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Healthcare's Hidden Civil Rights Legacy

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HEALTHCARE'S HIDDEN CIVIL RIGHTS LEGACY

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I. SUMMARY

Much of the health care civil rights story in the United States remains hidden. It is unfamiliar even to many who currently struggle to end racial disparities in health care. This Article describes the events between 1948 and 1968 that eliminated legally sanctioned segregation and narrowed the gaps in gross racial disparities in access to care. Yet these events also altered the organization of care in ways that have contributed to the persistence of disparities in access and outcomes. A sequence of events during this time ultimately led to a federal court ruling that the provisions in the 1946 Hill–Burton legislation permitting the use of federal matching funds for the construction of racially separate hospitals were unconstitutional.[1] This decision played a key role in the construction of Title VI of the Civil Rights Act of 1964 (Civil Rights Act) and in the reasoning behind it, as well as in the implementation of Medicare in 1966 to enforce compliance with the Act upon hospitals.

These noble efforts, however, left unaddressed the racial disparities in the practice patterns of physicians and contributed to profound shifts in the organization of care, producing an expansion of private accommodations, a reduced length of stay in hospitals, a greater reliance on ambulatory care, and a rapidly expanding separate nursing home sector. As a result, many disparities in specialized and diagnostic services persist, contributing to disparities in health outcomes. The basic legacy of the health care civil rights movement is

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1. Simkins v. Moses H. Cone Mem'l Hosp., 323 F.2d 959 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964).

the lesson that grassroots social movements and real accountability in the use of public funds can make a difference. In fact, in the absence of both, disparities will persist.

II. INTRODUCTION

Senator Trent Lott (R–Miss.), at the 100th birthday party for retiring Senator Strom Thurmond (R–S.C.) on December 5, 2002, said that he still wished Thurmond had won the presidential race in 1948. He declared: "When Strom ran for president, my state voted for him . . . [a]nd if the rest of the country had followed Mississippi's example, we wouldn't have faced many of the problems we have since."[2] Thurmond, as everyone was reminded by the brief public outrage that followed those comments, had bolted with the "Dixiecrats" from the Democratic Party because of its strong civil rights platform, and said that, "all the laws of Washington and all the bayonets of the army cannot force the Negro into our homes, our schools, our churches, and our places of recreation."[3] Senator Lott's slip in an unguarded moment broke through the façade of a carefully sanitized, reconstructed past for the person who was to assume the position of Senate Majority Leader and thus become a spokesman for his party and the nation as a whole.

Buried far deeper below the surface of the nation's collective consciousness about the racial divides of that past and not even mentioned by Thurmond in his 1948 segregationist battle cry, were the hospitals and the structure of the health care system of the United States. The subsequent battle regarding their integration proceeded quietly behind the scenes, rarely sparking headlines, public protests, or formal legal proceedings. Yet the scars of those battles now litter the health care landscape of this country. They add to the cost of health care, contribute to racial disparities in treatment, block meaningful health care reform, and generate a level of distrust that feeds a growing medical malpractice crisis and slows medical research and development. The story is a complex one, and parts of it have been extensively documented elsewhere.[4] This article tries, though it is often

2. *See, e.g.*, P. Mitchell Prothero, *Sen. Thurmond Celebrates 100 Years*, UPI, Dec. 5, 2002, LEXIS, Nexis Library, UPI File.

3. JOHN EGERTON, SPEAK NOW AGAINST THE DAY: THE GENERATION BEFORE THE CIVIL RIGHTS MOVEMENT IN THE SOUTH 477 (1994).

4. *See generally* COMMITTEE ON UNDERSTANDING AND ELIMINATING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE, INSTITUTE OF MEDICINE, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (Brian D. Smedley et al. eds., 2003) [hereinafter UNEQUAL TREATMENT]; DAVID BARTON SMITH, HEALTH CARE DIVIDED: RACE AND HEALING A NATION (1999) [hereinafter HEALTH CARE DIVIDED]. *See also* KEITH WAILOO, DRAWING BLOOD: TECHNOLOGY AND DISEASE IDENTITY IN TWENTIETH-CENTURY AMERICA (1997); VANESSA NORTHINGTON GAMBLE, MAKING A PLACE FOR OURSELVES: THE

difficult, to "connect the dots." It summarizes a hidden part of the civil rights story and how that struggle between 1948 and 1968 reshaped the organization of health care in the United States. "The past," as William Faulkner reminds us and as this account demonstrates, "is never dead. It's not even past."[5]

III. HEALTH CARE CIRCA 1948

Health care in the United States in 1948 was sharply divided along racial lines. In the South, Jim Crow laws imposed separate accommodations. In communities not large or affluent enough to afford separate, full-service hospitals, Blacks were sometimes cared for in basement wards and separate wings. In Wilmington, North Carolina, for example, the James Walker Memorial Hospital and Community Hospital provided a colored ward with about twenty-five beds and two toilets.[6] The ward was in a building separated from the main hospital, so patients requiring surgery had to be wheeled across an open yard to the hospital's operating rooms.[7] In many areas, blacks were excluded from the community's hospitals altogether. For example, in the 1940s, Broward County Florida had two hospitals—one municipal and one private—and both excluded the county's more than 30,000 black residents from any care.[8] Blacks were also excluded from white areas of the county by vagrancy laws that permitted local police to arrest them and put them on work gangs to harvest crops if they could not pay the heavy fines for violating such laws.[9] In 1940, a gang of white youth bent on more aggressively policing the streets shot a young black man in the abdomen. He died without access to hospital care, and an outraged black community pulled together to create Provident Hospital, a modest thirty-five-bed cottage hospital for blacks.[10]

In many larger southern communities, racially separate hospitals were clustered near each other to accommodate white physicians with racially mixed practices. In Mobile, Alabama, for example, four hospitals were clustered within several blocks of each other.[11] The 540-bed Mobile Infirmary Medical Center, the well-endowed, dominant institution in the region's medical and social hierarchy, served only whites.[12] Mobile General Hospital, the city's 247-bed public hospital, served the indigent in racially segregated units.[13] The

BLACK HOSPITAL MOVEMENT 1920–1945 (1995); DOUGLAS S. MASSEY & NANCY A. DENTON, AMERICAN APARTHEID: SEGREGATION AND THE MAKING OF THE UNDERCLASS (1993).

5. WILLIAM FAULKNER, REQUIEM FOR A NUN 92 (1951).
6. HEALTH CARE DIVIDED, *supra* note 4, at 75-76.
7. *Id.*; *see also* HUBERT A. EATON, EVERY MAN SHOULD TRY 53 (1984).
8. HEALTH CARE DIVIDED, *supra* note 4, at 19.
9. *Id.*
10. *Id.*
11. *Id.* at 155.
12. *Id.*
13. HEALTH CARE DIVIDED, *supra* note 4, at 155.

city's 262-bed Catholic facility, Providence Hospital, also provided accommodations to blacks in small and often overcrowded wards.[14] The only hospital in which black physicians could obtain admission privileges was a recently constructed thirty-five-bed facility, Saint Martin de Porres Hospital, which provided private care to paying blacks.[15] The area served by these hospitals was about one-third black,[16] so that while one could describe the care as separate, it could hardly be characterized as equal. Many of the black hospitals were castoff facilities vacated by white-only institutions after the construction of new accommodations. Indeed, with rare exceptions such as the twin towers of Atlanta, Georgia's public hospital, Grady Memorial, hospital care for blacks and whites in the United States was far from equal. Grady's twin towers, still a part of Atlanta's skyline, had been planned as an airtight defense of the separate but equal doctrine. Interestingly, its construction begun in 1954, the same year as the *Brown v. Board of Education* decision.[17]

