

Saint Louis University Law Journal

Volume 48
Number 1 *Unequal Treatment: Racial and Ethnic
Disparities in Health Care (Fall 2003)*

Article 6

12-1-2003

Dynamic Conservatism and the Demise of Title VI

Gordon Bonnyman
Tennessee Justice Center

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



Part of the [Law Commons](#)

Recommended Citation

Gordon Bonnyman, *Dynamic Conservatism and the Demise of Title VI*, 48 St. Louis U. L.J. (2003).
Available at: <https://scholarship.law.slu.edu/lj/vol48/iss1/6>

This Symposium is brought to you for free and open access by Scholarship Commons. It has been accepted for inclusion in Saint Louis University Law Journal by an authorized editor of Scholarship Commons. For more information, please contact [Susie Lee](#).

DYNAMIC CONSERVATISM AND THE DEMISE OF TITLE VI

GORDON BONNYMAN*

I. INTRODUCTION

“Dynamic conservatism” is the apparent oxymoron coined by the late M.I.T. organizational theorist Donald Schon.¹ He used the term to describe the propensity of social systems to adjust in many complex, frequently unconscious ways in order to resist real alteration of the status quo.² Paradoxically, the more profound the fundamental change, the more dynamic systems prove to be in resisting it. “Social systems resist change with an energy roughly proportional to the radicalness of the change that is threatened.”³

As David Barton Smith has documented, the national policy of eliminating racism from the American health care delivery system certainly involved radical change indeed, and, as Schon would have predicted, that policy has been met with energetic and dynamic resistance.⁴ For all of the widespread changes in the health care system over the past four decades, racial inequality has proven remarkably resilient. The evidence that David Williams and others have assembled establishes that sad fact beyond argument.⁵ Reading Smith and Williams together, one cannot help but think of William Faulkner’s famous dictum that “[t]he past is never dead. It’s not even past.”⁶

* Co-founder and Executive Director of the Tennessee Justice Center in Nashville, TN. For more information on the center, visit their website at <http://www.injustice.org/TJC.html>.

1. See DONALD A. SCHON, *BEYOND THE STABLE STATE* (1971). Schon observed, “The resistance to change exhibited by social systems is much more nearly a form of ‘dynamic conservatism’—that is to say, a tendency to fight to remain the same.” *Id.* at 32.

2. *Id.* at 38-60.

3. *Id.* at 38.

4. See generally DAVID BARTON SMITH, *HEALTHCARE DIVIDED: RACE AND HEALING A NATION* (1999) [hereinafter *HEALTH CARE DIVIDED*].

5. See, e.g., David R. Williams, *Race, Health and Health Care*, 48 *ST. LOUIS U. L.J.* 13 (2004). See also COMMITTEE ON UNDERSTANDING AND ELIMINATING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE, INSTITUTE OF MEDICINE, *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE* (Brian D. Smedley et al. eds., 2003) [hereinafter *UNEQUAL TREATMENT*].

6. WILLIAM FAULKNER, *REQUIEM FOR A NUN* 92 (1951).

This description of the story is not to say, of course, that no real improvement has occurred. Smith reminds us that, until Congress enacted Title VI of the Civil Rights Act of 1964,⁷ *de jure* racism was ubiquitous in health care facilities across the South.⁸ *De facto* segregation was commonplace in many other parts of the country as well.⁹ Explicitly racist policies rapidly disappeared in the face of creative, determined enforcement of federal civil rights laws, backed by the threat to withhold massive new Medicare and Medicaid funding.¹⁰ The present evidence shows that, to a troubling extent, the problem simply went underground, not away.

Changes in subsequent decades affecting the organization and financing of health care have been dynamic and profound. The alphabet soup that is now so familiar to us, but that was largely unimagined in 1965, attests to that reality,¹¹ yet the legal tools with which to combat racial inequality have not kept pace. In fact, one can follow in the sad history of Title VI enforcement a steady erosion of the national will to make the radical changes in the health care system that the law demanded.

II. THE INFLUENCE OF FEDERAL FUNDING POLICY ON MINORITY HEALTH CARE

Federal funding of the American health care system is enormous and pervasive. In the year 2000, federal spending constituted nineteen percent of total health expenditures and state and local governments accounted for approximately seventeen percent.¹² These figures understate the federal role, however, because federal law drives much of the spending by other entities. For example, the federal government defines state government contributions to Medicaid and mandates beneficiary contributions to the cost of Medicare-

7. Civil Rights Act of 1964, Pub. L. No. 88-352, § 601, Title VI, 78 Stat. 241, 252 (codified as amended at 42 U.S.C. § 2000d (2000)).

