> [hereinafter NATIONAL PARTNERSHIP].
- 36 DEPT HEALTH & HUMAN SERVS., STOPPING THE DISCRIMINATION BEFORE IT STARTS: THE IMPACT OF CIVIL RIGHTS LAWS ON HEALTH CARE DISPARITIES--A Medical School Curriculum, available at <http://www.hhs.gov/ocr/civilrights/resources/training/pptworkshop.pdf> [hereinafter STOPPING THE DISCRIMINATION].

- 37 See Hospital Survey and Construction Act, [42 U.S.C. § 291e\(f\) \(1958\)](#).
- 38 See generally Derrick Bell, Jr., [Brown v. Board of Education and the Interest-Convergence Dilemma](#), 93 HARV. L. REV. 518 (1980).
- 39 U.S. COMM'N ON CIVIL RIGHTS, FEDERAL TITLE VI ENFORCEMENT (1996), supra note 4, at 1.
- 40 SMITH, supra note 3, at 239-40.
- 41 Id.
- 42 INST. MED., IMPROVING THE QUALITY OF CARE IN NURSING HOMES, 238 app. A (1986).
- 43 See id. This prohibition was repealed in 1950 as part of the amendments to the SSA. Id.
- 44 See id.
- 45 SMITH, supra note 3, at 242. Only a small number of wealthy African Americans gained access to nursing homes by being housed in private facilities. Id.
- 46 David Barton Smith, Population Ecology and the Racial Integration of Hospitals and Nursing Homes in the United States, 68 MILBANK Q. 561, 577 (1990).
- 47 See SMITH, supra note 3, at 241.
- 48 See Hospital Survey and Construction Act, [42 U.S.C. § 291e\(f\) \(1958\)](#).
- 49 See id.
- 50 SMITH, supra note 3, at 241.
- 51 See Hospital Survey and Construction Act, [42 U.S.C. § 291e\(f\) \(1958\)](#).
- 52 Id. (emphasis added). This further supported the “separate but equal” paradigm accepted at the time, but this was rejected by the Supreme Court in the landmark case of [Brown v. Board of Education](#), 349 U.S. 294 (1955).
- 53 [Simkins v. Moses M. Cone Mem'l Hosp.](#), 323 F.2d 959, 968 (4th Cir. 1963).
- 54 U.S. COMM'N ON CIVIL RIGHTS, REPORT OF THE U.S. COMM'N ON CIVIL RIGHTS 130 (1963).
- 55 Id. When a “separate but equal” plan was in place, the hospital's application indicated how the hospital planned to separate the races. Id. at 130-31.
- 56 Id. at 130-32. The states were Alabama, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Virginia, and West Virginia. Id. at 130.
- 57 See id. at 132.
- 58 VANESSA GAMBLE, MAKING A PLACE FOR OURSELVES: THE BLACK HOSPITAL MOVEMENT, 1920-1945 50 (1995).
- 59 David Barton Smith, The Politics of Racial Disparities: Desegregating the Hospitals in Jackson, Mississippi, 83 MILBANK Q. 247, 248 (2005).
- 60 Id.
- 61 [347 U.S. 483 \(1954\)](#) (U.S. Supreme Court ruled that racial segregation of schools was unconstitutional).
- 62 [323 F.2d at 959](#).

- 63 U.S. COMMISSION ON CIVIL RIGHTS, REPORT ON THE UNITED STATES COMMISSION on Civil Rights 132 (1963). From 1954 to 1960, there were thirty-one racially segregated hospitals in North Carolina that received Hill-Burton funding. Four of the thirty-one facilities were designated as African American only. *Id.* Two additional grants were made by North Carolina in 1961 and 1962 for construction of two more white-only facilities. *Id.* at 133.
- 64 The two hospitals sued were Moses H. Cone Memorial Hospital and Wesley Long Community Hospital. [Simkins, 323 F.2d at 960.](#)
- 65 [Id. at 963.](#)
- 66 [Simkins, 323 F.2d at 967-69.](#) Each of the North Carolina hospitals' applications for Hill-Burton funds was based on a "separate but equal" plan and stated "certain persons in the area will be denied admission to the proposed facilities as patients because of race creed or color." [Id. at 962.](#) Based on this record, it was clear that the hospitals discriminated based on race. Hence, the central issue in the case was whether the hospitals receipt of federal funding and subjugation to "elaborate and intricate pattern of governmental regulation, both state and federal," made the hospitals state actors. [Id. at 964.](#) Being classified as a state actor meant that the hospitals were prohibited from discriminating against African Americans under the Equal Protection Clause. [Id. at 965-66.](#)
- 67 By the time the case was commenced, Moses H. Cone Memorial Hospital had received \$1.27 million and Wesley Long Community Hospital had received \$1.95 million. [Id. at 963.](#) These appropriations supporting racial bias for the most part were made after the Supreme Court's decision in *Brown v. Board of Education*. *Id.*
- 68 [Id. at 967.](#)
- 69 *Id.* at 969. The court ruled that the language violated the 5th and 14th Amendments of the U.S. Constitution. *Id.* at 969-70.
- 70 See *id.* at 968-69.
- 71 *Id.* at 969.
- 72 SMITH, *supra* note 3, at 100-02.
- 73 *Id.* at 145-59, 247-49; Falcone & Broyles, *supra* note 10, at 588-91; Fennell et al., *supra* note 10, at 174-76; Smith, *supra* note 10, at 862-64; Weissert & Cready, *supra* note 10, at 632, 642.
- 74 SMITH, *supra* note 3, at 200.
- 75 *Id.*
- 76 Justin Dimick, Black Patients More likely than Whites to Undergo Surgery at Low-Quality Hospitals in Segregated Regions, 32 HEALTH AFF. 1046, 1048 (2013).
- 77 *Id.* at 1047.
- 78 *Id.* at 1046.
- 79 *Id.* at 1051.
- 80 *Id.* In 2004, Dr. Peter Bach and colleagues "found that there is still a high degree of segregation in primary care," with most African American patients being served by a relatively small number (22%) of physicians who were not board certified and who had problems gaining access to high-quality services for their patients, including high quality specialist surgeons and high quality hospitals. *Id.* (citing Peter Bach, Primary Care Physicians Who Treat Blacks and Whites, 351 NEW ENG. J. MED. 575, 582 (2004)).
- 81 Julie P.W. Bynum et al., Measuring Racial Disparities in the Quality of Ambulatory Diabetes Care, 48 MED. CAR. 1057, 1059 (2010) (discussing how African Americans received 70% of recommended care compared to Caucasians who received 76%, and 47% of African Americans versus 31% of Caucasians received care from the hospitals with the lowest quality). Ambulatory care is "any health care you can get without staying in the hospital is ambulatory care. That includes diagnostic tests, treatments, or rehab