Private-practice care for blacks in the South was limited. Most white physicians who provided care for black patients either arranged to see them after normal office hours or provided separate accommodations. Recalling her childhood in the 1950s in Greenville, South Carolina, for example, one person said:

> When I was growing up, Dr. Bailey on Main Street in Greenville was the family physician. There was a separate waiting room for blacks, and you had to wait till all the white patients had been seen before he'd see the blacks. As long as white patients kept coming in, you kept being pushed further and further back.[18]

In the North, at least in urban areas with a large concentration of blacks, the degree of racial segregation in the health care system was almost as complete as in the South. While care could be just as separate and unequal as in the South, the way this was achieved in the North was more subtle. In Chicago, Illinois, for example, almost all black hospitalizations took place either at Cook County Hospital (Cook County) or the historically black, Provident Hospital, bypassing many voluntary hospitals that were closer in proximity to most black neighborhoods. Seventy-one percent of all black deaths and fifty-four percent of all black births took place at Cook County

14. *Id.*

15. *Id.*

16. *Id.*

17. *Id.* at 50. *See* Brown v. Bd. of Educ. of Topeka, Shawnee County, Kan., 347 U.S. 483 (1954) (overturning the "separate but equal" doctrine set forth in *Plessy v. Ferguson*, 163 U.S. 537 (1896)).

18. HEALTH CARE DIVIDED, *supra* note 4, at 10.

Hospital while only two percent of white births took place at Cook County.[19] These differences could not be explained by differences in health insurance coverage. Members of the Brotherhood of Sleeping Car Porters and some of the local members of the meat packing union had better coverage than most whites with employer-based coverage, but they were still routinely sent to Cook County for hospital care.[20] The segregation resulted from the exclusion of black physicians from the privileges of admitting patients to these hospitals and the informal understanding of white physicians, who did have such privileges, about where it was acceptable to admit their black patients.[21] In 1951, a black patient with a skull fracture was turned away from Woodlawn Hospital in a racially mixed neighborhood, only to die several hours later. This incident sparked the creation of the Committee to End Discrimination and a ten-year battle to open staff privileges at the voluntary hospitals to black doctors.[22]

Blocked in both the South and the North from white hospitals in the first half of the Twentieth Century, black physicians adapted by developing a separate system. More than 200 historically black hospitals served black communities at some time during the first half of the century, many providing nurse training programs and several dozen providing residency training programs for medical graduates.[23] Excluded from white professional societies, they had developed their own local professional societies that made up the National Medical Association and the National Association of Colored Graduate Nurses.[24] They formed their own hospital association and hospital standardization initiative through the National Hospital Association.[25] The vast majority of black physicians received their education at Meharry Medical College and Howard University College of Medicine, the nation's two

19. *Discrimination in Hospitals: Extension of Remarks of Hon. Barratt O'Hara of Illinois in the House*, 84th Cong. (1955) (not in permanent edition of the Congressional Record) (on file with author).

20. *See id.* A union study in 1954 revealed that almost twenty-three percent of insurance claims for minority members of the meatpacking industry, who were the "beneficiaries of the most liberal type of health insurance plan," were made at Cook County Hospital. *Id.*

21. Audio tape: Interview with Quentin D. Young, M.D., former Chairman of the Medical Committee for Human Rights and member of the Committee to End Discrimination in Chicago Medical Institutions, in Chicago, Ill. (June 14, 1997) (on file with author).

22. *Id. See also* COMMITTEE TO END DISCRIMINATION AT WOODLAWN HOSPITAL, FACT-FINDING REPORT (1953) (on file with author).

23. *See, e.g.*, NATHAN WESLEY, JR., A REPORT ON BLACK HOSPITALS: 1998 UPDATE AND SELECTED COMMENTARY, A COMPREHENSIVE REPORT ON THE STATUS OF BLACK HOSPITALS (1998).

24. *See* David B. Smith, *The Racial Integration of Medical and Nursing Associations in the United States*, 37 HOSP. & HEALTH SERVS. ADMIN. 387-401 (1992).

25. GAMBLE, *supra* note 4, at 35-69.

surviving historically black medical schools from the pre-Civil Rights era.[26] However, some northern medical schools, such as the University of Michigan and Ohio State University, had begun admitting two blacks to each of their classes during the 1940s. The assumption was that the black students would serve as lab partners and would be placed in residency programs at black hospitals, but they would not be considered for residencies at the school's own hospitals.[27]

The paradox about this separation was that it was a double-edged sword. It marginalized black physicians and dentists and limited their opportunities; yet, particularly in the South, it also insulated them from white control, and that insulation gave them the freedom to act as advocates for their patients and the communities that they served. They did not need to worry about losing hospital privileges that they did not have or about gaining membership in professional societies that they were not permitted to join. They also did not need to worry about being excluded from health insurance plans that neither they, nor their patients, participated in. What these black physicians and dentists did have was a loyal following of patients who trusted them, looked to them for broader community leadership, and assured them, at least in the urban areas of the South with a growing black middle class, a secure fee for service and thus a livelihood. The white establishment could not threaten that livelihood as it could threaten local businessmen whose loans and contracts could be terminated or teachers who could be fired if they pressed too hard for social change. If one looks at the NAACP archives of correspondence with local chapters during the 1940s and 1950s, the letterhead of those local chapters reflects that the majority of its officers were doctors and dentists. In fact, dentists were particularly prominent. Their practices were more self-contained. Unlike physicians, they were less likely to need the assistance of white specialists to care for their patients in hospitals. In many of the lawsuits that were brought to integrate schools and hospitals, dentists figured prominently as plaintiffs. From the 1930s through the 1960s, they were the backbone of civil rights efforts in the South. Without them, there may never have been a Civil Rights Movement.

While one had to assume that racial disparities in access to care were large, no one really knew because no one had tried to measure them. Society does not measure what it does not want to know and does not want to do anything about. The debate regarding national health insurance and President Harry

26. Paul B. Cornely, *Negro Students in Medical Schools in the U.S., 1955–56*, 48 J. NAT'L MED. ASS'N 264 (1956). In June 1955, there were a total of 173 black medical school students graduating in the United States. Of these students, 132 of these were graduates of either Meharry or Howard. *Id.*

27. Audio tape: Interview with Paul B. Cornely, Professor Emeritus, Department of Preventive Medicine and Public Health, Howard University College of Medicine, in Washington, D.C. (August 7, 1990) (on file with author).

