Pursuing Racial Justice (Part 2)
Not Separate but Still Unequal: Racial and Ethnic Disparities in Health Care

By Erica R. Berry

An African American woman walked into a hospital emergency room with a suspected broken arm. Interns, who were white, asked the woman to position her arm “like she would have a beer on a Saturday night.” The patient responded, “Do you think I’m a person on welfare?” The interns, in turn, responded, “Well, aren’t you?”

A second African American patient described a similar experience with his primary care physician. When the physician discovered that the patient had diabetes, he said, “I need to write this prescription for these pills, but you’ll never take them and you’ll come back and tell me you’re still eating pig’s feet and everything…. Then why do I still need to write this prescription.” The patient responded, “I don’t eat pig’s feet.”

A Laotian woman in California was diagnosed with tuberculosis. Public health authorities failed to use a Laotian interpreter. As a result of the communication gap, the woman was jailed for months when local law enforcement and public health officials concluded that she would refuse to follow her treatment regiment unless she was jailed.

Unbelievable occurrences such as these are not such a rarity for some racial and ethnic minority patients. Although the days of overt discrimination in health care are nearing eradication, embedded attitudes and feelings toward racial and ethnic minorities continue to result in a denial of equal access to health care services. Nearly a decade ago, CLEARINGHOUSE REVIEW published an article documenting the extent of racial discrimination in America’s healthcare system. Surprisingly and sadly enough, not much progress has been made since then. Over the past ten years, numerous scholars have documented the ongoing existence of racial and ethnic health disparities in all aspects, including access to services, treatment options, health status, and treatment outcomes, of our health care delivery system. However, the documentation fails to show the causes of these disparities between whites and nonwhites. More

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recent studies have attempted to give evidence not only that genetic, behavioral, or cultural factors or all three lead to these differences in health care delivery but also that bias, prejudice, and discrimination play a role.

Racism is interwoven into the fabric of our society and has a demonstrable impact on the delivery of health care in the United States. Unfortunately we cannot detect racism and discrimination as easily as in the past, and the “new and improved” discriminatory methods can be just as harmful to racial and ethnic minorities as the old, overt methods. Factors that create health care inequities, such as bias, prejudice, discrimination, or cultural differences or all of them, must be addressed as part of a multilevel and multifaceted response. Health care advocates must seek to make legal and policy changes that have an impact on all levels of the health care delivery system, from community clinics to the Centers for Medicare and Medicaid Services.

In this article I discuss racial disparities in health care, specifically with regard to health status, access to health care services, and quality of care. I review the barriers, such as lack of racial and ethnic data, that may prohibit us from effective-ly addressing racial and ethnic health care disparities. Next I discuss ways that racial discrimination may manifest itself in health care and what advocates should look for and inquire into in order to identify such discrimination. One of the most difficult tasks facing a health care advocate is being able to discern the differences between health care administrative practices that unfairly have an impact on low-income patients and those practices which intentionally or unintentionally discriminate against racial and ethnic minorities. I discuss last various legal and policy strategies that may be used to address racial and ethnic health care disparities. Due to recent cases, such as *Alexander v. Sandoval*, 532 U.S. 275 (2001) (Clearinghouse No. 51,706), implementing these strategies will be difficult and will require the involvement of not only legal services attorneys but also state and federal policymakers and health officials.

I. Disparities in Health Outcomes and Status
Racial and ethnic groups in the United States continue to experience major disparities in health status. Compared to the majority non-Hispanic white population, racial and ethnic minorities bear a disproportionate burden of mortality and morbidity across a wide range of health conditions. Although the health of all Americans has improved dramatically over the past decades, many aspects of the health status of people of color have failed to experience progress. In 1995 “the overall African-American mortality rate was 60
percent higher than that of whites precisely what it had been in 1950.8 Evidence of racial and ethnic disparities in health care is, with few exceptions, remarkably consistent across a range of illnesses. Many of these disparities are measured in terms of mortality rates, but the conditions contributing to these rates begin early in life and are sustained throughout life. Of all minority groups, African Americans experience the greatest inequities and encounter them from birth to death. The African American infant mortality rate (14 percent) is more than double that of whites (6 percent), while the Native American infant mortality rate (10 percent) is more than one and a half times that of whites.9