8. David B. Smith, *Healthcare's Hidden Civil Rights Legacy*, 48 ST. LOUIS U. L.J. 37 (2004); see also Sara Rosenbaum et al., *Civil Rights in a Changing Health Care System*, HEALTH AFFAIRS, Jan.-Feb. 1997, at 90, 91-94 (noting that “[e]ven after the end of *de jure* segregation in the United States, private hospitals, some of which received federal financial assistance, continued to discriminate on the basis of race.”).

9. See Smith, *Healthcare's Hidden Civil Rights Legacy*, *supra* note 8, at 23-25; SMITH, HEALTH CARE DIVIDED, *supra* note 4 *passim* (1999).

10. See SMITH, HEALTH CARE DIVIDED, *supra* note 4, at 121-42.

11. Financing or care delivery concepts that had not been conceived of, or at least that had not been implemented on a significant scale, include diagnosis related groups (DRGs), preferred provider organizations (PPOs), managed care organizations (MCOs), intensive care units (ICUs), ambulatory surgery centers (ASCs), skilled nursing facilities (SNFs), and prospective payment system (PPS), to name but a few. Some of these changes posed new civil rights challenges. See, e.g., Rosenbaum et al., *supra* note 8, at 95-102.

12. Cathy A. Cowan et al., *Burden of Health Care Costs: Businesses, Households, and Governments, 1987-2000*, HEALTH CARE FIN. REV., Spring 2002, at 131, 136.

covered services.¹³ These figures also omit substantial but indirect subsidies embedded in the tax code and other budget items.¹⁴ The Organization for Economic Cooperation and Development (OECD), using common international indices, attributes forty-four percent of total American health care spending to government.¹⁵ The strings that are attached—or are not attached—to funding of that magnitude powerfully influence which Americans receive medical treatment and on what terms they receive it.

The early history of the Civil Rights Act of 1964 demonstrated the potency of federal funding as a means of advancing the goal of equality. The principal tool for combating such discrimination was Title VI of the Act.¹⁶ It provides that “[n]o person in the United States shall, on the ground of race, color, or national origin, . . . be subjected to discrimination under any program or activity receiving Federal financial assistance.”¹⁷ Title VI regulations outlawed practices and methods of administering federal programs that were discriminatory in effect without requiring proof of discriminatory intent.¹⁸ When the political will existed to enforce the Act and subsequent regulations, as was the case when the Johnson Administration forced the desegregation of Southern hospitals, even energetic resistance to change could be—and was—overcome.¹⁹

Title VI remains on the books, of course, and still proclaims as national policy a determination that federal spending must not foster racial inequality. Given the influential role of federal funding in shaping health care delivery, one would expect that a generation after the enactment of Title VI, racial inequalities in health care would have long since disappeared. How, then, can we account for the stubborn persistence of inequalities over so many years? One can only conclude that, Title VI notwithstanding, federal funding of health services and the policies that guide the expenditure of federal health funds continue to tolerate, if not actively foster, racial discrimination.²⁰

13. Daniel M. Fox & Paul Fronstin, Letters, *Public Spending for Health Care Approaches 60 Percent*, HEALTH AFFAIRS, Mar.–Apr. 2000, at 271-73.

14. John Sheils & Paul Hogan, *Cost of Tax-Exempt Health Benefits in 1998*, HEALTH AFFAIRS, Mar.–Apr. 1999, at 176-81.

15. GERARD F. ANDERSON ET AL., MULTINATIONAL COMPARISONS OF HEALTH SYSTEMS DATA, 2002, at 3 (2002), available at <http://www.cmwf.org>.

16. Pub. L. No. 88-352, Title VI, § 601, 78 Stat. 241, 252-53 (codified as amended at 42 U.S.C. §§ 2000d-d-7 (2000)).

17. Pub. L. No. 88-352, Title VI, § 601, 78 Stat. 241, 252 (codified as amended at 42 U.S.C. § 2000d).

18. 45 C.F.R. § 80.3(b)(2)–(3) (2002); *Alexander v. Sandoval*, 532 U.S. 275, 280-82 (2001).

