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HEALTH CARE IN THE INNER CITY: ASKING THE RIGHT QUESTION

SIDNEY D. WATSON*

MIAMI—June Kirchik, fifty-eight years old, discovered a large lump in her breast. When she went to a private hospital, she was denied treatment because she was indigent and her case was not considered an emergency. A public hospital performed a biopsy, which was positive, and gave her an appointment for treatment three weeks later. When Mrs. Kirchik arrived for treatment, however, the public hospital turned her away because she had not yet applied for Medicaid. Mrs. Kirchik tried another public hospital, but was turned away because she was not a resident of the hospital's service area. When Mrs. Kirchik's story appeared in the newspaper, the first public hospital admitted her—to a private room—four months after she had first discovered the lump. Two weeks later, Mrs. Kirchik died.¹

The June Kirchiks of this country seem forgotten in the current debate about health care reform. Americans keep asking: How do we contain the ever-increasing costs of health care? How do we pay for health care? We are so focused on these questions that we have narrowed our vision too much and lost sight of the real questions and the real issues.

The real question for American health care reform ought to be: How do we improve Americans' health? Especially, how do we improve the health of those, like June Kirchik, who live in the inner city, are poor and overwhelmingly minority, and who are systematically under-served by our health care establishment? This is the question we should be asking. Sadly, we are not.

I. THE PROBLEM OF RACE AND HEALTH CARE

Race, poverty, and geographic inaccessibility to health care interact. As a result, an urban Black typically is sicker and in greater need of

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1. See Ellen Bilofsky, *Mammography for the Poor: The Deadly Waiting Game*, HEALTH/PAC BULL., Summer 1991, at 31.

health care than a suburban white, but is less likely to be able to afford or obtain health care. Given the greater poverty among minorities, health care discrimination based on race is virtually inevitable in a system in which one must purchase health care.²

Simple statistics tell a good part of the story and highlight what happens when we ask the wrong question. The poverty rate for Black³ families is three times the rate for white families.⁴ A third of all Black households, and almost half of all Black children, live in poverty.⁵ Nearly 30% of Black households report having no assets and more than 50% have assets of \$5000 or less.⁶

In a 1986 survey, 9% of Black Americans reported they could not get health care for "economic reasons."⁷ Only about half of all Blacks have private health insurance; one in five have Medicaid or Medicare; and one in five have no health coverage.⁸ Blacks are "50 percent more likely than whites to have no health insurance and 5 times as likely to be covered by Medicaid."⁹ "[Forty] percent of all Medicaid enrollees are black."¹⁰

The problem is exacerbated by the story the statistics do not relate. Blacks, particularly poor, inner-city Blacks, have greater health care needs than whites. Inner-city residents are exposed to twice the environmental health hazards that suburban dwellers face—bad air, polluted

2. See Mark Schlesinger, *Paying the Price: Medical Care, Minorities, and the Newly Competitive Health Care System*, 65 MILBANK Q. 270, 275-77 (Supp. 2 1987).

3. I use the terms "African American" and "Black" interchangeably because both terms currently are used, particularly in the African-American community. I use "Black" because the term does not designate merely a skin color but a specific cultural group and, as such, requires identification as proper noun.

Editor's Note: The contributors to this symposium have used the terms "African American," "black," and "black American," often interchangeably, in their articles. The *North Carolina Law Review* has elected to defer to its contributors' choices in the absence of any universally accepted racial or ethnic designation.

4. Schlesinger, *supra* note 2, at 270 (citing Woodrow Jones, Jr. & Mitchell F. Rice, *Black Health Care: An Overview*, in HEALTH CARE ISSUES IN BLACK AMERICA 3, 7 (Woodrow Jones, Jr. & Mitchell F. Rice eds., 1987)).

5. *Id.* at 275.

6. Cassandra Q. Butts, *The Color of Money: Barriers to Access to Private Health Care Facilities for African-Americans*, 26 CLEARINGHOUSE REV. 159, 160 (1992) (citing WILLIAM P. O'HARE ET AL., POPULATION REFERENCE BUREAU, AFRICAN AMERICANS IN THE 1990s, at 30 (1991)).

7. Schlesinger, *supra* note 2, at 276 (citing Howard E. Freeman et al., *Americans Report on Their Access to Health Care*, 6 HEALTH AFF. 6, 13-14 (1987)).

8. John C. Boger, *Race and the American City: The Kerner Commission in Retrospect*, *An Introduction*, 71 N.C. L. REV. 1289, 1329 (1993).

9. Schlesinger, *supra* note 2, at 276.

10. *Id.*

water, crime, and drugs.¹¹ Inner-city residents suffer from hypertension, heart disease, chronic bronchitis, emphysema, sight and hearing impairments, cancer, and congenital anomalies at a rate 50% higher than suburbanites.¹² The rate of neurological and mental disorders in inner-city residents is nearly twice that of suburbanites.¹³

The problem begins at birth. In this country, Black infants are twice as likely to die before their first birthday than are white infants. Babies born in America's inner cities are more likely to die than babies in Costa Rica and Jamaica. In fact, nineteen developed countries have lower infant mortality rates than the United States.¹⁴

The problem is exacerbated by the dual epidemics of AIDS and tuberculosis. Both diseases disproportionately affect Blacks and Hispanics, particularly those in the inner city.¹⁵ Together Blacks and Hispanics account for almost half of all people diagnosed with AIDS in the United States.¹⁶ A primary reason for the high rate of AIDS is that minority life in the inner city is identified with poverty, massive unemployment, and rampant intravenous drug use.¹⁷ Blacks and Hispanics have higher rates of tuberculosis than whites because life in the inner city is more likely to create the conditions in which tuberculosis spreads—overcrowded housing, homeless shelters, and prisons.¹⁸

Although minority inner-city residents have many illnesses and need more medical care than other Americans, they have less access to health care. A study of ten U.S. cities found that the number of office-based primary care physicians in poor, inner-city areas declined 45% from 1963 to 1980.¹⁹

Historically, inner-city Blacks, like other poor inner-city residents,

11. See Prepared Statement by Sylvia Drew Ivie, *Ending Discrimination in Health Care: A Dream Deferred*, in U.S. COMM'N ON CIVIL RIGHTS, CIVIL RIGHTS ISSUES IN HEALTH CARE DELIVERY 282, 295 (1980).

12. *Id.*

13. *Id.*

14. *Nightline: America's Infant Mortality Crisis* (ABC News television broadcast, Apr. 12, 1990), available in LEXIS, Nexis Library, Transcripts File [hereinafter *Nightline*].

15. NATIONAL COMM'N ON AIDS, THE CHALLENGE OF HIV/AIDS IN COMMUNITIES OF COLOR 3-11 (1992).

16. See *id.* at 4. As of September 1992, African Americans and Hispanics accounted for 46.4% of AIDS cases in the United States. While African Americans compose only 11.8% of the U.S. population, they comprise 29.7% of AIDS cases. Hispanics constitute only 9% of the population, but they account for 16.7% of AIDS cases. *Id.*

17. *Id.* at 9-10.

18. *Id.* at 8-9.

19. David A. Kindig et al., *Trends in Physician Availability in 10 Urban Areas From 1963 to 1980*, 24 INQUIRY 136, 140 (1987). This compares with a 27% decline in non-poverty areas of the cities. *Id.*

have relied on hospital emergency rooms and, where available, public outpatient clinics for care.²⁰ Federal budget cuts have forced many inner-city primary care clinics to close,²¹ however, and private hospitals, once a major source of emergency primary care, have abandoned the inner city.²²

*ATLANTA—Grady Memorial Hospital in downtown Atlanta turned away ambulances twenty-three times in 1990 because it had no beds available.*²³

*The waiting time for an appointment to receive treatment for AIDS is six months.*²⁴

Between 1937 and 1977, 210 private hospitals with 30,000 hospital beds in fifty-two of the largest cities in the country either closed or relocated.²⁵ A disproportionate number of these hospitals were located in neighborhoods where Blacks constituted at least 60% of the population. The hospitals that closed served the patients whom other hospitals were reluctant to serve, in areas where few doctors were willing to practice.²⁶ The facilities that closed served twice as many minority patients and twice as many Medicaid patients as the hospitals that remained open.²⁷ The private hospitals that remained behind often limited the number of Medicaid and Medicare patients treated, disproportionately excluding Black patients, who, as stated earlier, are five times as likely as whites to be covered by Medicaid.²⁸

*NEW YORK—New York City's six public hospitals have a 97% occupancy rate, and many private hospitals have closed their emergency rooms to keep out uninsured patients. The results are witnessed at Bellevue Hospital where patients wait as long as two days to be treated in the emergency room.*²⁹

At New York City's public hospitals, it takes six weeks to get a first

20. Henry T. Greely, *The Future of the American Health Care System: An Introduction to the Health Symposium*, 3 STAN. L. & POL'Y REV. 16, 17 (1991).