According to data from the National Center for Health Statistics, African Americans have higher death rates from coronary disease, breast cancer, and diabetes than do white Americans.10 African American men have the highest prostate cancer incidence and mortality.11 Overall, among adults, premature death rates for African Americans are approximately 55 percent higher than for whites.12

Diabetes kills African Americans at more than three times the rate for whites, American Indian or Alaska Natives at more than twice the rate, and Hispanics at more than one and a half times the rate.13 The data show a higher rate of uncontrolled hypertension among Mexican Americans than among white Americans and an elevated incidence of tuberculosis among Asian or Pacific Islander, African American, and Hispanic populations.14

Racial and ethnic minority adolescents and young adults are not immune from these health care imbalances. Native Americans face much higher death rates due to suicides and unintentional injuries than any other group, while African Americans face much higher rates of homicide than any other group.15 HIV (human immunodeficiency virus) kills African American and Hispanic young adults at significantly higher rates than non-Hispanic whites, Asians, or Native Americans.16

Women of color carry a double burden because of their race or ethnicity and gender. Frequently women do not receive the same quality of care as men, and this inequality is exacerbated when race and ethnicity are introduced into the equation. For example, African American women present more frequently than white women with late-stage breast cancer.17

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11 Minority Health Chartbook, supra note 7, at 34.
12 H.W. Nickens, The Role of Race/Ethnicity and Social Class in Minority Health Status, 30 HEALTH SERVS. RES. 151, 157 (1995). Between 1995 and 1997 life expectancy at birth for black males increased 2 years to a record high of 67.2 years, due in large part to declines in mortality from HIV (human immunodeficiency virus) infection and homicide. However, life expectancy was still 7.1 years shorter for black males than for white males in 1997. See NAT’L CTR. FOR HEALTH STATISTICS, HEALTH: UNITED STATES, 1999, at 6 (1999).
14 Weinick et al., supra note 10, at 37.
16 Id.
Notwithstanding higher mammography screening rates, African American women have a higher mortality rate for breast cancer than do white women.\textsuperscript{18} Moreover, Vietnamese women’s cervical cancer rate, the highest among all groups, is nearly five times the rate for white women.\textsuperscript{19} Mortality rates from motor vehicle–related injuries, chronic liver disease (cirrhosis), and homicide are higher for Native American or Alaska Native women than those for white women.\textsuperscript{20}

Finally, although African Americans and Hispanics represent approximately 13 percent and 14 percent, respectively, of the U.S. population, 55 percent of reported AIDS (acquired immune deficiency syndrome) cases occur among these two groups.\textsuperscript{21}

II. Disparities in Access to Health Care Services

Although many factors affect health status, the lack of health insurance and other barriers to obtaining health services diminish racial and ethnic minorities’ utilization of preventive services and medical treatments that could reduce disease and contribute to improved health status. Moreover, the interplay between race and poverty highlights the fragmentation of America’s health care delivery system along socioeconomic lines. This fragmentation has served as an additional barrier to receiving quality and meaningful health care. However, economic status is not the sole determining factor; institutional bias, patient perceptions, and provider stereotyping are contributing factors as well.

A. Health Insurance Coverage

Ethnic minorities are much more likely than whites to be uninsured. Over one-third of Hispanics (37 percent) are uninsured, the highest rate among all ethnic groups and two and a half times the rate for whites (14 percent). Nearly one-fourth of African Americans and about one-fifth of Asian Americans and Pacific Islanders and American Indians or Alaska Natives are uninsured.\textsuperscript{22}

Medicaid is an important health insurance safety net for many low-income people, including many members of racial and ethnic minority groups. Due to their lower incomes, African Americans, Hispanics, and American Indians or Alaska Natives are about three times as likely to participate in the Medicaid program as whites (19 percent, 16 percent, and 17 percent, respectively, versus 6 percent).\textsuperscript{23}

\textsuperscript{18} The Status and Progress of the Department of Health and Human Services Initiative to Eliminate Racial and Ethnic Disparities: Hearing Before the Congressional Black Caucus, Health Braintrust, 107th Cong. 8–9 (2002) (statement of Walter W. Williams, associate director for minority health, Ctrs. for Disease Control & Prevention, HHS (U.S. Department of Health and Human Services)).

\textsuperscript{19} MINORITY HEALTH CHARTBOOK, supra note 7, at 34.

