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RACIST HEALTH CARE?

Barbara A. Noah*

During the past few years, rationing has become an explicit feature in decisions concerning optimal delivery of health care services, and it poses difficult choices for health care providers and policymakers. Insurers and patients increasingly must balance the desire for access to every possible treatment against concerns about affordability. Cost-driven treatment decisions are becoming an unavoidable reality for most patients. Apparently, however, another more pernicious type of rationing occurs in this country. It does not depend on factors such as the likelihood of an optimal outcome, the comparative efficacy of different available treatment modalities, or even the ability to pay for care. Instead, a growing body of evidence suggests that the race of a patient may adversely affect the quantum and quality of health care provided to minority patients. Although no one has identified overt racism by providers, such inequities in the delivery of health care services pose serious problems.

This essay describes racial disparities in three separate health care contexts: the utilization of Medicare services, the selection of recipients for cadaveric organ transplantation, and the representation of racial and ethnic minority groups in clinical research. The essay then suggests ways in which medical educators, health care providers, and government agencies can work to address these disparities in care, and it explores possible constitutional and statutory remedies for the victims of disparate treatment. Ultimately, the medical establishment must face up to the possibility that African-American patients do not receive equal treatment in the health care system.

A study recently published by a team of investigators affiliated with the Health Care Financing Administration (HCFA) presents startling evidence of racial inequities in the delivery of health care services.1

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1. See Marian E. Gornick et al., Effects of Race and Income on Mortality and Use of

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Although previous studies have examined the utilization of health services among different racial groups, the studies often used race as a surrogate for socioeconomic status. Thus, these studies frequently attributed differences in the quality and quantity of care afforded to minority patients to disparities in income. The HCFA study represents one of the first attempts to control for income among different populations, allowing the investigators to identify variations in the utilization of health care services based on race alone.

The HCFA investigators used Medicare administrative data from 1993 concerning more than 26 million beneficiaries, combined with Census data on estimated household income, to determine whether and to what extent race and income affect the utilization of health care services and mortality. The investigators focused on four categories of health services: first, visits to physicians for ambulatory care and hospital discharges; second, hospitalizations for ischemic heart disease, coronary-artery bypass surgery, and a type of coronary angioplasty; third, mammographies (an elective Medicare service) and hip-fracture repairs (a non-elective Medicare service); and, fourth, the amputation of a lower limb and bilateral orchiectomy.

The data identified significant differences in rates of utilization of health care services and mortality between white and African-American patients. Among the HCFA study's findings, African-American men were 19% more likely to die than white men (after adjusting for age and gender only). After adjusting for income, the ratio did not change

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_Services Among Medicare Beneficiaries_, 335 New Eng. J. Med. 791, 797-98 (1996) (stating that "blacks and lower income white beneficiaries" of Medicare may be receiving poorer quality of care than "white or more affluent beneficiaries"). The authors note, however, that the opinions expressed in their article do not necessarily reflect those of HCFA. See _id._ at 798.

2. _Id._ at 792.


4. See Gornick et al., _supra_ note 1, at 792.

5. _Id._ An editorial accompanying the study suggests a pair of methodological weaknesses: the investigators relied solely on Medicare administrative data because they lacked access to detailed medical records, and they used aggregated rather than individual income data. See H. Jack Geiger, _Race and Health Care—An American Dilemma?_, 335 New Eng. J. Med. 815, 815-16 (1996).

6. See Gornick et al., _supra_ note 1, at 792. Bilateral orchiectomy involves the surgical removal of the testicles to treat metastatic prostate cancer.

7. _Id._ at 793.
dramatically; African-American men were still 16% more likely to die than white men. African-American women were 16% more likely to die than white women and adjusting for income made no difference among the women. After adjusting for income, African-American women were 25% less likely to have mammograms than white women, and African-American patients of both sexes were 7% less likely to visit physicians for ambulatory care.

The data also suggested a tendency of health care providers to pursue less aggressive therapies for African-American patients who did seek medical care. Certain types of procedures were performed less frequently on African-American patients than on white patients, even after income adjustment. For example, white patients were at least twice as likely to undergo a type of coronary angioplasty, coronary-artery bypass surgery, and hip repair surgery. In contrast, other procedures were performed more frequently among African-American patients. After adjusting for income, African-American patients were over three times more likely than white patients to have a partial or total amputation of the leg, and they were more than twice as likely to undergo bilateral orchiectomy as a treatment for prostate cancer. Significantly, in most of these comparisons, adjustments for income differentials did little to diminish the racial disparities. The greatest effects of income adjustments occurred in the figures for mammography and visits to

