

2011

Racial Inequities in Mortality and Access to Health Care: The Untold Peril of Rationing Health Care in the United States

Ruqaiijah A. Yearby

Saint Louis University School of Law

Follow this and additional works at: <https://scholarship.law.slu.edu/faculty>

 Part of the [Civil Rights and Discrimination Commons](#), [Health Law and Policy Commons](#), and the [Medical Jurisprudence Commons](#)

Recommended Citation

Yearby, Ruqaiijah A., "Racial Inequities in Mortality and Access to Health Care: The Untold Peril of Rationing Health Care in the United States" (2011). *All Faculty Scholarship*. 84.
<https://scholarship.law.slu.edu/faculty/84>

This Article is brought to you for free and open access by Scholarship Commons. It has been accepted for inclusion in All Faculty Scholarship by an authorized administrator of Scholarship Commons. For more information, please contact erika.cohn@slu.edu, ingah.daviscrawford@slu.edu.

Journal of Legal Medicine
January-March, 2011

Article

***77 RACIAL INEQUITIES IN MORTALITY AND ACCESS TO HEALTH CARE**

The Untold Peril of Rationing Health Care in the United States

Ruqaiijah Yearby, J.D., M.P.H. [FN1]

Copyright © 2011 by Taylor & Francis Group, LLC; Ruqaiijah Yearby, J.D., M.P.H.

INTRODUCTION

On February 25, 2007, a 12-year-old African American boy named Deamonte Driver died of a toothache because he did not receive a routine \$80 tooth extraction that may have saved him, [FN1] which was covered by his insurer: Medicaid. [FN2] Unable to afford \$80 or find a dentist that took Medicaid, Deamonte wound up in the emergency room, underwent two brain surgeries, and was in the hospital for six weeks of treatment, which cost approximately \$250,000. In the end, Deamonte still died from a brain infection caused by the spread of the bacteria from the abscess in his mouth.

While Deamonte did not die as a result of disparate treatment based on his race, his death occurred because of the disparate impact of income inequality on minorities. Specifically, minorities are disproportionately poor and lack health insurance or rely on government health insurance, such as Medicaid. [FN3] *78 As a result, they are disproportionately denied access to health care because either they cannot afford to pay or physicians will not accept patients covered under government health insurance. Wholly avoidable, Deamonte's death is a glaring example of the perils of the United States' policy of rationing access to health care based on ability to pay and how this policy exacerbates racial inequities in health care.

However, most United States citizens, including members of the United States Congress, deny that rationing occurs in the United States. For instance, during the recent battle over health care reform Republicans asserted that health care reform would lead to rationing of care, while Democrats vigorously denied that the United States rations or that health care reform would result in rationing. [FN4] This rhetoric fails to acknowledge the reality of some 46 million Americans who lack access to health care: rationing of health care already exists in the United States. [FN5]

In fact, access to health care in the United States has been rationed for decades based on a person's ability to pay. This system of rationing, which serves as a means to allocate scarce resources, [FN6] has led to an untold number *79 of deaths. Scholars have written about the rationing phenomena and proposed cost-benefit solutions. [FN7] However, the disproportionate effect that current and proposed rationing methods have on minorities has been ignored.

My article begins to fill this void by not only demonstrating how the current rationing policy disproportion-

ately affects minorities and exacerbates racial inequities in health care, but also by illustrating why current cost-benefit proposals will not benefit minorities. Specifically, section I briefly reviews rationing policies in the United States and general problems with the policies. Section II examines empirical data illustrating how rationing health care based on ability to pay has a disparate impact on African Americans. Section III discusses whether current rationing policy based on the ability to pay is race neutral, or merely an example of structural racial bias. In section IV, I critique the proposed cost-benefit solution to improving rationing methods and suggest that rationing care without addressing structural bias will only exacerbate racial inequities in health care.

I. RATIONING POLICIES IN THE UNITED STATES

As of 2007, health care costs constituted 16.2% of the United States gross domestic product, of which the government paid 46%. [FN8] In 2008, government health care spending increased significantly, totaling \$2.2 trillion, approximately \$7,681 per resident. [FN9] Private individuals also bear the burden of rising health care costs. According to the Kaiser Family Foundation, since 1999, health insurance premiums “for employer-sponsored coverage have increased by 131%, placing increasing cost burdens on employers and workers.” [FN10] Because wages continue to grow “at a much slower pace than health care costs, many face difficulty in affording out-of-pocket spending.” [FN11] Thus, financial resources for health care are becoming scarce. [FN12]

Based on this premise of scarcity, scholars have argued that health care must be rationed. [FN13] For example, economist Katherine Baicker noted that “[f]rom an economics perspective, there's no way around rationing. Some *80 care is being rationed now. Everyone isn't getting everything.” [FN14] When the government pays for health care, it means there is less left to fund public schools, roads, and other necessary public services. [FN15] As noted by David Orentlicher, to “have any money left to pay for these other goods, we must place greater limits on spending for health care services.” [FN16]

Yet, the question remains: What is the most effective way to ration health care? As discussed below, the United States has yet to find an effective method.

A. Rationing Policies in the United States

For at least the last 70 years, the United States has rationed health care as a means to allocate scarce resources. During the 1940s, access to scarce penicillin supplies was rationed based on membership in the military, while in the 1960s, access to scarce dialysis machines was rationed in Seattle based on disease prognosis. [FN17] The ultimate example of rationing access to health care in the United States is managed care, which began in the late 1970s.