\textsuperscript{20} OFFICE ON WOMEN’S HEALTH, HHS, THE HEALTH OF MINORITY WOMEN 6 (2000).


\textsuperscript{22} BROWN ET AL., supra note 9, at 5; see also KAREN S. COLLINS ET AL., DIVERSE COMMUNITIES, COMMON CONCERNS: ASSESSING HEALTH CARE QUALITY FOR MINORITY AMERICANS 2 (2002) (finding that 35 percent of Hispanics, 22 percent of African Americans, and 14 percent of Asian Americans surveyed were uninsured at the time of the survey).

\textsuperscript{23} COLLINS ET AL., supra note 22, at 2. Minorities, on average, are poorer than whites. While more than 20 percent of whites are poor or near poor (i.e., incomes below 200 percent of the federal poverty level), at least one-half of African Americans, Hispanics, and Native Americans are poor or near poor. See Henry J. Kaiser Family Found., Key Facts: Race, Ethnicity and Medical Care 3 (2000). However, the overall number of whites enrolled in Medicaid is greater than the number of minority enrollees. Between 1999 and 2000, there were 11.6 million white Medicaid enrollees, 6.4 million African American enrollees, and 5.8 million Hispanic enrollees. See Henry J. Kaiser Family Found., State Health Facts Online: Rate of Nonelderly Medicaid Enrollees by Race/Ethnicity, 1999-2000 (2001), at www.statehealthfacts.kff.org.
However, health insurance coverage does not equal access to health care services. In some cases, those minorities who have employer-based coverage may have very limited benefits or a benefit package that is offered with high copayments or deductibles or both. If a person is enrolled in the Medicaid program, access to services can be a monumental problem. Because of low reimbursement rates, many physicians do not accept Medicaid as payment, thus leaving many minority patients enrolled in Medicaid without adequate or convenient access to both primary and specialty care services.

B. Access to Medical Treatment

A number of studies have documented extreme disparities for people of color in accessing certain types of critical health care services. Why minorities are receiving differential treatment in general medical and surgical care is unclear. However, some studies “clearly identify racial and ethnic bias or stereotyping in clinical decision making as a contributing factor.”

First, with regard to access to basic primary care services, research shows that Hispanics are nearly twice as likely to lack a usual source of care as whites. This is most likely reflective of the high percentage of Hispanics who are uninsured and do not have the financial resources to pay for regular health care visits. Furthermore, only 59 percent of Hispanics, 66 percent of African Americans, and 73 percent of Asian Americans have as their regular source of care a doctor’s office, compared with 80 percent of whites. More important, one study revealed that within managed care, minorities, particularly Hispanics, reported barriers to care more frequently than did whites. Specifically, 33 percent of Hispanics reported not having a usual source of care, and they were twice as likely as whites to report long waits for care.

Once a minority patient accesses primary health care services, the question remains as to what type of services the patient is receiving. One study conducted in subsections of New York clearly reveals the inconsistencies that are perpetuated within the health care delivery system. Notwithstanding that African Americans have higher mortality and morbidity rates for cardiovascular disease, African Americans in the study were less likely to undergo treatment for their condition than were whites. For example, whites had 138 cardiac bypass procedures per 100,000 residents, while African Americans had only 31 per 100,000 residents. The study also showed that whites received hip replacements at a rate twice as high as African Americans, knee replacements at a rate 23 percent higher, and gall bladder operations at a rate 53 percent higher.

Another study found that “Hispanic children, working-age African-American adults and African-American and Hispanic elderly patients were at greater risk of being hospitalized for a preventable con-

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24 Geiger, supra note 8, at 223.
25 NAT’L CTR. FOR HEALTH STATISTICS, supra note 15, at 37.
26 COLLINS ET AL., supra note 22, at 35.
27 Kathryn A. Phillips et al., Barriers to Care Among Racial/Ethnic Groups Under Managed Care, 19 HEALTH AFFAIRS 4, 68 (2000).
28 Id. This study examined Medicaid managed care enrollees as well. The percentage of Medicaid enrollees reporting barriers was similar to the total managed-care-enrolled population, except that Medicaid enrollees were more likely to report use of the hospital emergency room and long waits for care. The differences seen between racial and ethnic groups also were seen among Medicaid enrollees. E.g., Medicaid-enrolled Hispanics were less likely than other Medicaid enrollees to have a usual source of care. Id.
29 Perez, supra note 3, at 400.
dition than were their white counterparts.” 31 This stood true “even after adjusting for patient differences in health care needs, socioeconomic status, insurance coverage, and the availability of primary care.” 32