21. See Boger, *supra* note 8, at 1330.

22. *Id.*

23. See Hal Straus & Mike King, *In Sickness and in Wealth, Urban Decay, Rural Waste*, ATLANTA CONST., Sept. 30, 1990, at A11.

24. See Kathleen Brockel & Stephanie J. Morrison, *The Age of Aids: Will Zell Miller Supply the Funds to Save Lives?*, ATLANTA CONST., Dec. 1, 1992, at A15.

25. Butts, *supra* note 6, at 161 (citing *The Closure of Hospitals That Serve the Poor: Implications for Health Planning, Hearing Before the Comm. on Energy and Commerce, Subcomm. on Health and the Env't*, 97th Cong., 2d Sess. (1982) (statement of Alan Sager, Ph.D.)).

26. Ivie, *supra* note 11, at 297-300.

27. Butts, *supra* note 6, at 161.

28. Schlesinger, *supra* note 2, at 276.

29. Straus & King, *supra* note 23, at A11.

*appointment at an AIDS clinic, and two months for an appointment at City Hospital's general medicine clinic. Women wait up to three months for prenatal care and four months for gynecological care.*³⁰

Most public hospitals in urban areas are located in the inner city and are the primary care providers for inner-city, poor minorities.³¹ These public facilities are grossly underfunded³² and suffer from rapidly deteriorating conditions, overcrowding, long waits for emergency treatment, staff shortages, and outdated equipment.³³ Patients with private insurance avoid these decaying inner-city public hospitals and choose newer, less crowded, more patient-friendly private facilities—the same ones that are more likely to limit the number of Medicaid and Medicare patients they treat.

The result is America's segregated health care system. The Black, poor, inner-city resident receives treatment at overcrowded, underfunded, disproportionately Black public hospitals. Those with private insurance, who are disproportionately white, receive care at more modern, better-equipped, and better-staffed private hospitals.

*NEW ORLEANS—"When sixty-four year old Marie Barnett arrived at Charity Hospital suffering from piercing pains in her arm and chest, she needed the constant medical care and high-tech attention of an intensive care unit. Unfortunately, the . . . unit . . . was full," half its beds had been converted to storage closets because of a lack of money to pay for nurses to staff the unit. Mrs. Barnett was put on a regular ward, "without special equipment to monitor her condition or extra staff to respond quickly to problems. A few hours later, she had a second heart attack"—finally earning a place in one of Charity's six intensive care beds. At Charity, New Orleans' only public hospital, the sick and poor, who are overwhelmingly Black, wait six months for a routine outpatient clinic appointment, pipe leaks are left unattended and nearly half of its 920 beds have been taken out of service since 1986 because of a budget stalled at 1985 levels.*³⁴

Compounding the problem, few urban Blacks who need care receive it, because the care provided by public hospitals effectively is rationed by the inconvenience and waiting time inherent in these overcrowded and understaffed facilities.³⁵ A worker employed at an hourly-wage job forgoes a hypertension checkup because the wait to be seen in a crowded public clinic would cost her a day's pay—three months later she dies of a

30. See Curtis Rist, *Cuts Force Long Waits*, NEWSDAY, Oct. 14, 1992, at 31.

31. Ivie, *supra* note 11, at 305-06.

32. *Id.*

33. Butts, *supra* note 6, at 160.

34. See Straus & King, *supra* note 23, at A11.

35. Greely, *supra* note 20, at 17.

heart attack. A teenage mother assumes that prenatal care is not particularly important when she is informed that she must wait eight weeks for her first appointment—the baby she delivers is twice as likely to die.³⁶

The care that public hospitals provide, moreover, is generally the more expensive, in-patient variety because overcrowding and underfunding prevent patients from obtaining preventive and primary care. A vicious circle develops: overcrowding and long waits cause patients to delay necessary care, which causes health conditions to worsen; more serious conditions, in turn, require more intensive and more expensive treatment, which, to close the circle, increases demand on the limited resources of the public hospitals. The consequences are needless suffering and death as many poor patients do not receive any medical care until they are beyond help.

*NEW ORLEANS—Manuela Chacon is a retired hotel housekeeper who was diagnosed with diabetes. Soon after, she felt dizzy so she went to Charity Hospital's one outpatient clinic early Monday morning. After waiting more than ten hours and taking a battery of tests, Ms. Chacon was told to return the next day. On Tuesday, after a six-hour wait and more tests, she was told to return on Friday. On Friday, she got her test results: her diabetes was under control, but she needed further tests and possible treatment because her liver enzyme levels were suspiciously low. Ms. Chacon was told to come back in six weeks—the first available date when a doctor could examine her.*³⁷

What Gunnar Myrdal concluded in 1944 in his seminal study of Blacks in America remains true today:

It is hard to separate the effects of discrimination from those of concentration of Negroes in those areas where medical facilities are not easily available and in those income brackets which do not permit the purchase of medical facilities in the competitive market. Discrimination increases Negro sickness and death both directly and indirectly and manifests itself both consciously and unconsciously. . . . Ill health reduces the chance of economic advancement, which in turn operates to reduce the chance of getting adequate medical facilities or the knowledge necessary for personal care.³⁸

In 1968 the Kerner Commission agreed with Myrdal's conclu-

36. In Detroit, a city with an infant mortality rate twice the national average, it takes eight weeks to get a prenatal care appointment at public Hutzel Hospital. *Nightline*, *supra* note 14.

37. See Straus & King, *supra* note 23, at A11.

38. GUNNAR MYRDAL, *AMERICAN DILEMMA* 174 (1944).

sions,³⁹ but made no recommendations directed specifically at health care reform. The Commission's strategy of integrating inner-city Blacks into the suburbs was designed to increase employment opportunities for Blacks, and with better jobs would come employer-provided health care. Those left behind in the inner city would be able to obtain medical care through the new federal programs—Medicaid for the poor and Medicare for the elderly. Urban Blacks have not been able to escape to the suburbs, however. The inner city is still a ghetto bereft of health care providers and populated predominately by poor minorities unable to purchase health care in a competitive market. Many urban Blacks have not entered the job force; those who are employed often hold low-paying, nonunionized jobs that do not provide health insurance. While Medicare has provided virtually universal coverage to the elderly population, Medicaid provides insurance to only 42% of the non-elderly poor. The details of the health care crisis for inner-city minorities may have changed, but the broad outlines remain the same: few providers of health care and little money with which to purchase care from even those few.

The best way to improve the health of minority inner-city residents is still that envisioned by the Kerner Commission: provide jobs, increase incomes, and improve socioeconomic status. Good health correlates primarily with higher socioeconomic status; poor health correlates directly with poverty.⁴⁰ Those who live in crowded conditions run a higher risk of disease. In the inner city, this risk is aggravated "by low wages and high unemployment, inferior education systems, unstable sources of health care, substandard housing, violence, and high transportation and food costs."⁴¹ To improve the health of inner-city minorities, we not only need to reduce the risk of disease, but also to increase access to jobs, better schools, adequate sources of health care, good housing, less crime, and more affordable transportation and food.

39. From the standpoint of health, poverty means deficient diets, lack of medical care, inadequate shelter and clothing, and often lack of awareness of potential health needs. . . .

. . . .

. . . Negro households generally are larger, requiring greater nonmedical expenses for each household, and leaving less money for meeting medical expenses. . . . In addition, fewer doctors, dentists, and medical facilities are conveniently available to Negroes—especially to poor families—than to most whites. This is a result both of geographic concentration of doctors in higher income areas in large cities and of discrimination against Negroes by doctors and hospitals.

REPORT OF THE NAT'L ADVISORY COMM'N ON CIVIL DISORDERS 269, 271-72 (Bantam Books 1968).

40. Marianne Foley & Glen R. Johnson, *Health Care of Blacks in American Inner Cities*, in *HEALTH CARE ISSUES IN BLACK AMERICA* *supra* note 4, at 211, 212.