8. Id. at 794.
9. Id. at 793.
10. Id. at 794.
11. Id.
12. Id. at 797-98.
13. Id. at 797 tbl.2. The authors concluded, however, that, with regard to hip fracture repair and other non-elective procedures, the rates did not suggest any racial inconsistencies because osteoporosis in the femur is 2.4 times more frequent among white women than African-American women over the age of 50. Id. at 798.
14. See id. at 797 tbl.2. “Diabetes is only 1.7 times as prevalent in elderly [African-American] persons as in whites, however, which suggests that the difference in the rates of amputation [of a lower limb] is not entirely explained by the difference in the prevalence of diabetes.” Id. at 791. As with the data on hip fracture repair, the data on bilateral orchiectomy may suggest a disparity that does not really exist because African-American men have 2.2 times the rate of metastatic prostate cancer as white men. Id. at 792. However, other troubling disparities, such as lower rates of access to primary and preventive care among African-Americans, may contribute to the differing rates of this advanced form of prostate cancer. See id. at 798 (discussing the reasons why African-Americans may suffer from higher rates of chronic diseases).
15. See id. at 794-95, 797 tbl.2. After adjusting the mortality and health services utilization rates for income-related differences, the investigators found that racial differences diminished somewhat but that the overall effect of the income adjustment was relatively insignificant. Id. at 791.
physicians for ambulatory care. For example, among the least affluent African-American women, the mammography rate was 39% lower than among the most affluent African-American women.

Of course, differences in access to, or the utilization of, preventive care over a patient’s lifetime may account for some of the observed disparities in mortality rates and choice of treatments. Once patients become eligible for Medicare at age 65, these differences in health status may be irreversible. The data may also simply reflect differences in the relative health status of the patients in the two groups. The data do not directly indicate that physicians or insurers provide suboptimal medical care to minority patients.

Even so, because the studied population shares a common insurer, Medicare, and thus enjoys uniformity of coverage for the services analyzed, the conclusions of the HCFA study deserve serious consideration. This absence of an “insurance discrimination” factor (whereby under-insurance may account for observed differences in treatment), together with the adjustment for income among the white and African-American patients studied, strongly underscores the significance of the findings. The HCFA study clearly demonstrates that equal health insurance by itself does not ensure equal care.

A variety of unconscious, and largely unprovable, factors may affect health care decisions for minority patients. For example, treating physicians may “give up” earlier on their African-American patients, either by concluding that certain treatments will be unavailing or by resorting to drastic solutions late in the disease process. Health care

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16. See id. at 794-95 (adjusting statistical differences between African-American and white patients for disparity in income).
17. Id. at 795.
18. Id. at 797-98. The authors of the HCFA study suggest that a variety of factors, such as educational, cultural, and behavioral variations, differences in supplementary insurance, and the availability of services, also may contribute to racial disparities in health care. Id. at 798; see also Jan Blumstein & Beth C. Weitzman, Access to Hospitals with High-Technology Cardiac Services: How Is Race Important?, 85 AM. J. PUB. HEALTH 345, 346-50 (1995) (discussing the relative scarcity of high-technology health care facilities in predominantly African-American neighborhoods, and noting that African-American patients may be less likely to travel to such facilities to receive high-quality care); Council on Ethical & Judicial Affairs, Am. Med. Ass’n, Black-White Disparities in Health Care, 263 JAMA 2344, 2344 (1990) (noting that African-Americans are more likely to require health care but are less likely to receive it).
19. The study reported only aggregated data. Gornick et al., supra note 1, at 792. Disaggregating the data may reveal additional useful information. For example, if the rates of usage remain consistent across doctors and institutions, this would suggest a systemic problem. However, if more pronounced treatment disparities appear at certain institutions or in certain regions of the country, the possibility of conscious discrimination at some facilities becomes more compelling.
providers sometimes may decide that simplicity or utility more readily dictates a decision to resort to drastic solutions; for example, a provider may perform a lower limb amputation in the case of diabetic complications rather than leg-sparing vascular surgery to improve circulation. Health care providers also may decide to pursue less aggressive, non-surgical therapies, such as medication and dietary changes, in the case of coronary illness among African-American patients. Physicians’ treatment decisions may reflect some unstated prejudices—negative or pessimistic assumptions about their African-American patients’ family support networks, dietary practices, or adherence to recommended post-treatment care regimens. In this sense, unconscious racism may be one factor that perpetuates the cycle of poorer health among African-Americans when compared to the white population.