Numerous studies document differences in access to diagnostic and therapeutic interventions for cardiac and stroke patients by race and ethnicity. 33 For example, one study finds that African Americans are 13 to 40 percent less likely to receive coronary angioplasty, and 32 to 70 percent less likely to receive bypass surgery than their white counterparts. 34 Another study shows that Hispanics have similar rates of bypass surgery to whites but are 18 percent less likely to receive catheterization and 35 percent less likely to receive angioplasty. 35 Even in studies where everyone is similarly insured, racial differences in the use of cardiac procedures remain. For example, a third study finds that, among Medicare beneficiaries, African-Americans are 60 percent less likely than whites to undergo heart bypass surgery. 36 Adjusting for income notably makes little difference in the findings: African American beneficiaries are still less than half as likely to undergo surgery than white beneficiaries. 37 According to another study, African Americans suffer strokes at a rate as much as 35 percent higher than whites, and the death rate among those suffering strokes is twice as high among African Americans as among whites. 38 However, among stroke patients, African Americans are significantly less likely than whites to receive diagnostic (i.e., cerebral arteriography) and therapeutic (i.e., carotid endarterectomy) interventions. 39

Finally, among all minorities, African Americans and Native Americans are found to suffer an excess risk of illness and death from end-state renal disease. Among Native Americans, for example, the rate of end-state renal disease is four times that of whites. This is a consequence of the higher rates of hypertension, diabetes, and sickle-cell disease among African Americans, diabetes among Native Americans, and less access to, and utilization of, early primary care intervention for both groups. Unfortunately, despite these alarming numbers, African Americans and Native Americans are less likely than whites to receive transplants and are less likely to be put on the waiting list for transplants. 40

C. Quality of Care

The quality of care that racial and ethnic minorities receive is a new element that scholars have begun to examine. In some studies, the quality of care is equated with actual access to various types of treatments and procedures. For example, in a recent study, researchers found that among

51 Darrell J. Gaskin & Catherine Hoffman, Racial and Ethnic Differences in Preventable Hospitalizations Across 10 States, 57 MED. CARE RES. REV. 85, 97 (Supp. 2000). A preventable condition is one “that might not have occurred had the patient received appropriate and timely outpatient care in the case of acute health problems as well as effective, timely, and continuous care for certain chronic disease conditions.” Id. at 86.
52 Id. at 97.
53 See, e.g., P.A. Johnson et al., Effect of Race on Presentation and Management of Patients with Acute Chest Pain, 118 ANNALS INTERNAL MED. 593 (1993); C. Maynard et al., Characteristics of Black Patients Admitted to Coronary Care Units in Metropolitan Seattle: Results from the Myocardial Infarction Triage and Intervention Registry (MITI), 67 AM. J. CARDIOLOGY 18 (1991); E.Z. Oddone et al., Racial Variations in the Rates of Carotid Angiography and Endarterectomy in Patients with Stroke and Transient Ischemic Attack, 153 ARCHIVES INTERNAL MED. 2781 (1993).
55 Id.
56 Id.
57 Id.
58 Geiger, supra note 8, at 229.
59 Id. at 7.
60 Id. at 229.
Medicare beneficiaries enrolled in managed care health plans, African Americans received poorer quality of care than whites.\textsuperscript{41} Quality of care was measured using four clinical indicators or measures: breast cancer screening, eye examinations for patients with diabetes, beta blocker use after myocardial infarction, and follow-up after hospitalization for mental illness. For all four measures, the study concluded that African Americans were less likely to receive any of these services.\textsuperscript{42}