41. *Id.* at 214.

The other contributors to this Symposium identify and evaluate strategies to accomplish these socioeconomic goals. Until these goals, which will have a profound, long-term effect on minority health, are accomplished, any strategy to provide adequate health care for minority urban populations must expand beyond the narrow financing questions that predominate the political debate. Reformers need to address the larger question of how to improve American health generally and, specifically, the health of minorities in the inner city. Achieving real improvement requires addressing four issues: (1) health care financing, (2) attracting sufficient health care providers into the inner city, (3) combating discrimination in the delivery of health care, and (4) developing new health care delivery systems responsive to the needs of inner-city residents.

My point is not that the present national debate focused on health care financing—providing the means to purchase health care—is wrong; it is, however, only the beginning. If we are serious about improving the health of inner-city Blacks and assuring that health care providers are available in the inner city, we must focus attention equally on dismantling the race discrimination that pervades health care delivery and on developing new health care delivery systems that meet the needs of poor, inner-city, minority patients.

II. HEALTH CARE FINANCING

Today's front-burner issue, health care financing, is the place to begin. Middle-class and upper-middle-class Americans justifiably worry about the spiralling cost of health care and insurance underwriting practices that limit their access to private health insurance.⁴² American businesses today pay drastically higher premiums than they once did and, ironically, provide less health care for their employees. State governments appropriate ever-increasing amounts of money for what is now their first or second largest expenditure, the Medicaid program.⁴³ More and more Americans are uninsured and hospitals complain that they can no longer bear the cost of treating increasing numbers of uninsured patients. Meanwhile, insurance companies are increasingly reluctant to underwrite the costs of care for the indigent.

Twenty-five years after the last major federal initiative on health

42. Celinda Lake, *Health Care: The Issue of the Nineties*, 10 YALE L. & POL'Y REV. 211, 213 (1992).

43. See Robert L. Schwartz, *Medicaid Reform Through Setting Health Care Priorities*, 35 ST. LOUIS U. L.J. 837, 840 (1991) (noting that Medicaid generally receives the largest or the second largest appropriation in a state).

care—Medicaid and Medicare—Congress seems poised again to enact major health care legislation. A recent count noted more than forty proposals for health care financing reform in Congress.⁴⁴ President Clinton has appointed Hillary Rodham Clinton to head a task force on health care reform that is charged with issuing a report in May 1993.⁴⁵ In the midst of this activity, two types of financing reforms have taken center stage: market reform plans and single payor programs.⁴⁶

Market reform proposals, while differing in their details, share four key ingredients. First, they rely on a pluralist approach to health care financing—employers provide insurance for workers and their dependents as the primary means of providing health care,⁴⁷ and state and federal programs cover persons not insured by an employer. Second, they require health insurance policies to provide a set, minimum package of health care benefits. Third, most contain provisions prohibiting exclusions for pre-existing conditions and other barriers to insurability. Fourth, all rely on a variety of measures to reduce unnecessary health care expenditures and contain health care costs.⁴⁸

In contrast, single payor proposals make the government directly responsible for financing and administering health insurance by divorcing health insurance from employment and covering everyone under a unitary public insurance program. Financing is achieved primarily through the tax system rather than through premiums paid by individuals and employers to insurance companies. The best known and most

44. Theodore R. Marmor & Michael S. Barr, *Making Sense of the National Health Insurance Reform Debate*, 10 YALE L. & POL'Y REV. 228, 228 n.6 (1992).

45. Hillary Rodham Clinton to Head Health Care Reform Task Force, Medicare & Medicaid Guide (CCH) No. 733, at 6 (Feb. 4, 1993).

46. Madison Powers, *Efficiency, Autonomy and Communal Value in Health Care*, 10 YALE L. & POL'Y REV. 316, 316 (1992).

47. "Employer mandate" proposals require businesses to provide private health insurance benefits to their employees. "Play-or-pay" proposals give employers an option. They either must provide private insurance to their employees or pay a payroll tax for the government to use in setting up a public program to cover uninsured employees. Employers receive a tax credit for the amount they spend on health insurance benefits, up to the limits of the health insurance payroll tax level.

48. See Powers, *supra* note 46, at 317. Some of the most discussed market reform plans include the Health America plan sponsored by members of the Senate Democratic Leadership, the Consumer-Choice Plan for the 1990s proposed by Stanford economists Alain Enthoven and Richard Kronick, the plan proposed by the National Leadership Coalition for Health Care Reform, the Health Access America plan proposed by the American Medical Association, the plan proposed by the Health Insurers Association of America, former President Bush's plan, *id.* at 316, and President Clinton's plan. The Clinton plan, as presented during the campaign, would provide every American a basic health benefits package either through employment or by buying into a public program. Clinton's plan would hold down total health care spending by creating a national health standards board to set ceilings on national health spending. *Clinton's Words*, HEALTH ADVOC., Fall 1992, at 1, 7.

widely touted single payor proposal today is the Physician's National Health Plan, which is modeled on the Canadian health care system.⁴⁹ Under the Physician's Plan each person would receive a national health card, pay no medical bills for services, and choose his or her own health care providers. Levels of care and rates of provider reimbursement would be determined through the political process rather than through individual or employer contracts with insurance companies.⁵⁰

Whatever health care financing reform legislation Congress passes most likely will shape American health care for the next twenty-five years. My fear is that the debate, and any resulting legislation, will focus too narrowly on one issue: containing rising health care spending. If it does, poor people—particularly poor, urban minorities—may lose for another twenty-five years their chance to gain access to health care.

In reforming health care financing, we should not focus solely on issues framed from the narrow vantage point of consumer, provider, or employer. We need to reform health care finance and delivery as part of our response to a broader, more fundamental question: How can we best improve the health of Americans?

To improve the health of America's inner-city Blacks and poor, any health care financing reform package must contain certain crucial characteristics: universal coverage for all residents, comprehensive coverage of preventive and primary health care, no serious financial barriers to participation, and provider reimbursement rates for any public system comparable to those of privately provided insurance.

A. Universal Coverage

The most basic strategy to improve the health of poor, urban minorities requires universal health care financing for all Americans—Black and white, young and old, urban and rural, sick and well. Nearly 32% of Hispanics and 21% of African Americans have no health insurance.⁵¹ In 1991, 726,000 additional Americans went without health insurance; 57% of the newly uninsured were African American.⁵²

Our present system of health care financing disproportionately excludes minority, inner-city residents from the primary source of coverage—employer-provided health insurance. First, inner-city minorities are more likely than suburbanites to be unemployed and, therefore, unin-

49. David U. Himmelstein et al., *A National Health Program for the United States*, 320 *NEW ENG. J. MED.* 102, 102-03 (1989).

50. Powers, *supra* note 46, at 318.

51. Medicare & Medicaid Guide (CCH) No. 728, at 3 (Dec. 30, 1992).

52. *Id.*

sured. Second, even when inner-city minorities are employed, they are more likely to be working in service jobs or nonunionized jobs and trades that traditionally do not provide their workers with health insurance. Even for those inner-city minorities with employer-provided insurance, the promise of health insurance is often illusory because of limitations on coverage for pre-existing conditions. As noted earlier, low-income Blacks suffer a disproportionate rate of chronic illnesses such as heart disease and high blood pressure.⁵³ Private insurance's exclusion of coverage for pre-existing illnesses means that even Blacks who have private insurance may not have coverage for the very condition that most demands treatment.

Not surprisingly, a disproportionate number of minorities do not qualify for Medicare. Since minorities are less likely to be employed than whites, they are also less likely to be eligible to receive Medicare benefits that are conditioned on a sufficient work record.

Moreover, a disproportionate percentage of those ineligible for the Medicaid program are minorities.⁵⁴ Even though a greater percentage of minorities are poor, not all poor people are eligible for Medicaid—only those who fit within certain categories defined by federal law.⁵⁵ Medicaid does not cover those who are temporarily or partially disabled, young adults, childless couples, unemployable people below age sixty-five, undocumented aliens, or anyone else who does not fit within the federal statutory categories.⁵⁶ In addition, income eligibility levels vary drasti-

53. See *supra* notes 12-13 and accompanying text.

54. Michele Melden et al., *Health-Care Rights of the Poor: An Introduction*, 1 D.C. L. REV. 181, 189 (1992).

55. Historically, the federal categories were limited to those receiving cash welfare payments—parents and children who, because one parent is absent, disabled, or unemployed, receive Aid to Families with Dependent Children (AFDC), and the aged, blind, and disabled who receive Supplemental Security Income (SSI). In the 1980s, federal law extended Medicaid coverage to pregnant women, infants, and children through age five whose incomes are less than 133% of the federal poverty level, and to children age six and older born after September 30, 1983, whose family income does not exceed the federal poverty level. While federal law requires states to provide Medicaid to these groups, states may also provide Medicaid to people who fit these categories—the disabled, pregnant women, children, and one-parent families—but who have incomes somewhat higher than required by welfare eligibility guidelines. See Melden et al., *supra* note 54, at 181-84.