Truman's subsequent effort to produce effective legislation was hindered by this indifference. While racial *health* disparities were well documented, documentation of *access* disparities—the "smoking gun" that could assign some of the responsibility to the way health care was organized and financed—were lacking. Opponents of national health insurance insisted that no drastic measures were required and that anyone who really needed medical care received it. Indeed, despite the stark racial separation documented in this Article, no spokesperson for any group in the United States, regardless of any political ideology or racial attitudes, has *ever* advocated that essential care should be denied to those who cannot afford to pay for it, nor has anyone *ever* acknowledged that he or she has discriminated on the basis of race in the provision of care. National estimates of the use of health care by blacks did not begin to be collected until the introduction of the National Health Interview Survey in 1958.[28] This information about income and racial disparities in access to care played an important role in increasing the pressure for the passage of the Medicare and Medicaid legislation in 1965.[29]

IV. CUTTING THE GORDIAN KNOT

What was most troubling in 1948 was not that these conditions existed, but rather how impossible it seemed that there would ever be any significant change. In most communities, the racial integration in hospitals and health care was off the radar screen, and integration efforts focused on schools and public accommodations, which seemed easier to achieve. There had only been a few modest successes in health care by 1948. Black physicians had gained

28. *See* Nat'l Center for Health Statistics, U.S. Dep't of Health and Human Servs., *Nat'l Health Interview Survey*, *at* http://www.cdc.gov/nchs/about/major/nhis/hisdesc.htm (last modified March 21, 2003) [hereinafter *NHIS*]. The *NHIS* is the principal source of information on the health of the civilian non-institutionalized population of the United States and is one of the major data collection programs of the National Center for Health Statistics (NCHS). *Id.* The National Health Survey Act of 1956 provided for a continuing survey and special studies to secure accurate and current statistical information on the amount, distribution, and effects of illness and disability in the United States and the services rendered for or because of such conditions. *Id.* No nationally representative surveys on access to health care services that included comparisons by race and income had been completed before this survey. *See* RONALD ANDERSEN & ODIN W. ANDERSON, A DECADE OF HEALTH SERVICES: SOCIAL SURVEY TRENDS IN USE AND EXPENDITURE 6-8 (1967). The survey referred to in the Act is now called the *NHIS*, and it was initiated in July 1957. *See NHIS*, *supra*. While these national surveys were complemented by a series of surveys beginning in 1953 and conducted by the Health Information Foundation and National Opinion Research Center (HIF/NORC), which focused on health insurance issues, racial disparities in access to care were not reported before the HIF/NORC survey conducted in 1964. *See* ANDERSEN & ANDERSON, *supra*, at 5-6.

29. The statistics collected by the National Health Survey that showed a direct relationship between use of services and income and an inverse relationship between medical need and income provided the context in which the Medicare and Medicaid legislation was debated.

hospital privileges at public hospitals in some urban areas, where black votes increasingly mattered to elected officials.[30] In addition, growing nursing workforce shortages in the 1940s had forced some white hospitals to begin hiring black nurses.[31] However, voluntary hospitals and local medical societies were insulated, self-perpetuating private governments that answered to no one, and the public political process seemed equally impermeable and was thus ineffective in forcing change upon these institutions. At a national legislative level, the seniority system allowed southern senators and congressmen to adeptly control the agenda. Indeed, the entire system by which medical care was organized and financed seemed designed to block racial integration.

Most white hospital administrators and physicians, whatever their personal feelings, acquiesced to the status quo. A few hospitals, particularly those operated by religious orders and not tied as tightly to local medical communities, such as Providence Hospital in Mobile, Alabama, attempted to integrate their wards, but they were threatened by financial ruin from the white flight of patients to neighboring segregated facilities. Many white health care administrators and physicians in the urban North and border states tend to have selective and generously rosy recollections of their racial integration initiatives and the acceptance of the communities that they served when recalling the integration efforts in the early Sixties. For example, the CEO of Methodist Hospital in Gary, Indiana (Methodist Hospital), during the 1960s, stated several years ago that the only thing that was not integrated by the beginning of the 1960s at Methodist Hospital was room assignments and that all they needed to do when remedying this was to instruct the registrars to stop matching patients in rooms by race. He claimed that there existed a smooth transition with only rare cases meeting objections, which merely required relocating the objecting patient.[32] Board meeting minutes of that time, however, paint a picture of chaos and crisis. According to the Methodist Hospital Board (the Board) meeting minutes, the CEO reported to the Board that, while only two or three percent of the black patients objected to mixed room assignments, approximately ninety percent of the white patients did.[33] "[W]e have a condition of chaos and lowered level nursing care for the patients in the hospital."[34]

30. *See, e.g.*, AUBRE DE L. MAYNARD, SURGEONS TO THE POOR: THE HARLEM HOSPITAL STORY (1978).

31. Smith, *The Racial Integration of Medical and Nursing Associations in the United States*, *supra* note 24, at 392.

32. Interview with Everett Johnson, Chief Executive Officer in the 1960s of Methodist Hospital of Gary, Ind., in Atlanta, Ga. (June 10, 1996).

33. Minutes from the Special Meeting of the Board of Directors of Methodist Hospital of Gary, Ind. 2 (Mar. 18, 1964) (on file with the NAACP in its Legal Defense Fund Files).

34. *Id.*

For some leaders of the National Medical Association and the NAACP, the hope had been that the *Brown v. Board of Education*[35] decision would open the courtroom door to Fourteenth Amendment equal protection challenges of racial restrictions in access to staff privileges and hospital care. Nonetheless, medical staff bylaws for both public and private hospitals usually stated that the physician had to be a member in good standing in the local medical society in order to be considered for membership in the medical staff. This stipulation was one of the requirements for approval by the American College of Surgeons' hospital standardization program that was the main source for accreditation of hospitals at the time. Ultimately, the College would be relieved of this duty and the Joint Commission on Hospital Accreditation was formed in 1951.[36] Because most medical societies in the South specifically excluded blacks from these private, partially social fraternities, black physicians could never get past the first hurdle. In addition, it seemed dubious that the Equal Protection Clause of the Fourteenth Amendment really applied to the vast majority of hospitals in the United States, which were private, voluntary, or for-profit institutions. While most voluntary hospitals received some public subsidies and other dispensations from state and local governments, it seemed a stretch, at the time, to argue that they were really functioning as an "arm of the state" and were thus subject to the Equal Protection Clause of the Fourteenth Amendment. The first case to decide the issue of whether such institutions were subject to the Fourteenth Amendment was brought by Dr. Hubert A. Eaton and two of his colleagues against The James A. Walker Memorial Hospital in Wilmington, North Carolina.[37] Walker paid no city or county taxes, the hospital was built on land donated by the city, and it had contracts with the county for the care of indigents. The District Court, however, rejected the plaintiffs' claim that these circumstances constituted state action. The Supreme Court refused to review the case in 1959.[38] This potential avenue for hospital integration appeared closed.

Indeed, only through an improbable sequence of events was this Gordian knot at least partially cut. That sequence of events begins with the Hill–Burton Act of 1946 (the Hill–Burton Act).[39] Its author, Senator Lister Hill (D–Ala.), who would later sign the pledge of massive resistance to the implementation of

35. Brown v. Bd. of Educ. of Topeka, Shawnee County, Kan., 347 U.S. 483 (1954). *See* discussion *infra* text accompanying note 37.

36. *See* JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, JCAHO CORPORATE OVERVIEW BROCHURE 3 (2003), http://www.jcaho.org/about+us/corporate+brochure.htm.

37. Eaton v. Bd. of Managers of James Walker Mem'l Hosp., 261 F.2d 521 (4th Cir. 1958), *cert. denied*, 359 U.S. 984 (1959).

38. 359 U.S. 984 (1959).

39. Hospital Survey and Construction (Hill–Burton) Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946) (codified as amended at 42 U.S.C. §§ 291–291o-1 (2000)).