Managed care organizations rationed care as a means to lower health care costs by limiting access to physicians, primary care gatekeepers, and pre-admission or service authorizations. [FN18] According to several scholars, each of these methods of rationing failed in part because they explicitly limited access to health care, forcing public “tragic choices” about life and death. [FN19] Perhaps reflecting wisdom gained from past failures, rationing is no longer explicit. Instead, rationing is implicitly based on one's ability to pay.

A patient's ability to pay for health care is determined by two main factors-- health insurance and income. [FN20] Those who lack private health insurance and who lack the income to pay for health care are often left

without access to health care, unless they qualify for government health insurance, such as Medicaid. Nevertheless, even those fortunate enough to be covered by government health insurance, such as Medicaid, also have limited access *81 to health care because the government reimburses providers less than what it costs to render the services. [FN21]

However, ability to pay is only used to ration non-emergency health care. [FN22] Specifically, Americans' access to basic health care services, such as preventative services and care for chronic conditions, are limited based on Americans' ability to pay for the services. [FN23] Scholars have deemed this *first dollar* rationing because access to health care is limited by denying coverage for initial services. [FN24] Under first dollar rationing, coverage is denied "either because of a lack of coverage for basic services or because of high deductibles and coinsurance, even though more expensive, tertiary care is often covered." [FN25]

Medicaid coverage governed by the first dollar rationing method does not necessarily increase access to health care. Reimbursement rates are so low that recipients often forgo care because physicians refuse to accept Medicaid, and there are abnormally long wait times to see physicians who accept Medicaid. [FN26] Ironically, once an uninsured or Medicaid patient's condition becomes more serious and the cost of care becomes more expensive, access to health care is gained through the use of emergency rooms in public hospitals. [FN27] Hence, as further illustrated below, first dollar rationing based on ability to pay has resulted in delayed access to health care and a misuse of scarce resources.

B. General Problems with Rationing Policies in the United States

In the United States, some 45.7 million do not have, nor are they entitled to, any non-emergency health care. [FN28] There are severe health consequences for adults without insurance. A poignant example of the problem with the current rationing policy and its severe consequences is the story of a mother of two in her mid 30's who died because she was uninsured and could not afford *82 her medicine. [FN29] She was a working mom, but she had no health insurance. When the money got tight, she had to make a choice: either she was going to buy groceries for her kids or she was going to buy her three blood pressure medicines that she had to take every day. She chose her kids. [FN30] She showed up at an emergency room with a hemorrhagic stroke. Despite the best efforts of the emergency room staff to save her life, she died. This story is not an aberration.

Eleven percent of the uninsured are in fair or poor health, compared to five percent of those covered by private health insurance. [FN31] The uninsured are less likely to receive recommended preventive and primary care services, face significant barriers to care, and ultimately face worse health outcomes. [FN32] Studies show that uninsured women with breast cancer are diagnosed later during its development, when treatment is less effective. [FN33] Increasing the likelihood of serious harm, uninsured men with hypertension are more likely to go without screenings and prescribed medication and to skip recommended doctor visits. [FN34] Data from the Institute of Medicine's (IOM Report) 2002 report, *Caring Without Coverage: Too Little, Too Late*, showed that, on average the uninsured only received about half the care that privately insured patients received, and the uninsured tended to wait longer and get sicker before seeing a doctor. [FN35]

Compared to the insured, a larger share of the uninsured are unable to pay medical bills. In addition, the uninsured report problems procuring dental care, filling a prescription due to cost, and accessing physician care. [FN36] Illustrated by empirical data, rationing by ability to pay leads to the under-treatment of those that are unable to pay such as the uninsured, which results in unnecessary deaths. Unfortunately, those most affected by rationing are racial minorities, who are disproportionately uninsured, and already subject to racial inequities in ac-

cessing health care because of their race. [FN37]

***83 II. RACIAL INEQUITIES IN ACCESSING HEALTH CARE AND MORTALITY**

African Americans and Hispanics are more likely than Caucasians to work in low-wage jobs, and tend to have reduced access to employer-sponsored coverage relative to their higher-wage counterparts. [FN38] Consequently, minorities are more likely than Caucasians to be uninsured or be covered by Medicaid. In addition to lacking access to health care, minorities disproportionately live in poverty. In 2007, the United States Census Bureau reported that 24.5% of African Americans and 21.5% of Hispanics were living at the poverty level, compared to 8.2% of Caucasians. [FN39] By 2008, over half of Hispanics, African Americans, and American Indians and Alaska Natives were poor or near poor, compared with 27% of Caucasians and 31% of Asians. [FN40]

As a result of their lack of employer-sponsored health care insurance and poverty, minorities are disproportionately unable to afford to pay for health care. Lacking access to health care is a central factor in the continuation of racial inequities in access to health care, which causes increased mortality in minority communities. [FN41] Because racial inequities in accessing health care already exist, it is important not to exacerbate the endemic problem by limiting minorities' access to health care through rationing. Although not the only cause, current rationing practices result in racial inequities in health, which *84 manifest themselves in two ways: disparate access to health care and increased mortality.