In addition to the possibility of individualized prejudices, unconscious racism may appear at an institutional level as well. In this era of cost-consciousness, hospitals and insurers have created complex guidelines to limit the care that patients receive. For example, an insurance plan that refuses reimbursement for an elective procedure if the patient has received less than optimal management of his or her disease may negatively impact minority patients, who tend to have less access to care overall. Although these guidelines certainly are not race-based, they may perpetuate the prevalence of certain conditions among minority patients. As noted above, a variety of factors other than unconscious discrimination contribute to this problem: African-Americans tend to make fewer visits to physicians for ambulatory care than white patients, and they often seek initial care at later stages of disease than white patients. Low incomes appear to exacerbate these problems, but the HCFA study has demonstrated that differences in income alone do not fully account for observed disparities in health care

20. Many people who have learned racist attitudes as children may decide to discard these attitudes as adults, but they may not succeed in keeping unconscious attitudes from affecting their decisionmaking, making prejudicial decisions despite their own best efforts. See, e.g., Edward P. Boyle, Note, It’s Not Easy Bein’ Green: The Psychology of Racism, Environmental Discrimination, and the Argument for Modernizing Equal Protection Analysis, 46 VAND. L. REV. 937, 939 (1993).

21. See id. (“Institutional racism occurs when the group in power structures its social institutions so as to maintain its dominance over other groups.”).


23. See Gornick et al., supra note 1, at 793 (noting that in 1993 African-American Medicare beneficiaries made 7.2 visits per person to physicians for ambulatory care compared with 8.1 visits per person among white patients).
delivery. Institutional policies may reflect unconscious biases or, at the very least, a lack of concern for existing disparities.

Racial inequities appear in a variety of other health care contexts. Recent statistics suggest some disparities in the rationing of expensive, lifesaving procedures and technology. In the area of organ transplantation, for example, demand far exceeds supply, and the debate continues about how best to distribute organs available for transplant. In 1984, Congress created the Organ Procurement and Transplantation Network (OPTN). The United Network for Organ Sharing (UNOS), a private non-profit organization, operates OPTN under contract with the federal government. UNOS coordinates procurement and allocation functions and also works to develop equitable policies for organ distribution.

For a variety of reasons, African-American patients wait longer to obtain kidney and other organ transplants than white patients. In part, organ donation rates by African-Americans have lagged behind the rest of the population, although donations among African-Americans recently have increased. Because white donors continue to account for most organ donations, the number of organs available for minorities is limited where immunologic matching is deemed essential. In addition,

24. See id. at 794-95.
28. See id. (discussing the duties that Congress mandated UNOS perform).
30. See Stuart Auerbach, Organ Donations by Minorities Rise: Blacks' and Hispanics' Rates Now Nearly Equal Population Share; Asians' Up Sharply Too, Wash. Post, Feb. 27, 1996, at 7 (Health Section) (noting that African-Americans donated 11.5% of the 5100 organs that were donated in 1994, which represented only slightly less than this group's 12.1% share of the population).
31. See Khauli, supra note 25, at 1231-32 (stating that the long waiting time for organ transplants by minorities may be in part due to the assumption that "universal benefit will result from better matching").
demand for transplants may be higher for racial minorities. For instance, African-Americans constitute 12% of the population in the United States but account for 34% of persons suffering from end stage renal disease (ESRD).\textsuperscript{32} The confluence of these supply and demand factors results in longer waiting times for racial minorities.\textsuperscript{33} African-Americans recently accounted for approximately one-third of patients on the waiting list to receive kidneys.\textsuperscript{34}

The emphasis on obtaining better results through close or exact tissue-matching helps to explain some of the disparities. Generally, donated organs are allocated to medically qualified candidates using a point system that takes into account patient proximity. The current policies also permit variances to the point system and allow alternative local organ distribution units to be established subject to OPTN approval.\textsuperscript{35} For kidneys, livers, and pancreata, potential recipients are ranked with points allocated to reflect different criteria, including blood type, histocompatibility, sensitivity of the patient to transplantation, degree of urgency, and waiting time.\textsuperscript{36}