Brown, crafted the bill carefully. The Hill–Burton Act provided matching funds to states for the construction of hospitals based on a plan developed by the state that would assure adequate hospital facilities without discrimination on account of race, creed, or color. Hill, however, made sure to insert in section 622(f) of the original legislation the following provision:

> [A]ssurance shall be received by the State from the applicant that (1) such hospital or addition to a hospital will be made available to all persons residing in the territorial area of the applicant, without discrimination on account of race, creed, or color, but an exception shall be made in cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group.[40]

Most southern states proceeded with the construction of racially separate facilities using federal Hill–Burton Act funds. They would have done so even if the phrase "separate hospital facilities are provided for separate population groups" had been excluded. The phrase inserted by Hill was the only one ever inserted in federal legislation in the Twentieth Century that explicitly permitted the use of federal funds for racially exclusionary services, but it was certainly not the only federal funding program where racially discriminatory practices took place. Unanticipated by its author, the *Brown*[41] decision in 1954 would bring that phrase unwanted attention.

The NAACP, with the endorsement of the National Medical Association and National Dental Association, focused most of their efforts for health care equality on this most transparently vulnerable link—the Hill–Burton Act, which funded hospital construction on a "separate but equal" basis. Their strategy was three pronged: (1) lobby for legislation that would explicitly eliminate the separate but equal provision; (2) pressure the Executive Branch to cease such practices on their own, and (3) bring court cases that would result in a federal court ruling that this provision in the Hill–Burton Act was unconstitutional. In 1961, they were able to interest Senator Jacob Javits (R–N.Y.) in sponsoring a bill to eliminate the Hill–Burton Act's "separate but equal" provision, but it went nowhere. In that same year, they were hopeful that newly-elected President Kennedy, who had promised in the campaign to end racial discrimination by executive order "with the stroke of a pen,"[42] could help their cause, but no action was immediately forthcoming.

40. Hospital Survey and Reconstruction Act § 622(f), 60 Stat. at 1043 (codified as amended at 42 U.S.C. § 291e(f) (1946)). This section was omitted in the general revision of the Hill–Burton Act by the Hospital and Medical Facilities Amendments of 1964, Pub. L. No. 88-443, 78 Stat. 447.

41. 347 U.S. 483 (1954).

42. *See, e.g.*, TAYLOR BRANCH, PARTING THE WATERS: AMERICA IN THE KING YEARS 1954–63, 587 (1988).

Within the new Kennedy Administration, there was a flurry of activity to find something the President could do without introducing his own civil rights legislation and facing the embarrassment of certain defeat, which would have been assured by the southern members of his own party. The General Counsel for the Department of Health, Education and Welfare (DHEW), however, concluded that without explicit authorization from Congress to withhold funds or without explicit rejection by the federal courts of the constitutionality of parts of legislation that permitted "separate but equal" use of federal funds, the Executive Branch had no authority whatsoever to withhold funds on such a basis.[43] In terms of current federal activity, only the Hill–Burton Act made clear the intention of Congress to allow money to be spent in ways that would condone discrimination on the basis of race.

Meanwhile, George Simkins, a dentist in Greensboro, North Carolina, had organized a suit against two of Greensboro's hospitals.[44] Greensboro had three hospitals: Wesley Long Community Hospital (Wesley Long), an all-white hospital; L. Richardson Hospital (L. Richardson), an all-black facility that provided privileges to both black and white physicians and dentists; and Moses H. Cone Memorial Hospital (Moses Cone), the largest and most well-endowed facility that restricted privileges to white physicians but provided some limited space for black patients transferred from L. Richardson by white physicians who also had privileges at Moses Cone for specialized services that were not available at L. Richardson.[45] Moses Cone had received about $1.2 million in Hill–Burton Act funds, and Wesley Long received about $1.9 million.[46] A patient had come to Dr. Simkins with an abscessed swollen jaw, but L. Richardson had a two-week waiting list for a bed. The hospital had become so overcrowded that they moved patients into beds in the hallways. Moses Cone had empty beds but refused to take the patient. The suit, brought by Simkins, claimed discrimination in access to hospital privileges for black physicians and dentists in Greensboro and discrimination in access to treatment for black patients. It also challenged the constitutionality of the "separate but equal" provisions in the Hill–Burton Act.[47]

To the surprise of both the defendants and the plaintiffs, the Justice Department intervened, seeking a determination of the constitutionality of the controversial Hill–Burton Act. All parties acknowledged the fact of racial

43. *See generally* David Barton Smith, *Addressing Racial Inequities in Health Care: Civil Rights Monitoring and Report Cards*, 23 J. HEALTH POL., POL'Y & L. 75 (1998); Memorandum from Parke M. Banta, General Counsel to the Sec'y of the Dep't of Health, Educ. & Welfare, to the Secretary (Sept. 19, 1961) (on file with the author).

44. Simkins v. Moses H. Cone Mem'l Hosp., 323 F.2d 959 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964).

45. *See id*. at 965.

46. Simkins v. Moses H. Cone Mem'l Hosp., 211 F. Supp. 628, 638 (E.D. N.C. 1962).

47. *Simkins*, 323 F.2d at 961-62.

discrimination in terms of the exclusion from the two hospitals. The *Simkins* case hinged, as the earlier *Eaton*[48] case had, on whether the hospitals could be considered instruments of the state, and thus come under the constitutional prohibitions of the Fourteenth Amendment. In *Simkins*, the District Court ruled that the hospitals were not instruments of the state and dismissed the case.[49] The Fourth Circuit Court of Appeals reversed this ruling in a 3–2 split decision, concluding that the hospitals, by virtue of their involvement in the state Hill–Burton plan, were indeed instruments of the state. It also ruled that the Hill–Burton Act's "separate but equal" provision was unconstitutional.[50] On March 2, 1964, the Supreme Court declined to review the decision, and the Kennedy Administration got the clarification that it sought from the courts.[51]

The site of this major breakthrough embraces special ironies today. The Fourth Circuit Court of Appeals is located in a building that once housed the Confederate Treasury and the offices of Jefferson Davis, President of the Confederacy. It was the last federal court of appeals to be racially integrated as the Senate confirmation of an African-American justice came only in 2001, with Senator Trent Lott casting the lone dissenting vote.[52] It is a court that has, in more recent history and partly through judicial appointments supported by Strom Thurmond, quietly moved the federal judicial system ever further toward the right side of the political spectrum.[53]

The new court decision had not taken place in a vacuum, of course. Protests that had been simmering in the 1950s exploded almost spontaneously into a widespread grassroots movement in the early 1960s. Many of the images of this period still regularly flash before us in the background of news pieces and documentaries. The student lunch counter sit-in movement had begun at a Woolworth's in Greensboro in February 1960, and it spread quickly to more than one hundred communities. In May 1963, Birmingham, Alabama's Bull Connor had turned high-pressure fire hoses and police dogs on school children demonstrating against segregated accommodations in downtown Birmingham. The children filled the jails and flooded the national news with images that stunned the nation. In June, President Kennedy, after much prodding, introduced his long-delayed civil rights bill to Congress.[54]

48. Eaton v. Bd. of Managers of James Walker Mem'l Hosp., 261 F.2d 521 (4th Cir. 1958), *cert. denied*, 359 U.S. 984 (1959).

49. *See* Simkins v. Moses H. Cone Mem'l Hosp., 211 F. Supp. 628, 634-35, 641 (E.D. N.C. 1962).

50. *Simkins*, 323 F.2d at 969.

51. Moses H. Cone Mem'l Hosp. v. Simkins, 376 U.S. 938 (1964) (denying certiorari).

52. Deborah Sontag, *The Power of the Fourth: How One Appellate Court Is Quietly Moving America Ever Rightward*, N.Y. TIMES, Mar. 9, 2003, (Magazine) at 38, 45.