A. Racially Disparate Access to Health Insurance

People of color comprise one-third of the United States population, but of the 45.7 million non-elderly Americans who were uninsured in 2008, more than half (55%) were minorities. [FN42] Specifically, 32% of Latinos are uninsured, 28% of Native Americans are uninsured, and 21% of African Americans are uninsured, compared to 13% of Caucasians. [FN43] Additionally, public health care programs like Medicaid disproportionately serve minorities. Minorities are less likely than Caucasians to receive health coverage through their employer because they are more likely to be working in low-wage jobs. [FN44]

In 2005-2006, the largest difference in physician visits between insured and uninsured populations was seen among African Americans and individuals of two or more races. [FN45] This racial difference in physician visits is not new. In 1986, a national survey of the use of health care services found that “even after taking into account persons' income, health status, age, sex, and whether they had one or more chronic or serious illnesses, blacks have a statistically significantly lower mean number of annual ambulatory [walk-in] visits and are less likely to have seen a physician in a year.” [FN46] These are just a few examples of the well documented racial inequities in access to health care, which have resulted in serious harm. Unable to see a doctor because of their inability to pay for health care, minorities often forgo care, leading to unnecessary deaths.

B. Increased Mortality

A recent research study showed that the uninsured are 1.8 times more likely to die from their injuries from auto accidents and 2.6 times more likely to die from gunshot wounds than privately insured patients. [FN47] According to Professor Dietrich Jehle, the first author of the study, “uninsured adult patients in general have a 25% greater mortality rate than insured adults for all medical conditions.” [FN48] These results are consistent with several previous research studies, which also found that the uninsured have a higher death rate *85 from trauma

injuries due to treatment delays, different care due to receipt of fewer diagnostic tests, and decreased health literacy. [FN49]

Another study showed that regardless of insurance status, African American and Hispanic patients had higher mortality rates from trauma injuries than Caucasian patients. [FN50] Even though insured African American and Hispanic patients had increased mortality rates compared with insured Caucasian patients, “the highest adjusted odds of death were for uninsured Hispanic patients followed by uninsured African American patients when compared with insured Caucasian patients, suggesting that insurance status has a stronger association with mortality after trauma.” [FN51]

In 2002, the IOM Report found that approximately 18,000 people died in that year because they lacked insurance. [FN52] By 2006, the number of deaths was approximately 22,000. [FN53] Three years later, another Institute of Medicine study, *America's Uninsured Crisis: Consequences for Health and Health Care*, showed that uninsured adults were more likely than insured adults to die from stroke, cancer, heart failure, and congestive heart failure. [FN54] Moreover, uninsured adults have significantly worse control of their diabetic condition than insured adults and also “are less likely than insured adults to be aware of hypertension and, if hypertensive, more likely to have inadequate blood pressure control.” [FN55] Finally, the study found that uninsured adults hospitalized with serious acute conditions “are at greater risk than insured adults of higher mortality in hospital and for at least 2 years after admission.” [FN56] Although this data was not broken down into racial categories, when combined with other research studies it seems to suggest that lack of insurance causes minorities a comparatively higher incidence of disability and mortality, in other words, racial inequities in health.

In addition to higher uninsured rates, African Americans are more likely than Caucasians to die from chronic illnesses such as heart disease and diabetes, as well as cancer. [FN57] African American women were 10% less likely to *86 have been diagnosed with breast cancer; however, they were 34% more likely to die from breast cancer, as compared to non-Hispanic white women. [FN58] Moreover, in 2005, diabetic African Americans were found to be twice as likely as diabetic Caucasians to be hospitalized [FN59] and in 2006, African Americans were 2.3 times as likely as Caucasians to die from diabetes. [FN60] Additionally, these reports showed that African American men were 2.4 times as likely to die from prostate cancer compared to Caucasian men [FN61] and had lower 5-year cancer survival rates for lung and pancreatic cancer compared to Caucasian men. [FN62] African American men also were 30% more likely to die from heart disease, as compared to Caucasian men. [FN63]

Not all of the racial inequities in mortality can be attributed to rationing policies. [FN64] However, the above data suggest that the current structure of the rationing system, that makes access to care based on insurance status or ability to pay rather than need, has a disproportionately negative effect on minorities' access to health care. Yet, before a solution can be crafted, it is necessary to understand why seemingly race neutral rationing policies have a disproportionate effect on minorities.

III. IS RATIONING BASED ON ABILITY TO PAY RACE NEUTRAL?

Scholars assert that rationing based on ability to pay is neutral because it is market-based. [FN65] Markets give the illusion that decisions are made rationally without outside influence. Yet, markets are not neutral. They incorporate the ideologies and practices of the group in power. [FN66] One example of the non-neutrality of markets is the rationing of health care based on ability to pay. As Professor Orentlicher notes, “by shifting costs back to patients, society returns to the illusion that allocation decisions are made freely by individuals *87 exer-

cising their autonomy, when, in fact, a societal choice has been made to allocate medical resources on the basis of wealth rather than medical need or likelihood of receiving benefit.” [FN67] The distribution of health care based on income has a disproportionate effect on minorities. Thus, although rationing seems to be race neutral because it does not explicitly mention race, I submit that the rationing policy is a subtle form of structural racial bias. [FN68]