Another measure of quality of care for people of color is the nature of the patient-provider relationship, including issues such as linguistic access and cultural competence.\textsuperscript{43} Individuals who are limited-English proficient face significant challenges navigating the health care system and communicating with providers. An encounter with a medical provider can be futile if the patient is unable to communicate with the physician or to comprehend important information from the physician or both. A recent national survey of adults found that 43 percent of Hispanics who primarily spoke Spanish reported communication problems with their physicians, compared to 26 percent of Hispanics who primarily spoke English.\textsuperscript{44} Among Hispanics who spoke primarily Spanish, only 37 percent found it very easy to understand materials from the doctor’s office, compared with 51 percent of Hispanics whose primary language was English. Among Asian Americans, rates of comprehension were even lower; only 16 percent of those whose primary language was not English, compared with 47 percent of those who spoke primarily English, said that understanding doctor’s materials was very easy.\textsuperscript{45} In most instances, patients who were in need of a language interpreter during a health care visit went without this service.\textsuperscript{46}

Cultural competence is a topic that has also received attention from those leading efforts to eliminate health care disparities and improve medical outcomes. Cultural competence is usually measured by the comfort levels and perceptions of racial and ethnic minority patients when interacting with their providers. As demonstrated by a study sponsored by the Commonwealth Fund, health care providers need to do a better job of acknowledging and understanding their patients’ cultural and linguistic differences, how these differences might affect care, and how best to meet all their patients’ health care needs.\textsuperscript{47} Compared with whites, minority patients feel less welcomed by the health care system, have more reservations about the benefits and

\textsuperscript{41} Eric C. Schneider et al., Racial Disparities in the Quality of Care for Enrollees in Medicare Managed Care, 287 JAMA 1288 (2002).

\textsuperscript{42} Id. at 1292.

\textsuperscript{43} Cultural competence in health care is defined as “the incorporation of an awareness of health beliefs and behaviors, disease prevalence and incidence, and treatment outcomes for different patient populations.” Risa Lavizzo-Mourey & Elizabeth R. MacKenzie, Cultural Competence: Essential Measurements of Quality for Managed Care Organizations, 124 ANNALS INTERNAL MED. 919, 920 (1996).

\textsuperscript{44} COLLINS ET AL., supra note 22, at 10.

\textsuperscript{45} Id. at 11.

\textsuperscript{46} Id. at 19.

\textsuperscript{47} Id. at 18.
value of health care, and are more likely to face significant language barriers.\footnote{Id.} For example, of the patients surveyed, 15 percent of African Americans, 13 percent of Hispanics, and 11 percent of Asian Americans felt they would have received better care if they were of a different race or ethnicity, compared to 1 percent of white respondents. Moreover, 30 percent of racial and ethnic minorities who responded to the Commonwealth Fund survey felt treated with disrespect by their health care provider compared to 9 percent of whites.\footnote{Id. at 19. The reasons given were related to communication: patients felt that their providers talked down to them, treated them rudely, did not listen to them, or ignored them. “Insurance issues” was the most commonly cited subject around which disrespect occurred. Id.}

Over the last decade, the cumulative results of research regarding racial and ethnic disparities are frustrating: research consistently finds significant inequalities in health status and health access among Americans. As pointed out a decade ago, despite extraordinary technological advances in the delivery of medical services in the United States, “serious inequities in … health status for the most vulnerable” remain.\footnote{Perkins, supra note 4, at 373 (quoting S. Funkhouser & D. Moser, Is Health Care Racist? 12 ADVANCED NURSING SCI. 47, 52 (1990)).}

III. Challenges to Eliminating Racial and Ethnic Health Care Disparities

As we become more aware of the extent of racial and ethnic health care disparities, taking steps to address them becomes even more pressing. However, as we form our strategy, two issues must be addressed: lack of racial and ethnic data in various levels of the health care delivery system and difficulties in obtaining legal remedies for violations of antidiscrimination laws.

A. Racial, Ethnic, and Primary Language Data Collection

Without adequate, reliable, and consistent data, a proper assessment of the true extent of racial and ethnic disparities in the country’s health care system is nearly impossible. These data are vital to developing and implementing effective prevention, intervention, and treatment programs. Collecting appropriate data related to racial or ethnic differences in the process, structure, and outcomes of care can help identify discriminatory practices, whether they are the result of intentional behaviors and attitudes or unintended but no less harmful biases or policies that result in racial or ethnic differences in care that cannot be justified by patient preferences or clinical need.