In the case of kidney transplantation, UNOS has developed a prioritization system that relies heavily on HLA antigen matching to determine which patients will receive kidneys as they become available.\textsuperscript{37} This policy establishes point values for the quality of antigen matches, strongly favoring a lack of mismatches.\textsuperscript{38} The current system significantly curtails access by African-Americans to cadaveric kidneys because the likelihood of a perfect HLA match is very low when matching white donors with African-American recipients.\textsuperscript{39} The recent increase in African-American donors will ameliorate this problem somewhat, but, as noted above, African-Americans constitute a disproportionately large percentage of ESRD patients awaiting transplant. Increased kidney donation rates among minorities will not fully

\begin{thebibliography}{9}
\bibitem{32} Gaston, supra note 27, at 1354.
\bibitem{33} Khauli, supra note 25, at 1231-32.
\bibitem{34} See Gaston, supra note 27, at 1352 (stating that 31% of the people on waiting lists for a kidney are African-American).
\bibitem{35} 59 Fed. Reg. 46,482, 46,486-87 (1994) (to be codified at 42 C.F.R. \textsection{} 121) (proposed Sept. 4, 1994). For example, alternative local organ distribution units might be permitted to develop interregional or intraregional organ sharing arrangements. \textit{Id.}
\bibitem{36} \textit{Id.}
\bibitem{37} Gaston, supra note 27, at 1353.
\bibitem{38} See \textit{id.} ("Enhanced gift survival for [HLA] matched recipients ... was determined to outweigh all other claims on a donated organ and to justify the excess cost and effort required to transport kidneys on a national level.").
\bibitem{39} See \textit{id.} at 1354 ("[T]here will always be white patients who match the donor population better than [African-American] patients.").
\end{thebibliography}
meet the needs of the African-American patients at any time in the near future.

Physicians and medical ethicists have expressed concerns about the criteria used to determine which patients will receive organs for transplantation. In particular, the emphasis on tissue matching for kidney allocation has attracted significant criticism. The preference for a perfect antigen match in kidney transplantation appears unnecessary in this era of highly efficacious anti-rejection drugs such as cyclosporine. Physicians question the heavy emphasis on perfect HLA matching, suggesting that the relatively small gains in successful outcomes do not justify the disparate impact of such policies on African-American transplant candidates. One group of commentators argue that the emphasis on HLA matching unjustly disfavors interracial transplantation, noting that white dialysis patients are more than twice as likely as African-American patients to receive a kidney allograft. They contend that enhanced transplant survival for perfectly matched kidneys does not necessarily outweigh other factors relevant to the selection process such as age and waiting time. These commentators suggest explicitly offsetting the racial disparities that result from the HLA matching system by awarding points to African-Americans to compensate for points accumulated by caucasians on the basis of HLA matching.

Although successful transplantation obviously represents the primary goal, the federal statute directs OPTN to allocate organs "equitably among transplant patients" and "in accordance with established medical criteria." Overemphasis on improving outcomes does not promote equitable allocation and also makes little financial sense. The costs associated with preserving and transporting perfectly matched kidneys to more distant locations outweigh the medical costs saved through

40. See id.
41. See id.
42. Id. at 1352 (8.3% versus 3.9%). "At the University of Alabama at Birmingham (with a waiting list [for kidney transplantation] that is 65% [African-American]) only one of 33 kidneys . . . received as part of the [perfect] antigen-match program has been for [an African-American] patient." Id. at 1353.
43. See id. at 1354 (noting that, although a clear correlation exists between HLA match and outcome in transplantation from living donors, the benefits of a perfect HLA match in cadaveric transplants is less clear).
44. Id. at 1355. Of course, before tissue matching can begin, the patient must meet specified medical criteria to gain access to the transplant waiting list. One study found that in the southeastern United States, physicians refer African-American patients for transplantation less frequently than white patients. See J. Michael Soucie et al., Race and Sex Differences in the Identification of Candidates for Renal Transplantation, 19 AM. J. KIDNEY DISEASES 414, 414-17 (1992).
fewer retransplantations or returns to dialysis.\textsuperscript{46} In addition to reducing the disparate impact on minority transplant candidates created by the current preference for perfect matches, a system that combines partial matching with a regional hierarchical approach may prove more cost effective.\textsuperscript{47}

The conflict between concerns about transplant efficacy and distributive justice continue in the area of organ transplantation. In 1996, the federal government held a public forum to discuss proposed changes to policies for allocation of livers and to patient listing criteria for liver, kidney, and kidney/pancreas transplants.\textsuperscript{48} Under rules proposed in 1994, the OPTN would consider somewhat different criteria during the organ allocation process. In addition to considering established medical criteria and length of time on the national waiting list, OPTN would be charged with the task of developing policies that more effectively take into account potential recipients whose immune systems make it difficult for them to receive organs, thereby seeking to minimize organ wast­age.\textsuperscript{49} However, the proposed rules have not been finalized.