Structural racial bias operates at the societal level, “privileging some groups and denying others access to the resources of society.” [FN69] Structural racial bias is a result of “[p]ower relationships [that] exist between opposing groups where dominant groups hold power over others and use that power to secure material and social resources such as wealth, income, or access to health care and education.” [FN70] Consequently, scholars suggest that “[g]roups remain dominant in a system over time because their position enables them to continue despite the will or aims of others they have power over.” [FN71]

The structural bias of health care is the allocation of health care based on ability to pay, not need. This structure of rationing is not rationally related to medical need, as evidenced by the data discussed in section IIB concerning the unnecessary deaths of the uninsured minorities. Furthermore, this rationing system is ineffective in allocating scarce health care resources. A recent report estimated that 30.6%, or \$230 billion, of direct medical expenditures between 2003 and 2006 were excess costs due to health and health care inequities incurred by racial minorities. [FN72] Irrational and ineffective, the rationing system is structured to benefit the privileged.

Structural bias allows those with privilege, such as wealthy Caucasians, to obtain the best quality health care available. [FN73] The privileged obtain access because they are able to afford health insurance or pay for health care not covered by insurance. As illustrated by empirical data in section IIA, those without privilege such as minorities, who are disproportionately poor, have limited access to health care because they do not have health insurance and cannot afford to pay for it. [FN74] Adding insult to injury, the wealthy, who have health insurance, receive discounts on the cost of health care, while indigent *88 minorities, who do not have health insurance, are charged more for the health care services they receive and are increasingly required to pay upfront for the care they receive. [FN75] Unable to shoulder the full cost of, or pay up front for, health care, minorities often forgo treatment until it is too late, resulting in racial inequities in mortality.

The effect of this structural bias is evidenced by empirical data of the health status and mortality rates of uninsured minorities. Compared to the privately insured, the uninsured tend to be in worse health. [FN76] In fact, 11% of the uninsured are in fair or poor health compared to 5% of those covered by private health insurance. [FN77] Moreover, 19 years of data shows that more African Americans have died from coronary disease, breast cancer, and diabetes than Caucasians, even though more Caucasians suffer from these diseases than African Americans. [FN78]

The best example of the structural bias of rationing is Deamonte Driver's story, discussed above. Deamonte died of a toothache because he did not receive a routine \$80 tooth extraction that may have saved him. [FN79] Deamonte's family was no different than most working poor families. His mother worked several jobs, but none provided insurance, or paid enough for the family to buy insurance. Deamonte had had coverage under Medicaid, which covers oral health services. However, he never received the dental care he needed because there was a shortage of dentists willing to treat those who cannot afford to pay for health care or rely on government programs for insurance. By the time his mother was able to locate a dentist, Deamonte was no longer covered by Medicaid and thus did not receive treatment.

Lacking health insurance, Deamonte received all of his care in an emergency room or hospital. Instead of a tooth extraction, his care included two brain surgeries, six weeks of hospitalization, and physical and occupational therapy. [FN80] On his last day, Deamonte played cards and watched a show on television with his mother. As his mother was leaving, Deamonte said to her: "Make sure you pray before you go to sleep." [FN81] The next morning, Deamonte was dead from a brain infection caused by the spread of the bacteria from the abscess in his mouth. Deamonte did not have to die: he was a 12-year-old boy with a cavity. He died because health care in the United States is provided based on ability to pay, not medical need. Clearly, this is an irrational way to allocate health care resources.

***89** Notwithstanding, the irrationality of the system and failure to allocate scarce resources, the wealthy remain dominant under the current structure of health care rationing because they can afford unlimited access to basic health care, which keeps them healthy. [FN82] Whereas, minorities are barred access to health care until their condition is so bad that the cost of care is astronomical, the care given is less likely to be effective, and they die unnecessarily. [FN83]

For over 20 years, scholars have written about the irrationality and ineffectiveness of the rationing system of health care based on ability to pay. In fact, some scholars have suggested fixing the rationing system by implementing a cost-benefit system, the model of rationality. However, the effect rationing has on minorities has been ignored in the critique of rationing and in the development of solutions. I assert that simply changing the method of rationing will not address the structural racial bias that is the foundation of our current rationing system. By failing to acknowledge and address the structural racial bias that caused Deamonte's death under the current system, the new system will only perpetuate the same harms: the unnecessary deaths of minorities.

IV. COST-BENEFIT RATIONING: PANACEA OR PERIL

To better allocate scarce resources, scholars have suggested the implementation of a cost-benefit method of rationing known as the quality-adjusted life-year (QALY). [FN84] Professor Peter Singer proposes rationing based on the use of QALY to empirically show "what brings about the greatest health benefit, irrespective of where that benefit falls." [FN85] Hypothetically, under the QALY approach, there is more benefit from granting care to those who are worst off, because they have the greatest unmet needs, "but occasionally some conditions will be both very severe and very expensive to treat." [FN86] Consequently, the QALY approach may "then lead us to give priority to helping others who are not so badly off and whose conditions are less expensive to treat." [FN87] Under the QALY model, there is a potential that the care of minorities may not be cost efficient because their care may be too expensive.