Most important, data collection is useful as a civil rights compliance tool. In other civil rights settings, data on race and ethnicity are routinely collected. For instance, the U.S. Department of Education collects data on race and ethnicity in the public school setting, and the Equal Employment Opportunity Commission collects data on race, gender, and ethnicity of employers with more than fifteen employees. In some cases the data collected by these entities show a pattern of practice of discrimination.\footnote{Perez, supra note 3, at 404.}

The need for racial, ethnic, and primary language data is even more overwhelming in light of the Supreme Court’s decision in Sandoval, which I discuss further below.\footnote{Alexander v. Sandoval, 532 U.S. 275 (2001) (Clearinghouse No. 51,706).} The availability of such data would ensure accountability for the proper and fair delivery of health care services to racial and ethnic minorities enrolled in publicly financed health care delivery systems. Moreover, the collection of racial and ethnic data would allow providers to track disparities, assess the impact of quality improvement efforts, and identify best practices for addressing gaps in health status and care.

Federal, private, and state-supported data collection efforts unfortunately are
scattered and unsystematic, and many health plans, with a few notable exceptions, do not collect data on enrollees’ race, ethnicity, or primary language.\textsuperscript{53} Data collection is regrettably not required in the health care setting. The U.S. Department of Health and Human Services (HHS) has the authority under its Title VI regulation to require providers and states to collect data on race, ethnicity, and language of preference.\textsuperscript{54} However, a circuit court has refused to enforce the regulation to require federal fund recipients to collect such data.\textsuperscript{55}

We must note that collecting data on race, ethnicity, and primary language does not violate federal law. A number of providers have raised concerns that collecting data on race and ethnicity is illegal under federal law. To the contrary, as stated earlier, Title VI regulations explicitly empower HHS to require the collection of such data. HHS has taken a number of steps to educate providers on this issue.\textsuperscript{56}

B. Alexander v. Sandoval

Title VI of the Civil Rights Act of 1964 “conditions a health care provider’s receipt of federal funds upon the provider’s agreement that it will not engage in activities that have the effect of discriminating on the basis of race [or national origin].”\textsuperscript{57} The U.S. Supreme Court holds that the language of Title VI itself addresses intentional discrimination.\textsuperscript{58} However, the regulations issued pursuant to Title VI make clear that Title VI reaches beyond intentional discrimination. The regulations prohibit health care providers from using “criteria or methods of administration which have the effect of subjecting individuals to discrimination on the basis of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program [with] respect to individuals of a particular race, color or national origin.”\textsuperscript{59}

Title VI applies to a range of discrimination concerns, including access to health services. Until last year, private litigants were permitted to sue to enforce Title VI regulations prohibiting acts with discriminatory effects. However, the Supreme Court ruling in \textit{Sandoval} is that there is no implied private right of action to enforce the Title VI regulations.\textsuperscript{60}

Because an overwhelming percentage of actual discrimination in health care involves disparate impact, the holding of \textit{Sandoval} hinders advocates from effectively addressing racial and ethnic disparities.\textsuperscript{61} However, advocates’ hands are not completely tied, as there are other actions that advocates could take and additional avenues that they could follow. Private plaintiffs may be able to establish that the conduct in question amounts to intentional discrimination under Title VI, or they may be able to enforce the disparate impact protection through the civil


\textsuperscript{54} U.S. Department of Health and Human Services Title VI Regulation, Nondiscrimination Under Programs Receiving Federal Assistance Through the Department of Health and Human Services Effectuation of Title VI of the Civil Rights Act of 1964, 45 C.F.R. § 80.6 (2001). Title VI provides that “[n]o 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.” 42 U.S.C. § 2000d.

\textsuperscript{55} Madison-Hughes v. Shalala, 80 F.3d 1121 (6th Cir. 1996) (Clearinghouse No. 49,112).

\textsuperscript{56} PEROT & YOUDELMAN, supra note 53, at 3.

\textsuperscript{57} Perkins, supra note 4, at 379 (citing 42 U.S.C. § 2000d).

\textsuperscript{58} \textit{Sandoval}, 532 U.S. at 280; see also Guardians Ass’n v. Civil Serv. Comm’n of N.Y. City, 463 U.S. 582, 610–11 (1983).

\textsuperscript{59} 45 C.F.R. § 80.3(b)(2) (2001).


