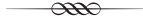


Addressing Racial Inequality in Health Care



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*F*ocusing on the role of race in health policy is not easy. Any such analysis raises a host of complex issues that lie at the policy intersection of health care and civil rights. More fundamentally perhaps, such an exploration cannot proceed without confronting two matters that many might prefer to avoid. The first is the historical dominance of racially biased attitudes, beliefs, and customs in medicine no less than in other areas of life, such as education, employment, housing, transportation, public accommodations, and even marriage and family formation. The second, which follows on from the first, is the need for the medical system itself to be an equal player in a broad national undertaking, which includes active policy interventions when necessary, to find ways to erase discrimination's vestiges.

Some may believe that race is too profound a societal issue to lend itself to a public policy response. Research on health and health care unfortunately tends to bolster this perception by failing to push beyond statistical analysis of racial disparities to explore their underlying causes.¹ Even more troubling are the disparity studies that conclude by speculating on the possible roles of patient attitudes and preferences without giving equal weight to the possible roles of systemic factors. There are far too few studies, such as that conducted by Schulman and colleagues (1999), which attempt to probe the role in health disparities that may be played by physician perception and clinical judgment. Furthermore, it is not uncommon to find that such evidence is either met with denial or whitewashed when it is presented (Geiger 2004).

In their watershed chronicle of race and health care, *An American Health Dilemma*, W. Michael Byrd and Linda A. Clayton present an almost overwhelming picture of a problem that lies at the juncture of culture and policy (2002). In the authors' view, the attitudes, preferences, and beliefs that must change are not those of individual patients but those of the health care system itself. This study depicts a threefold dilemma: a social expectation that minority Americans will experience substandard health status; a highly privatized health system that accords broad discretion to entrepreneurs and marginalizes poor and minority members;

and a widespread refusal to acknowledge the problem of racial segregation and exclusion in health care. This exhaustive exploration underscores that were the nation to minimize the role of law and policy in changing health care culture, it would commit an error as serious as ignoring policy tools in other social settings.

Using the law to move a nation to address race is inherent to democratic government. Law can be understood as the formal language by which society shapes, institutionalizes, and preserves its mores (Friedman 2002); and thus, the notion that racial matters should be addressed in laws that govern the health care system is hardly radical. Indeed, official racial segregation sanctions once dominated the law, not merely in the southern states, but also as part of the federal Hospital Survey and Construction Act of 1946 (Hill Burton), which authorized the construction of segregated facilities (Smith 1999). Just fifty years have passed since *Brown v. Board of Education*, and it has only been forty years since *Simkins v. Moses Cone Hospital*, in which the federal courts declared segregated health facilities unconstitutional.² Furthermore, scores of communities managed to preserve health care's racial divide even after this decision, through the use of laws and policies governing hospitals' medical staffing privileges (Smith 1999; Byrd and Clayton 2002; Bobinski 2003; Trubek and Das 2003; IOM 2003; U.S. Commission on Civil Rights 1999).

Not only do the specific remedial tools that public policy can bring to bear on social problems argue for a vibrant role for law in race and health care. The very use of the legal process itself signals the nation's willingness to use a public, democratic forum—its most formal, transparent, and visible means of social ordering—to address race. Robert Caro's description, in *Master of the Senate* (2002), of the debate over the 1957 Civil Rights Act illuminates the role of lawmaking in challenging racial beliefs. As Caro notes, the true import of this debate for national civil rights policy lay far less in the law that ultimately emerged (true reform would not arrive until the Civil Rights Act of 1964) than in the act of public debate itself. The issue of race in health care is simply too important to leave to the less visible world of shifting social attitudes.

Despite the distance yet to travel, the paucity of data measuring racial progress, and lingering barriers to care, efforts to address race in health care reveal the profound impact of laws. These include legislation desegregating U.S. hospitals and creating public financing programs, which exerted an enormous impact on systemic barriers to care (Smith 1999). Legislation also established community health centers in medically underserved, disproportionately minority communities (Davis and Schoen 1977; IOM 2003; U.S. Commission on Civil Rights 1999; Byrd and Clayton 2002; GAO 2003; Shone et al. 2003).