53. *See id.*

54. Special Message to the Congress on Civil Rights and Job Opportunities, *in* PUB. PAPERS OF JOHN F. KENNEDY 483, 492 (June 19, 1963).

Almost in direct response, Medgar Evers, the NAACP Field Director in Mississippi, was shot to death in Jackson, Mississippi on June 12, 1963.[55] In August, Washington, D.C. played host to a demonstration in support of civil rights legislation that included Martin Luther King's "I Have A Dream" speech.[56] Several weeks later, a bomb at the 16th Street Baptist Church in Birmingham, where many protest marches had been organized, killed four young girls during Sunday school services. Trying to mend badly damaged political fences in preparation for a difficult election, President Kennedy took his fateful trip to Dallas that November.

President Lyndon B. Johnson turned the passage of Kennedy's proposed civil rights bill into the only appropriate way to honor the death of our nation's fallen leader.[57] The bill worked its way through Congress shadowing the *Simkins* case in the courts. The Supreme Court's seeming affirmation of *Simkins* by refusing to hear the case came just days before the debate regarding the civil rights bill was to begin in the Senate. It transformed a vague and controversial section of the bill into something that now seemed like almost a redundant detail. Title VI of the bill simply made more explicit the unofficial ruling of the Supreme Court. President Johnson signed the Civil Rights Act into law on July 2, 1964, with Title VI essentially unaltered.[58] In theory, not only was the "separate but equal" provision struck from the Hill–Burton Act's hospital construction funding, but also now, federal funds could not be allocated to agencies or organizations that discriminated on the basis of race.

The enforcement of Title VI in the Hill–Burton Act, of course, would have not done much by itself to assure the integration of hospitals. It would have been almost impossible for federal officials to force the integration of facilities that had already received funds. Refusal to grant additional funds on a separate-but-equal basis would have forced some facilities to choose not to seek additional funds. Moses Cone, for example, briefly explored the possibility of returning the Hill–Burton Act funds it had received to avoid any potential challenge to their autonomy in such matters.[59]

These same turbulent events of the early Sixties also helped consolidate a new consensus for health care reform. The prolonged social debate after World War II resulted from a broad recognition that some kind of federal action was needed to assure access to medical care. The resulting gridlock reflected two seemingly unresolvable issues: (1) whether the program should

55. *See, e.g.*, Branch, *supra* note 42, at 824-25.

56. Dr. Martin Luther King, Jr., Address delivered at the March on Washington for Jobs and Freedom (Aug. 28, 1963) (commonly referred to as the "I Have A Dream" speech).

57. HEALTH CARE DIVIDED, *supra* note 4, at 100.

58. *See* Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241 (codified as amended at 42 U.S.C. §§ 2000a–2000h-6 (2000)).

59. HEALTH CARE DIVIDED, *supra* note 4, at 94 n.71, 347 (citing Minutes of Executive Committee, Moses Cone Memorial Hospital 1048 (Mar. 11, 1964)).

be administered by the states or federal government, and (2) whether it should be financed by social insurance as a "right" or supplied only to the indigent on the basis of a means test.[60] If only for a fleeting moment in the middle of the 1960s, the answer shifted to a federally funded and rights type of solution. Few could advocate for state and local autonomy in the face of such vivid images of defiance of the rights of African-Americans. There was also a yearning for reconciliation and less of a willingness to revert to the almost punitive means-tested formulas. It was a moment in many ways similar to the convulsive experiences of the Great Depression that produced the passage of the original Social Security legislation.[61] The Medicare legislation[62] was passed as a result of this brief moment of convergence. It was, in a very real sense, the major unacknowledged gift to the American people of the Civil Rights Movement. The same coalition that had worked for passage of the Civil Rights Act also worked for the passage of Medicare.[63] The only organized medical group to support the passage of Medicare was the National Medical Association (NMA). The NAACP, at its annual convention in June 1964, supported the passage of the Medicare legislation. The President of the NMA also testified in support of its passage at hearings before the Senate Finance Committee in May of 1965.[64] The language President Johnson used in arguing for the passage of Medicare was even reminiscent of that used to support the passage of the Civil Rights legislation. Johnson signed the Medicare and Medicaid legislation into law on July 30, 1965, and only a week later, he signed into law the Voting Rights Act.[65]

60. HERMAN MILES SOMERS & ANNE RAMSAY SOMERS, MEDICARE AND THE HOSPITALS: ISSUES AND PROSPECTS 5 (1967).

61. *See* Social Security Act of 1937, Pub. L. No. 74-271, 49 Stat. 620 (codified as amended at 42 U.S.C. §§ 301–1397 (2000)).

62. Social Security Amendments of 1965, Pub L. No. 89-97, Title XVIII, § 102, 79 Stat. 291 (July 30, 1965) (codified as amended in 42 U.S.C. 1395-1395gggg).

63. *See generally* DONA COOPER HAMILTON & CHARLES V. HAMILTON, THE DUAL AGENDA: RACE AND SOCIAL WELFARE POLICIES OF CIVIL RIGHTS ORGANIZATIONS (Robert Y. Shapiro ed., 1997).

64. *NMA President's Testimony in Support of H.R. 6675: "An Act to Provide Hospital Insurance Program for the Aged Under the Social Security Act"*, 57 J. NAT'L MED. ASS'N 335 (1965).

65. *See* HEALTH CARE DIVIDED, *supra* note 4, at 120-121. President Johnson signed the Medicare legislation on July 30, 1965 at the Truman Library in Independence, Missouri. *Id.* at 120. Johnson signed the 1965 Voters' Rights Act on August 6, 1965. *See* Social Security Amendments of 1965, Pub L. No. 89-97, Title XVIII, § 102, 79 Stat. 291 (July 30, 1965) (codified as amended in 42 U.S.C. 1395-1395gggg) (Medicare); Social Security Amendments of 1965, Pub L. No. 89-97, Title XIX, § 121, 79 Stat. 343 (codified as amended at 42 U.S.C. 1396–1396v (2000) (Medicaid); Voting Rights Act of 1965, Pub. L. No. 89-110, Title I, § 2, 79 Stat. 437 (Aug. 6, 1965).

V. ENFORCING TITLE VI IN THE MEDICARE PROGRAM

Unlike the Hill–Burton Act, which offered time-limited matching funds for approved hospital construction projects, Medicare represented a profound shift in the financing of medical care in the United States. Combined with Medicaid, it meant that the bulk of the income received by most hospitals and physicians would flow from public sources. At least in theory, hospitals and physicians would now have to choose between complying with the requirements imposed by Title VI of the Civil Rights Act and thereby assuring their financial health, or not complying, and almost certainly assuring their financial ruin. Medicare was scheduled to go into effect on July 1, 1966.[66] Implementing a program of such size and complexity in less than a year represented a major challenge. The cooperation of hospitals and physicians was essential to assure an orderly transition. The American Medical Association had opposed the passage of Medicare, and some local medical societies were threatening to boycott participation in the program. If Medicare's supporters had envisioned it as strictly a health insurance program, there is no question that it would have delayed enforcement of Title VI of the Civil Rights Act because its detractors would have found a way to circumvent the requirements of the Civil Rights Act altogether. The Johnson Administration, in spite of the warnings of many experts, however, chose to use the Medicare program as a way to end the racial segregation in hospitals once and for all.