19. SMITH, HEALTH CARE DIVIDED, *supra* note 4, at 121-42.

20. See UNEQUAL TREATMENT, *supra* note 5; ROBERT M. MAYBERRY ET AL., MOREHOUSE MED. TREATMENT AND EFFECTIVENESS CTR., RACIAL AND ETHNIC DIFFERENCES IN ACCESS TO MEDICAL CARE: A SYNTHESIS OF THE LITERATURE (1999) (report commissioned by the Kaiser Family Foundation).

Some of the causes of racial disparities in health status are subtle and poorly understood. A number of major causes are starkly obvious, however, and can be laid directly at the feet of government health policy. A couple of examples will be illustrative of this fact.

The first example involves financial barriers to health care. Many minority Americans lack equal access to health care simply because they lack insurance and cannot pay out of pocket. America is the only major industrialized democracy that leaves a substantial part of its population without health insurance.²¹ It is well-known that racial and ethnic minorities make up a disproportionately large share of the more than 40 million people in the United States who lack health insurance.²² African-Americans are nearly twice as likely as whites to be uninsured, and Latinos are three times as likely.²³ It is also well understood that being uninsured impairs access to care and results in increased morbidity and mortality.²⁴ So while being insured is no guarantee that an African-American or Latino will receive equal treatment, the lack of insurance fairly promises that he will not.

Therefore, if we are serious about eliminating racial disparities in health care and health status, then the United States must provide for universal health insurance of its citizenry. The United States spends more than twice as much on health care as do most other industrialized democracies,²⁵ and public expenditures in the United States are comparable to those of other countries that guarantee universal coverage as a matter of national policy.²⁶ Indeed, while Americans disparage Britain's National Health Service as "socialized medicine,"²⁷ the United States pours substantially more government subsidies into its health care system than does the United Kingdom.²⁸ Thus, America's

21. See ANDERSON ET AL., *supra* note 15, at 3.

22. See U.S. CENSUS BUREAU, U.S. DEPT. OF COMMERCE, POPULATION PROFILE OF THE UNITED STATES: AMERICA AT THE CLOSE OF THE 20TH CENTURY 57 (1999) (hereinafter POPULATION PROFILE OF THE UNITED STATES) (observing that in 1999, there were 42.6 million uninsured people in America); UNEQUAL TREATMENT, *supra* note 5, at 83 (stating that "[r]acial and ethnic minority Americans are significantly less likely than white Americans to possess health insurance.").

23. POPULATION PROFILE OF THE UNITED STATES, *supra* note 22, at 58.

24. COMMITTEE ON THE CONSEQUENCES OF UNINSURANCE, INSTITUTE OF MEDICINE, COVERAGE MATTERS: INSURANCE AND HEALTH CARE 5-6 (2001), available at <http://www.nap.edu/openbook/0309076099/html/R1.html>; COMMITTEE ON THE CONSEQUENCES OF UNINSURANCE, INSTITUTE OF MEDICINE, CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE (2001), available at <http://www.nap.edu/openbook/0309083435/html/R1/html>.

25. ANDERSON ET AL., *supra* note 15, at 9 (noting that in the United States in 2000, health care spending per capita was more than twice the OECD median).

26. *Id.* at 3.

27. See, e.g., THE DANGERS OF SOCIALIZED MEDICINE (Jacob G. Hornberger & Richard M. Ebeling eds., 1994).

28. In the United States, public funding of health care in 2000, adjusted for differences in the cost of living, totaled \$2,051 per capita, or 43% more than the corresponding figure (\$1,429) for

failure to achieve universal coverage is not because of a lack of resources or a lack of willingness to spend public funds on health care; rather, it is because of common misperceptions about the nation's health care system.

The failure to eliminate financial barriers to health care reflects political priorities. For all of our periodic political clamor about the plight of the uninsured and the need to contain costs, we have yet to match reality with rhetoric. National health policy consistently fuels rises in prices and provider incomes—already the highest in the world—at the expense of coverage for working families.²⁹ As long as national policy leaves a large, and growing, segment of the minority population without health coverage, financial barriers to treatment will ensure the perpetuation of racial inequalities in health care.³⁰

Although assuring universal health insurance coverage is necessary for the elimination of racial inequalities, it alone is not sufficient. As Williams and Smith both document, inequalities are not just the result of financial barriers resulting from a lack of health insurance.³¹ Racial discrimination occurs even when minority patients are adequately insured. Such discrimination may not be racially motivated or, at least not consciously so, but the fact that those who engage in the discrimination are not consciously racist makes the effects no less damaging.