Addressing race and health care requires understanding the interaction between civil rights law and the vast body of law that collectively defines and influences the financing and provision of health care (Rosenbaum and Teitelbaum 2003). One law in particular—Title VI of the 1964 Civil Rights Act—has tended to dominate legal analysis of race and health care. Title VI prohibits discrimination in federally assisted programs and services and defines virtually all sources of public health care financing as a form of federal assistance. Furthermore, Title VI reaches

not only intentional discrimination (known as disparate treatment) but also seemingly neutral conduct that nonetheless—as shown by statistical evidence—has an adverse impact on racial and ethnic minority groups (Perez 2003). This latter form of conduct has long been termed “disparate impact” and has obvious parallels to more recent discussion of health disparities.

This classic legal construct, which grounds the problem of disparities in the law of civil rights, may now be giving way to shared ownership with the law of health care quality. Shifting the legal paradigm from civil rights to health quality may make the conversation easier and remedies more attainable. Certainly, the task of proving a legal wrong cannot be any more challenging under a quality paradigm than as a civil rights violation. Proving the latter is extraordinarily difficult given the lack of a universal and compulsory system for collecting data on patient care by race, the most crucial evidence in a disparate treatment claim.

Even assuming statistics do exist, litigating a case of discrimination requires a plaintiff to be able to prove not only injury but also at least proximate causation, a very high bar. The result is that only those acts that have the most visible and overt potential impact on minority populations, such as hospital closures or relocations, or the segregation of patient floors or wings by race, have tended to be litigated (Rosenbaum, Markus, and Darnell 2000). Furthermore, many of the most troubling examples of racial disparities may be replete with confounding factors where the law is concerned. Proving a civil rights claim requires isolating these potential confounders to show that the injury was indeed racial rather than economic or tied to health status. In this regard, of course, an added complication is the extent to which physicians’ choice of diagnosis and treatment approaches in specific types of cases affects the outcome of care (IOM 2003). Basing treatments on individuals’ financial status or ability to “benefit” from treatment may be troubling but nonetheless may not violate Title VI, whose scope is confined to racially identifiable injury. Health care discrimination cases brought under Title VI thus remain relatively few and far between (Rosenbaum, Markus, and Darnell 2000; Watson 1990).

Federal oversight of civil rights compliance—groundbreaking in the early years of the Civil Rights Act—has also become virtually nonexistent (U.S. Commission on Civil Rights 1999). The near-total absence of federal enforcement has become an even more critical problem in the wake of the 2001 Supreme Court decision in *Alexander v. Sandoval*.³ That decision virtually eliminated individuals’ ability to bring suits aimed at halting practices with discriminatory effects at least against private recipients of federal funds, such as hospitals, nursing homes, and managed care organizations (Rosenbaum and Teitelbaum 2003).

The modern consumerism movement might have given new strength to challenges to perceived discrimination in health care. But modern health care consumerism has its roots in the law of markets, not in the law of civil rights; and, as a result, the legal framework of open markets applies (Havighurst 2002). Market advocates emphasize information, choice, and transparency rather than the establishment of legal rights of patients and substantive operational duties on the part of providers (Halvorson and Isham 2003). While the concept of transparency might

propel such advances in industry practices as the greater availability of racially relevant information on quality and utilization, the disproportionately weak purchasing power of many racial and ethnic minority groups, related to their higher poverty, health risks, and lack of insurance, makes this result unlikely.

Health policy debates that focus on race are thus fraught with legal complications and raise issues that the nation—especially the medical care system—would prefer to avoid. Furthermore, the relatively limited power of minority consumers as a group may serve to undermine rather than advance their position in an age of consumerism. Still, despite these challenges, the discussion of race and health care has not only persisted but broadened to include health care quality along with civil rights. Indeed, the continued dominance of race as a public policy matter in both legislatures and the courts has, if anything, reinforced the search for the means to advance the issue of race in health policy.⁴

What Does the Evidence Show?

Considerable research into racial disparities in health supports several basic conclusions. First, while patient preference and what is referred to as “lifestyle” may play some role, socioeconomic factors appear to be powerful drivers of racial disparities in health. This is particularly true for measures of mortality and morbidity from preventable causes as well as complications of illness (IOM 2003; Bobinski 2003; U.S. DHHS 2000). Second, even when patient characteristics are controlled, differences in use and outcomes are evident, a finding that suggests the role of the medical care system itself in contributing to racial disparities (Geiger 2004). Barriers seem to arise after individuals have already entered the medical care system, when practice style rather than individual behavior tends to dominate the course of events (IOM 2003).