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visits.” See Ambulatory Patient Services, WEB MD, <http://www.webmd.com/health-insurance/insurance-basics/terms/ambulatory-patient-services> (last visited Aug. 27, 2014).

82 Falcone & Broyles, *supra* note 10, at 588-93; Weissert & Cready, *supra* note 10, at 642; see generally David Barton Smith, Addressing Racial Inequities in Health Care: Civil Rights Monitoring and Report Cards, 23 J. HEALTH POL. POL’Y & L. 75, 75-76 (1998).

83 National statistics show “[a]bout 32 percent entered from a private residence, 45 percent were admitted from a hospital, and about 12 percent were admitted from another nursing home.” DEP’T HEALTH & HUMAN SERVS., CURRENT POPULATION REPORTS: 65+ IN THE UNITED STATES 68 (2005).

84 See N.Y. STATE ADVISORY COMM. TO THE U.S. COMM’N ON CIVIL RIGHTS, Minority Elderly Access to Health Care and Nursing Homes 19 (1992) (presentation of William B. Camello, Director, Bureau of Health Facilities Coordination of the N.Y. State Dep’t of Health) [hereinafter MINORITY ELDERLY ACCESS].

85 See Falcone & Broyles, *supra* note 10, at 583.

86 See MINORITY ELDERLY ACCESS, *supra* note 84, at 19.

87 See Falcone & Broyles, *supra* note 10, at 583.

88 David Falcone et al., Waiting for Placement: An Explanatory Analysis of Determinants of Delayed Hospital Discharge of Elderly Patients, 26 HEALTH SERVS. RES. 339, 340 (1991).

89 Falcone & Broyles, *supra* note 10, at 585, 588-92 (delay averaged 10.7 days); see Smith, *supra* note 10, at 851, 857-61; David Falcone and Robert Broyles, What Types of Hospital; Patients Wait for Alternative Placement, 5 AGING & SOC. POL’Y 77 (1993) (delay averaged 11 days); S. Ettner, Do Elderly Medicaid Patients Experience Reduced Access to Nursing Home Care, 121 J. HEALTH ECON. 259, 260 (1993); Falcone, *supra* note 88, at 340.

90 Weissert & Cready, *supra* note 10, at 642, 645.

91 *Id.*

92 *Id.*

93 Wallace, *supra* note 24, at 676-77.

94 Falcone & Broyles, *supra* note 10, at 591-92.

95 Alan Stevens, et al, Predictors of Times to Nursing Home Placement in White and African American Individuals With Dementia, 16 J. AGING & HEALTH 375, 388 (2004).

96 *Id.* at 390.

97 Vincent Mor et al., Driven to Tiers: Socioeconomic and Racial Disparities in the Quality of Nursing Home Care, 82 MILBANK Q. 227, 238 (2004).

98 See Sullivan, Study Charges Bias, *supra* note 15; Sullivan, New Rules Sought, *supra* note 15.

99 See Sullivan, Study Charges Bias, *supra* note 15; Sullivan, New Rules Sought, *supra* note 15.

100 Substandard quality of care means that the facility has violated one of the Medicaid regulations regarding resident behavior and facility practices, quality of life, or quality of care that caused actual or serious actual harm to one or more nursing home residents. See 42 C.F.R. § 488.301 (2012).

