

Civil Rights and Health Disparities

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“A close look at the health care industry’s institutional practices reveals an English-only, ethnocentric, racist culture that does interfere with patient care.”¹

In recent history, civil rights law has been an effective tool in combating discrimination in healthcare, but more can and should be done. In 2003, the Institute of Medicine released a seminal report titled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*.² The report concluded that “[r]acial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patients’ insurance status and income, are controlled.”³ Regulations implementing Title VI of the Civil Rights Act of 1964 provide that “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 otherwise subjected to discrimination under any program or activity receiving Federal financial assistance from the Department of Health, Education, and Welfare.”⁴ In the healthcare setting, the antidiscrimination provisions of Title VI apply to programs and activities that receive federal financial assistance, such as Medicare and Medicaid. The Office of Civil Rights (OCR) within the Department of Health and Human Services (DHHS) is responsible for enforcement of the antidiscrimination provisions.⁵

Early efforts to address discrimination in healthcare using civil rights laws were remarkably effective. The first early challenge was to eliminate racial segregation in healthcare facilities.⁶ By executive orders in 1948, President Harry Truman outlawed discrimination in federal employment and ended segregation in the armed services including Veterans Administration hospitals.⁷ In 1961, President Kennedy required medical schools and their hospitals receiving research grants to desegregate.⁸ The effects of Kennedy’s action were immediate and powerful. Medical schools needed federal research funds and wanted the prestige that came with research grants, so they quietly

¹ Lisa C. Ikemoto, *Racial Disparities in Health Care and Cultural Competency*, 48 ST. LOUIS UNIV. LAW J. 75, 76 (2003).

² INSTITUTE OF MEDICINE, *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* (2003) [hereinafter *UNEQUAL TREATMENT*], available at <http://www.nap.edu/books/030908265X/html/>.

³ *Id.* at 1.

⁴ 45 C.F.R. § 80.1 (2000) available at <http://www.hhs.gov/ocr/part80rg.html>.

⁵ See, e.g., Office for Civil Rights, <http://www.hhs.gov/ocr/discrimrace.html#regulations> (last visited July 18, 2006).

⁶ David Barton Smith, *Racial and Ethnic Health Disparities and the Unfinished Civil Rights Agenda*, 24 HEALTH AFFAIRS 317, 318 (2005).

⁷ *Id.* at 318.

⁸ *Id.* at 319.

and quickly removed the “white” and “colored” signs previously adorning their segregated waiting rooms.⁹

The most successful efforts to address discrimination in health care came with implementation of Medicare in 1966, since hospitals were required to certify compliance with Title VI of the Civil Rights Act as a condition to participate in Medicare.¹⁰ Federal officials enforcing Title VI compliance required more than token desegregation. Southern hospitals tried to replace official desegregation with “voluntary” segregation, allowing black patients the option of being admitted to a segregated waiting room or hospital wing, but officials quickly prohibited such practices.¹¹ Federal efforts extended beyond integration of hospitals. Officials advised hospitals that they would lose Medicare funding unless their blood supplies were integrated, and Louisiana integrated its blood supplies overnight.¹²

Although overt segregation in healthcare facilities has been eliminated, it is clear that “racial disparities in many areas of health status are well-documented, disturbing, and preventable.”¹³ It is widely acknowledged that such disparities result from a number of causes including socioeconomic and insurance status.¹⁴ Less widely accepted is the notion that illegal discrimination is one of the “root causes”¹⁵ of disparities. However, since the publication of *Unequal Treatment* in 2003 it is hard to argue that racial and ethnic discrimination in the provision of health care has ended.