Third, racial disparities in access to health care and outcomes appear pervasive, affecting numerous health conditions and health care settings, even when investigators control for insurance status and income. Were race a predictor of health care and outcomes only in isolated circumstances, the inference might be weaker, but the pattern surmounts the bounds of mere coincidence (IOM 2003; Kaiser Family Foundation 2003; Collins, Hall, and Neuhaus 1999; Geiger 2004).

Fourth, for a number of reasons, the nation’s approach to health insurance significantly discriminates against racial and ethnic minorities. In a voluntary, employment-based health care system, economically disadvantaged individuals (who are more likely to be members of racial and ethnic minority groups) are more likely to be either uninsured or publicly insured (Kaiser Family Foundation 2003; Hall, Collins, and Glied 1999). These racial disparities permeating the health insurance system persist even into old age. Among Medicare beneficiaries aged sixty-five and older, non-Latino white beneficiaries are significantly more likely to possess supplemental employer-sponsored or other private coverage, while their minority counterparts are six to seven times more reliant on Medicaid to supplement Medicare (Kaiser Family Foundation 2003).

Fifth, large racial gaps appear in patients’ access to health care, even when

personal characteristics are held constant. Minority patients, particularly those of Latino descent, are more likely to lack a usual source of health care and less likely to use any medical services. Regardless of whether the measure is primary care or specialty care, minority populations also show a consistent pattern of lower levels of utilization, and disparities persist even when researchers control for income (Kaiser Family Foundation 2003).

Finally, and perhaps most compelling from a policy standpoint, even when minority patients have entered the health system, they are less likely to receive the level of care accorded nonminority patients for the same conditions regardless of insurance status (Bobinski 2003; IOM 2003). Medicare managed-care enrollees, for example, receive differential levels of treatment based on race for comparable cardiovascular conditions such as acute myocardial infarction (Schneider, Zaslavsky, and Epstein 2002). Latino and African American patients with public insurance do not receive coronary artery bypass surgery at rates comparable to their white, publicly insured counterparts. African American patients are also less likely to receive treatment for early-stage lung cancer and, not surprisingly, post lower five-year survival rates. Minority nursing home residents with cancer are more likely to experience untreated daily pain (Kaiser Family Foundation 2003).

Studies reveal important racial disparities in managing chronic illness as well. Medicaid-insured African American and Latino children use less primary care, depend more extensively on emergency departments, experience higher rates of hospitalization, and die at significantly higher rates than their white counterparts (IOM 2003; Kaiser Family Foundation 2003). Together, these results reveal a broad and consistent relationship between the race of patients and the use and outcome of care, regardless of whether treatment entails primary care or specialized services. The health care financing system intensifies these results because it works least well for economically disadvantaged racial and ethnic minority groups.

The cumulative evidence flowing from this immense body of research supports several major policy inferences. The most controversial is the inference that the medical care system itself acts in ways that are discriminatory in result, if not in design. This inference is controversial because its ultimate evidentiary source is real clinicians and institutions interacting with real patients. It suggests that the very act of medical decision making can increase the potential for racially identifiable outcomes even where none are intended (Bloche 2001).

This link between the conduct of individual physicians and institutions and patterns of patient care is hardly a new one. In a compelling study conducted nearly forty years ago, two Yale researchers, physician Raymond Duff and sociologist August Hollingshead, chronicled the relationship between patients and clinicians at Yale New Haven Hospital. They observed a correlation between patients' economic and racial characteristics and the extent to which the hospital and its medical staff—as a result of both individual conduct and institutional protocols—acted as their “committed sponsors.” Patients who experienced what Hollingshead and Duff brilliantly termed “committed sponsorship” from their physicians showed better survival rates and health outcomes; those who did not fared poorly, as measured by mortality, morbidity, and overall health quality (Duff and Hollingshead

1968). This seminal work points to the fundamental connection between the relationship between physicians and patients, on one hand, and good results in a complex health system, on the other. This finding should hardly surprise anyone who knows the system, yet it has only recently reemerged as a focus of policy attention.

The potential of the U.S. health care enterprise to produce racially identifiable results extends beyond the individual conduct of clinicians and institutions, however. Equally important to both minority patients and minority communities are the broad discretion accorded the health care industry—at both the practitioner and corporate entity level—to select both product and geographic markets and the general lack of governmental standards or oversight of aggressive market conduct (Rosenbaum 2003). It is true that the government has made modest investments in programs to compensate for market failure in the area of primary care, such as community health centers and other community-based and publicly supported services. But these providers (whose services are consistently recognized for their high quality) hardly can overcome the effects of an immense and inaccessible system of specialized and extended health services.