Medicaid is a joint federal-state program. It is state-administered and state-designed, but each state's program must conform to numerous federal statutory and regulatory requirements in order for the state to receive federal matching funds. See 42 U.S.C. § 1396 et seq. (1988). In 1989 Medicaid spent \$62.4 billion, with \$35.5 billion coming from the federal government and \$26.9 billion from the states. Rand E. Rosenblatt, *Statutory Interpretation and Distributive Justice: Medicaid Hospital Reimbursement and the Debate Over Public Choice*, 35 ST. LOUIS U. L.J. 793, 793 n.1 (1991) (citing Katherine R. Levit & Mark S. Freeland, *National Medical Care Spending*, HEALTH AFF., Winter 1988, at 124, 131 (Exhibit 5) (1991)).

56. Melden et al., *supra* note 54, at 188-89.

cally from state to state. Many states, faced with declining revenues, ever increasing health care costs, and expanding federal categories of people eligible for Medicaid, have attempted to limit the number of people on Medicaid by holding down their Medicaid financial eligibility levels. Currently, only 42% of people living at or below the federal poverty level receive Medicaid.⁵⁷ Seventy-five percent of those ineligible are workers or their dependents, most of whom are newly employed or employed at jobs that pay enough to disqualify them for Medicaid, but do not provide private health insurance.⁵⁸

Popular opinion assumes that inner-city residents without private insurance, Medicaid, or Medicare nonetheless find health care. We assume they may be inconvenienced by the form and location of the services, but that they still have access. Sadly, this assumption is wrong.⁵⁹ While emergency rooms in hospitals that accept Medicare are legally obliged to provide emergency services,⁶⁰ other private health care providers have no such obligation. Long waiting lists for the few public services available to the uninsured poor mean that many either never obtain medical care or obtain care only when their condition is beyond treatment.⁶¹

To improve Americans' health, America needs true universal health care coverage. Single payor proposals explicitly provide universal coverage. While many market reform proposals also purport to create universal coverage, the details of how they will provide coverage are not always clear. With market reform proposals, the question remains: Will the proposal, in fact, provide insurance coverage for the poor and minorities in the inner-city? Market reform plans that encourage or require employers to provide health insurance for their workers and dependents provide little help in inner cities plagued by staggering unemployment. Proposals that encourage or require individuals to purchase their own health insurance are irrelevant to the one-third of Black households that live at or below the federal poverty level.⁶²

To accomplish real universal health care coverage, market reform plans must expand government health insurance programs to include all low-income people without regard to their welfare or categorical status. Income eligibility guidelines need to be set at levels that realistically re-

57. *Id.* at 188.

58. Geraldine Dallek, *Health Care for America's Poor: Separate and Unequal*, 20 CLEARINGHOUSE REV. 361, 363 (1986) (Special Issue).

59. Schwartz, *supra* note 43, at 841.

60. 42 U.S.C. § 1395dd (1988).

61. See *supra* notes 20-39 and accompanying text.

62. See *supra* note 5 and accompanying text.

flect the cost of buying private health insurance and the income at which households can afford to purchase private insurance.

Such universal health care coverage will be expensive, but compassion compels America to fund care for all its people—the United States and South Africa are the only industrialized countries that do not have a national system to finance health care for all citizens.⁶³ While universal health coverage is costly, it is not prohibitively expensive.⁶⁴ In fact, in terms of broad, societal costs, universal health insurance is a more cost-effective method of providing health care than our present system. When the uninsured delay needed treatment, not only does treatment become more expensive, but other costs also are incurred by the uninsured as more time is lost from work, and more short- and long-term disabilities occur.⁶⁵

How do we improve the health of inner-city minorities? We begin by providing them with health insurance. This insurance coverage should include a federally mandated minimum benefit package that includes preventive and primary care as well as physician and hospital services.

B. Preventive and Primary Health Care Coverage

The skewed structure of health care delivery in this country favors high-tech, hospital-based, end-stage cures rather than basic, primary care.⁶⁶ Historically, American health insurance has not paid for preventive or “well” care such as regular check-ups, pap smears, and mammograms; rather, coverage generally reimburses for medical treatment only after a disease or illness develops. For example, the Medicaid programs of only three Southeastern states—Kentucky, Mississippi, and North Carolina—pay for yearly checkups, routine mammograms, and other disease screenings and preventive care. The other states in the re-

63. GEORGE J. ANNAS ET AL., *AMERICAN HEALTH LAW* 44 (1990).

64. The Congressional Budget Office estimated the costs of universal health insurance under both a market reform plan and a single payor plan. It concluded that under either plan those presently uninsured could be insured without a dramatic increase in national spending on health care. Using 1989 statistics with the market reform plan, the change in national health care spending would range from a decrease of \$17.3 billion to an increase of \$30 billion, depending on the assumptions used. Under the single-payor model, the change in spending would range from a decrease of \$58.1 billion to an increase of \$7.4 billion. Medicare & Medicaid Guide (CCH) ¶ 39,740 [1992-91 Transfer Binder] (Jan. 17, 1992).

65. See *infra* text accompanying note 71 (discussing prenatal care).

66. See Jane Perkins, *The Effects of Health Care Cost Containment on the Poor: An Overview*, 19 CLEARINGHOUSE REV. 831, 833 (1985) (discussing a recent Medicare Program and noting that the program “represents an important departure from the previous, cost-based, ‘fee-for-service’ system”).

gion wait until patients become acutely ill before paying for treatment.⁶⁷ Medicare only began covering mammograms for women over sixty-five in 1991.⁶⁸ Until recently, Medicare reimbursement encouraged more expensive hospital services rather than office-based treatment.⁶⁹

Health care for the urban uninsured also focuses on acute, hospital-based treatment rather than preventive care. Underfunded, understaffed public hospitals necessarily have had to conduct triage—treating the most seriously ill and placing those in need of non-emergency care on long waiting lists. Those on the waiting lists often end up in emergency rooms and hospital beds because they do not receive the routine, preventive care that could have cured or forestalled their illnesses.⁷⁰

This problem is particularly acute among, and well illustrated by, inner-city women's need for routine prenatal care. Because of the lack of prenatal care in the inner city, a high number of low-weight babies are born to poor, minority residents.⁷¹ These children subsequently have a greater number of long-term illnesses and disabilities. This sequence eventually exacts a far greater price than providing preventive care from the start.

When short shrift is given to basic and preventive care, everyone suffers and the overall costs of providing health care rise. We need to abandon our historical emphasis on coverage limited to hospitalization, end-stage cures, and triage in favor of an outlook that emphasizes prevention. Any health care financing proposal should focus on providing preventive and primary care.

C. *No Deductibles or Co-payments*

Private insurance and Medicare generally require patients to pay deductibles and co-payments as health care cost-containment mechanisms.⁷² The theory is that if a third-party insurer fully reimburses,

67. Hal Straus & Mike King, *Holes in the Safety Net*, ATLANTA CONST., Oct. 2, 1990, at A9.

68. Bilofsky, *supra* note 1, at 31.

69. Stuart Guterman & Allen Dobson, *Impact of the Medicare Prospective Payment System for Hospitals*, 7 HEALTH CARE FIN. REV. 97, 103-12 (1986).

70. In a Washington, D.C. study, one-fourth of the hospital admissions of indigent patients arriving at emergency rooms could have been avoided had the patient previously had access to primary care. For those with chronic diseases, the percentage of avoidable admissions rose to 45%. Stephan G. Lynn, *National Alert—Gridlock in the Emergency Department*, HEALTH/PAC BULL., Spring 1991, at 5, 7.