***90** For example, empirical data show that diabetic African Americans were twice as likely as diabetic Caucasians to be hospitalized [FN88] and 2.3 times as likely as diabetic Caucasians to die from diabetes. [FN89] Increased hospitalization and death are a result of lack of access to health care caused by structural racial bias. Therefore, under the QALY model it may not be cost effective to provide care to diabetic African Americans, because their care will be more expensive care as a result of hospitalization. Instead, it may be more cost effective to give care to diabetic Caucasians. If this is the case, then the outcome under the QALY model is no different than the outcome achieved under the current rationing model. The only difference is that diabetic African Americans will be denied care based on the premise that their care is not cost efficient, rather than saying their care is denied because they are poor. Either way the care is still denied.

To improve the allocation of scarce health care resources for everyone, the underlying problem of structural

bias must be addressed. There are two ways to address structural racial bias under the QALY approach. [FN90] First, the QALY approach should take into consideration the benefits and costs that health care brings in addition to the improvement in health itself. Currently, 30% of Americans self-identify as members of a racial minority group and by 2045, half of the population will be members of a racial minority group. [FN91] As the minority population grows, there are significant health and economic consequences in failing to eliminate policies and biases that aggravate racial inequities in access to health coverage and care. Thus, even if it is not cost efficient to provide care to minorities now, unless racial inequities are addressed the excess costs of racial inequities will ultimately make health care a scarce resource for everyone. [FN92] Increasing minorities' access to health care by paying for expensive care will not only benefit minorities' health, but it will also decrease excess cost and free up more resources for others. Therefore, if the excess cost of racial inequities is considered, then care to minorities in poorer health will be cost efficient.

Second, the QALY approach should give priority to those whose condition is a result of structural bias. Specifically, uninsured minorities suffering from the same ailments as others should receive priority over others because their health is a direct result of the current structure of the health system that values money over need. [FN93] Adding my suggestions to the QALY approach will not be easy because it will create some explicit "tragic choices" of comparing the value of one person's life against another's life. However, unless structural bias is factored into the costs of QALY, racial inequities in health care will persist and minorities will continue to die needlessly.

CONCLUSION

The United States' system of rationing health care resources based on ability to pay is irrational. It prioritizes wealth over need, an ineffective and inequitable allocation of scarce resources. It is regarded as neutral because it does not explicitly mention wealth. Nevertheless, this system of rationing is the manifestation of structural bias, prioritizing wealth over the common good. Minorities tend to lack wealth. Hence, they are disproportionately affected by this rationing policy and suffer the most harm. As Professors David Williams and Pamela Jackson noted: "[R]ace is a marker for differential exposure to multiple disease-producing social factors. Thus, racial [inequities] 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." [FN94] Deamonte Driver's tragic death is a chilling example of the patterned social inequities that result from inequities in financial resources and access to health care. To prevent others from suffering the same fate, policy makers and scholars must seriously consider the significance of this harm when crafting and implementing new methods of rationing health care. The unpalatable alternative is that the method will change; yet people will continue to die needlessly.

[FN1]. Associate Professor, University at Buffalo Law School and School of Public Health and Health Professions, B.A. (Honors Biology), University of Michigan, 1996; J.D., Georgetown University Law Center, 2000; M.P.H., Johns Hopkins School of Public Health, 2000. Many thanks to Professor W. Eugene Basanta, Director of SIU's Center for Health Law and Policy, and Ross Silverman, the Editor of the *Journal of Legal Medicine*, for putting together an excellent Conference and symposium issue on the rationing of health care that featured numerous valuable contributions. Finally, my gratitude extends to Rebecca French, Devonya Havis, Teresa Miller, and Ayanna Yearby for their support.

[FN1]. Mary Otto, *For Want of a Dentist: Pr. George's Boy Dies After Bacteria from Tooth Spread to Brain*,

WASH. POST. Mar. 2, 2007, at A14.

[FN2]. 42 U.S.C. §§ 1396, 1396a(a)(1)-(2), (5) (2006 & Supp. 2009). Medicaid is a joint federal and state partnership, which the states administer, the purpose of which is to grant reasonable access to those “whose income and resources are insufficient to meet the costs of necessary medical services, and ... rehabilitation and other services.”

[FN3]. MEGAN THOMAS & CARA JAMES, *THE ROLE OF HEALTH COVERAGE FOR COMMUNITIES OF COLOR* 2-5 (KAISER FAMILY FOUND. 2009). Although other government health insurance programs, such as Medicare and the Children's Health Insurance Program, exist, this article focuses exclusively on Medicaid because a majority of the uninsured are adults who, if government health programs covered them, would be covered under Medicaid.

[FN4]. Robert Farley, *There's Rationing in Health Care Now, and There Still Would Be Under Reform Bill*, ST. PETERSBURG TIMES, Aug. 25, 2009; David Leonhardt, *Limits in a System That's Sick*, N.Y. TIMES, June 17, 2009, at 22; Melissa Block, *Doctors Say Health Care Rationing Already Exists*, NAT'L PUBLIC RADIO: ALL THINGS CONSIDERED (July 1, 2009), transcript available at <http://www.npr.org/templates/transcript/transcript.php?storyId=106168331>. However, in a town hall speech on August 16, 2009 concerning health care reform. President Barack Obama did acknowledge the reality of rationing; see President Obama Remarks at a Town Hall Meeting in Grand Junction, Colorado (Aug. 15, 2009), http://www.whitehouse.gov/the_press_office.