101 Sullivan, Study Charges Bias, *supra* note 15.

- 102 Id. This practice of steering is common in the real estate industry. See generally CHARLES S. AIKEN, *THE COTTON PLANTATION SOUTH SINCE THE CIVIL WAR* 320-27 (1998); STEPHEN GRANT MEYER, *AS LONG AS THEY DON'T MOVE NEXT DOOR: SEGREGATION and Racial Conflict in American Neighborhoods* (2000); ANDREW WIESE, *PLACES OF THEIR OWN: AFRICAN AMERICAN SUBURBANIZATION IN THE TWENTIETH CENTURY* (2004); Michael B. de Leeuw et al., *The Current State of Residential Segregation and Housing Discrimination: The United States' Obligations Under the International Convention on the Elimination of All Forms of Racial Discrimination*, 13 *MICH. J. RACE & L.* 337, 339-71 (2008); George Galster & Erin Godfrey, *By Words and Deeds: Racial Steering by Real Estate Agents in the U.S. in 2000*, 71 *J. AM. PLANNING ASS'N* 251, 251-53 (2005); John A. Powell, *Reflections on the Past, Looking to the Future: The Fair Housing Act at 40*, 41 *IND. L. REV.* 605, 612-13 (2008). The Supreme Court has defined racial steering in the real estate industry as “real estate brokers and agents preserv[ing] and encourag[ing] patterns of racial segregation” by “steering members of racial and ethnic groups to buildings occupied primarily by members of such racial and ethnic groups and away from buildings and neighborhoods inhabited primarily by members of other races or groups.” *Havens Realty Corp. v. Coleman*, 455 U.S. 363, 366 n.1 (1982).
- 103 See *MINORITY ELDERLY ACCESS*, supra note 84, at 27.
- 104 Id. at 5.
- 105 See id. at 37-38 (citing Jeffrey Ambers, Executive Director of Friends and Relatives of the Institutionalized Aging).
- 106 Id. at iii (transmittal letter). Notwithstanding these findings, no formal government action was taken to put an end to this racial bias in admissions.
- 107 Recently a research study showed that changes in hospital policies and shifts in payment incentives in the mid-1980s have led to an increase in African Americans' use of nursing homes. Smith, supra note 10, at 876. Because of the financial burden on hospitals from transfer delays of elderly African Americans, “[h]ospitals hired full-time discharge planners, acquired or built nursing homes or short-stay long-term-care units, and engaged in a variety of partnerships with long-term-care chains to reduce the placement problems for which they now received no reimbursement.” Id. However, this study only reviewed use data, which does provide information regarding delays in transfer. Furthermore, in the 1990s, after the implementation of changed hospital policies and shifts in payment incentives, two lawsuits were filed regarding delays in transfer to nursing homes. See *Taylor v. White*, 132 F.R.D. 636, 640, 644 (E.D. Pa. 1990) (challenging the delay in transfer to nursing homes and the poor quality of care provided in Philadelphia nursing homes, case filed on behalf of nursing home residents); *Linton ex rel. Arnold v. Comm'r Health & Env't, Tenn.*, 779 F. Supp. 925, 927 (M.D. Tenn. 1990) (challenging racial bias committed by the state of Tennessee through its policy of limiting the number of Medicaid beds in nursing homes). Tennessee had to change its policies, and the case in Pennsylvania permitted class certification to the plaintiffs. Id. at 936; *Taylor*, 132 F.R.D. at 649.
- 108 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 § 121(a), 42 U.S.C. § 1396 (2006).
- 109 *Linton*, 779 F. Supp. at 927.
- 110 *Taylor*, 132 F.R.D. at 640; *Linton*, 779 F. Supp. at 927-29.
- 111 *Linton*, 779 F. Supp. at 928-29, 931.
- 112 Id. at 928-29, 932.
- 113 See *Taylor*, 132 F.R.D. at 644.
- 114 *United States v. Lorantffy Care Ctr.*, 999 F. Supp. 1037, 1048 (N.D. Ohio 1998) (case filed by federal government against a nursing home for violating the Fair Housing Act based on evidence of racial discrimination).
- 115 Ruqaijah Yearby, *Litigation Integration and Transformation: Using Medicaid to Address Racial Inequalities in Health Care*, 13 *J. HEALTH CARE L. & POL'Y* 325, 355-58 (2010)[hereinafter Yearby, *Litigation*].

- 116 See Smith, *supra* note 10, at 868.
- 117 Yearby, *Breaking the Cycle*, *supra* note 32, at 1303-04.
- 118 Smith, *supra* note 10, at 861. Several research studies show that even when payment status is controlled, there are still significant inequities in access and quality of nursing home care that are only explained based on a difference in the patient's race. Mor et al., *supra* note 97, at 237; David C. Grabowski, *The Admission of Blacks to High-Deficiency Nursing Homes*, 42 *MED. CARE* 456, 456-60 (2004) (explaining the results of a study showing that, on average, racial minorities are admitted to nursing homes with more quality-of-care deficiency citations compared to Caucasians); see 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); Fennell et al., *supra* note 10, at 174-76; Falcone & Broyles, *supra* note 10, at 588-92; Smith, *supra* note 10, at 851, 862-63; Weissert & Cready, *supra* note 10, at 632, 642.
- 119 See Civil Rights Act of 1964 § 601, [42 U.S.C. § 2000d \(2012\)](#).
- 120 See [42 U.S.C. § 2000d-1 \(2012\)](#).
- 121 Roma J. Stewart, *Health Care and Civil Rights*, in *CIVIL RIGHTS ISSUES IN HEALTH CARE DELIVERY* 39, 48.
- 122 [45 C.F.R. § 80.6\(a\) \(2014\)](#) (emphasis added).
- 123 *Id.*
- 124 *Id.* § 80.8(c).
- 125 See, e.g., [42 C.F.R. § 488.456\(c\) \(2014\)](#) (regulating the termination of provider agreements).
- 126 President Lyndon B. Johnson championed the Civil Rights Act, which was enacted in memorial to President Kennedy. SMITH, *supra* note 3, 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 159-60, 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. See *id.* at 159.
- 127 See [42 U.S.C. § 2000d-1 \(2012\)](#).
- 128 See [42 U.S.C. § 2000d \(2012\)](#); SMITH, *supra* note 3, at 16.
- 129 SMITH, *supra* note 3, at 16.
- 130 *Id.* at 143-59, 174-76, 195-200.
- 131 *Id.* at 146.
- 132 Physicians receiving payments under Medicare Part B are exempted from compliance with Title VI because these payments are not defined as federal financial assistance. *Id.* 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 Randall, *supra* note 118, at 47-65.
- 133 SMITH, *supra* note 3, at 159-63.
- 134 See *infra* Section III.B.
- 135 CALMAN, *supra* note 11, at 172-74; see also Yearby, *Twenty-Five Years*, *supra* note 9, at 59.