Discretion over the design of health care markets can have important racial implications. With the demise of health planning in most states and communities, providers' decisions regarding location and services—such as whether to stay in the city or move to the suburbs and whether to offer outpatient and diabetes management programs—become matters of business strategy rather than community need. U.S. civil rights law has been particularly unhelpful regarding the basic business of health care: virtually every case challenging health care closures and relocations on civil rights grounds has lost. One review of cases from 1965 to 1998 suggests that Title VI claims tend to succeed only when evidence shows discrimination within a particular market or institution, rather than refusal by a health care provider to either enter or remain in a market (Rosenbaum, Markus, and Darnell 2000). Similarly, although refusal by hospitals and nursing homes to accept Medicaid patients has been shown to have a disproportionate adverse impact on minority patients in violation of Title VI, this evidence has virtually never been used by courts or legislatures to compel provider participation in Medicaid.

Managed care had the potential to open new markets to publicly insured minority patients by imposing on network providers a contractual duty of care toward plan members. However, this is not how managed care has in fact played out. Residential segregation in many communities has limited care networks to the physicians and safety net providers already serving affected neighborhoods. Moreover, those physicians who are members of networks have resisted the “all-products” clauses that insurers attempted to write into their provider agreements, insisting on maintaining the right to select their patients (Rosenbaum et al. 1997).

Medicaid managed care is especially important for minority populations, given the tendency toward a racially identifiable distribution of health plan members by payer type. Medicaid has played a fundamental role in reducing disparities, and its value for persons with chronic illness and disabilities compared with more limited conventional insurance can hardly be overstated (Rosenbaum 2002; Weil 2003). But Medicaid managed care today is dominated by specialty compa-

nies typically affiliated with safety net providers who already treat beneficiaries. As impressive as the health care safety net has been in terms of clinical quality and overall commitment to community-wide outcomes, individual clinics continue to report serious problems ensuring access to specialty care for their publicly insured patients (Gusmano, Fairbrother, and Park 2002). Although the growing dominance of managed care organizations in public insurance for lower-income patients may appear to have improved access by integrating service delivery and financing, the extent of improvements remains an open question characterized by a conflicting body of evidence (Rosenblatt, Law, and Rosenbaum 1997).

The Law and Policy Implications of Race and Health Care

Maintaining a focus on the intersection between racial disparities and legal interventions remains an important policy priority. Legislation introduced in both the House and the Senate in 2003 attests to the persistence of racial inequality in health care as a target of legal intervention. This legislation would address racial disparities through an array of venues, from more active enforcement by civil rights agencies to additional programs and services aimed at improving minority access to health care.⁵

A good part of the problem of using civil rights laws aimed at the protection of racial and ethnic minority groups to address racial disparities in health and health care is the confounding effects of socioeconomic and health insurance status. In this regard, legislation reforming insurance coverage would by definition amount to a legal intervention aimed at reducing racial disparities. For example, a uniform, universal health insurance scheme that did not distinguish by employment, family income, or place of residence in either coverage or financing might be expected to reduce barriers to health care and improve the supply and distribution of health resources in poorer communities. Past efforts to expand Medicare and Medicaid coverage certainly are dramatic testaments to the power of major insurance reform in fostering racial equality (Davis and Schoen 1977; Kaiser Family Foundation 2003).

But favorable racial results are a possible byproduct of insurance reform rather than a specific remedy aimed squarely at reducing documented disparities. Furthermore, the evidence shows that financing improvements alone might well mitigate the role of race in health care only modestly, since, even controlling for income and coverage, researchers find that disparities persist (IOM 2003).

These studies suggest the importance of addressing racial disparities in health and health care directly, rather than hoping for progress as a felicitous byproduct of insurance reform. From a public policy standpoint, reducing disparities requires a formal and enforceable scheme that promotes accountability toward discrete subgroups of patients as well as the overall population. Such a scheme would act as a lever for advancing reforms that otherwise might languish, and whose importance easily can be obscured by the aggregated results of generalized improvement activities.