[FN5]. Patient Protection and Affordable Care Act. Pub. L. No. 111-148; 3403 (Mar. 23, 2010), Interestingly, the Patient Protection and Affordable Care Act specifically prohibits the use of rationing. Because the Act has only been in place for seven months, it is difficult to predict whether this Act will improve access to health care and address some of the problems discussed in this article. Moreover, it is unclear whether the individual mandate for health insurance will ever take effect because there are several lawsuits challenging the federal government's authority to mandate insurance. See Michael Felberbaum, *Health Care Reform Suit Gets Past Key Hurdle*, THE STAR LEDGER, Aug. 3, 2010, at 4; *Health Care Reform and the Courts*, N.Y. TIMES, May 20, 2010, at A26. Consequently, even though the Act's insurance requirements for individuals and employers does have the potential of addressing the problem of the uninsured, this article focuses on the how the health care system is regulated prior to the implementation of the Act because it is too early to understand and measure the true effects of the Act.

[FN6]. See generally 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 (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); M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 YALE J. HEALTH POL'Y, L. & ETHICS 95 (2001) (discussing the institutional, economic, and legal factors that contribute to racial disparities); Barbara Noah, *Racial Disparities in the Delivery of Health Care*, 35 SAN DIEGO L. REV. 135 (1998) (discussing how health care is rationed based on race); David Orentlicher, *Destructuring Disability: Rationing of Health Care and Unfair Discrimination Against the Sick*, 31 HARV. C.R.-C.L. L. REV. 49 (1996); Richard Lamm, *Rationing of Health Care: Inevitable and Desirable*, 140 U. PA. L. REV. 1511, 1518 (1992) (discussing how rationing of health care can be by price, quantity, chance, or prioritization).

[FN7]. Peter Singer, *Why We Must Ration Health Care*, N.Y. TIMES, July 19, 2009, at 38; Orentlicher, *supra* note 6; Lamm, *supra* note 6.

[FN8]. NAT'L CTR. FOR HEALTH STATISTICS, HEALTH, UNITED STATES, 2009, table 123 (2009).

[FN9]. *Id.*

[FN10]. KAISER FAMILY FOUND., EMPLOYER HEALTH BENEFITS: 2009 ANNUAL SURVEY (2009).

[FN11]. Eric Kimbunde et al., *U.S. Health Care Costs: Background Brief* (Mar. 2010), <http://www.kaiseredu.org/Issue-Modules/US-Health-Care-Costs/Background-Brief.aspx>.

[FN12]. Singer, *supra* note 7, at 38; Govind Persad et al., *Principles for Allocations of Scarce Medical Interventions*, 373 LANCET 423, 423 (2009).

[FN13]. Singer, *supra* note 7, at 38; Persad et al., *supra* note 12, at 423; *see* Orentlicher, *supra* note 6; Lamm, *supra* note 6, at 1518. *Cf.* Amitai Etzioni, *Health Care Rationing: A Critical Evaluation*, 10 HEALTH AFFAIRS 88 (1991) (challenging the need for health care rationing based on the assumption that health care resources are scarce).

[FN14]. Farley, *supra* note 4.

[FN15]. Block, *supra* note 4.

[FN16]. Orentlicher, *supra* note 6, at 49.

[FN17]. Persad et al., *supra* note 12, at 423.

[FN18]. David Orentlicher, *The Rise and Fall of Managed Care: A Predictable "Tragic Choices" Phenomenon*, 47 ST. LOUIS U. L.J. 411, 415 (2003).

[FN19]. *Id.* at 413; *see also* GUIDO CALABRESI & PHILLIP BOBBITE, TRAGIC CHOICES (1978).

[FN20]. There are several proxies for a patient's ability to pay, such as lack of or type of health insurance. Nevertheless, some scholars argue that data regarding socioeconomic status would be a better predictor of ability to pay. *See* Paul Braverman et al., *Socioeconomic Disparities in Health in the United States: What the Pattern Tells Us*, 100 AM. J. PUBLIC HEALTH S186, S186-90 (2010); Nancy Krieger, *Monitoring Socioeconomic Determinants for Healthcare Disparities: Tools from the Public Health Disparities Geocoding Project*, in ELIMINATING HEALTHCARE DISPARITIES IN AMERICA: BEYOND THE IOM REPORT 259-60 (Williams ed., 2007). However, this data is almost nonexistent because health records and the United States public health surveillance system do not track socioeconomic data. Krieger, *supra*, at 260.

[FN21]. Lamm, *supra* note 6, at 1518.

[FN22]. Emergency Medical Treatment & Labor Act (EMTALA), 42 U.S.C.A. § 1395dd (2006). Enacted in 1986 to ensure public access to emergency services regardless of ability to pay, the Act requires all hospitals that receive federal Medicare funds and that have emergency departments or provide emergency medical care to screen every patient seeking emergency room services, and, if the patient has an emergency medical condition, they must stabilize the patient before transferring him or her. *See id.* §§ 1395dd(a), (d)(2)(a), & (e); However,

empirical evidence suggests that the uninsured receive less aggressive emergency care than privately insured individuals. Heather Rosen et al., *Downwardly Mobile: The Accidental Cost of Being Uninsured*, 144 ARCH. SURGERY 1006, 1010 (2009).

[FN23]. Lamm, *supra* note 6, at 1518.