- 136 CALMAN, *supra* note 11 at 172-73 (emphasis added).
- 137 SMITH, *supra* note 3, at 161-64.
- 138 *Id.* at 159-63, 236-52.
- 139 Smith, *supra* note 46, at 576.
- 140 See *id.* Even though nursing homes still prefer private pay patients, Medicaid pays for the majority of care. Currently, three main parties fund nursing homes: Medicare, Medicaid, and private parties. Of the payments received by nursing homes in 2001, Medicare accounted for 11.7%, Medicaid for 47.5%, and private payors (including out-of-pocket, private health insurance, and other private funds) were responsible for 38.5%. See CTRS. FOR MEDICARE & MEDICAID SERVS., OFFICE OF THE ACTUARY, TABLE 13: NURSING Home Care Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Selected Calendar Years 2001-2016, available at <http://www.cms.hhs.gov/nationalhealthexpenddata/downloads/proj2006.pdf> (last visited Aug. 27, 2014). Medicare spending on nursing home care totaled \$9.5 billion in 2000 and \$11.6 billion in 2001. *Id.*
- 141 SMITH, *supra* note 3, at 159-61.
- 142 *Id.*
- 143 *Id.*
- 144 *Id.* at 160.
- 145 See *id.* at 160, 236.
- 146 Yearby, *Litigation*, *supra* note 115, at 350-51.
- 147 SMITH, *supra* note 3, at 249.
- 148 SMITH, *supra* note 3, at 86. Most divisions of HHS regulating operating programs thought of OCR as a nuisance. *Id.* at 87.
- 149 *Id.*
- 150 Stewart, *supra* note 121, at 39, 45.
- 151 *Id.*
- 152 *Id.* at 318, 321-22. Because of lawsuits against the government for its failure to enforce Title VI, much of its investigative staff was applied to address individual complaints. *Id.*
- 153 *Id.*
- 154 *Id.*
- 155 *Id.* (emphasis added).
- 156 *Id.* at 324-25.
- 157 *Id.*
- 158 HHS issued a proposed rule on nondiscrimination requirements for block grants in 1986 but never issued a final rule. See U.S. COMM'N ON CIVIL RIGHTS, FEDERAL TITLE VI ENFORCEMENT (1996), *supra* note 4, at 221. HHS has also failed to monitor the states regulation of Title VI compliance under Medicaid. *Id.* at 232.

- 159 In response to a question from U.S. Commission on Civil Rights Commissioner Freeman regarding enforcement measures employed once discrimination is proven, Stewart said “[u]nfortunately, under the statute, the main remedy that we have is cutoff of Federal funds. OCR is reluctant to cut off funds to hospitals because the very beneficiaries that we seek to assist would be further damaged. However, once a finding of discrimination is made, we undertake the attempt to achieve voluntary compliance. Most of our cases are, in fact, resolved through voluntary decisions.” Stewart, *supra* note 121, at 39, 45.
- 160 See U.S. COMM’N ON CIVIL RIGHTS, FEDERAL TITLE VI ENFORCEMENT (1996), *supra* note 4, at 223.
- 161 HHS has not revised these regulations to include changes made by the Civil Rights Restoration Act of 1987 and does not address block grant programs. Therefore, states regulate all Title VI compliance by Medicaid certified facilities. See *id.* at 224. HHS issued a proposed rule on nondiscrimination requirements for Medicaid in 1986 but never issued a final rule. *Id.*
- 162 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, 29-30 (2001) (citing HOUSE COMM. ON GOV’T OPERATIONS, INVESTIGATION OF THE OFFICE FOR CIVIL RIGHTS IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, H.R. Rep. No. 100-56, at 14, 22-25 (1987)).
- 163 Lado, *supra* note 162, at 28 (citing Michael Meltsner, [Equality and Health](#), 115 U. PA. L. REV. 22, 22 (1966)).
- 164 TEN-YEAR CHECK-UP, *supra* note 22, at 5-6.
- 165 *Id.* at 5.
- 166 *Id.*
- 167 HEALTH CARE CHALLENGE, *supra* note 22, at 74.
- 168 *Id.* at 203.
- 169 *Id.*
- 170 See [Madison-Hughes v. Shalala](#), 80 F.3d 1121 (6th Cir. 1996).
- 171 *Id.*
- 172 *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 for civil rights enforcement, but it provides thousands of dollars in grants to researchers to collect the same data for racial disparities research, which it does nothing with other than publish in medical journals. See *id.* at 1130-31.
- 173 *Id.* at 1125.
- 174 *Id.*
- 175 *Id.* at 1127-28.
- 176 *Id.* at 1128.
- 177 See *id.*
- 178 See Lado, *supra* note 162, at 26-33 (citing HOUSE COMM. ON GOV’T OPERATIONS, INVESTIGATION OF THE OFFICE FOR CIVIL RIGHTS IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, H.R. Rep. No. 100-56 at 14, 22-25 (1987)); see also U.S. COMM’N ON CIVIL RIGHTS, FEDERAL TITLE VI ENFORCEMENT (1996), *supra* note 4, at 230; U.S. COMM’N ON CIVIL RIGHTS, FEDERAL TITLE VI ENFORCEMENT TO ENSURE NONDISCRIMINATION in Federally Assisted Programs (1995).