Although recent instances of intentional discrimination have been documented,¹⁶ so-called “disparate impact” discrimination perhaps poses a greater challenge. This “unintentional” discrimination results from practices that are facially neutral but have the effect of discriminating on the basis of race, color or national origin.¹⁷ It is difficult to prove intentional discrimination. For example, failure to provide translation services for patients with limited English proficiency could be intentional discrimination, but it would be easier to prove that the failure to provide translation services had the effect of discriminating on the basis of national origin. Although Title VI directly addresses only intentional discrimination, “actions having an unjustifiable disparate impact on minorities [can] be redressed through agency regulations designed to implement the purposes of Title VI.”¹⁸ Therefore, a plaintiff could establish the prima facie elements of a disparate impact case by showing that defendants violated language assistance regulations issued by DHHS and that failure to comply with such regulations disparately impacted

⁹ *Id.*

¹⁰ *Id.* at 319.

¹¹ *Id.* at 320.

¹² *Id.*

¹³ Thomas E. Perez, *The Civil Rights Dimension of Racial and Ethnic Disparities in Health Status*, UNEQUAL TREATMENT at 627.

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.* at 639.

¹⁷ *Id.* at 630.

¹⁸ *Alexander v. Choate*, 105 S. Ct. 712, 716 (1985) (citing *Guardians Assn. v. Civil Service Comm’n of New York City*, 103 S.Ct. 3221, 3223 (1983)).

plaintiffs. The plaintiffs would not be required to prove that defendants *intentionally* discriminated against plaintiffs.

Prior to 2001, private plaintiffs could file suit to challenge disparate impact discrimination. However, in *Alexander v. Sandoval*, the U.S. Supreme Court ruled that there is no private right of action to enforce Title VI regulations prohibiting disparate impact discrimination.¹⁹ Therefore, enforcement is relegated to OCR rather than private plaintiffs. Professor Thomas Perez recognizes that *Sandoval* “represents a significant setback for civil rights advocates, who had pursued a steady diet of civil rights cases in health care using the disparate impact theory,”²⁰ but bravely argues that there are advantages of having OCR rather than private plaintiffs pursue claims of discrimination. He notes that patients may file a complaint with OCR without the necessity of retaining legal counsel or suffering the expenses and uncertainty of litigation.²¹ Others are less optimistic. One article concluded that HHS “has kept a low profile these past three decades and has been underfunded and largely ineffective at driving change.”²² Further, OCR is now the sole enforcer of Title VI unintentional discrimination since *Sandoval*, but “[d]espite the increased role that the OCR would need to assume to maintain enforcement levels, it was given no additional resources.”²³

OCR has recently pursued a number of initiatives that show promise. In May 2006 OCR issued a report outlining its grassroots outreach efforts to reach minority communities and educate such communities about health disparities, race discrimination and Title VI.²⁴ In 2006, OCR also created a new brochure to help educate patients about their rights to be free from discrimination in health care.²⁵ However, two things must happen if civil rights laws are to once again be a powerful tool in reducing health disparities. First, federal legislation must overturn the holding in *Sandoval* to once again allow private plaintiffs to pursue disparate impact discrimination claims. Also, OCR must be adequately funded with a mandate from Congress that such additional funding be devoted to addressing health disparities.

¹⁹ UNEQUAL TREATMENT at 630 (citing *Alexander v. Sandoval*, 121 S. Ct. 1511 (2001)).

²⁰ *Id.* at 631.

²¹ *Id.*

²² June Eichner & Bruce C. Vladeck, *Medicare As A Catalyst For Reducing Health Disparities*, 24 HEALTH AFFAIRS 365, 372 (2005).

²³ *Id.* at 372.

²⁴ Office for Civil Rights, *OCR Promising Practices: Grassroots Outreach Efforts to Reach African American Communities about Health Disparities, Race Discrimination, and Title VI*, (May 2006), <http://www.hhs.gov/ocr/promisingpractices.html> (last visited July 18, 2006).

²⁵ Office for Civil Rights, *Protecting Your Civil Rights in Health Care and Social Services and Your Health Information Privacy Rights*, <http://www.hhs.gov/ocr/OCRbro20051202.pdf> (last visited July 18, 2006).