What followed, according to many observers, was as close to a miracle as anything ever accomplished by the federal bureaucracy. The Office of Equal Health Opportunity had been set up in the Surgeon General's Office of the Public Health Service at the end of 1965 with only six months to go before the implementation of Medicare.[67] It consisted of only one professional staff person, and the procedures for assuring Title VI compliance with Medicare providers had yet to be worked out. Secretary John Gardner, the only Republican in President Johnson's cabinet, announced that the DHEW was now a civil rights organization. This was not just public relations rhetoric. It was a maneuver to, at least in the short run, circumvent congressional oversight and control to ensure that the initiative never had the resources to make the Medicare–Title VI compliance initiative anything more than a symbolic paper-pushing process.

Secretary Gardner directed the temporary reassignment of 750 DHEW employees to the Office of Equal Health Opportunity. Each division chief was responsible for recruiting a quota of volunteers from their staff and for assuming responsibility for their salaries and travel expenses. If the quota was

66. *See* Social Security Amendments of 1965, Pub L. No. 89-97, Title XVIII, § 102, 79 Stat. 291 (codified as amended in 42 U.S.C. 1395-1395gggg).

67. HEALTH CARE DIVIDED, *supra* note 4, at 128-129.

not met, they were to draft people. In reality, enough people within the DHEW had become so involved in local civil rights demonstrations and activities that, not only was it never necessary to draft anyone, but most of the volunteers they did recruit were also passionately committed to the success of the effort. Civil rights groups such as the NMA, the NAACP Legal Defense Fund, and the Medical Committee for Human Rights played the role of its staunchest allies and severest critics. Local community civil rights groups included black employees at the local hospitals, so that when surveys and inspections for Title VI compliance were undertaken, the prior intelligence gathering was precise and concealment almost impossible. Many hospital officials used it as an opportunity to integrate hospital services that they had come to believe was the right thing to do, but had hesitated in the face of what they assumed to be overwhelming community hostility. Now, all hospitals would have to comply, and even hospital officials hostile to integration recognized that it would be essential for the financial survival of their institution. As the July 1, 1966, deadline approached, more than 1,000 hospitals had quietly and uneventfully integrated their medical staffs, waiting rooms and hospital floors.[68]

It should be noted that Virginia, Mississippi, Alabama, and some other southern states resisted these efforts at first by arguing instead for a "freedom of choice" plan for achieving compliance with Title VI.[69] That is, a black patient should have the right to "choose" whether they wanted to be admitted to an all-black facility or one that had previously been all white. They argued that patients should be free to "choose" whether they wanted to be placed in a white wing or in a semi-private room with a white patient. As one black witness testified in one of the early hearings on this issue, he did not "choose" to have his daughter placed in a white wing because "'[w]ho knows what would be done to her in the hospital after making such a choice.'"[70] The only way to assure integration was to take the choice away from the individual and insist that everyone, regardless of race or income, be treated equally in the Medicare program. It is chilling for anyone familiar with this history and the purpose of the Medicare program to hear our current President arguing for "freedom of choice" in "reforming" the Medicare program. That proposal, if implemented, would force the "choice" of Medicare beneficiaries with low or moderate incomes towards more restrictive plans separate from those plans "chosen" by the more affluent who can afford the additional out-of-pocket costs.

68. *See id.* at 134-42.

69. *Id.* at 148.

70. *Id.* at 148, 351 (citing Memorandum from Marilyn Rose, former legal counsel to the Office of Equal Health Opportunity, to author (Nov. 20, 1997)).

Yet, instead of lagging behind other sectors of American life, hospitals were leading integration efforts. Those involved shook their heads in disbelief. They perhaps had a right to be skeptical.

VI. THE END OF AN ERA

The Office of Equal Health Opportunity had walked a political tight rope between enforcing Title VI of the Civil Rights Act in the new Medicare program and not interfering with the practice of medicine. Soon after the implementation of Medicare, the Office of Equal Health Opportunity lost its balance. DHEW's General Counsel had chosen to exempt physicians from compliance with Title VI. The General Counsel argued that Part B of Medicare,[71] the part that paid for physician services through a voluntary, federally-subsidized plan, was a "contract of insurance" with its subscribers and not a direct grant of public funds.[72] This logic seemed convoluted to many at the time, and it is certainly even more so now with the growth of integrated delivery systems and managed care. However, the reality was that it would have been almost impossible to define what Title VI compliance meant for physician practices, and it would have been impossible to enforce. Nevertheless, Title VI compliance for hospitals would be meaningless without the ability to exert some control over the referral patterns of physicians. Physicians could, as they had done in Chicago, simply selectively refer their white and black patients to different hospitals maintaining de facto segregation.

The Mobile Infirmary Medical Center in Alabama (the Infirmary) became a key test case for addressing medical staff organized de facto segregation.[73]

71. *See* 42 U.S.C. §§ 1395–1395w-4 (2000).

72. HEALTH CARE DIVIDED, *supra* note 4, at 162-163. Title VI of the Civil Rights Act had included a compromise amendment offered by Senator Long (La.) that stated: "Nothing in this title shall add to or detract from any exiting authority with respect to any program or activity under which Federal financial assistance is extended by way of a contract of insurance or guaranty." Pub. L. No. 88-352, Title VI, § 605, 78 Stat. 253 (1964) (codified at 42 U.S.C. § 2004-d (2000)). The interpretation by the DHEW that this exempted Part B of Medicare from Title VI enforcement was vigorously challenged by Civil Rights Commission Reports in 1975 and 1980. *See* U.S. COMM'N ON CIVIL RIGHTS, 6 FEDERAL CIVIL RIGHTS ENFORCEMENT EFFORT—1974: TO EXTEND FEDERAL FINANCIAL ASSISTANCE 118-19 (1975); Letter from Eileen M. Stein, General Counsel, to Louis Nunez, Staff Director (Oct. 7, 1980) ("Applicability of Title VI to Medicare Part B"), *reprinted in* U.S. COMM'N ON CIVIL RIGHTS, CIVIL RIGHTS ISSUES IN HEALTH CARE DELIVERY: A CONSULTATION SPONSORED BY THE UNITED STATES COMM'N ON CIVIL RIGHTS APRIL 15–16, 1980, 851-64. The opposition to the 1964 civil rights bill, fearing that Title VI might be used to break down discrimination in housing through federal insurance programs for home mortgages and bank deposits, had been able to amend Title VI of the bill to exempt such guaranty and contracts of insurance.

73. Audio tape: Interview with Marilyn Rose, Attorney for the Office of Equal Health Opportunity, Dep't of Health, Educ. & Welfare during 1966–67, in Washington D.C. (Oct. 3, 1997) (on file with the author).

The Infirmary had signed the Title VI assurances, but by its patient admissions, it had remained almost exclusively white. The Infirmary never turned away a patient, but many of its medical staff chose to admit only their white patients to the Infirmary. A member of the Infirmary medical staff served as a secret informant to the Office of Equal Health Opportunity so that its officials had a clear understanding of the intention of many of the physicians on the hospital's staff to block the integration of the Infirmary through selective referrals.[74] Faced with this situation, the Office of Equal Health Opportunity argued that the hospital, by virtue of its board's authority to approve the members and privileges of its medical staff, had the authority to control their referral practices and refused to grant it Title VI certification to allow it to receive Medicare funds in July 1966. A bitter, protracted seven-month battle ensued that culminated in the suspicious death of the key medical staff informant and the cave-in of the Department of Health, Education and Welfare, which removed the Office of Equal Health Opportunity from the decision-making process and certified the Infirmary for Medicare funds. Shortly afterwards, the Office of Equal Health Opportunity was eliminated, and its functions were absorbed into the Office for Civil Rights, a single central office responsible for all civil rights enforcement, not just for Medicare enforcement. Many of the key staff either resigned or refused reassignment to the central office. The brief, turbulent life of one of the most productive agents of organizational change in the history of the federal bureaucracy had ended.