71. Pregnant women who do not receive prenatal care are three times more likely to have low-weight babies. A COMMON DESTINY: BLACKS AND AMERICAN SOCIETY 402 (Gerald D. Janes & Robin M. Williams, Jr. eds. 1989) [hereinafter COMMON DESTINY].

72. Deductibles are a set amount the patient must pay for medical care before insurers

creating "free" medical care, people will use expensive, perhaps unnecessary, services, thereby increasing the overall costs of medical care. These arguments, while plausible in theory, fail in fact. It is usually the physician—not the insured—who decides which tests will be run, which procedures will be performed, and when a patient will be hospitalized.⁷³ Studies indicate that co-payments and deductibles do not discourage the use of or reduce the cost of acute or inpatient care; they do, however, discourage the use of routine preventive services⁷⁴ and increase the administrative costs of delivering health care.⁷⁵

Co-payments may actually increase the overall cost of medical care for the poor. Poor people lack sufficient disposable income to afford deductibles and co-payments. After paying for food and shelter even those whose incomes are 200% to 250% of the federal poverty level have little or no income left to pay for health care.⁷⁶ Co-payments and deductibles cause the poor to delay obtaining needed medical care. In the long run, medical costs increase when care is delayed until conditions become emergencies that require more extensive and expensive treatment.⁷⁷

Any reformulated financing system that seeks to improve America's health must recognize the long-term health benefits and cost savings that result from treating people early and preventing disease from progressing. Instead of cost-sharing programs, we need to create incentives to encourage people to use preventive care programs and to obtain medical care early.

D. Cost Containment

The present debate on health care financing focuses on the need for cost containment. Appropriate cost containment is, of course, essential. Without it, we will squander the financial resources to provide universal health care coverage. Many forms of cost containment—elimination of unnecessary or ineffective treatments, health care planning, coordination of capital expenditures, and bulk purchasing arrangements, for example—facilitate cost-effective delivery of medical care. However, other

will begin paying. Co-payments are either a set amount or a percentage of each charge the patient must pay even when insurance pays the remainder of the cost.

73. William Hsiao & Nancy L. Kelly, *Restructuring Medicare Benefits*, in *Conference on the Future of Medicare*, Subcomm. on Health of the House Comm. on Ways and Means, 98th Cong., 1st Sess. 35, 37 (1983).

74. ANNAS et al., *supra* note 63, at 795; Alan Sager, *Health Care for All and Not a Penny More: A Proposal*, HEALTH/PAC BULL., Spring 1988, at 21, 22.

75. Sager, *supra* note 74, at 22.

76. Melden et al., *supra* note 54, at 188.

77. See Perkins, *supra* note 66, at 841.

cost containment mechanisms—restrictive eligibility levels, cost sharing requirements, low provider reimbursement levels, and some managed care systems—can limit minority, and particularly poor minority, access to necessary health care.⁷⁸

Two popular cost containment strategies—managed competition and managed care—present particular risks for low-income, minority patients. Managed competition encourages providers to deliver care through “community health partnerships” similar to health maintenance organizations.⁷⁹ Case management systems require patients to obtain care from a case manager, usually a primary care physician, who contracts with the insurer to deliver primary care services and to make referrals to specialists and hospitals.

Both community health partnerships and case management plans attempt to save costs by paying providers prospectively on a per-patient basis, regardless of the actual cost of care. Under traditional fee-for-service medical payment, the provider is paid for each service provided and has no financial incentive to forgo additional, expensive treatment since each additional service is reimbursed. Prospective payment systems, by paying a set amount for each patient treated regardless of the type or number of services provided, create a financial incentive for physicians to minimize costs and to use services more efficiently.⁸⁰

However, prospective payment systems can also reduce health care access for minorities. Prospective payment systems can create physician incentives to treat only those patients likely to be profitable given the prospective reimbursement rate; and, of course, patients who need less medical treatment are more profitable patients under a prospective payment system. Since Blacks have more health problems than whites and the poor are sicker than the middle class, poor, minority, inner-city residents need more health services than do white, middle-class residents. A prospective payment system that pays the same prospective rate for all

78. See Laura M. Rosenthal, *Health Coverage for the Uninsured: A Primer for Legal Services Advocates*, 24 CLEARINGHOUSE REV. 1250, 1259 (1991).

79. Managed competition has received a great deal of recent publicity, including an endorsement by President Clinton during his campaign. See *Clinton's Words*, *supra* note 48, at 1, 7. Originally coined by Stanford economist Alain Enthoven, the phrase now represents a variety of approaches, all of which basically rely on health care providers and insurance companies to contain increases in health care costs. For example, one aspect of managed competition assists small purchasers of health care, such as small businesses, to join together in larger purchasing units to negotiate lower insurance premiums.

80. Medicare employs such a system, paying hospitals a set amount based on the patient's primary and secondary diagnosis, regardless of the actual cost of providing care to the individual patients.

patients may cause providers to exclude those who are sicker—inevitably people of color and those who are poor.

Even when providers treat poor, minority patients, prospective reimbursement systems still may limit access to necessary medical care. Unrealistically low per capita reimbursement levels can create incentives for doctors to minimize costs by forgoing necessary as well as unnecessary treatment. Rather than totally excluding minority patients, providers simply may provide them with less medical care than their conditions require. The effect on minorities and poor patients can be devastating.⁸¹

While case management systems and managed competition plans offer promise for both controlling costs and improving the delivery of health care, any system that seeks to insure the poor and minorities through a prospective payment strategy must take into account variations in health status and index provider reimbursement to health status. Payments need to reflect the costs of treating higher risk groups like urban minorities accurately. Otherwise, these cost containment strategies will further reduce access to health care for poor minority urban dwellers.

Universal health care financing alone, even a plan that provides routine and preventive health care at competitive reimbursement rates with no co-payments or deductibles, will not solve the inner city's health care crisis or improve the health of inner-city Blacks. Inner-city dwellers have greater and special health care needs: higher rates of environmental diseases, mental illness, and alcohol and drug abuse. AIDS and tuberculosis are epidemic in the inner city. The infant mortality rate in America's inner cities is higher than that in most third-world countries. At the same time, there is a dearth of providers in the inner city. Private hospitals have "run away" to the suburbs; private doctors have chosen to practice in the suburbs. Universal health care financing, without other structural changes, simply will freeze the present inequities into America's health care system without improving the health of urban minorities. Improving America's health requires programs to attract providers to the inner city, to enforce vigorously existing civil rights laws to combat discrimination in providing health care services, and to develop new health care delivery systems that meet the needs of those who continue to dwell in the inner city.

81. Medicaid case management plans, while varying in their organization designs and locations, have encountered remarkably similar problems regarding access to necessary specialized medical services. In Louisville, Kentucky, there was a 40% drop in the number of specialty visits by patients during the first nine months of the program. Perkins, *supra* note 66, at 840.

III. ATTRACTING PROVIDERS

The inner city needs hospitals, outpatient facilities, primary care physicians, dentists, and other health care professionals. Health policy needs not only new strategies for financing health care, but also to attract providers back into the inner city. Private hospitals abandoned the inner city because their base of insured patients left before them, but universal health care financing, even with competitive reimbursement policies, will improve only marginally the shortage of inner city health care providers. Comparable and competitive health care reimbursement for services provided to inner-city residents might create a financial incentive that slows the outward migration of hospitals from the inner city, but equal reimbursement alone will not be enough to attract *new* institutional providers.

Health planning is needed to complement competitive financing. Health planning programs assess the need for capital expenditures. As a prerequisite to building or expanding, health care facilities must obtain a certificate of need from the appropriate state agency. Health planning agencies can deny certificates to hospitals that seek to leave the city, where facilities are needed, and relocate in suburban areas that have sufficient medical services. Planning agencies can also encourage new hospitals and outpatient clinics to locate in the inner city and other areas that need providers.

In the late 1980s the federal government ended its financial support for state health planning activities. Although strapped for money to continue their programs, most states have maintained some sort of state planning programs, often on a reduced basis.⁸² Federal support for health planning activities should be re-established.

Doctors and other health care professionals need incentives to locate in the inner city. Currently, doctors have no economic incentive to practice in cities. It is impossible, in any practical sense, to produce so many physicians that a given area becomes super-saturated with care such that physicians there will relocate for economic reasons. A doctor can maintain a thriving practice almost anywhere.⁸³ When faced with a choice, most doctors, like other middle- and upper-middle-class Americans, choose to live in suburban and smaller urban areas. Like others, they are drawn by good housing and schools, easy access to shopping, and cultural attractions.⁸⁴

From the average doctor's perspective, inner-city minority patients

82. James B. Simpson, *State Certificate-of-Need Programs: The Current Status*, 75 AM. J. PUB. HEALTH 1225, 1226-27 (1985).