The power of law to compel change in custom and practice is fundamental

to the premise of law itself, and evidence of this power is visible in civil rights laws such as Title VI of the 1964 Civil Rights Act, financing programs such as Medicare and Medicaid, and laws aimed at improving health care quality (Smith 1999; Rosenblatt, Law, and Rosenbaum 1997). Perhaps the most famous articulation of the role of law in altering outmoded or inappropriate custom arises in the context of legal accountability for one's conduct, in the landmark case of *The T. J. Hooper*. In that 1932 case, Judge Learned Hand emphasized that reasonable conduct—determined by objective evaluation of relevant evidence rather than by industry custom—was the proper legal standard for ensuring public accountability.⁶

Two important legal traditions could anchor a formal scheme of public accountability for reducing health disparities: the law of civil rights and the law of health care quality. The point at which these two legal traditions converge in the flow of federal Medicare and Medicaid funds deserves careful attention because of the power of financing to shape the structure and process of medical care.

Innovations in Civil Rights Law

Individual enforcement has always been a central tool of civil rights law because of the lack of agency oversight, but in this regard the *Alexander v. Sandoval* decision represents an unprecedented diminution of individuals' ability to counter industry practices that have discriminatory effects (Rosenbaum and Teitelbaum 2003). In a post-*Sandoval* world, even if individuals claiming disparate impact surmount barriers such as the lack of data, cost of litigation, and difficulty in meeting the legal burden of proof, this decision amounts to a total bar to individual enforcement of Title VI's de facto discrimination ban, at least regarding private entities.

But *Sandoval* addressed only the question of whether individuals could enforce the discriminatory impact rule. It did not grapple with whether Title VI's effects test is enforceable by federal agencies. This crucial fact raises once again the notion of breathing new life into direct federal enforcement of providers' legal obligations under federal civil rights law. A policy statement released by Justice Department officials in the wake of the *Sandoval* decision reiterated the power of agency enforceability. Moreover, recent administration actions regarding access to care by persons with limited English proficiency suggest a renewed willingness to use civil rights law to reduce health disparities (Rosenbaum and Teitelbaum 2003).

Civil rights laws that link eligibility for federal grants and contracts to non-discrimination standards could be effectuated by conditioning Medicare and Medicaid payments on evidence of provider adherence to specific conduct aimed at promoting access and quality of care for minority patients. The standards could then be enforced through the reporting of patient care data by race. In essence, this is the approach taken by the Office for Civil Rights in its formulation of standards of conduct for programs and entities serving non-English speaking persons. This approach could be extended to other aspects of health care operations as well, including service arrangements, the design and implementation of residency and health professions training programs, and other practices linked to access to care.

Such a regulatory approach effectively mirrors the early days of Title VI, when federal officials conditioned eligibility for Medicare and Medicaid payments on a showing of nondiscrimination (Smith 1999). For this approach to work, officials would have to develop specific performance standards in areas that research links to reducing disparity. For example, agencies might condition federal payments on modifications in facility staffing, training programs, clinical affiliations, practice techniques, and diversity training. To be legally viable as a Title VI-propelled standard, the conduct in question must be reasonably related to disparate racial outcomes and need not be linked to evidence of intentional discrimination. A second civil rights-based approach—closely linked to the first but cast as an incentive—would be to establish legal “safe harbors.” The federal guidance regarding the obligations of health care providers toward persons with limited English proficiency (LEP) contains the seeds of this approach. This guidance, originated by the Clinton administration in 2000 and revised by the Bush administration in 2003, details broad standards that federally assisted providers must satisfy to comply with Title VI. (Ironically, perhaps, the *Sandoval* decision also involved barriers to such federally assisted services.) Although the Bush administration exempted physicians in private practice whose only source of federal assistance is Medicare, these guidelines nonetheless retain considerable breadth. In effect, the LEP guidance creates legal safe harbors against civil liability for “disparate impact” under Title VI.

This approach is loosely modeled on strategies for enforcing antitrust and fraud and abuse statutes that could be used to address other goals for reducing health disparities as well. Recent research links improvements in health care quality to reductions in racial disparities (Sehgal 2003). Thus, tying training programs and quality improvement activities to data on access and outcomes by race might ensure compliance by health care institutions with federal civil rights standards.

In short, developing health-care-related Title VI standards for racial and ethnic minority patients similar to the LEP standard should be feasible. Such standards could establish goals aimed at eliminating health care disparities and allow providers to show compliance with those goals by collecting, analyzing, and publishing data. This approach borrows heavily from the methods developed for measuring improvements in health care quality now widely accepted by providers and purchasers alike.

Developing such policies would be complex, but no less so than creating any performance measurement system that is valid, reliable, and reasonably calculated to measure the desired conduct, adjusted to control for individual cases. Given systems for collecting information by racial and ethnic origin, providers can adapt systems for measuring quality to those measuring progress in reducing racial disparities. This approach would acknowledge the basic link between civil rights law and efforts to remedy racial disparities through health care financing.