A glaring example of such discrimination, and of the government's complicity in its perpetuation, is the widespread practice among physicians of discriminating against Medicaid patients. Many doctors set quotas on the number of such patients they accept, or they refuse to treat Medicaid patients altogether.³² The practice is open, widespread and unapologetic—just like the

the United Kingdom. ANDERSON ET AL., *supra* note 15, at 18. In the United States, public spending accounted for 44% of total per capita health care expenditures of \$4,631. *Id.* at 3, 12. In the United Kingdom, public spending accounted for 81% of total per capita health expenditures of \$1,763. *Id.* at 12, 18. Public funding of health care in the United States accounted for 5.8% of the GDP, while public funding in the United Kingdom accounted for 5.9% of GDP. *Id.* at 17. Americans' confusion regarding the extent to which the government underwrites its health care system was typified by an encounter that former Senator Jim Sasser (D-Tenn.) is reputed to have had with an angry constituent during the 1994 electoral race in which he lost his seat to Dr. Bill Frist, who is now the Senate Majority Leader. An elderly Tennessean wagged her finger in his face and warned him, "You keep the federal government's hands off my Medicare." Even if the story itself is apocryphal, it nicely captures a lack of awareness that is commonplace regarding the role of government in financing and shaping health care delivery.

29. See Uwe E. Reinhardt et al., *Cross-National Comparisons of Health Systems Using OECD Data, 1999*, HEALTH AFFAIRS, May–June 2002, at 169, 175.

30. Robert J. Blendon et al., *Inequities in Health Care: A Five-Country Survey*, HEALTH AFFAIRS, May–June 2002, at 182 *passim*.

31. See generally Smith, *Healthcare's Hidden Civil Rights Legacy*, *supra* note 8; Williams, *supra* note 5.

32. Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty and Physician Self-Interest*, 21 AM. J.L. & MED. 191, 193 (1995) (noting that twenty-five percent of the nation's

explicitly racially discriminatory practices of the early 1960s. The overwhelming majority of physicians who today discriminate against Medicaid patients would be appalled by the suggestion that they refuse care to patients on the basis of their race. Nevertheless, discrimination on the basis of Medicaid status has a similar effect because the poverty experienced by many minority patients makes them particularly dependent upon the Medicaid program for health coverage.³³ To a significant extent, therefore, Medicaid operates as a proxy for race, at least in states with substantial minority populations.³⁴

Given the disproportionately adverse impact of Medicaid discrimination on minorities, one would expect that state and federal government agencies would invoke Title VI against recipients of federal funds who engage in such discrimination.³⁵ It is only fair that a medical professional trained at public expense be held responsible for serving the diverse American public without discrimination.³⁶ But this has not happened. For one thing, as will be

physicians refuse to treat Medicaid patients and that two-thirds of those physicians that do treat such patients limit the number they treat).

33. "Blacks are . . . five times more likely than whites to be covered by Medicaid." Sidney D. Watson, *Health Care in the Inner City: Asking the Right Question*, 71 N.C. L. REV. 1647, 1648 (1993) (citations omitted). Though doctors often express unfavorable attitudes towards Medicaid's administration and policies and cite factors such as low payment rates and perceived red tape, these factors cannot fully explain providers' negative perceptions of the program. Research suggests that antipathy towards Medicaid patients themselves is a major factor contributing to the refusal to treat this population. See Janet D. Perloff et al., *Medicaid Participation Among Urban Primary Care Physicians*, 35 MED. CARE 142, 152-54 (1997); see generally, E. Kathleen Adams, *Effect of Increased Medicaid Fees on Physician Participation and Enrollee Service Utilization in Tennessee, 1985-1988*, 31 INQUIRY 173 (1995).

34. See, e.g., *Linton v. Carney*, 779 F. Supp. 925 (M.D. Tenn. 1990), *aff'd* *Linton v. Comm'r of Health & Env't, State of Tenn.*, 65 F.3d 508 (6th Cir. 1995), and *cert. denied*, 517 U.S. 1155 (1996).

35. Federal regulations require state Medicaid agencies, as well as the Office for Civil Rights (OCR), to ensure compliance with Title VI by various types of Medicaid providers such as hospitals and medical staffs. 45 C.F.R. § 80 (2002).