- 179 All of the federal Title VI cases have been brought by those affected, including African-Americans. These cases have varied from challenging the relocation of hospitals from predominately minority areas to the substandard level of care in health care facilities whose patients are predominately minority. See [Mussington v. St. Luke's-Roosevelt Hosp. Ctr.](#), 824 F. Supp. 427 (S.D.N.Y. 1993) (basing on procedural deficiencies, the court dismissed the class action lawsuit challenging the relocation of infant health-related services out of the Harlem area as proof of racial bias through disparate impact); [NAACP v. Med. Ctr., Inc.](#), 657 F.2d 1322 (3d Cir. 1981) (dismissing a racial bias case challenging the relocation of health services from a predominately African-American neighborhood to a predominately white neighborhood for lack of evidence); [Jackson v. Conway](#), 620 F.2d 680 (8th Cir. 1980) (basing on procedural deficiencies, the court dismissed the class action suit challenging a hospital closure in Missouri as proof of racial bias through disparate impact).
- 180 See [Taylor v. White](#), 132 F.R.D. 636, 639 (E.D. Pa. 1990); [Linton ex rel. Arnold v. Comm'r Health & Env't, Tennessee](#), 779 F. Supp. 925 (M.D. Tenn. 1990) (case challenging racial bias committed by the state of Tennessee through its policy of limiting the number of Medicaid beds in nursing homes).
- 181 [532 U.S. 275 \(2001\)](#).
- 182 *Id.* at 279.
- 183 *Id.*
- 184 *Id.* at 278.
- 185 See *id.* at 279.
- 186 *Id.* at 278-79. The argument that making English the official language of the state was not intentional racism is a weak argument. There are no reasons other than bias to sustain the enactment of an English-only law.
- 187 *Id.* at 279.
- 188 *Id.* at 285.
- 189 See, e.g., 45 C.F.R. § 80 (2013) (noting statutory authority arises from section 602 of Title VI); [45 C.F.R. § 80.3\(b\)\(2\) \(2013\)](#).
- 190 [Alexander v. Sandoval](#), [532 U.S. 275 \(2001\)](#).
- 191 *Id.*
- 192 *Id.* at 285-88.
- 193 This is one of Justice Stevens' major points in his dissent. *Id.* at 313-17 (Stevens, J., dissenting). The distinction was made in a civil rights case involving Title VII and applied to all civil rights litigation. See Smith, *supra* note 82, at 90 (citing [Griggs v. Duke Power Co.](#), [401 U.S. 424 \(1971\)](#)).
- 194 See Smith, *supra* note 82, at 90.
- 195 See [Sandoval](#), [532 U.S. at 294](#) (Stevens, J., dissenting).
- 196 See *id.* at 294-95.
- 197 *Id.* at 294.
- 198 SMITH, *supra* note 3, at 100-02.
- 199 See *id.*
- 200 *Id.*

- 201 See *Mussington v. St. Luke's-Roosevelt Hosp. Ctr.*, 824 F. Supp. 427 (S.D.N.Y. 1993) (based on procedural deficiencies, the court dismissed the class action lawsuit challenging the relocation of infant health-related services out of the Harlem area as proof of racial bias through disparate impact); *NAACP v. Med. Ctr., Inc.*, 657 F.2d 1322 (3d Cir. 1981) (dismissing a racial bias case challenging the relocation of health services from a predominately African-American neighborhood to a predominately white neighborhood for lack of evidence); *Jackson v. Conway*, 620 F.2d 680 (8th Cir. 1980) (based on procedural deficiencies, the court dismissed the class action suit challenging a hospital closure in Missouri as proof of racial bias through disparate impact).
- 202 Smith, *supra* note 139, at 576-77.
- 203 See *id.* (indicating that achieving greater access to health care for African American Medicaid patients would increase the costs of the program, straining participating health care facilities).
- 204 *Id.*
- 205 Lado, *supra* note 162, at 29 (emphasis added).
- 206 *Id.* at 29-30.
- 207 U.S. COMM'N ON CIVIL RIGHTS,MISSION, available at [http:// www.usccr.gov/about/index.php](http://www.usccr.gov/about/index.php) (last visited Dec. 11, 2013). The United States Commission on Civil Rights is an independent, bipartisan, fact-finding federal agency that plays a vital role in advancing civil rights through objective and comprehensive investigation, research, and analysis on issues of fundamental concern to the federal government and the public. *Id.*
- 208 TEN-YEAR CHECK-UP, *supra* note 22, at 5-6; U.S. COMM'N ON CIVIL RIGHTS,Federal Title VI Enforcement (1996), *supra* note 4, at 233-34.
- 209 U.S. COMM'N ON CIVIL RIGHTS,FEDERAL TITLE VI ENFORCEMENT (1996), *supra* note 4, at 233-34.
- 210 UNEQUAL TREATMENT, *supra* note 11. 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, 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.
- 211 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 Caucasians 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").
- 212 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 in diabetes care in terms of treatment, testing, and patient education).
- 213 UNEQUAL TREATMENT, *supra* note 11, at 187-89.
- 214 *Id.*
- 215 *Id.*
- 216 *Id.* at 188.
- 217 *Id.*
- 218 *Id.* at 178.