The Law of Health Care Quality

For decades, civil rights law has “owned” the concept of racial disparities; indeed, the concept of disparity in treatment originated in civil rights theory and practice. Racial disparities as a distinct concept in health quality, in contrast, first

loomed large in the late 1990s as part of a deliberate effort by the Clinton administration to broaden the legal and policy approach to race in health care. This new paradigm has gained sufficient momentum so that the Bush administration has continued to emphasize racial disparities as a separate and independent measure of health quality, albeit by softening the language about the effects (or extent) of disparities in its reports to Congress (Geiger 2004).

In reconceptualizing racial disparities as an independent measure of health quality, federal officials have succeeded in accomplishing what two generations of civil rights legal advocacy could not: framing evidence of racial disparities as related not only to legal discrimination but to poor quality. This reframing has not only expanded public understanding of the problem, but also served to minimize the need to distinguish between economic and racial factors, a necessary step in using civil rights law as legal leverage over the health care system. Disparities in health care have become an all-important component of the growing effort to identify formal interventions aimed at promoting health care quality. Research suggests a focus on three distinct areas: health care management and practice (staff privilege rules, clinical program affiliations, training programs, and participation in public insurance programs), the process of care (staff training and education and clinical practice style), and clinical outcomes and consumer experiences. Of particular importance, in our view, is broadening the avenues into and through care and the nature of health professionals who achieve formal status and influence. In view of the link between the physician-patient relationship and health quality, public programs could link institutional eligibility for training funds to race-conscious admissions policies, as permitted by the Supreme Court in 2003. Also important could be incorporating cultural training into education curricula, as it appears to influence the quality of clinical care (Betancourt 2003).

As with a civil rights approach, enforcing the law of quality could entail both regulations and incentives. Enforcement of a quality-based model could occur through not only federal payers (Medicare, Medicaid, and the Children's Health Insurance Program) but also state payers (and regulatory and licensure agencies) and even public and private employers. The latter could include private employer-sponsored health plans and public employee plans for both civilian and military workers, such as the Federal Employees Health Benefits Program, which can achieve similar results through contractual specifications.

A health quality agenda for reducing racial disparities requires widespread acceptance of the need to collect and publish much more extensive data on patients' race, payer, and income. The health care system has ferociously resisted collecting such data in a civil rights context, so these efforts do not exist outside of a few Medicare reporting systems. Indeed, one of the best-known pieces of civil rights litigation stemmed from the secretary of Health and Human Services' unsuccessful effort to mandate a collection system (Rosenbaum, Markus, and Darnell 2000).

The world of health quality has no equivalent to *Sandoval*. No court has ruled that individuals cannot sue over quality of care and medical negligence, and basic common law principles could form the foundation for medical tort claims under

state law (Rosenblatt, Law, and Rosenbaum 1997). Extending confidentiality to information collected for studying racial disparities could address this legal exposure, just as the law protects information stemming from medical peer review (Marchev 2003).

Achieving consensus on the use of law and policy to encourage efforts to reduce racial disparities would be difficult, but the discomfort caused by this debate only underscores its importance. Ideally U.S. mores, preferences, attitudes, and beliefs would be free of racial overtones. But despite decades of progress, race remains very much alive in the American consciousness and national experience. Thus race in all its complexity must continue to play a central role in the U.S. health policy debate, no matter how painful the discussion or complex the policy response. In our view, belief in simpler solutions such as better insurance coverage and more patient choice overlooks more than two centuries of history as well as a litany of studies showing that race really matters. The sooner the nation actively adopts the goal of reducing disparities in health care policy and practice, the stronger the health care system will be.

Notes

1. A comprehensive treatment of race and health policy would focus not only on medical care but also on the inequalities in health determinants that underlie disparities in health (Bobinski 2003).
2. *Brown v. Board of Education*, 347 U.S. 483 (1954); *Simkins v. Moses H. Cone Memorial Hospital*, 323 F.2d 959 (4th Cir. 1963).
3. *Alexander v. Sandoval*, 532 U.S. 275 (2001).
4. *Grutter v. Bollinger*, 123 S. Ct. 2325 (2003).
5. Healthcare Equality and Accountability Act, S. 1833; H.R. 3459 (108th Cong., 1st sess., 2003).
6. *The T. J. Hooper*, 60 F. 2d 737, 2d Cir. (1932).

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