Certain clinical research practices play a role in perpetuating racial and gender inequities in health care. For instance, new drug trials and other types of biomedical research frequently fail to include subjects from minority groups.\textsuperscript{50} The desire to simplify and streamline such research has led investigators to prefer homogenous patient populations for virtually all studies.\textsuperscript{51} Before the National Institutes of Health (NIH) issued a directive in 1990, new drug investigations almost uniformly tested drugs only on white male subjects, excluding women and

\begin{itemize}
\item \textsuperscript{46} See David W. Gjertson et al., National Allocation of Cadaveric Kidneys by HLA Matching: Projected Effect on Outcome and Costs, 324 NEW ENG. J. MED. 1032, 1034-35 (1991) (stating that a hierarchical HLA matching system would not increase costs and would increase overall survival rates if the hierarchical system replaced the present absolute HLA matching system).
\item Id. at 1035.
\item Id. at 1035.
\item Id. at 1035.
\item \textsuperscript{47} Id. at 1035.
\item \textsuperscript{49} 59 Fed. Reg. 46,482, 46,497 (1994). In discussing the proposal, the PHN notes that organ allocation poses difficult issues:
\item \textsuperscript{50} Rebecca Dresser, Wanted: Single, White Male for Medical Research, HASTINGS CENTER REP. Jan.-Feb. 1992, at 24, 24.
\item \textsuperscript{51} Id. at 25.
\end{itemize}
members of other races.\textsuperscript{52} The 1990 policy requires that applicants for clinical research grants either include women and minorities in their studies or provide a ""clear and compelling rationale"" for failing to include these groups.\textsuperscript{53} The NIH policy finally recognized that using a homogenous research population may provide little therapeutic benefit for persons outside that population when a treatment becomes generally available. The Food and Drug Administration (FDA) also has tried to address the issue through product approval guidelines that apply whether or not the clinical trials receive NIH funding.\textsuperscript{54}

Although researchers offer a number of possibly valid reasons for excluding women from clinical studies—including concerns about harm to fertile women who may become pregnant, and complications posed by the female hormonal cycle—\textsuperscript{55} no such justifications exist for excluding African-Americans and other minorities from biomedical research populations. On the contrary, scientific research has documented the wide variation of the pharmacokinetic effects of drugs across racial and ethnic lines.\textsuperscript{56} One cannot, therefore, safely extrapolate from

\textsuperscript{52} Id. at 24.

\textsuperscript{53} Id. (quoting NIH, Priority Announcement, Special Instructions to Applicants Using Form PHS 398 Regarding Implementation of the NIH/ADAMHA Policy Concerning Inclusion of Women and Minorities in Clinical Research Study Populations, Dec. 1, 1990).

\textsuperscript{54} See 60 Fed. Reg. 46,794 (1995) (to be codified at 21 C.F.R. §§ 314, 316) (proposed Sept. 8, 1995) (proposing rule that would require manufacturers seeking new drug approval to submit safety and efficacy data reflecting breakdown according to gender, age, and racial subgroups (in addition to aggregate data), but that would not require inclusion of these groups in clinical trials); 58 Fed. Reg. 39,406, 39,408 (1993) (summarizing a guideline concluding that the exclusion of women from early clinical trials is not medically necessary since the risk of fetal exposure can be minimized by patient behavior and laboratory testing); see also Lars Noah, \textit{Constraints on the Off-Label Uses of Prescription Drug Products}, 16 J. PROD. & TOXICS LIAB. 139, 139-40 (1994) (describing the prevalence of off-label prescribing by physicians, necessitated by limitations in clinical testing, and the FDA's regulatory responses).

\textsuperscript{55} See Joan W. Scott, \textit{How Did the Male Become the Nonnative Standard for Clinical Drug Trials?}, 48 FOOD & DRUG L.J. 187, 187 (1993) (describing two contradictory assumptions that have contributed to this phenomenon: that women are identical to men so that female participation in drug trials is unnecessary, and that women are so unlike men that female participation in drug trials would destroy the purity of the experiment).

\textsuperscript{56} See Paul Cotton, \textit{Is There Still Too Much Extrapolation from Data on Middle-aged White Men?}, 263 JAMA 1049, 1049-50 (1990) (stating that, although different races may respond differently to the same drug, white men still are preeminently used in drug testing); Craig K. Svensson, \textit{Representation of American Blacks in Clinical Trials of New Drugs}, 261 JAMA 263, 264-65 (1989) (concluding that, because investigators do not adequately account for racial differences as a source for variability in drug research results, insufficient data exist to assess the safety and efficacy for the African-American population of many drugs currently on the market); Hong-Hao Zhou et al., \textit{Racial Differences in Drug Response: Altered Sensitivity to and Clearance of Propranolol in Men of Chinese Descent as Compared with American Whites}, 320 NEW ENG. J. MED. 565, 566-68 (1989) (concluding that Chinese men have greater
data based on white males to others in the population. In fact, the risks to women and minorities who make an informed choice to participate in closely monitored and controlled research are more justifiable than the greater risks associated with the use of approved drugs or treatments, untested in these populations, on a widespread basis. Some have suggested that decisions to exclude women and minorities from biomedical research reflect an assumption that white males most deserve the benefits that this research produces. Furthermore, diseases that affect a disproportionately large number of women or minorities historically have received low research funding priority.