The year 1966 was the high-water mark of the Civil Rights era, and by 1968 the federal civil rights offensive was in retreat. Urban riots, rather than nonviolent protests, now began to capture media attention. The war in Vietnam shifted attention and drained resources. In the early, heady atmosphere, civil rights activities focused on the low-hanging fruit and the easy, visible symbols of inequality. As the targets shifted towards more difficult, structural changes that threatened the vested interests of the establishment, the backlash gained momentum. Subsequent civil rights initiatives in health care were caught in this conflicting current, as were every other aspect of national life.

VII. WHAT HAD HAPPENED AND WHAT HAD NOT

Of course, as with the issue of race in other facets of American life, there are two conflicting interpretations of what happened during the Civil Rights era and what did not. The skeptical version concludes that the influence of race on opportunities for health care treatment remained largely unchanged, and the only real change was that such influences became more subtle and hidden. The optimistic version of the situation concludes that, minor

74. *Id.*

annoyances and statistical aberrations aside, the problem of race has been fixed and health care is now race blind. The reality is a complex mixture of both views. The gross disparities in access to care by race had indeed been eliminated. At the same time, however, the adaptation of the health care system to the contradictions of race shaped a peculiar accommodation that continues to contribute to the distinctive problems faced by both providers and consumers of health care and to the persistence of disparities in outcomes and treatment in the United States.

Before Medicare and its companion program for the poor, Medicaid, the common complaint was that the poorer you were, the more health care you needed and the richer you were, the more health care you got. The gift of the Civil Rights Movement through the enactment of Medicare and Medicaid was to eliminate, at least in gross terms, the second part of this complaint. In 1964, low-income persons received twenty-five percent fewer age-adjusted visits to doctors as compared to high-income persons and seven percent fewer hospital admissions.[75] By 1975, the relationship between income and use of care had been reversed, with low-income persons receiving eighteen percent more age-adjusted visits to doctors and fifty-one percent more hospital admissions.[76] Racial differences in the use of care mirrored, in a less dramatic way, the changes in use by income. In 1964, blacks received twenty-three percent fewer visits to doctors as compared to whites and twenty-five percent fewer hospital admissions.[77] By 1975, blacks were making four percent fewer visits to doctors and had four percent *more* hospital admissions.[78] Within the Medicare program itself, there has been a progressive narrowing of differences in expenditures for white and non-white beneficiaries. In 1967, the first full year of the program, hospital expenditures for non-whites were twenty-six percent lower than for whites, physician expenditures forty percent lower, and skilled nursing home expenditures sixty-six percent lower.[79] These differences in expenditures per beneficiary have progressively shifted. In 1995, for example, the Medicare program was spending twenty-one percent more for hospital care, thirteen percent more for medical services, and two percent less for nursing care per non-white beneficiary than per white beneficiary.[80] Except for physician visits, black use of health care relative to white use of health care has progressively increased. The largest racial disparity in use was for nursing home care. In 1964, blacks sixty-five and older were sixty-two percent less likely to be residents in nursing homes than whites. In 1999,

75. HEALTH CARE DIVIDED, *supra* note 4, at 202-03.
76. *Id*.
77. *Id*.
78. *Id.*
79. *Id.* at 206.
80. HEALTH CARE DIVIDED, *supra* note 4, at 206.

however, they were nine percent *more* likely to be residents in nursing homes.[81] However, because black/white disparities in health quality persist, it is unclear how close these shifts in health care use reflect the actual need.

The institutions that cared for blacks and the poor before Medicare was enacted were the major casualties of this transformation. Seventy black hospitals closed or merged with historically white ones between 1961 and 1988.[82] Only a handful of the more than 100 historically black hospitals that existed at the beginning of this period continue to exist. These include the teaching hospitals of Meharry and Howard University, a few small, struggling community hospitals, and a small contingent of municipal hospitals that have historically served black communities (such as Harlem Hospital Center and Kings County Hospital Center in New York, Cook County Hospital in Chicago, DC General Hospital in Washington, Grady Memorial Hospital in Atlanta, etc.). Some hospitals that were the only places black physicians could receive post-graduate training have been converted into nursing homes or supportive residences for the elderly, such as Mercy–Douglas in Philadelphia, Pennsylvania, and Homer G. Phillips Hospital in St. Louis, Missouri. Others, such as Lincoln Hospital in Durham, North Carolina, were razed to make way for a public clinic. Good Samaritan Hospital of Charlotte, North Carolina, the oldest privately funded hospital in the state providing care exclusively for blacks, was razed just before its 100th anniversary in 1991 to make room for the new football stadium for the National Football League's Carolina Panthers. The hospital had been the center of the once thriving black community.[83] A plaque on the stadium wall, erected only after an organized protest, is the only evidence left of this once vibrant training center for nurses and other allied health professionals.[84]

The victors in the Civil Rights struggle were those communities that worked with black physicians and their hospitals, but they were treated as if they were conquered by an invading army and their resources cannibalized for other purposes. It was not supposed to work that way, but indeed that is what happened. Many black professionals and patients felt violated by what happened and were less trustful of the new white-dominated institutions. Yet acknowledging the personal advantages that these better-endowed institutions offered, many had, however reluctantly, voted with their feet.

81. NAT'L CTR. FOR HEALTH STATISTICS, DEP'T OF HEALTH AND HUMAN SERVS., CHARTBOOK ON TRENDS IN THE HEALTH OF AMERICANS 266 (2002), *available at* http://www.cdc.gov/nchs/hus/htm.

82. *See* Wesley, *supra* note 23, at 28.

83. Valca Valentine, *Historic Black Hospital Now Just History*, CHARLOTTE OBSERVER, Sept. 16, 1990, at 1B.

84. Audio tape: Interview with Reginald Hawkins, retired dentist and Presbyterian minister, in Charlotte, N.C. (Feb. 2, 2000) (on file with author).

The most profound legacy of the Civil Rights era for health care, however, was how the selective enforcement of Title VI distorted the manner in which services were organized. Title VI was rigorously enforced in hospitals. This meant no separate waiting rooms or wards and no racial room-matching of patients. If necessary, this would be enforced with on-site inspections. For nursing homes, these requirements were essentially ignored. There were no on-site inspections, and all nursing homes were required to do was sign a form indicating that they did not discriminate and include similar notifications in their advertising.[85] Physician services in the Medicare program were specifically exempted from Title VI compliance. Much of what is distinctive about the way health care became organized in the United States was influenced by this selective enforcement of Title VI.