36. The federal government heavily subsidizes physicians' education by a number of direct and indirect means. See, e.g., Fitzhugh Mullan et al., *Doctors, Dollars, and Determination: Making Physician Work-Force Policy*, HEALTH AFFAIRS, Supp. 1993, 138. That no one appears to have a firm grasp of the amount of those subsidies is a measure of just how unaccountable training programs and the medical profession are for the use of public funds. In addition to various programs that support medical schools, the government is believed to pay more than half of the cost of graduate medical education. Medicare and Medicaid were estimated to contribute \$10.5 billion a year for the training of medical residents, with state governments contributing an additional \$3.3 billion in non-Medicaid funding in 1998 and 1999. See Karen Matherlee, Nat'l Health Pol'y Forum, Issue Brief, *Federal and State Perspectives on GME Reform*, June 22, 2001, at 2 (2001). As of 1999, there were approximately 98,000 physicians in graduate training in the United States. TASK FORCE ON ACADEMIC HEALTH CTRS., TRAINING TOMORROW'S DOCTORS: THE MEDICAL EDUCATION MISSION OF ACADEMIC HEALTH CENTERS 6 (2002), available at

discussed below, the Department of Health and Human Services (HHS) applies a fiction that doctors who receive Medicare payments are not recipients of federal funds and therefore need not comply with Title VI.

The problem is not limited to a failure to take appropriate enforcement action. Many state Medicaid agencies pursue policies that actually reinforce the effects of private Medicaid discrimination. For example, through a mechanism known as “limited bed certification,” some states enforce policies for nursing homes that limit the admission of Medicaid patients and segregate those whom they do admit.³⁷ Because, as previously noted, African-Americans and other minority groups are much more dependent upon Medicaid than are whites, these policies are racially discriminatory in their effect.

Federal law provides that in order for a facility to participate in the Medicaid program, the state must survey the facility and certify that it meets quality and resident protection requirements.³⁸ Some states, acting at the direction of the facilities that they are supposed to regulate, certify only a limited subset of the facilities’ beds as “Medicaid beds.”³⁹ This result means that while more affluent private-pay patients have access to all of the facility’s beds, Medicaid patients can only use those that are set aside as “Medicaid beds.” This practice has long since been found to violate Title VI,⁴⁰ yet the federal agency that oversees Medicaid still tolerates the practice. Indeed, the practice is so commonplace that the Centers for Medicare and Medicaid Services advise low-income patients needing nursing home care to do the following: “Check with the nursing home to see if they accept Medicaid, and if they have a Medicaid bed available. . . . You may be moved to another room or another section of the nursing home when your care is paid by Medicaid.”⁴¹

Other states seek to limit access to emergency rooms for Medicaid patients or impose penalties when Medicaid patients receive medically necessary but

<http://www.cmwf.org>. Using these figures, government subsidies thus represent an annual public expenditure of more than \$140,000 per medical resident.

37. *Linton*, 779 F. Supp. at 927-28.

38. 42 U.S.C. §1396r(g)(1)(A) (2000).

39. *E.g.*, *Linton*, 779 F. Supp. at 927.

40. *Id.* at 934-35. It should be noted that in the wake of *Alexander v. Sandoval*, the *Linton* court could no longer entertain the private plaintiffs’ Title VI suit against the nursing homes’ admission practices. *See Alexander v. Sandoval*, 532 U.S. 275 (2001) (holding that there is no private right of action to enforce disparate impact regulations under Title VI). In the *Linton* case, decided before *Alexander v. Sandoval*, the plaintiffs proved that those practices were discriminatory in effect though, facially neutral in intent. *Linton*, 779 F. Supp. at 934-35.

41. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH AND HUMAN SERVS., GUIDE TO CHOOSING A NURSING HOME 36 (2003), available at <http://www.medicare.gov/Publications/Search/View/ViewPubList.asp>.

non-emergency care through hospital emergency departments.⁴² Use of emergency rooms for routine care is time consuming and frequently demeaning for patients, and the care received in such settings is inherently discontinuous. Resort to emergency rooms is an unpleasant necessity for many Medicaid patients, especially for minority patients as they cannot obtain access to primary care through private physicians' offices.⁴³ Rather than pressure physicians who receive federal funds to open their practices to Medicaid and other minority patients on a non-discriminatory basis, state policymakers often respond to this phenomenon with punitive practices aimed at restricting access to the only care available.⁴⁴