Prospective solutions to the problem of racial disparity in health care delivery will likely be more effective at raising awareness of and prompting response to the problem. An editorial accompanying the HCFA study makes a number of suggestions about how the medical community should respond to the evident racial inequities in the delivery of health care services. Dr. Jack Geiger, of the City University of New York Medical School, concludes that, after controlling for the "major confounding variables . . . investigators tend to invoke unspecified cultural differences, undocumented patient preferences, or a lack of information about the need for care as reasons for the differences. The alternative explanation is racism—that is, racially discriminatory rationing by physicians and health care institutions." In response to these findings, Dr. Geiger suggests that hospitals incorporate into their quality assurance protocols an ongoing evaluation and monitoring of racial disparities in the provision of services. He also urges medical schools to train students about issues surrounding race and health care, including courses designed to increase sensitivity and improve understanding of diverse ethnic groups. In addition, physicians already in

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sensitivity than white men to the effects of the drug on heart rate and blood pressure); see also The 1984 Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure, 144 ARCH. INT. MED. 1045, 1054 (1984) (noting that, although African-Americans suffer from a higher incidence of hypertension, certain ACE inhibitors are less effective in treating this condition among African-Americans than in the white population).

57. See Dresser, supra note 50, at 26 (describing a study in which the "normal" dosage of Lithium for white males was found to be frequently toxic for African-American patients).
58. Id. at 28.
59. Id. at 26.
60. Geiger, supra note 5, at 816.
61. Id.
62. Id.
63. See id. (noting that in one study only 13 out of 78 medical schools offer such courses and that "all but one of those courses were elective").
practice can educate their peers about these issues through continuing medical education programs.

Regulatory agencies also can play a role in focusing attention on the problem of racial inequalities in the health care system. HCFA might require more careful utilization review methods designed to identify and correct any observed racial inequities in the delivery of Medicare services. Similarly, UNOS, which already has demonstrated some awareness of the problem, will no doubt continue to gather information and shape its allocation policies in a manner that promotes sensitivity to race issues in the transplantation process. By carefully monitoring compliance with its 1990 directive, NIH can reduce or eliminate underrepresentation of minorities and women in clinical trials. Taken together, these approaches might close the gap in access to health care and, eventually, in the comparative health status of caucasian and minority patients.

Although the medical community must take steps to prevent racial bias in the delivery of health care services, victims of existing inequities may wish to pursue certain legal remedies. Title VI of the Civil Rights Act of 1964 provides the most promising federal statutory avenue for dealing with racial discrimination in health care delivery. In enacting Title VI, Congress prohibited any entity that opts to receive federal financial assistance from discriminating on the basis of race in providing goods or services to the intended beneficiaries of the federal program. Because federal financial assistance includes Medicare and Medicaid funds and nearly every hospital and nursing home in the United States receives such funds, Title VI applies to the majority of health care institutions.

The United States Supreme Court has held that Title VI prohibits both intentional discrimination and disproportionate adverse impact.


65. See 42 U.S.C. § 2000d (1994) (“No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”).


67. See Lau v. Nichols, 414 U.S. 563, 569 (1974) (“Simple 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.” (quoting 110 Cong. Rec. 6543 (1964) (statement of Sen. Humphrey quoting from President Kennedy’s June 19, 1973 message to Congress))). In a later case, the Court held that, although Title VI itself prohibits only intentional discrimination, the implementing regulations authorize disproportionate adverse impact claims. Alexander v. Choate, 469 U.S. 287, 293 (1985).
The statute is enforced primarily by the administrative agencies that provide the federal funding. The regulations implementing Title VI grant to federal agencies the power to terminate funding to any recipient that violates the nondiscrimination requirement. The implementing regulations specifically state that facially neutral policies that have a disproportionate negative impact on racial minorities violate Title VI even if no discriminatory intent exists, and administrative agencies have consistently concluded that the regulations implementing Title VI prohibit policies that have a disproportionate adverse impact on minorities.