83. H.R. REP. NO. 266, 94th Cong., 1st Sess. 25 (1976).

84. *Id.*

are less desirable patients to treat. Because they lack education, such patients may not understand the need for or be able to afford preventive care; they may not know how or appreciate the need to follow their doctor's instructions. Because of their socioeconomic status, they are sicker when they seek care and thus more difficult to cure. Cultural differences often make communication difficult.

Because of these factors, strategies in addition to universal health care financing are necessary to attract health care professionals into the inner city.⁸⁵ Medical education scholarships and loan forgiveness programs have shown some success in attracting health care providers into medically underserved areas; such programs need to be reinstituted and generously funded. From 1972 to 1987, the National Health Service Corps Program provided grants and scholarships to medical students who agreed to work in medically underserved areas following completion of their training.⁸⁶ The program attracted 13,600 young doctors, as well as many dentists, nurses, and other health professionals, into rural and inner-city areas. In 1985 alone, the program placed 1500 doctors in community health centers in poor communities. When the federal government abolished the program in the late 1980s, many poor communities were unable to replace the National Health Service Corps doctors they lost.⁸⁷

Yet incentives to practice in the inner city need to be structured carefully to assure that the health professionals they attract are sensitive to their patients' cultures. Unwilling, hostile doctors on a short tour of duty in the ghetto will not help. In fact, such doctors can inflict tremendous harm. Medical school admissions policies should seek explicitly to attract and train doctors sensitive to the needs of minorities and poor people.

One way to do this is to recruit minority health professionals. Black doctors are more likely to practice in poor, urban areas with high minority populations than are white doctors, and consequently more often

85. We need to do more than just create incentives for city practices. Inner cities need doctors trained in primary care—family practice, obstetrics/gynecology, internal medicine, and general pediatrics. Federal and state loan forgiveness programs, grants, and scholarship programs should be developed and expanded to encourage doctors to enter primary care practice in lieu of more specialized areas of care. Physician reimbursement also needs to be reformed so that primary care physicians are reimbursed at levels comparable to that of paid specialists. See PHYSICIAN PAYMENT REVIEW COMM'N, ANNUAL REPORT TO CONGRESS (April 29, 1989), reprinted in Medicare & Medicaid Guide (CCH) ¶ 37,830, at 19,832 [1989-2 Transfer Binder].

86. ANNAS et al., *supra* note 63, at 721.

87. *Id.* at 722.

treat minority and poor patients.⁸⁸ Sadly, though, while African Americans make up 12% of our population, they represent only 3% of our doctors.⁸⁹

A concerted effort to attract and train African-American and other minority doctors is therefore needed. Additional programs, such as the Disadvantaged Minority Health Improvement Act of 1990, aimed specifically at increasing the number of minority health care professionals, would help.⁹⁰ Minority health care providers are likely not only to be sensitive to the needs of minority patients, but also are likely to educate their fellow doctors about minority patients' needs and preferences.

IV. CIVIL RIGHTS ENFORCEMENT

Even when Blacks are able to find geographically accessible private health services, lingering discrimination limits available medical care.⁹¹ Prior to the passage of the 1964 Civil Rights Act, health care providers openly discriminated against Blacks. Most hospitals excluded Black patients and Black physicians altogether.⁹² Health care discrimination is no longer illuminated by WHITE ONLY signs, but apparently race-neutral policies can operate disproportionately against minorities, setting up barriers that exclude them from health care.

For example, many hospitals admit only patients who have a treating physician with admitting privileges.⁹³ Other hospitals require substantial deposits before a patient will be treated in the emergency room or admitted for in-patient care.⁹⁴ Increasingly, hospitals and doctors refuse to deliver babies for mothers who have not received a minimum amount

88. COMMON DESTINY, *supra* note 71, at 436-37.

89. *Minority Medical Schools: Rough Sailing Ahead*, in FAULKNER & GRAY'S MED. & HEALTH, June 17, 1991 (Christina Kent ed.).

90. See Disadvantaged Minority Health Improvement Act of 1990, Pub. L. No. 101-527, § 782(b)(2), 104 Stat. 2311, 2318.

91. Cf. Butts, *supra* note 6, at 160 n.4 (noting that African Americans comprised only three percent of the physicians in the United States in 1991).

92. See H.R. REP. NO. 914, 88th Cong., 2d Sess., pt. I, at 25-26, pt. II, at 24, *reprinted in* 1964 U.S.C.A.N. 2391, 2511.

93. See Stan Dorn et al., *Anti-Discrimination Provisions and Health Care Access: New Slants on Old Approaches*, 20 CLEARINGHOUSE REV. 439, 441 (1986) (Special Issue). Since Blacks and other minorities often do not have private physicians, see COMMON DESTINY, *supra* note 71, at 431, this policy tends to exclude minority patients.

94. See Dorn et al., *supra* note 93, at 441. Thirty-four percent of Blacks, Hispanics and Native Americans have incomes below the poverty line, compared with only 11% of whites. Because minorities are more likely to be poor, they are also more likely to be turned away by hospitals because they cannot pay in advance. See U.S. DEP'T OF HEALTH & HUMAN SERVS., REPORT OF THE SECRETARY'S TASK FORCE ON BLACK AND MINORITY HEALTH 189 (1985) (Executive Summary) [hereinafter SECRETARY'S TASK FORCE].

of prenatal care.⁹⁵ Many doctors refuse to treat Medicaid patients. While most hospitals participate in the Medicaid program, many explicitly cap the number of Medicaid patients they will treat. Others use a variety of mechanisms to exclude Medicaid patients.⁹⁶ Each of these policies operates to exclude a disproportionately large number of minorities. Each may foreclose access to health care in inner cities.

Even when poor minorities find a hospital that will treat them, they often receive segregated treatment. Prior to the passage of the 1964 Civil Rights Act, hospitals that admitted Blacks segregated them in separate wards with Black physicians and support staff.⁹⁷ Although this blatant discrimination has ended, many hospitals continue to separate poor Blacks by assigning Medicaid and uninsured patients, who are disproportionately Black, to one area of the facility while assigning privately insured patients, who are disproportionately white, to other areas.

America also operates a dual system of long-term care. Licensed nursing homes, primarily funded by the Medicaid program, serve whites; substandard boarding homes, for which Medicaid does not pay, serve Blacks.⁹⁸ Nursing homes are the most segregated publicly licensed health care facilities in America.⁹⁹ Elderly Blacks have more health problems and are more likely to be disabled than elderly whites, with a correspondingly greater need for nursing home care.¹⁰⁰ Yet, even after

95. See Dorn et al., *supra* note 93, at 441. While 80% of white women receive prenatal care during the first trimester of pregnancy, only 60% of Black women receive such care. The percentages for Hispanic and Native American women are even lower. See SECRETARY'S TASK FORCE, *supra* note 94, at 188.

96. For example, a requirement that all patients have a treating physician with admitting privileges excludes most Medicaid patients when the only physicians with admitting privileges take few, if any, Medicaid patients. See Dorn et al., *supra* note 92, at 441. Because Medicaid patients include a disproportionate number of minorities, anti-Medicaid policies effectively block minority access. See Dallek, *supra* note 58, at 365-71.

Still other hospital business policies create language and cultural barriers. These include a lack of interpreters and translations of signs and forms, and preadmission inquiries into a patient's citizenship, national origin, or immigration status. See Dorn et al., *supra* note 93, at 441.

97. See H.R. REP. NO. 914, 88th Cong., 2d Sess., pt. I at 25-26, pt. II at 24, *reprinted in* 1964 U.S.C.A.N. 2391, 2511.

98. See *Linton v. Tennessee Comm'r of Health & Env't*, 779 F. Supp. 925, 932 (M.D. Tenn.), *aff'd*, 923 F.2d 855 (6th Cir. 1990); David B. Smith, *Population Ecology and the Racial Integration of Hospitals and Nursing Homes in the United States*, 68 MILBANLE Q. 561 (1990); *HCFA Statistics Demonstrate Racial Disparities in Medicaid Coverage for Nursing Home Care*, National Senior Citizens Law Center, Oct. 11, 1991, at 1.