Hospitals could minimize the effects of racial integration by expanding private accommodations and minimizing inpatient use. One of the most troubling ironies is that Medicare, which forced hospital integration, also financed the growing separation through the financing of private accommodations. Most of the hospitals in tense, racially mixed communities converted to private accommodations. The Mobile metropolitan area now provides almost all private accommodations as does Charlotte, North Carolina. Hospitals in racially tense neighborhoods in Philadelphia, such as St Mary's Medical Center, were constructed in the 1970s with all private accommodations explicitly for this purpose. In Durham, North Carolina, a participant in the construction of Durham Regional Hospital, which would combine the services provided by a historically-black and a historically-white hospital, said, "'[w]e argued in the planning for weeks about whether it should have any semiprivate rooms because of the race problem. It took care of itself.'"[86] The unique emphasis in the United States has been on reducing acute bed capacity and length of stay. The United States has one of the lowest average length of stays and the lowest acute bed-to-population ratio of any developed nation in the world.[87] Yet, the cost of hospital care in the United States per capita is about twice that of any other country[88] and the "drive through" deliveries and one-day mastectomies have sparked a consumer rebellion.

The general consensus among health care policy makers and managers in the 1950s was that long-term care should be organizationally integrated into a

85. HEALTH CARE DIVIDED, *supra* note 4, at 160-61.

86. *Id.* at 233, 363 (citing an interview with a physician at Watts Hospital, Durham, N.C. (August 28, 1996)).

87. ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, HEALTH AT A GLANCE 27, 37 (2001).

88. GERARD F. ANDERSON ET AL., MULTINATIONAL COMPARISONS OF HEALTH SYSTEMS DATA, 2002, at 9 (2002), *available at* http://www.cmwf.org (comparing the performance of health care systems in eight industrialized countries).

hospital complex or health care campus. If development had continued in this direction, Title VI would have been enforced for nursing homes because the non-discrimination provisions would have been imposed for all services provided by the entity. What happened, of course, was quite different. A completely independent, for-profit, chain-operated, long-term sector emerged; and in the decade after the passage of Medicare and Medicaid, nursing home beds in the United States more than doubled, expanding to more than one million beds and exceeding the hospital sector in total beds. Not surprisingly, the long-term care sector is far more racially segregated, still engages in overt room matching, and continues to provide access in such a way that blacks are more likely to be admitted to the more substandard homes.[89]

Exempt from Title VI oversight, physician practice patterns contribute to many of the persistent disparities in treatment, yet the only major efforts to attempt to hold the health care system accountable to Title VI since 1968 have involved class action suits focused on the closing and relocation of hospitals that have adversely affected black communities. These attempts have largely been ineffective.[90] The relocation of hospitals are events that cannot be easily concealed from the communities the hospitals serve, and the focus on such challenges underscores the almost complete failure to routinely collect information to provide at least some minimal assurances that the patients are being treated fairly. In introducing his civil rights bill more than forty years ago, President Kennedy said, "[s]imple justice requires that public funds, to which all taxpayers of all races contribute, not be spent in any fashion which encourages, entrenches, subsidizes or results in racial discrimination."[91] At least in health care, assurance of such simple justice still eludes us. More than one-half trillion public taxpayer dollars (more than $500,000,000,000) now flow into our health care system annually without holding health care providers accountable.[92]

VIII. WHAT HAPPENS NOW?

In the last two years, there has been much activity focused on reducing racial disparities in health care treatment. The Institute of Medicine has recently produced a report on racial disparities in treatment and strategies for

89. *See generally* David Barton Smith, *Population Ecology and the Racial Integration of Hospitals and Nursing Homes in the United States*, 68 MILBANK Q. 561 (1990); David Barton Smith, *The Racial Integration of Heath Facilities*, 18 J. HEALTH POL., POL'Y & L. 851, 855-57 (1993).

90. *See, e.g.*, HEALTH CARE DIVIDED, *supra* note 4, at 173-83.

91. Special Message to the Congress on Civil Rights and Job Opportunities, *supra* note 54.

92. *See* National Health Care Source of Funds: Selected Calendar Years, *in* Ctr. for Medicare and Medicaid Servs., U.S. Dep't of Health and Human Servs., 2002 Data Compendium, *available at* http://cms.hhs.gov/researchers/pubs/datacompendium/ (last modified on Sept. 24, 2003).

eliminating them called *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*.[93] The Institute of Medicine also released a widely praised final report—*Crossing the Quality Chasm*— that identifies equity as one of the key goals for improving the quality of care in the nation's hospitals.[94] Additionally, we are three years into the broadly supported national initiative, *Healthy People 2010*, which has as one of its major goals the elimination of racial and income disparities in outcomes.[95] A national report measuring progress in reducing disparities in health is about to be released by the Agency for Healthcare Research and Quality.[96] Yet during these same two years, there has been a massive disengagement in employer-sponsored health insurance and growing payment restrictions in Medicare and Medicaid that seem to guarantee increasingly separate and unequal care.

These modern contradictions seem so perfectly embodied in the new Senate majority leader, Senator William Frist (R–Tenn.), that it would make for implausible fiction. In 1968, the Hospital Corporation of America, which Frist's father helped found, became the first of a new breed of companies to take advantage of the new Medicare and Medicaid programs in creating a for-profit hospital chain. Some of those resulting profits now make him one of the Senate's wealthiest legislators. As a cardiovascular surgeon, Senator Frist has been presented as a healer of the racial divisions made more visible by Senator Lott's comments. Ironically, the strongest and most consistent evidence of racial disparities in treatment, according to the Institute of Medicine's recent review of the research, are in cardiovascular care![97] These large racial disparities in treatment for cardiovascular care that cannot be explained by insurance alone and seem to be at the center of all of the unfinished business of the Civil Rights era in terms of Title VI compliance in health care quality.

Why should such contradictions be viewed any differently than the one observed by President Abraham Lincoln at the time of the Civil War about a government and a Union that "cannot endure, permanently half *slave* and half

93. UNEQUAL TREATMENT, *supra* note 4.

94. COMM. ON QUALITY OF HEALTH CARE IN AMERICA, INSTITUTE OF MEDICINE, CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 5-6 (2001).

95. U.S. DEP'T OF HEALTH AND HUMAN SERVS., OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION, HEALTHY PEOPLE 2010, http://www.healthypeople.gov.

96. AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, DEP'T OF HEALTH AND HUMAN SERVS., NATIONAL HEALTHCARE DISPARITIES REPORT: COMMENT ON DISPARITY MEASURES. A preliminary background report is available at http://www.ahcpr.gov/qual/nhdr02/nhdrprelim.htm. Congress mandated that the Agency for Healthcare Research and Quality produce an annual report on health care disparities in the United States. *See* Healthcare Research and Quality Act of 1999, Pub. L. No. 106-129, 113 Stat. 1653 (codified as amended at 42 U.S.C. §§ 299–299c-7 (2000)).

97. UNEQUAL TREATMENT, *supra* note 4, at 5.

free,"[98] or any differently than what Gunnar Myrdal observed in *An American Dilemma* during World War II about the values of equality and disparities in opportunities?[99] Perhaps it is time to take a fresh look at that past and design a more promising future. The true legacy of the Civil Rights era for health care must be the lesson that grassroots social movements and real accountability in the use of public funds can and should make a difference.

98. Abraham Lincoln, A House Divided: Speech Delivered at Springfield, Illinois at the Close of the Republican State Convention (June 16, 1858), *in* ABRAHAM LINCOLN: HIS SPEECHES AND WRITINGS 372-81 (Roy P. Basler ed., 1981) (1946).

99. *See* GUNNAR MYRDAL, AN AMERICAN DILEMMA: THE NEGRO PROBLEM AND MODERN DEMOCRACY (1944).