[FN24]. Other countries, such as Great Britain, use *last-dollar* rationing to control health care costs. Under last dollar rationing, “access to very high-cost services is impeded whereas the initial, or first-dollar, costs of basic care are covered. Hence, although access to primary physician care is open to all, those who are more severely ill and likely to require expensive therapies are more likely to confront rationing.” Most experts agree that last-dollar rationing utilizes resources in a way to maximize the public’s health because it provides the most health care resources, which provide the most benefit to the population. *Id.*

[FN25]. *Id.*

[FN26]. *Id.*

[FN27]. *Id.*

[FN28]. KAISER FAMILY FOUND., *THE UNINSURED: A PRIMER* 1 (2009).

[FN29]. Block, *supra* note 4.

[FN30]. *Id.*

[FN31]. KAISER FAMILY FOUND., *supra* note 28, at 6.

[FN32]. *Id.* at 1-7.

[FN33]. STAN DORN, *UNINSURED AND DYING BECAUSE OF IT: UPDATING THE INSTITUTE OF MEDICINE ANALYSIS ON THE IMPACT OF UNINSURANCE ON MORTALITY* 2 (Urban Inst. 2008).

[FN34]. *Id.*

[FN35]. INST. OF MED., *CARING WITHOUT COVERAGE: TOO LITTLE, TOO LATE* 1-3 (2002).

[FN36]. THOMAS & JAMES, *supra* note 3, at 1-2.

[FN37]. See Thomas E. Perez, *The Civil Rights Dimension of Racial and Ethnic Disparities in Health Status*, in INST. OF 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); Neil S. Calman, *Out of the Shadow: A White Inner-City Doctor Wrestles with Racial Prejudice*, 19 HEALTH AFF. 170, 172-74 (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); 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); 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, 824 (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); Ruqaiijah Yearby, *Striving for Equality, but Settling for the Status Quo in Health Care: Is Title VI More Illusory Than Real?*, 59 RUTGERS L. REV. 429, 462-70 (2007) (discussing how racial discrimination plays a part in geographical racial segregation and socioeconomic status); Ruqaiijah Yearby, *Does Twenty-Five Years Make a Difference in "Unequal Treatment"?: The Persistence of Racial Disparities in Health Care Then and Now*, 19 ANNALS HEALTH L. 57, 57-61 (2010) (discussing how current federal programs aimed at elimination of racial discrimination in health care have been successful, and calling "scholars, researchers, and federal officials to adopt a new approach to eradicate racial disparities"); Ruqaiijah Yearby, *African Americans Can't Win, Break Even, or Get Out of the System: The Persistence of Racial Disparities in Health Care in "Post-Racial" America*, 83 TEMPLE L. REV. (forthcoming 2011).

[FN38]. THOMAS & JAMES, *supra* note 3, at 1-3; KAISER FAMILY FOUND., *supra* note 28, at 5.

[FN39]. U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2007, at 12 (2008) (finding that the average African-American family median income was \$33,916, 62% of the median income for Caucasians, while the median income for Hispanic households was \$38,679, 70% of the median income for Caucasians).

[FN40]. THOMAS & JAMES, *supra* note 3, at 5.

[FN41]. *See generally supra* note 37 (demonstrating other significant factors that cause the continuation of racial inequities in health care are residential segregation, socioeconomic status, and racial discrimination).

[FN42]. KAISER FAMILY FOUND., *supra* note 28, at 5.

[FN43]. *Id.*

[FN44]. THOMAS & JAMES, *supra* note 3, at 1; KAISER FAMILY FOUND., *supra* note 28, at 4 (finding that 66% of the uninsured are from families with 1 or more full-time workers and 14% are from families with part-time workers).

[FN45]. *See Braverman et al., supra* note 20, at S186-90.

[FN46]. Robert Blendon et al., *Access to Medical Care for Black and White Americans--A Matter of Continuing Concern*, 261 J.A.M.A. 278, 279 (1989).

[FN47]. Henry Davis, *Serious Injuries Worse for Uninsured*, BUFFALO NEWS, July 26, 2010, at B1.

[FN48]. *Id.*

[FN49]. Rosen et al., *supra* note 22, at 1010; Adil H. Haider, *Race and Insurance Status as Risk Factors for Trauma Mortality*, 143 ARCH. SURGERY 945, 948-49 (2008).

[FN50]. Haider, *supra* note 49, at 948-49.

[FN51]. *Id.* Race persists as a risk factor for mortality in patients with and without insurance, which confirms that racial disparities in trauma mortality cannot be completely explained by insurance status alone. Hence, according to the authors, insurance status is not the only factor that needs to be addressed.

[FN52]. INST. OF MED., *supra* note 34, at 1-3.

[FN53]. DORN, *supra* note 32, at 2-3 (finding that the actual number of deaths may be even higher and total 27,000).

[FN54]. INST. OF MED., AMERICA'S UNINSURED CRISIS: CONSEQUENCES FOR HEALTH AND HEALTH CARE 4 (Report Brief, 2009) (emphasis added).

[FN55]. *Id.*

[FN56]. *Id.*

[FN57]. NAT'L CTR. FOR HEALTH STATISTICS, CTRS. FOR DISEASE CONTROL & PREVENTION, HEALTH, DEATHS: LEADING CAUSES FOR 2006, at 12, table F (2010), *available at* http://www.cdc.gov/nchs/fastats/black_health.htm (last visited Aug. 9, 2010).