- 219 Patient Protection and Affordable Care Act, [Pub. L. No. 111-148, § 1, 124 Stat. 119](#), 119 (2012).
- 220 HHS ACTION PLAN, *supra* note 34.
- 221 JOHN E. MCDONOUGH, *INSIDE NATIONAL HEALTH REFORM* 304 (2011).
- 222 [42 U.S.C. § 300u-6](#) (2012).
- 223 *Id.*
- 224 *Id.* § 1557.
- 225 TEN-YEAR CHECK-UP, *supra* note 22, at 5-6; U.S. COMM'N ON CIVIL RIGHTS, *Federal Title VI Enforcement* (1996), *supra* note 4, at 233-34; *UNEQUAL TREATMENT*, *supra* note 11, at 6-12, 101-112, 169-174, 187-188, 626-663.
- 226 *Id.* §§ 280j, 299b-31.
- 227 [Madison-Hughes v. Shalala](#), 80 F.3d 1121 (6th Cir. 1996).
- 228 *Id.* § 300kk. This section also applies to state Children's Health Insurance Programs. *Id.*
- 229 *Id.* § 1396w-5.
- 230 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 post-slavery segregation, motivates our focused analysis of black-white health disparities.”). 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.
- 231 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](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 bias or exclusion”); see also Satcher et al., *supra* note 230, at 459.
- 232 Lu Ann Aday, Sr. Res. Assoc., Ctr. for Health Admin. Studies, Univ. of Chi., *Statement Before the U.S. Commission on Civil Rights: Selected Aspects of a National Study of Access to Medical Care*, in *CIVIL RIGHTS ISSUES IN HEALTH CARE DELIVERY* 19, 20.
- 233 *HEALTH CARE CHALLENGE*, *supra* note 22, at 3.
- 234 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).
- 235 *Id.* at 793-94.
- 236 Bach et al., *supra* note 16, at 1198-202.
- 237 *Id.* at 1202.
- 238 Ayanian et al., *supra* note 16, at 1260-61.
- 239 *Id.* at 1265.

- 240 Id.
- 241 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 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.”).
- 242 U.S. DEPT OF HEALTH & HUMAN SERVS., Call to the Nation, 15 *Prevention Rep.* 1, 1 (2001).
- 243 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).
- 244 Calman, *supra* note 11, at 172-74 (describing the main types of prejudice in health professionals and exploring how they impact and limit patients' health care opportunities); Perez, *supra* note 11, at 626, 628, 633, 636-37 (discussing the nature of the subtle but ongoing racial bias in health care); Randall, *supra* note 11, at 8-9 (explaining that based on the Supreme Court's holding in *Alexander v. Choate*, Title VI's prohibition on bias only extends to intentional bias, and does not extend to unconscious bias, which is especially prevalent in the health care sector); Schulman et al., *supra* note 11, 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.”); Williams, *supra* note 24, at 173, 177-80 (explaining that residential segregation continues to have pervasive adverse effects on the health of by negatively impacting education and employment, which in turn influence access to health care); Williams & Collins, *supra* note 24, at 405-07 (arguing that residential segregation and institutional bias 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 9, 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, *supra* note 9, 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 9, at 57-60 (discussing the successes and failures of federal programs aimed at the 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).
- 245 See Andrew Grant-Thomas & John A. Powell, [Toward a Structural Racism Framework](#), *POVERTY & RACE* 1 3-6 (2006) (defining “structural racism” as looking at the social and inter-institutional dynamics when analyzing and understanding racism).
- 246 Jay Newman, [Prejudice as Prejudgment](#), 90 *ETHICS* 47, 47-49 (1979).
- 247 Beverley Daniels Tatum, [Defining Racism: “Can We Talk?”](#), in *RACE, CLASS, AND GENDER IN THE UNITED STATES* 124, 127 (Paula S. Rothenberg ed., 2004).
- 248 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”).
- 249 JOEL KOVEL, [WHITE RACISM: A PSYCHOHISTORY](#) 31-32 (1970).
- 250 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.”).

- 251 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, 621, 623 (2005) (discussing the nature, prevalence and consequences of aversive racism in the United States).
- 252 See Sabin et al., supra note 18, at 897-98, 906-07 (comparing implicit and explicit racial preferences among doctors); van Ryn & Burke, supra note 24, at 813-14 (examining the degree to which race and socioeconomic status affect physicians' perceptions of patients).
- 253 See Sabin et al., supra note 18, at 907 (discussing the quality of care effects of bias in healthcare); Yearby, Twenty-Five Years, supra note 9, at 59 (discussing studies of physicians' implicit and explicit attitudes about race and their effect on patients' access to quality healthcare).
- 254 Schulman et al., supra note 11, 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 9, at 59.
- 255 Schulman et al., supra note 7, at 623-24, 624 tbl.4; see also Yearby, Twenty-Five Years, supra note 9, at 59.
- 256 John Ayanian, The Effect of Patients' Preferences on Racial Differences in Access to Renal Transplantation, 341 NEW ENG. J. MED. 1661, 1661, 1663 (1999).
- 257 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).
- 258 Id. at 69, 75.
- 259 Id. at 73.
- 260 van Ryn & Burke, supra note 24, 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).
- 261 Id. at 821.
- 262 See id. at 822-23 (suggesting that physicians apply general race differences to their impressions of patients and fail to incorporate “disconfirming individual information”).
- 263 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).
- 264 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).
- 265 Id. at 351, 353.
- 266 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).
- 267 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).
- 268 Id. at 1232.
- 269 Id. at 1235-36.
- 270 Id. at 1234 tbl.1.