III. THE DEMISE OF TITLE VI

Why has Title VI not been more effective? As early achievements in the desegregation of Southern hospitals demonstrated, the law certainly could produce change when there was the political will to enforce it. But as Smith has recounted, that political will began to wane almost as soon as Title VI became law, and as federal enforcement withered, social and institutional

42. See, e.g., OFFICE OF THE ASS. SEC'Y FOR PLANNING & EVAL., U.S. DEP'T OF HEALTH & HUMAN SERVS., CHILDREN'S HEALTH INSURANCE EXPANSIONS: STATE EXPERIENCES IN DEVELOPING BENEFIT PACKAGES AND COST-SHARING ARRANGEMENTS, at Section IV (1998), at http://aspe.os.dhhs.gov/health/reports/benefits/state_approaches_to_costsharing.htm#_Toc411996435 (Feb. 17, 1998) (reviewing the experiences and discussing cost-sharing mechanisms used by various states). See also VERNON SMITH ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, STATES RESPOND TO FISCAL PRESSURE: STATE MEDICAID SPENDING GROWTH AND COST CONTAINMENT IN FISCAL YEARS 2003 AND 2004, at 30 (2003), at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22126> (noting that two states have "imposed new or higher copays for . . . hospital ER visits for non-emergency services").

43. The Medicaid Access Study Group, *Access of Medicaid Recipients to Outpatient Care*, 330 NEW ENG. J. MED. 1426, 1428 (1994); Gary P. Young et al., *Ambulatory Visits to Hospital Emergency Departments: Patterns and Reasons for Use*, 276 JAMA 460, 460, 462 (1996).

44. The Tennessee Hospital Association's president recently attributed a 31% increase in emergency room visits in Tennessee to the inability of patients in the state's Medicaid managed care program to find physicians willing to accept them. John Gerome, *Study Blames TennCare for Rise in ER Visits*, KNOXVILLE NEWS-SENTINEL, Dec. 14, 2002, at http://www.knoxnews.com/kns/state/article/0,1406,KNS_348_1608692,00.html. "When TennCare patients cannot find doctors willing to see them or take care of them in a timely manner, they have little choice but to turn to hospitals who do not turn patients away." *Id.* (quoting Craig Becker, President of the Tennessee Hospital Association). Tennessee nonetheless imposes co-payments for emergency department visits for waiver-eligible enrollees above poverty unless they are admitted for inpatient care, even if the care obtained in the emergency room was medically necessary. See Bureau of TennCare, *New TennCare Co-Pay Schedule for Uninsureds and Uninsurable*, at <http://www.state.tn.us/tenncare/copay.html> (last visited Nov. 21, 2003).

arrangements evolved in ways that perpetuated racial inequalities in health care.⁴⁵

Legislative and executive branch policies have conspired to fatally undermine enforcement of Title VI as applied to health care from the beginning. Congress refused to budget adequate staff and administrative resources to monitor and enforce compliance.⁴⁶ The short-lived effort by the Department of Health, Education, and Welfare (HEW) to eradicate segregation in Southern hospitals was only made possible by the temporary transfer of agency personnel into enforcement positions, a practice that could not be sustained for more than a short time.⁴⁷ HEW used the few enforcement resources Congress provided to focus primarily on the daunting challenges of school desegregation.⁴⁸ Little attention was paid to the health care system despite the pervasive presence of federal funding in that system.⁴⁹ Moreover, after the health programs administered by the former HEW were reassigned to the new HHS in 1980, the new agency's Office for Civil Rights (OCR) continued to lack the resources and administrative wherewithal to fulfill its enforcement responsibilities.⁵⁰

Federal agency officials have also shared Congress's ambivalent attitude towards enforcement. HEW interpreted Title VI in a manner that effectively exempted physicians from compliance, and that interpretation has never been revised.⁵¹ By application of an ironic legal fiction, receipt of Medicare payments is not considered to make a physician a recipient of federal funds and therefore subject to Title VI.⁵² This dispensation has severely impaired Title

45. In a particularly ironic manifestation of dynamic conservatism, Smith describes how Southern hospitals exploited the very federal programs that had forced their abandonment of explicit segregation to finance de facto re-segregation. The hospitals used Medicare funding for the construction of private hospital rooms, largely motivated by a quietly acknowledged desire to perpetuate the segregation of the races. SMITH, HEALTH CARE DIVIDED *supra* note 4, at 229-33.

46. *Id.* at 125, 164-66.

47. *Id.* at 132-33, 160.

