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Access to Health Care: What a Difference Shades of Color Make

Gwendolyn Roberts Majette*

I. INTRODUCTION

In 1999, Congress provided funding to the Office of Minority Health “for a one-time Institute of Medicine study of the prevalence and impact of ethnic bias in medicine.”¹ On March 20, 2002, the Institute of Medicine reported its findings.² The report attracted worldwide attention and confirmed what minority communities have known for years: that race and ethnicity affect access to, and the quality of, health care received.³ Prognostications of these findings existed in 1999 when the *New England Journal of Medicine* published a study designed specifically to evaluate the effect of a patient’s race and sex on the physician’s recommendation for cardiac catheterization.⁴ The

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1. H.R. REP. NO. 106-370, at 149 (1999) (this report accompanied H.R. 3037 Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill, 2000.); Consolidated Appropriations Act, Pub. L. No. 106-113, 113 Stat. 1501 (1999).

2. See Opening Statement by Alan Nelson on Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, available at <http://www4.nationalacademises.org/news>.

3. Nelson, *supra* note 2; Louis W. Sullivan, *Effects of Discrimination and Racism on Access to Health Care*, 266 JAMA 2674 (1991).

4. Kevin A. Schulman, M.D., et al., *The Effect of Race and Sex on Physician’s Recommendations for Cardiac Catheterization*, 340 NEW ENG. J. MED 618 (1999). Cardiac catheterization is an invasive procedure whereby a long, fine, flexible tube is inserted into a blood vessel to the heart. It is used to assess the anatomy and physiology of the heart and vasculature for diagnostic purpose and therapeutic intervention.

study concluded that race and sex are important, independent factors that influence how physicians manage chest pain.⁵

Access to health care encompasses at least four aspects of health care coverage: affordability, availability, usability, and acceptability.⁶ More simply, access is entry into the health care system. Gaining access is difficult for people of color because the United States health care system is based on a white male paradigm. This paradigm explicitly highlights race, ethnicity and sex, and implicitly economic status, due to the dominance of white males in employment positions of power and high compensation.⁷

This article outlines some of the major issues that affect access to health care for various minority communities, focusing on barriers to access for four distinct racial/ethnic groups: African Americans, Asian Americans, Hispanic Americans, and Native Americans. This comparative analysis shows that race, ethnicity, and sex affect whether one receives health care, as well as the quality of health care received. The only difference among the various ethnic groups is how the adverse effect manifests itself.

Part I outlines two key factors affecting access to care – race and ethnicity – and defines access to care. Part II defines the barriers to access of health care and discusses some of the previously unsuccessful legal solutions and remedies. Part III outlines how practitioners in various disciplines can combine their knowledge to develop a strategy that will end the use of a patient's race and ethnicity as a determinative factor in one's receipt of quality health care.

CHURCHILL'S MED. DICTIONARY 310 (1989); HARRISON'S PRINCIPLES OF INTERNAL MED. 871 (Jean D. Wilson, M.D. et al. eds., 12th ed. 1991).

5. Schulman et al., *supra* note 4, at 623.

6. Rose L. Pfefferbaum et al., *Providing for the Health Care Needs of Native Americans: Policy, Programs, Procedures, and Practices*, 21 AM. INDIAN L. REV. 211, 256 (1997).

7. See Judy Scales-Trent, *Women of Color and Health: Issues of Gender, Community, and Power*, 43 STAN. L. REV. 1357, 1358, 1362-1364 (1991); Susan L. Waysdorf, *Fighting for Their Lives: Women, Poverty, and the Historical Role of United States Law in Shaping Access to Women's Health Care*, 84 KY. L.J. 745, 745 (1995-96); Carol Jonan Bess, *Gender Bias in Health Care: A Life or Death Issue for Women with Coronary Heart Disease*, [] HASTINGS WOMEN'S L.J. 41, 49 (1995); Jane Perkins, *Race Discrimination in America's Health Care System*, CLEARINGHOUSE REV. at 373 (Special Issue 1993).