- 271 Louis A. Penner et al., Aversive Racism and Medical Interactions with Black Patients: A Field Study, *J. EXPERIMENTAL SOC. PSYCHOL.*, Mar. 2010, at 436, 436.
- 272 *Id.* (citations omitted); see also Dovidio et al., *supra* note 266, at 480-82.
- 273 Green et al., *supra* note 267, at 1235.
- 274 Elizabeth A. Mort et al., Physician Discretion and Racial Variation in the Use of Surgical Procedures, 154 *ARCHIVES INTERNAL MED.* 761, 762-63, 765 *Hol.* 3 (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, 1082-83 (2010) (finding that carotid endarterectomy reduces the ten-year stroke risk in patients seventy-five and under).
- 275 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).
- 276 Penner et al., *supra* note 271, at 438.
- 277 *Id.* at 436-38.
- 278 *Id.* at 437.
- 279 *Id.*
- 280 Mullings & Schulz, *supra* note 24, at 12.
- 281 Bowser, *supra* note 27, at 102.
- 282 See *id.* (“Such [racially biased] institutional practices impose substantial injuries on minorities, even if they do so in a quiet, unconsidered manner.”).
- 283 See Clark, *supra* note 11, at 1029 (describing 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).
- 284 See *id.* at 1028-29.
- 285 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).
- 286 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).
- 287 See *id.* at 1040-45.
- 288 *Id.* at 1039.
- 289 *Id.*
- 290 See *id.* at 1039-40 (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, *supra* note 10, at 476-77 (“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’....”).

- 291 See Clark, *supra* note 11, at 1040-41.
- 292 See *id.* at 1033-34, 1040.
- 293 See *id.* at 1034-35 (“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.”).
- 294 *Id.* at 1034.
- 295 *Id.*
- 296 *Id.* at 1034-35.
- 297 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).
- 298 *Id.* at 1033-34.
- 299 *Id.* at 1034 (describing how physicians followed white patients who moved to the suburbs during the 1970s and 1980s).
- 300 See Gwendolyn Roberts Majette, [Access to Health Care: What a Difference Shades of Color Make](#), 12 ANNALS HEALTH L. 121, 130 (2003).
- 301 See Clark, *supra* note 11, at 1034-35 (describing the “ghettoization” of hospitals that remain in areas serving minority communities).
- 302 *Id.* at 1039.
- 303 *Id.* at 1038.
- 304 See *id.* at 1038-39.
- 305 *Id.*
- 306 *Id.* at 1039.
- 307 See *id.* at 1036-37 (“[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.”).
- 308 SMITH, *supra* note 3, at 200 (citing Alan Sager, *Urban Hospitals in the Face of Racial Change: A Statement on Hospital Financing*, U.S. COMM'N ON CIVIL RIGHTS 283-435 (1980)); see also SAGER & SOCOLAR, *supra* note 17, at 27, 29-31.
- 309 SMITH, *supra* note 3, at 200.
- 310 SMITH, *supra* note 3, at 200 (citing David G. Whiteis, *Hospital and Community Characteristics in Closures of Urban Hospitals, 1980-87*, 107 PUB. HEALTH REPS. 409-16 (1992)).
- 311 Whiteis, *supra* note 356, at 414.
- 312 SAGER & SOCOLAR, *supra* note 310, at 42.
- 313 Yearby, *supra* note 32, at 1035.
- 314 Clark, *supra* note 11, at 1028-29, 1071, 1072-73 (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 300, at 128-30.

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- 315 Fennell et al., *supra* note 10, at 118; Grabowski, *supra* note 134, at 456; Mor et al., *supra* note 97, at 227; Smith, *supra* note 10, at 857, 860-61.
- 316 Falcone & Broyles, *supra* note 10, at 583.
- 317 Jeff Kelly Lowenstein, Lower Standards: A Chicago Reporter Analysis Shows That the Quality of Black Seniors' Nursing Home Care Is Drastically Behind That of White Seniors, CHI. REP., Jul. 1, 2009, at 8, available at 2009 WLNR 3644014 (discussing a study conducted by Chicago Reporter of twenty-one nursing homes in the Chicago area that found lower quality care in predominantly African American nursing homes even when poverty is controlled for) [hereinafter Lowenstein, Lower Standards]; Fennell et al., *supra* note 10, at 174.
- 318 Falcone & Broyles, *supra* note 10, at 583.
- 319 *Id.* at 584.
- 320 *Id.*
- 321 *Id.* at 591-93.
- 322 *Id.* at 592.
- 323 *Id.*
- 324 *Id.*
- 325 *Id.* at 592-93; MINORITY ELDERLY ACCESS, *supra* note 84, at 19; Sullivan, Study Charges Bias, *supra* note 15; Sullivan, New Rules Sought, *supra* note 15; Grabowski, *supra* note 118, at 456.
- 326 42 C.F.R. §§ 488.308(a) & 488.308(b) (2013).
- 327 42 C.F.R. §§ 488.300-.335 (2013).
- 328 This survey is called an annual standard survey. There are three other types of surveys: complaint, revisit, and extended standard survey. See 42 C.F.R. §§ 488.308-310 (2013).
- 329 42 C.F.R. § 488.314 (2013).
- 330 See Social Security Act, 42 U.S.C. § 1395i-3(g)(2)(A) (2012). The majority of nursing homes are also certified to participate in the Medicaid program. See 42 C.F.R. § 488.300 (2013). Thus, the survey team usually cites the nursing home for both Medicare and Medicaid violations. 42 C.F.R. §§ 488.330(a)(1)(i), (b) (2013).
- 331 42 C.F.R. § 488.301 (2013). A deficiency or citation is a violation of the Medicare or Medicaid participation requirements found in the program regulations. *Id.* There are a total of 190 possible Medicare deficiencies divided into seventeen different categories, of which HHS can cite a nursing home. See HHS, OFFICE OF THE INSPECTOR GENERAL, OEI-02-01-00600, NURSING HOME DEFICIENCY TRENDS AND SURVEY AND CERTIFICATION PROCESS CONSISTENCY (2003), available at <http://oig.hhs.gov/oei/reports/oei-02-01-00600.pdf>. Most deficiencies are categorized into three main areas: quality of care, 42 C.F.R. § 483.25 (2013), quality of life, 42 C.F.R. § 483.15 (2013), and resident behavior and facility practice, 42 C.F.R. § 483.13 (2013). Medicaid regulations are based exclusively on the Medicare regulations, but differ slightly on specific deficiency number designations.
- 332 42 C.F.R. § 488.404(a) (2013).
- 333 42 C.F.R. § 488.404(b) (2013). The scope of the deficiency means whether the deficiency was isolated, constituted a pattern of behavior, or was widespread. 42 C.F.R. § 488.404(b)(2) (2013). The severity is whether a facility's deficiencies caused: "(i) [n]o actual harm with a potential for minimal harm; (ii) no actual harm with a potential for more than minimal harm, but not immediate