Even so, Title VI only prohibits those inequities that arise from the application of facially neutral policies. Title VI does not prohibit racial inequities whenever they occur. Thus, the difficulty lies with pinpointing the policy creating the disproportionate impact. HCFA might argue, on the basis of its recent study, that discriminatory criteria in the health care decisionmaking process impede the Medicare program’s goal of providing consistent, high quality care to all beneficiaries. HCFA will find it difficult, however, to identify precisely which policies are causing the disproportionate impact. In contrast, federal agencies can more readily identify policies causing disparate racial impact in the allocation of kidneys for transplant and in clinical research.

Individual litigation under Title VI offers less promise. The Supreme Court has held that a private right of action under Title VI exists only in limited circumstances. In a private suit, the plaintiff may secure equitable relief if able to prove intentional discrimination. The Court has not, however, clearly answered the question of whether similar relief might be available where the plaintiff can only prove the disparate impact of a facially neutral policy. Lower courts faced with challeng—

68. See 42 U.S.C. § 2000d-1 (providing an opportunity for a hearing prior to termination of federal financial assistance based on a violation of Title VI or its implementing regulations).
69. See 45 C.F.R. § 80.3(b)(2) (1996) (prohibiting activities that impair agency objectives with regard to race, color, or national origin).
70. Watson, supra note 66, at 948. Title VI regulations prohibit “criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color, or national origin.” 45 C.F.R. § 80.3(b)(2).
71. See Guardians Ass’n v. Civil Servo Comm’n, 463 U.S. 582, 593-95 (1983) (White, J., plurality opinion).
72. In Guardians Association, the Court held that Title VI required only proof of disparate impact (and not discriminatory intent) where the plaintiff seeks declaratory and injunctive relief, rather than money damages. In a plurality opinion, three of the five Justices concluded that, although Title VI itself required proof of intent to discriminate, the regulations promulgated under Title VI did not require proof of intent but were nonetheless valid. See id. at 642-45
es to hospital closings and relocations have utilized a rational basis test, which makes defending Title VI discrimination claims relatively easy for health care entities. Courts have upheld such actions even where plaintiffs have suggested less discriminatory alternatives. The lack of rigorous scrutiny in Title VI litigation creates significant barriers to challenging policies that have a disproportionate impact on minorities. Plaintiffs will prevail under this standard only if they can prove that the challenged policies are arbitrary and fail to advance any legitimate purpose.

One commentator has suggested strengthening the standard of review for Title VI challenges. Under the proposed approach, the defendant would have to demonstrate that the challenged policy significantly furthers an important purpose. Courts would be required to give more consideration to the availability of less discriminatory alternatives as proof that the interests behind the challenged policy are insufficient to justify its disparate racial impact. Unless the courts accept such an approach, however, administrative agencies will shoulder most of the responsibility for enforcing Title VI in the health care arena. To date, they have not done so.

In addition to statutory rights of action, patients who have suffered disparate treatment based on their race might consider an equal protection challenge. Interesting parallels exist between health care discrimination and recent scholarship suggesting constitutional approaches to what has been characterized as "environmental racism." As it

(Stevens, J., dissenting). Two Justices concluded that proof of discriminatory intent was not required as an element in establishing a Title VI violation. See id. at 592-93 (White, J., plurality opinion); id. at 623 (Marshall, J., concurring in part and dissenting in part). See generally RODNEY A. SMOLLA, FEDERAL CIVIL RIGHTS ACTS § 8.02[3], at 8-9 to 8-10 (3d ed. 1994).

73. See NAACP v. Medical Ctr., Inc., 657 F.2d 1322, 1333-34 (3d Cir. 1981) (noting that, even if plaintiffs had presented a prima facie case of disparate impact, defendants need only present evidence of an acceptable reason but are not required to show absence of discriminatory motive).

74. See Bryan v. Koch, 627 F.2d 612, 617-19 (2d Cir. 1980) (holding that Title VI does not require federal fund recipient to consider alternatives to the closing of a public health facility if the criteria used to make the decision are reasonably related to a goal such as cost savings). Judge Kearse urged the court to engage in a two-pronged evaluation of the agency action: (1) examine the process by which the decision was reached and (2) then inquire into the substantive merits of the decision. Id. at 623 (Kearse, J., concurring in part and dissenting in part).

75. See Watson, supra note 66, at 976; see also Amy Jurevic, Disparate Impact Under Title VI: Discrimination, By Any Other Name, Will Still Have the Same Impact, 15 ST. LOUIS U. PUB. L. REV. 237, 264 (1996) (proposing that, once the plaintiff makes a prima facie case of disparate impact, the disparate impact must be sufficiently justified).