48. *Id.* at 167-68, 183.

49. *Id.* at 183-87.

50. SMITH, HEALTH CARE DIVIDED *supra* note 4, at 183-87. See H.R. REP. NO 100-56 (1987) (findings from an investigation of the OCR detailing the various ways in which the Office failed to fulfill its responsibilities).

51. 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 Nuñez, 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 COMMISSION ON CIVIL RIGHTS APRIL 15-16, 1980, 851-64.

52. SMITH, HEALTH CARE DIVIDED *supra* note 4, at 161-64. The rationale for the initial exemption was that Medicare's Part B, which covers physician payments, was funded by beneficiaries' premiums rather than congressional appropriations. *Id.* at 162-63. Whatever doubtful merit that distinction might have had has long since become moot. Appropriations from

VI enforcement throughout the health care system. Medicare payments are the principal source of federal funding for most physicians, and it is physicians who direct most of the medical care that Americans receive.

Another crucial administrative policy that has reduced Title VI to all but a dead letter has been the refusal to collect data necessary for the assessment and enforcement of compliance. Justice Department regulations implementing Title VI required HEW (and now require HHS) 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.”⁵³ If Title VI is to have any meaning today, it is through its prohibition of policies and practices that, though racially neutral in intent, are discriminatory in their effect. To monitor and enforce that prohibition requires the collection and analysis of statistical data that can reveal patterns of discrimination of which even the perpetrators may be unaware.⁵⁴

HHS, however, has never required health care providers to collect such data, much less report it.⁵⁵ This failure makes it impossible to monitor compliance on a routine basis. The absence of a requirement that providers collect and maintain such data severely hampers the government’s ability to investigate alleged discrimination when it receives a complaint⁵⁶ because of the obvious impracticality of obtaining and analyzing records that it has never required recipients to keep.⁵⁷

the federal treasury now account for approximately seventy-five percent of Medicare payments to doctors. CRAIG CAPLAN & RYAN COOL, PUB. POL’Y INST., AM. ASSOC. OF RETIRED PERSONS, THE STATUS OF THE MEDICARE PART A AND PART B TRUST FUNDS: THE TRUSTEES’ 2003 ANNUAL REPORT 3 (March 2003), available at http://research.aarp.org/health/dd87_medicare.html.

53. 28 C.F.R. § 42.406(a) (2003).

54. The medical literature on racial disparities in health care and health status is almost entirely based on such analysis. Without provider-specific statistics, it is impossible to trace observed inequalities in treatment back to the actors responsible for those inequalities. See UNEQUAL TREATMENT, *supra* note 5 *passim*.

55. See, e.g., *Madison-Hughes v. Shalala*, 80 F.3d 1121, 1124-25 (6th Cir. 1996) (dismissing plaintiffs’ complaint and pointing out the lack of the existence of a “mandatory legal requirement that HHS routinely collect such data”).

56. See, e.g., *United States v. Harris Methodist Fort Worth*, 970 F.2d 94, 104 (5th Cir. 1992) (holding that the HHS’s proposed search of a hospital’s records for evidence of compliance with Title VI constituted an unreasonable search under the Fourth Amendment).

57. The Health Insurance Portability and Accountability Act (HIPAA) afforded HHS an opportunity to rectify its decades-old failure to collect data essential to monitoring and enforcing compliance with the Civil Rights Act. HIPAA required the promulgation of standards for certain common health care-related electronic transactions. See Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended at 42 U.S.C. §§ 1320d-1320d-8 (2000)). When it issued the regulations that established the standards, HHS acknowledged that the research community had requested the inclusion of such data in claims forms. Health Insurance Reform: Standards for Electronic Transactions, 65 Fed. Reg.

By 1979, when education programs and related civil rights enforcement responsibilities were reassigned to a newly formed Department of Education, OCR's enforcement of Title VI in federal health care programs had been reduced to meaningless paper shuffling.⁵⁸ When the U.S. Civil Rights Commission reviewed federal enforcement in the health industry two decades later, its summary of that record was damning:

For 35 years, HHS (and its predecessor agency, HEW) have condoned policies and practices resulting in discrimination against minorities and women in health care.

....