II. BARRIERS TO ACCESS TO HEALTH CARE

A. Availability of Insurance

Studies have repeatedly shown that persistent barriers to health care access are a major cause of the poor health status of people of color.⁸ Because health care is expensive, the main determinant to accessing health care is the availability of insurance. In the United States, availability of insurance is almost inextricably tied to employment.⁹ Because people of color, and especially women, are stereotyped into marginal, low or no-skilled, low paying jobs, or are unemployed, they represent a disproportionate number of the uninsured population.¹⁰ For example, the uninsured rate for Hispanics¹¹ is 35% and 32.8% for Native Americans.¹² For African Americans and Asian Pacific Islanders, the rates are 22.8% and 22%, respectively.¹³ In contrast, the uninsured rate for Caucasians is 12.7%.¹⁴

Financing health care for the Native American community is a significant problem, despite the federal government's responsibility to provide health care for American Indians and Alaska Natives from federally recognized tribes.¹⁵ This is because fi-

8. MARSHA LILLIE-BLANTON & ANA ALFARO-CORREA, JOINT CENTER FOR POLITICAL AND ECONOMIC STUDIES, IN THE NATION'S INTEREST: EQUITY IN ACCESS TO HEALTH CARE PROJECT ON THE HEALTH CARE NEEDS OF HISPANICS AND AFRICAN AMERICANS 8-11 (1995).

9. RAND E. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 38 (1997); LILLIE-BLANTON & ALFARO-CORREA, *supra* note 8, at 8.

10. Judy Scales-Trent, *Women of Color and Health: Issues of Gender, Community, and Power*, 43 STAN. L. REV. 1357, 1359 (1991); Susan L. Waysdorf, *Fighting for Their Lives: Women, Poverty, and the Historical Role of United States Law in Shaping Access to Women's Health Care*, 84 KY. L.J. 745, 756 (1995-96); LILLIE-BLANTON & ALFARO-CORREA, *supra* note 8, at 11.

11. "Within the Hispanic population, Mexican Americans have significantly higher rates of poverty and lower rates of insurance coverage compared with Puerto Ricans." KAREN SCOTT COLLINS ET AL., THE COMMONWEALTH FUND, DIVERSE COMMUNITIES, COMMON CONCERNS: ASSESSING HEALTH CARE QUALITY FOR MINORITY AMERICANS 1 (2002). This survey was conducted from April 30 to November 5, 2001, available at http://www.cmwf.org/programs/minority/collins_diversecommunities_523.pdf.

12. INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 67-69 (2002), available at <http://www.nap.edu/books/030908265X/html/>.

13. *Id.* at 66-68. Within the Asian American population, "those of Korean or Vietnamese heritage appear to have the highest rates of poverty and lowest rates of health insurance coverage." COLLINS ET AL., *supra* note 11, at 1.

14. *Id.* at 66.

15. The following statutes establish the legal framework for the provision of health care services to Native Americans: (1) The Snyder Act of 1921, ch. 115, 42 Stat. 208 (codified in part at 25 U.S.C. §13). This statute provides basic authorization

nancing for Native American health programs¹⁶ is dependent upon adequate congressional appropriations, and Congress has consistently failed to provide resources sufficient to address the health care needs of the Native American community.¹⁷

An additional insurance barrier for racial and ethnic minorities is immigration status.¹⁸ Recent changes to Medicaid, a public insurance program, deny services to immigrants, even though

for Indian health care. It authorized the Bureau of Indian Affairs to "direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians . . . for relief of distress and conservation of health." (2) The Indian Health Care Improvement Act, Pub. L. No. 94-437, 90 Stat. 1400 (codified in scattered sections of 25 U.S.C.). The goal of this Act is to provide "the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy." 25 U.S.C. § 1602(a) (2002). Some of the specific goals of the Act were "to increase the number of Indian health professionals, to eliminate deficiencies in health status and resources, to improve health facilities, and to provide health care services for urban Indians." Yvette Roubideaux, *Current Issues in Indian Health Policy*, UDALL CTR. FOR STUD. IN PUB. POL'Y 6, Oct. 1998. (3) The Indian Health Care Improvement Act Amendments of 1992, Pub. L. No. 102-573, 106 Stat. 4526. This statute amended the Indian Health Care Improvement Act to set forth health status objectives with respect to Indians by the year 2000 and set a goal to increase the number of educational degrees awarded to Indians who pursue health and allied health professions to 0.6%. *See also* Roubideaux, *supra* at 3.