jeopardy; (iii) actual harm that is not immediate jeopardy; or (iv) immediate jeopardy to a resident's health or safety." 42 C.F.R. § 488.404(b)(1) (2013).

334 42 C.F.R. §488.404(b) (2013).

335 42 C.F.R. § 488.301 (2013).

336 Id.

337 Grabowski, *supra* note 118, at 456. Once HHS approves the findings of noncompliance, it imposes sanctions, posts the findings on the Nursing Home Compare website, and notifies the state long-term care ombudsman, the physicians and skilled nursing facility administration licensing board, and the state Medicaid fraud and abuse control units. See Social Security Act, 42 U.S.C. § 1395i-3(g) (5) (2012).

338 Grabowski, *supra* note 118, at 456.

339 Fennell et al., *supra* note 10, at 174. The authors also noted that, "[i]ndeed, it is possible for a nursing home to provide, on average, high quality of care and to also exhibit a substantial disparity on the levels of care received by majority and minority residents." Id.

340 42 C.F.R. § 483.20(b)(1) (2013). A nursing home is required to assess the condition of every resident within 14 days of a resident's admission and whenever there is a significant change in the resident's condition. 42 C.F.R. § 483.20(b)(2). This data is then coded and transmitted to the Minimum Data Set (MDS), which is used by States to determine the quality of care in nursing homes. 42 C.F.R. § 483.20(f).

341 Fennell et al., *supra* note 10, at 176.

342 Id.

343 Id.

344 Lowenstein, Lower Standards, *supra* note 317, at 8.

345 Id.

346 Id. (noting disparate ratings among black and white homes belonging to same owner).

347 Jeff Kelly Lowenstein, Disparate Nursing Home Care, CHI. REP., Jul. 1, 2009, <http://www.chicagoreporter.com/disparate-nursing-home-care>.

348 Lowenstein, Lower Standards, *supra* note 317.

349 Id.

350 Lowenstein, Disparate Nursing Home Care, *supra* note 347.

351 Lowenstein, Lower Standards, *supra* note 317.

352 Deborah L. Shelton & Jeff Kelly Lowenstein, Nursing Homes Face Vote on RN Time: Facility Residents Would See 46 Minutes With Nurses Each Day, CHI. TRIB., Mar. 6, 2012, at 4, available at 2012 WLNR 4841716.

353 Id.

354 Id.

355 Fennell et al., *supra* note 10, at 174.

- 356 Andrea Gruneir et al., Relationship Between State Medicaid Policies, Nursing Home Racial Composition, and the Risk of Hospitalization for Black and White Residents, 43 HEALTH SERVS. RES. 869, 871 (2008).
- 357 Jackie Spinner, Illness, Race Tied in Study of Care; Comparison Made at Nursing Homes, WASH. POST, Jan. 15, 2008, at B01.
- 358 42 U.S.C. § 3000kk (2012); Yearby, supra note 32, at 1310-11, 1312.
- 359 HHS ACTION PLAN, supra note 34.
- 360 Id.
- 361 NATIONAL PARTNERSHIP, supra note 35.
- 362 STOPPING THE DISCRIMINATION, supra note 36.
- 363 Dovidio et al., supra note 266, at 483; Majette, supra note 300, 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).
- 364 Nilanjana Dasgupta & Anthony G. Greenwald, On the Malleability of Automatic Attitudes: Combatting Automatic Prejudice With Images of Admired and Disliked Individuals, 81 J. PERS. & SOC. PSYCHOL. 800, 812-14 (2001).
- 365 State CME Requirements, MEDSCOPE.ORG, [http:// www.medscape.org/public/staterequirements](http://www.medscape.org/public/staterequirements) (last visited Sept. 22, 2014).
- 366 OFFICE OF MINORITY HEALTH, THE NATIONAL CLAS STANDARDS, available at <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>.
- 367 As discussed in Part III.A, Title VI prohibits disparate treatment and disparate impact racial bias. See infra Part III.A.
- 368 § 18113 (2012).
- 369 See JANICE L. DREASCHSLIN, ET AL., DIVERSITY AND CULTURAL COMPETENCE IN HEALTH CARE: A SYSTEMS APPROACH (2012).
- 370 For a full discussion of this solution, see Yearby, supra note 115, at 340-43.
- 371 Smith, supra note 10, at 856, 862, 866.
- 372 Rosenbaum & Teitelbaum, supra note 243, at 250.
- 373 Id.
- 374 UNEQUAL TREATMENT, supra note 11, at app. B.
- 375 Rosenbaum & Teitelbaum, supra note 243, at 250.
- 376 Dr. Martin Luther King, Jr., Address at the Medical Committee for Human Rights (Mar. 25, 1966).
- 377 Satcher et al., supra note 230, at 459 (“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 post slavery segregation, motivates our focused analysis of black-white health disparities.”).