[FN58]. NAT'L CANCER INST., SEER CANCER STATISTICS REV., 1975-2006, table 1.20 (2009), http://seer.cancer.gov/csr/1975_2006/results_single/sect_01_table.20_2pgs.pdf.

[FN59]. CTRS. FOR DISEASE CONTROL AND PREVENTION, NAT'L DIABETES SURVEILLANCE SYSTEM (2009), <http://www.cdc.gov/diabetes/statistics/dmfirst/fig6.htm>.

[FN60]. CTRS. FOR DISEASE CONTROL AND PREVENTION, 57 NAT'L VITAL STAT. REP. table 17 (2009), http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_14.pdf.

[FN61]. NAT'L CANCER INST., *supra* note 58.

[FN62]. CTRS. FOR DISEASE CONTROL AND PREVENTION, HEALTH UNITED STATES, 2008, table 53 (2009), <http://www.edc.gov/nchs/data/hus/hus08.pdf>.

[FN63]. CTRS. FOR DISEASE CONTROL AND PREVENTION, *supra* note 60.

[FN64]. *See generally supra* note 37 (explaining other significant factors that cause the continuation of racial inequities in health care, including residential segregation, socioeconomic status, and racial discrimination).

[FN65]. Singer, *supra* note 7, at 38; Orentlicher, *supra* note 6, at 49; Lamm, *supra* note 6, at 1518.

[FN66]. Cass R. Sunstein, *Why Markets Don't Stop Discrimination*, in REASSESSING CIVIL RIGHTS 22, 33 (Ellen Frankel Paul et al. eds., 1991) (stating that "markets incorporate the norms and practices of advantaged groups").

[FN67]. Orentlicher, *supra* note 18, at 419-20.

[FN68]. For further discussion of structural, institutional, and interpersonal racial biases in health care, see Leith Mullings & Amy Schulz, *Intersectionality and Health: An Introduction*, in GENDER, RACE, CLASS &

HEALTH 12 (2006); 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).

[FN69]. Mullings & Schulz, *supra* note 68, at 12.

[FN70]. Lynn Weber, *Reconstructing the Landscape of Health Disparities Research: Promoting Dialogue and Collaboration Between Feminist Intersectional and Biomedical Paradigms*, in GENDER, RACE, CLASS & HEALTH, *supra* note 68, at 36.

[FN71]. *Id.*

[FN72]. THOMAS LAVEIST ET AL., THE ECONOMIC BURDEN OF HEALTH INEQUALITIES IN THE UNITED STATES 1 (2009).

[FN73]. Weber, *supra* note 70, at 36.

[FN74]. KAISER FAMILY FOUND., *supra* note 28, at 6.

[FN75]. *Id.* at 9.

[FN76]. *Id.* at 6.

[FN77]. *Id.*

[FN78]. Robert Weinick et al., *Racial and Ethnic Differences in Access to and Use of Health Care Services, 1977 to 1996*, 57 MED. CARE RES. & REV. 37, 51 (2000).

[FN79]. *Id.*

[FN80]. Otto, *supra* note 1.

[FN81]. *Id.*

[FN82]. SHANNON BROWNLEE, OVERTREATED: WHY TOO MUCH MEDICINE IS MAKING US SICKER AND POORER 1-30 (2007) (explaining why access to unlimited health care is not always a benefit); KAISER FAMILY FOUND., *supra* note 28, at 6 (illustrating that, nevertheless, access to health care still provides a measurable benefit); DORN, *supra* note 32, at 2; INST. OF MED., *supra* note 34, at 1-3.

[FN83]. DORN, *supra* note 32, at 2; INST. OF MED., *supra* note 34, at 1-3.

[FN84]. John Freeman, *Let's Get Rational About Health Care Rationing*, BALT. SUN, Feb. 8, 2010, at 13A; Singer, *supra* note 7, at 38; Persad et al., *supra* note 12, at 423.

[FN85]. Singer, *supra* note 7, at 38.

[FN86]. *Id.*

[FN87]. *Id.*

[FN88]. CTRS. FOR DISEASE CONTROL AND PREVENTION, *supra* note 59.

[FN89]. CTRS. FOR DISEASE CONTROL AND PREVENTION, *supra* note 60.

[FN90]. See Leiyu Shi, *Primary Care, Social Inequalities, and All-Cause, Heart Disease, and Cancer Mortality in US Counties*, 95 AM. J. PUB. HEALTH 674 (2005) (explaining that another solution is to increase access to primary care and income equality); see also Leiyu Shi, *The Effect of Primary Care Physician Supply and Income Inequality on Mortality Rates Among Blacks and Whites in US Metropolitan Areas*, 91 AM. J. PUB. HEALTH 1246 (2001).

[FN91]. THOMAS & JAMES, *supra* note 3, at 1.

[FN92]. LAVEIST ET AL., *supra* note 72

[FN93]. Although I only discuss granting priority to minorities, I believe all the uninsured and poor should receive priority in coverage of health care compared to the insured and wealthy under the QALY approach.

[FN94]. David R. Williams & Pamela Braboy Jackson, *Social Sources of Racial Disparities in Health*, 24 HEALTH AFFAIRS 325, 325 (2005).

32 J. Legal Med. 77

END OF DOCUMENT