\textsuperscript{61} Perez, supra note 3, at 395.
IV. Discrimination in Health Care Settings

Discrimination in health care can take many forms. Some are obvious, some not so obvious. Legal services attorneys must remain alert and know how to detect racial and ethnic discrimination within a health care delivery system. As stated earlier, the days of overt discriminatory methods are fading, and individuals and institutions are creating more innovative and discreet methods of providing inadequate and subpar health care services to racial and ethnic minorities. Examples of possible intentional discrimination include a hospital policy to offer written materials only in English and a home health agency’s refusal to provide services in a predominantly minority housing development.

Additional examples of discriminatory conduct are numerous. A hospital in New York City had de facto segregated maternity wards; the segregation appeared to be based on source of payment, although source of payment was a proxy for race. In another case, a hospital located near the Mexican border in McAllen, Texas, dressed its security personnel in uniforms that closely resembled the U.S. Border Patrol and maintained this policy until an Office for Civil Rights complaint was filed. Of course, the policy had the effect of deterring Hispanics in the area from using the facility. A legal services client may not be able to get a bed in a nursing home or may have difficulty receiving interpreter services as part of the client’s managed care program. Legal services attorneys must not attribute these occurrences to a poorly structured or administered health care delivery system. Instead they must evaluate the underlying repercussions of such action. One factor to consider may be the frequency of such occurrences. Moreover, although an administrative policy may appear neutral on its surface, advocates should make a concerted effort to document whether one particular racial or ethnic group is disproportionately affected by this “neutral” policy. A policy’s disproportional impact could be a telltale sign that the particular institution or provider is attempting to minimize its delivery of health care services to a racial or ethnic group.

Some additional forms of discrimination that are receiving heightened attention include possible “redlining” and limitation of provider networks within a managed care system. Redlining is most frequently associated with housing and mortgage lending and the practice of literally drawing a red line around certain poor, predominantly minority sections of cities and refusing to grant a mortgage or sell homeowner’s insurance. In the health care setting, this type of practice has not been studied in any detail. However, redlining is a concern in a number of settings, including home health, man-

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63 Perez, supra note 3, at 394.
64 45 C.F.R. § 80.7 (2001).
65 On a hospital policy to provide written materials only in English, see Jane Perkins, Race and Health, 36 CLEARINGHOUSE REV. 15 (May–June 2002). On a home health agency’s refusal to offer services in a predominately minority housing development, see Perez, supra note 3, at 396.
66 See Perez, supra note 3, at 395.
67 In re McAllen Med. Ctr. 1-3 (HHS Office for Civil Rights filed Jan. 1991) (alleging violations of the Hill-Burton Act and Title VI of the Civil Rights Act of 1964) (Clearinghouse No. 49,113). Additional information about the cases discussed herein may be obtained by contacting the Office for Civil Rights.
68 Perez, supra note 3, at 398.
aged care, and the pharmacy setting. A survey of 347 pharmacies in New York City found that, in nonwhite neighborhoods, only 25 percent of the pharmacies had sufficient supplies of pain medication, while 72 percent of white neighborhoods had adequate supplies.69 The National Medical Association, raising concerns about redlining in managed care, complains that managed care organizations are bypassing predominantly minority zip codes in their marketing.70 To date, these concerns have not been systematically studied. However, under managed care, market pressures ensure that the patient pool is as healthy as possible. That a managed care organization may conclude, as a result, that a minority community is poorer, sicker, and therefore not an economically viable area in which to conduct business is a valid concern.71 Another valid concern is that, within the context of managed care, some health plans may limit their provider networks in a manner that excludes minority physicians or physicians who practice in predominantly minority neighborhoods.72

With all of these different forms of racial discrimination in health care, legal services advocates must carefully monitor their clients’ situations and examine what actions they can take to address these problems. With the Supreme Court’s decision in Sandoval hanging overhead, legal services attorneys will have to be both creative and diligent in resolving racial and ethnic health care disparities.

First, legal services advocates should be mindful that Title VI still prohibits intentional discrimination. Thus, if a racial or ethnic minority patient clearly is not receiving health care services because of the patient’s race or inability to speak English, a Title VI claim is still an option.73 An example of this type of intentional discrimination would be a hospital failing to supply written materials in English when a large portion of the service area is Spanish-speaking.74

Second, one of the more important advocacy efforts must entail using the Office for Civil Rights complaint process.75 The office’s nearly forty-year history of investigating Title VI complaints has taken on a heightened importance following the Sandoval decision.76 According to the office, “[i]n more than 60 percent of [its] compliance reviews during the past year and-a-half, OCR’s involvement resulted in

Legal services attorneys should inform both providers and health care consumers about their respective obligations and rights under the law.