99. Butts, *supra* note 6, at 163-64 (citing DAVID B. SMITH, *DISCRIMINATION IN ACCESS TO NURSING HOMES IN PENNSYLVANIA* 5-7 (1991)). Private nursing homes are more segregated than state-run homes, and when blacks do manage to gain access to nursing homes, they are more likely to reside in nursing homes that have been cited as substandard. See *id.* at 164.

100. *Id.*

controlling for income, elderly Blacks have considerably lower rates of nursing home use.¹⁰¹ Indeed, in 1990 in Tennessee, Blacks comprised 39.4% of the Medicaid-eligible population, but comprised only 15.4% of the Medicaid-covered nursing home population.¹⁰²

Much of the discrepancy in Black and white use of nursing homes results from nursing homes' ability to control the number of beds certified for Medicaid payment. Many nursing homes will not accept Medicaid patients, other than continuing care for private-pay residents who exhaust their resources and become eligible for Medicaid. Such patients are generally white rather than Black, because Blacks are more likely to be poor and without the private resources initially to finance nursing home care.¹⁰³

In the language of civil rights laws, much racial discrimination in health care results from facially neutral policies that have a disproportionately adverse impact. The policies are "facially neutral" because they do not mention race specifically. Indeed, they may not have been enacted with the subjective intent of discriminating on the basis of race. Nevertheless, their impact is disproportionate because they hit minorities harder than whites. Their effect is especially adverse in the health care context because such exclusionary policies can be deadly.

Congress passed Title VI of the 1964 Civil Rights Act¹⁰⁴ to ensure that federal money could not be used to support segregated health care facilities.¹⁰⁵ Title VI prohibits programs and activities receiving federal financial assistance, including hospitals and nursing homes, from discriminating on the basis of race.¹⁰⁶ Title VI's implementing regulations prohibit facially neutral policies and practices that have a disproportion-

101. *Id.*

102. *Linton*, 779 F. Supp. at 932.

103. Other nursing home discrimination is more blatant, such as racial steering—social workers identify certain facilities by race and then make referrals based on race. Since nursing homes control the number of beds certified for Medicaid payment, if a home wishes to accept a white Medicaid patient, another Medicaid bed can be certified; if the home does not wish to accept a black Medicaid patient, the home simply may refuse to certify another bed for Medicaid payment even though it has bed space available.

104. Pub. L. No. 88-352, 78 Stat. 252 (codified at 42 U.S.C. §§ 2000d to 2000d-4 (1982)).

105. See 110 CONG. REC. 1658 (1964).

106. See 42 U.S.C. §§ 2000d to 2000d-4 (1988). The operative section of Title VI provides: "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." *Id.* § 2000d.

Both Medicaid and Medicare are considered federal financial assistance for purposes of Title VI. See *Frazier v. Board of Trustees*, 765 F.2d 1278, 1289 (5th Cir. 1985), *cert. denied*, 476 U.S. 1142 (1986); *United States v. Baylor Univ. Medical Ctr.*, 736 F.2d 1039, 1046 (5th Cir. 1984), *cert. denied*, 469 U.S. 1189 (1985). The Title VI regulations list a number of other health grant programs that also provide federal financial assistance, including health planning

ately adverse impact on minorities, even in the absence of intentional discrimination.¹⁰⁷ They also require recipients of federal funds to take affirmative action to overcome the effects of prior discrimination,¹⁰⁸ prohibit recipients from subjecting individuals to separate or segregated treatment on the basis of race,¹⁰⁹ and prohibit recipient hospitals and other institutions from establishing facility locations with discriminatory effects.¹¹⁰

Nevertheless, Title VI so far has proved ineffective in ending the health care discrimination caused by the myriad policies that disproportionately exclude minorities. Almost from the enactment of Title VI, the Department of Health and Human Services'¹¹¹ Office of Civil Rights (OCR) health care enforcement efforts have been criticized as inadequate.¹¹² Under the Reagan and Bush administrations, OCR almost completely abdicated its Title VI health care monitoring and enforcement responsibilities.

The most fundamental shortcoming of OCR's Title VI enforcement effort is that it has produced no data for evaluating Title VI compliance. Although under-utilization of health services by minorities has been documented repeatedly,¹¹³ the only study analyzing Title VI compliance by health facilities was conducted by the General Accounting Office in 1971

grants, loans and loan guarantees for hospitals and other medical facilities. Maternal and Child Health grants, and Crippled Children's Services grants. See 45 C.F.R. § 80 app. A (1983).

107. These regulations prohibit "criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color, or national origin." 45 C.F.R. § 80.3(b)(1)(vii)(2) (1989). For a discussion of case law upholding the validity of this regulation, see Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination—It Shouldn't Be So Easy*, 58 FORDHAM L. REV. 939, 948-55 (1990).

108. 45 C.F.R. § 80.3(b)(6)(i) (1989).

109. *Id.* §§ 80.3(b)(1)(iii), 80.5(a).

110. *Id.* § 80.3(b)(3).

111. Prior to the establishment of the Department of Health and Human Services, health care civil rights enforcement was the responsibility of the Department of Health, Education and Welfare.

112. See Ken Wing, *Title VI and Health Facilities: Forms Without Substance*, 30 HASTINGS L.J. 137, 138 (1978).

113. See INSTITUTE OF MEDICINE, *HEALTH CARE IN A CONTEXT OF CIVIL RIGHTS* 36-39 (1981) (documenting racial disparities in those seeking professional health care); COMMON DESTINY, *supra* note 71, at 431 (reporting that "Blacks are twice as likely as whites to be without a regular source of medical care"); SECRETARY'S TASK FORCE, *supra* note 94, at 188-89 (comparing use of health professionals by Black, Hispanic, and white populations); Paula Diehr et al., *Use of Ambulatory Care Services in Three Provider Plans: Interaction between Patient Characteristics and Plans*, 74 AM. J. PUB. HEALTH 47, 49 (1984) (noting that differences in rate of physician visitation cannot be attributed to differences in ability to pay because when middle class whites and Blacks are compared, Blacks still use doctors significantly less than whites); Howard E. Freeman et al., *Americans Report on Their Access to Health Care*, 6

and 1972.¹¹⁴ Although required by federal law to collect data necessary to effective enforcement,¹¹⁵ OCR has never attempted to compile this data on a regular basis.¹¹⁶ The data that is collected is not analyzed, but merely is generally stored and forgotten.¹¹⁷

Data compilation and analysis are necessary for OCR to identify patterns of discrimination. OCR has relied for too long on individual complaints as a means of enforcement. More far-reaching results and more economical enforcement can be achieved through systematic compliance reviews than from investigation of isolated individual complaints.

Specific definitions of prohibited discrimination and acceptable remedial action are also needed. The Title VI regulations specifying prohibited practices are quite vague.¹¹⁸ While they identify broad categories of prohibited activities, the regulations do not identify specific health care provider policies and practices that impermissibly exclude and segregate minorities.¹¹⁹

Although federal law requires HHS to supplement the general Title

HEALTH AFF. 6, 12-18 (1987) (recognizing that although Blacks are generally in worse health than whites, they receive fewer services from doctors and hospitals).

114. See Wing, *supra* note 112, at 176-79. OCR also conducted a limited survey of hospital compliance in 1981.

115. Federal regulations require OCR to "provide for the collection of data and information from applicants for and recipients of federal assistance sufficient to permit effective enforcement of title VI," 28 C.F.R. § 42.406(a) (1992), and also require

timely, complete and accurate compliance reports at such times, and in such form and containing such information, as the responsible Department official or his designee may determine to be necessary to enable him to ascertain whether the recipient has complied or is complying with this part. For example, recipients should have available for the Department racial and ethnic data showing the extent to which members of minority groups are beneficiaries of and participants in federally-assisted programs.

45 C.F.R. § 80.6(b) (1991).

116. See Wing, *supra* note 112, at 184.

117. See *Madison-Hughes v. Sullivan*, Civ. No. 393-0048 (M.D. Tenn. complaint filed Jan. 19, 1993) (allegations contained in plaintiff's complaint).

118. See 45 C.F.R. § 80.3(b) (1991). For example, the regulations prohibit "criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color, or national origin." *Id.* § 80.3(b)(1)(vii)(2); see also *supra* notes 93-103 and accompanying text (discussing the segregated system of health care in the United States).