There is little doubt that racial, ethnic, and gender disparities in health care will persist in the 21st century unless Federal enforcement of civil rights laws is strengthened.⁵⁹

Agency failure to enforce Title VI has become even more critical since the Supreme Court ruled that only the government could challenge discrimination that violates the effects test imposed by the regulations.⁶⁰ Now, private litigants may only obtain relief under Title VI upon a showing of discriminatory intent.⁶¹ Such a showing is an almost impossible burden of proof that makes the law useless for dealing with the current manifestations of discrimination. As Professor Williams points out, even the perpetrators of discrimination are unaware of their own biases.⁶² Health care providers and minority patients alike are unaware of the extent of racial inequalities in health care.⁶³ Even if a patient suspects racial bias, the patient-provider relationship is such that it is impossible in most circumstances for the patient to confirm or dispel—much less prove—his suspicions. The inability of victims of discrimination to invoke Title VI against such practices effectively makes private enforcement impossible.

50,312, 50,337-38 (August 17, 2000). The agency also conceded that the collection of racial data is necessary for understanding and reducing disparities in health care. *Id.* The agency refused the request anyway, stating that it would work with researchers to develop alternative data collection methods. *Id.* Three years later, the data collection requirements remain unchanged. 45 C.F.R. § 162.1102 (2002).

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

59. 2 U.S. COMM'N ON CIVIL RIGHTS, *THE HEALTH CARE CHALLENGE: ACKNOWLEDGING DISPARITY, CONFRONTING DISCRIMINATION, AND ENSURING EQUALITY* 14-15 (1999) (The Role of Federal Civil Rights Enforcement Efforts).

60. *Alexander v. Sandoval*, 532 U.S. 275, 293, 307 (2001).

61. *Id.* at 285-86, 293.

62. See Williams, *supra* note 5.

63. *Id.*; see generally *UNEQUAL TREATMENT*, *supra* note 5.

When neither victims nor perpetrators are aware of the influence of latent racial bias, and when systemic data that would reveal the manifestation of such bias in patterns of discrimination is not collected, the prohibition against discrimination ceases to be enforceable law and is reduced to the status of mere moral exhortation.

IV. AN UNFINISHED AGENDA

Ironically, the best present hope for fulfilling the promise of Title VI may lie in an appeal to the values of those whom the law has failed to reach. The medical profession, which has largely been exempted from Title VI, perceives itself as committed to patient care on a non-discriminatory basis. Doctors have a high regard for science and for evidence-based treatment norms. These values, and the medical profession's quest to provide quality care, are incompatible with racial bias in the delivery of health care.⁶⁴ There is some evidence that these principles are already beginning to favorably influence the medical treatment of minority Americans.⁶⁵

Still, the good will of providers will not be enough to overcome the dynamic conservatism of racial inequality in health care, with its demonstrated capacity for self-perpetuation in the midst of cultural and institutional change. Too many of the barriers and burdens that minority Americans face are the product of public policies and institutional arrangements that are beyond the ability of individual health care providers to correct.

The Civil Rights Act of 1964 expressed recognition that the government has an indispensable role in dismantling racial discrimination. Not the least of the reasons why the Act was, and is still, necessary, is that, as Justice Brandeis remarked, "[o]ur government is the potent, the omnipresent teacher. For good or for ill, it teaches the whole people by its example."⁶⁶ Title VI of the Act committed the federal government to ensuring that public funding and public policy would foster racial justice. Until we reaffirm that commitment and revitalize Title VI, the law will be no match for systems and policies that

64. See Sidney D. Watson, *Race, Ethnicity and Quality of Care: Inequalities and Incentives*, 27 AM. J.L. & MED. 203 *passim* (2001).

65. Citing the need to collect racial information in order to combat disparities in health status, the California Medical Association and other organizations of health care providers have formally opposed Proposition 54, the 2003 California ballot initiative that would have prohibited the collection of such information. Coalition for an Informed California, *Endorsements* (2002), at <http://www.defeat54.org/endorsers.asp> (last visited Oct. 27, 2003). In addition, recent research suggests that cardiologists may have modified their treatment patterns to eliminate racial disparities that were documented in earlier studies. See generally, Saif S. Rathore et al., *Race, Quality of Care, and Outcomes of Elderly Patients Hospitalized With Heart Failure*, 289 JAMA 2517 (2003) (finding that "[b]lack and white Medicare patients receive comparable quality of care during hospitalization for heart failure").

66. *Olmstead v. U.S.*, 277 U.S. 438, 485 (1928) (Brandeis, J., dissenting).

unconsciously conspire to perpetuate the tragic legacy of racial inequality in health care.