References:

70 Perez, supra note 3, at 398.
71 Sidney D. Watson, Race, Ethnicity & Hospital Care: The Need for Racial and Ethnic Data, 30 J. HEALTH L. 125, 127 (1997).
72 R. Kington et al., Increasing Racial and Ethnic Diversity Among Physicians: An Intervention to Address Health Disparities in The Right Thing To Do, The Smart Thing To Do: Enhancing Diversity in Health Professions 57 (2001). A number of studies show that African American and Hispanic physicians are more likely to care for African American and Hispanic patients, respectively; they are assumed to be more likely to care for poor patients. Id
73 Under Title VI, health care providers who receive federal financial assistance have a legal obligation to ensure that people with limited English skills can meaningfully access health care. 42 U.S.C. § 2000d.
74 Perkins, supra note 65.
75 For information on how to file an effective complaint with the Office for Civil Rights, see Randal S. Jeffrey et al., Drafting an Administrative Complaint to Be Filed with the U.S. Department of Health and Human Services’ Office for Civil Rights, 35 CLEARINGHOUSE REV. 276 (Sept.–Oct. 2001).
substantial corrective actions and changes in policies and practices to ensure nondiscriminatory access to quality health care services.\textsuperscript{77} By filing such a complaint, the legal services community puts the federal government on notice that its money is being used in a discriminatory fashion. The office is required to investigate once a complaint is filed.\textsuperscript{78}

Third, upon receiving an appropriate request, legal services should strongly advocate on both the state and federal level for the collection of racial and ethnic data. A recent Institute of Medicine Report underscores the existence of racial and ethnic health care disparities and the need for racial and ethnic data.\textsuperscript{79} State policymakers and private health plans should be made aware specifically that the collection of racial and ethnic data is not only legal in a majority of states but also beneficial. The availability of reliable data would allow both state health care delivery systems and private health plans to construct and implement effective prevention and intervention programs targeting racial and ethnic minority patients. The collection of such data has proved both helpful and necessary in other interest areas, including housing, employment, and education. Data collection can only produce equally beneficial results in the health care arena.

Fourth, legal services programs may be able to use state law to address discrimination in health care programs. For example, some states have implemented language assistance laws that require the provision of interpreter or translation services or both for patients using various types of health care entities.\textsuperscript{80} If these entities evidently are not complying with the linguistic access provisions, an individual action possibly may be pursued. Most important, a majority of states have various antidiscrimination laws that prohibit discrimination in public accommodations or in other forms of business activity. Other state provisions, including tort and negligence provisions and, possibly, antifraud statutes, may prove helpful.\textsuperscript{81}

Legal services attorneys should inform—by, for example, posting notices in legal services offices and organizing community outreach sessions—both providers and health care consumers about their respective obligations and rights under the law.

RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE, including differences in health status and access to care, continue to demonstrate how much work advocates have before them. Discrimination in the health care system is slowly and needlessly harming and, in some cases, killing racial and ethnic minorities. The evidence of this discrimination is overwhelming. We have reached a point where solutions must be developed and put into action. This type of campaign requires the enthusiastic participation and contribution of legal services advocates and their clients. Without their participation, racial and ethnic minorities will continue to be treated as second-class citizens in America’s health care system.

\textsuperscript{77} Id. at 7.

\textsuperscript{78} See 42 C.F.R. §§ 80 et seq. (2001).

\textsuperscript{79} INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (Brian D. Smedley et al. eds., 2002), available at www.nap.edu.

\textsuperscript{80} See, e.g., CAL. HEALTH & SAFETY CODE § 1259 (West 2001); FLA. STAT. ANN. § 381.026(4) (b)(7) (West 2001); MASS. ANN. LAWS Ch. 111, § 25J (Law Co-op. 2002); N.Y. COMP. CODES R. & REGS. tit. 10, § 405.7 (2002); 25 TEX. ADMIN. CODE § 30.27 (West 2002).

\textsuperscript{81} Perkins, supra note 65. Legal services attorneys should research, in depth, the state’s level of sovereign immunity before pursuing a legal claim. Id.