The Title VI regulations are purposely broad and general. Soon after passage of Title VI, a task force was created to develop consistent, enforceable Title VI regulations for all federal agencies charged with enforcing the Act. Ultimately, the task force drafted twenty-two sets of regulations, all of which follow the same basic pattern and describe prohibited discrimination in the same general terms. Linda R. Singer et al., Comment, *Title VI of the Civil Rights Act of 1964—Implementation and Impact*, 36 GEO. WASH. L. REV. 824, 846 (1968).

119. Wing, *supra* note 112, at 185-86.

VI regulations with more specific guidelines for each program to which it extends assistance,¹²⁰ the agency has not issued guidelines for health care providers. These guidelines are intended to provide the specificity lacking in the general Title VI regulations—to give examples of prohibited practices in the context of particular programs, to outline required and suggested remedial action, and to provide data collection requirements for health care providers.¹²¹ Guidelines are needed for hospitals, nursing homes, and state Medicaid agencies, as well as outpatient and community clinics.¹²² They would give providers better notice of specific activities that violate Title VI, thereby streamlining OCR enforcement activities.

Race discrimination in American health care remains a silent, pervasive problem. OCR needs to begin collecting and examining data so that the nature of the problem can be better understood and appropriate corrective measures identified. The health of poor minorities will not be improved until we fully identify their problems.

V. ALTERNATIVE PROVIDERS

Since the American health care system is market-driven, it generally delivers care in a manner that meets the needs of those with money and insurance to purchase care—middle-class, white patients with education, motivation, and time.¹²³ The inner-city minority poor have different needs and different health problems. Many of the health problems that disproportionately affect Black central-city dwellers, such as high infant mortality, tuberculosis, and drug and alcohol abuse, result from a combination of problems: substandard housing, bad sanitation, poor diet, the lack of health-care providers, and the lack of transportation, money, and the motivation to seek help. To improve health, delivery systems must make care accessible despite the realities of life in the inner city. This requires education, outreach, and coordination.

Preventive health care begins with education. Sex education can help teach teenagers to avoid unwanted pregnancies and sexually trans-

120. 28 C.F.R. § 42.404 to .405 (1992).

121. OCR issued guidelines for hospitals and nursing homes in 1966, prior to promulgation of the federal regulation. These guidelines, however, unlike other Title VI guidelines, were written in letter form by a former director of OCR and were merely circulated by OCR staff. They have never been issued through formal administrative rulemaking process and are not published in the Code of Federal Regulations. Their legal status is difficult to define. See Wing, *supra* note 112, at 155 n.68.

122. Ivie, *supra* note 11, at 312-13.

123. The market has been responsive to changes in middle-class lifestyle. Although the house call has gone the way of the carrier pigeon, "urgent care centers" now provide evening and weekend primary care for those with money or insurance to pay for care.

mitted diseases. Community education programs can assist in reducing drug, tobacco, and alcohol use—all of which play a role in minority illness.¹²⁴ These and other education efforts must form an integral part of any reformed health care delivery program.

Outreach programs have demonstrated their effectiveness in improving prenatal and infant health. Norfolk, Virginia, for example, has a Perinatal Lay Home Visitor program in which women from low-income communities are trained to provide information and referrals to their neighbors and friends.¹²⁵ The program has strengthened the community by creating a source of information within it, and, after four years, the number of low birth weight babies relative to all births in Norfolk has been halved.¹²⁶ Other effective prenatal care programs send nurses and social workers into poor areas to seek out pregnant women and provide on-the-scene prenatal care and other services ranging from transportation to food stamps.¹²⁷

These same outreach concepts should be applied to other health problems such as teenage pregnancy, hypertension, AIDS, and tuberculosis.¹²⁸ Nurses and other providers who go into the community can provide information and care to community members who might otherwise never see a health care provider.

Similarly, health care can be delivered in new locations by going where people gather rather than requiring people to come to care. Travel time and expense create barriers to access for inner-city minorities who are more likely than whites to be dependent on public transportation.¹²⁹ Transportation problems can be alleviated by taking care to people rather than expecting people to get to the sources of care. Children can be provided a full range of preventive and primary health services at school. Adults can be seen at their work place. Both children and adults can be treated at their churches, a historically important gathering place for African Americans.

Unfortunately, targeting the poor with unique providers runs the risk that these providers will become separate and, by definition, unequal. Most doctors and hospitals who serve only the poor do, in fact, provide

124. See *COMMON DESTINY*, *supra* note 71, at 413-15.

125. *Nightline*, *supra* note 14 (interviewing Margaret Konefal, Resource Mothers Program).

126. *Id.*

127. See Mike King & Hal Straus, *Whitney Kelly/Roadside birth, burial*, *ATLANTA CONST.*, Oct. 1, 1990, at A6.

128. See *COMMON DESTINY*, *supra* note 71, at 440.

129. See Ivie, *supra* note 11, at 298.

unequal care.¹³⁰ In some cases, the differences may be only cosmetic or accommodational, such as no decorator-designed offices or longer waiting times. In others, the differences mean less than optimal service—fewer prescription drugs, less staff, less care. Under our present system, inequality results from inadequate financing. Even with financing reforms, however, the poor do not have the political clout to demand better services. Programs designed specifically for their needs may slip inexorably into providing substandard care.

Some separate, specialized providers, however, have a long tradition of providing high quality care to the poor. Migrant Health Centers and Indian Health Services, in rural areas, and Community Health Centers, in more urban areas, provide a model for health care programs to meet the needs of poor, inner-city minorities.¹³¹ More than 90% of the patients served by Community Health Centers have family incomes less than twice the poverty level, 42.7% of the patients are uninsured, and 42.9% are publicly insured by Medicaid or Medicare.¹³² Sixty percent of all Community Health Center patients are minorities, and the patients served by urban centers are 37% Black and 27.2% Hispanic.¹³³ On the whole, Community Health Centers operating in urban areas provide better health care at lower cost than do private physicians or public hospitals.¹³⁴

The superior health care provided by Community Health Centers reflects a philosophy broader than that of most health care providers. Community Health Centers operate on the belief that many of the most serious medical problems of the poor have multiple underpinnings, all of which must be treated if medical care is to be effective. Health center services at Community Health Centers are offered by multidisciplinary

130. Dallek, *supra* note 58, at 369.

131. Sara Rosenbaum & Anne Dievler, A Literature Review of the Community and Migrant Health Center Programs 12-13, 35 (1992) (unpublished report, George Washington University Center for Health Policy Research). Community Health Centers operate as community-based providers. Each Center is controlled by a local board of directors, a majority of whom are low-income patients of the Center. The Centers seek to train and hire low-income people from their service area in clerical and para-professional health care positions. *Id.* at 9.

132. *Id.* at 14.

133. *Id.*

134. Gary D. Sandefur, *Blacks, Hispanics, American Indians, and Poverty—and What Worked*, in QUIET RIOTS: RACE AND POVERTY IN THE UNITED STATES 46, 68 (Fred R. Harris & Roger W. Wilkins eds., 1988); Rosenbaum & Dievler, *supra* note 131, at 17. Rosenbaum and Dievler reviewed 55 studies of the effectiveness of community and migrant health centers. Measured in terms of program outcomes, outputs, or contribution to the community, they found health centers to have a positive effect on patients, the appropriate utilization of health care services, the contribution of health centers to the community, and the efficiency of services delivered by health centers. *Id.*

teams and extend beyond traditional medical care to include environmental, preventive, and social services.¹³⁵

To meet the health care needs of minority inner-city residents more adequately, we must confront and accept the realities of life in the inner city. We need to develop systems that deliver comprehensive services and primary care—systems that focus on preventing illness, early intervention, continuity of care, and coordinated service delivery, as well as better integration of medical and social services.

VI. CONCLUSION

Even with all these changes in place—universal financing, an adequate number of providers, the elimination of discrimination, and the creation of new delivery systems—access to health care probably can increase the health status of inner-city minorities only slightly. Race, geography, and economic status all play a role in the poor health status of disadvantaged minorities.

How can we best improve the health of inner-city minorities? We need not only to provide better access to health care, we also need jobs that pay a living wage and programs that deliver decent housing, adequate sanitation, and good education. Only when all of these strategies coalesce will we make real headway in the fight to improve the health of poor minorities in the inner city.

135. Rosenbaum & Dievler, *supra* note 131, at 8.