76. Watson, supra note 66, at 976.

77. For example, recent articles have suggested that environmental racism impacts decisions such as siting of toxic dumps and cleanup efforts but conclude that equal protection
currently exists, however, equal protection analysis may not provide a workable remedy for existing health care disparities. First, plaintiffs will encounter difficulty demonstrating the necessary "state action" if their complaint centers around the decision of a provider not to pursue a particular course of treatment. The receipt of federal funding triggers statutory obligations but does not necessarily constitute state action, as required by the Fourteenth Amendment. 78 In all three of the contexts presented above—Medicare services, kidney allocation, and clinical trials—plaintiffs will find it difficult to prove state action.

Second, plaintiffs cannot easily prove discriminatory intent. If a plaintiff cannot prove an intent to discriminate, courts will simply examine whether the government had a rational basis for its actions, rather than reviewing the actions under a strict scrutiny standard. 79 Clearly, discrimination can exist without proof of invidious intent, but not all documented inequities across racial lines constitute discrimination. Intent in the equal protection context embodies ideas of willfulness and morally reprehensible motivation.

Thus, as with statutory rights of action, constitutional challenges seem unavailing. No matter how compelling the evidence of racial inequities in the health care context, nothing convincingly suggests a pattern of widespread intentional discrimination. Even so, disparate health treatment decisions that do not result from poor preventive care, or from a patient's presenting a more acute condition, may well arise

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78. See, e.g., Blum v. Yaretsky, 457 U.S. 991, 1011-12 (1982) (finding no state action by a nursing home even though the bulk of its activities were financed by state Medicaid program); Rendell-Baker v. Kohn, 457 U.S. 830, 840-41 (1982) (finding no state action by a private school even though the bulk of its funding was received from the state); see also Moose Lodge No. 107 v. Irvis, 407 U.S. 163, 176-77 (1972) (holding that pervasive regulation of an activity does not by itself constitute state action).

79. See, e.g., Washington v. Davis, 426 U.S. 229, 244-45 (1976) (holding that plaintiff was required to prove discriminatory intent); United States v. Yonkers Bd. of Educ., 837 F.2d 1181, 1216 (2d Cir. 1987) ("[T]o prove a claim of discrimination in violation of the Equal Protection Clause a plaintiff must show not only that the state action complained of had a disproportionate or discriminatory impact but also that the defendant acted with the intent to discriminate.").
from unconsciously biased decisions on the part of health care professionals.\textsuperscript{80} Given these complexities, it may be appropriate to reconsider the current equal protection analysis requirement that plaintiffs prove intentional discrimination.\textsuperscript{81} Socioeconomic factors explain only a portion of the racial disparities that exist in health care delivery. Recognition of these disparities, whatever their source, demands a swift response. The medical and legal communities must begin to address differences in the rate at which certain medical procedures are performed, organ allocation policies that create racial disparities in the rate of transplantation, and the failure to include historically underrepresented groups in clinical research. Existing legal remedies will provide little recourse to the victims of these disparities. Until changes in the relevant statutory and constitutional standards permit a judicial response, government agencies and the medical community must confront the problem at its source, by regulating and educating health care providers and others who control access to care.

\textsuperscript{80} Cf. Vernellia R. Randall, \textit{Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy! An African American Perspective on Bioethics}, 15 ST. LOUIS U. PUB. L. REV. 191, 231 (1996) (discussing the African-American bioethical perspective). Professor Randall concludes that the disparate care received by African-American patients constitutes a more explicit and avoidable kind of racism: “Eurocentric bioethical principles such as autonomy, beneficence, and informed consent . . . leave considerable room for individual judgment by health care practitioners. . . . In a racist society (such as ours), the judgment is often exercised in a racist manner.” \textit{Id}. at 231.

\textsuperscript{81} See Charles R. Lawrence III, \textit{The Id, the Ego, and Equal Protection: Reckoning with Unconscious Racism}, 39 STAN. L. REV. 317, 321-23 (1987) (critiquing the “false dichotomy” between disproportionate impact and intentional discrimination). Professor Lawrence argues that the required proof of discriminatory intent for an equal protection claim ignores the pervasiveness and the profound impact of unconscious discrimination. \textit{See id}. at 324 (arguing that a collective unconscious within the general population is the origin of many discriminatory acts). He proposes a new test that would evaluate governmental conduct “to determine whether it conveys a symbolic message to which the culture attaches racial significance,” in which case strict scrutiny would apply. \textit{Id}. Professor Lawrence’s test would not apply strict scrutiny in those cases where “nonrace-dependent decisions that disproportionately burden blacks only because they are overrepresented or underrepresented among the decision’s targets or beneficiaries.” \textit{Id}. 