16. Roubideaux, *supra* note 15, at 2. The health care system for Native Americans consists of three types of programs: Indian Health Service, Tribal Health Programs, and Urban Health Programs. The Indian Health Service "is a comprehensive primary care-oriented system of health facilities located on or near Indian reservations." *Id.* The Tribal Health Programs allow federally recognized tribes to assume management of part or all of their health care programs from the Indian Health Service. *Id.* at 3, 7; Indian Self-Determination and Educational Assistance Act of 1975, Pub. L. No. 93-638, 88 Stat. 2203. The Urban Health Programs "receive federal funding under Title V of the Indian Health Care Improvement Act to provide health care services for American Indians and Alaska Natives who reside in urban areas." Roubideaux, *supra* at 4. In 1998, over half of the American Indian population in the United States lived in urban areas, yet less than one percent of the Indian Health Service budget is dedicated to urban Indian health programs. *Id.*

17. Roubideaux, *supra* note 15, at 8-10; Pfefferbaum et al., *supra* note 6, at 211; INST. OF MED., *supra* note 12, at 67. The Indian Health Design Team charged with restructuring the Indian Health care system with tribal and local community input noted as a serious issue that the Indian health programs continuously received inadequate funding. Roubideaux, *supra* at 8-9; Pfefferbaum et al., *supra* note 6, at 211.

18. Kathleen A. Maloy et al., *Effect of the 1996 Welfare and Immigration Reform Laws on Immigrants' Ability and Willingness to Access Medicaid and Health Care Systems*, CTR. FOR HEALTH SERVS. RES. AND POL'Y, GEO. WASH. UNIV. MED. CTR. 6, 2000, available at <http://www.gwu.edu/~chsrf/pdf/synth.pdf>; Michael E. Fix & Jeffrey S. Passel, URBAN INSTITUTE, *Trends in Noncitizens' and Citizens' Use of Public Benefits Following Welfare Reform: 1994-1997*, at 4 (Mar. 1999), available at <http://www.urban.org/Template.cfm?Section=ByAuthor&NavMenuID=63&template=/TaggedContent/ViewPublication.cfm&PublicationID=6341>.

they are legal residents.¹⁹ Moreover, immigrants are less likely to have employer-sponsored health insurance because they often work in low-wage, low-benefit jobs.²⁰ This issue is especially important for the immigrant-dominant, Hispanic, and Asian Pacific Islander populations.²¹

For those minorities fortunate enough to have insurance, additional barriers exist with respect to the type of insurance typically purchased by minorities. Studies show that “racial and ethnic minorities are more likely than whites to be enrolled in ‘lower-end’ health plans.”²² These plans generally have fewer resources and place more restrictions on services covered by the policies.²³

B. Availability of Health Care Providers

Another barrier to health care is the lack of accessible medical providers. Studies show that there is a limited supply of health resources in poor, racial, and ethnic minority communities, thus necessitating the creation of hospital-based providers and community health centers.²⁴ Geographic proximity is critical for Hispanic and African American communities, because people in these communities are more likely to rely on public transportation, which increases the time and costs required to receive care.²⁵ This is also an important issue in the Native American community, because most health care services provided by the Indian Health Service are provided in rural areas and on reservations. Yet, over 50% of Native Americans live in

19. Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (“PRWORA”), Pub. L. 104-193, 110 Stat. 2105 (codified as amended in scattered section of 8 U.S.C.). Maloy et al., *supra* note 18, at 34; Fix & Passel, *supra* note 18, at 4; Lisa C. Ikemoto, *The Fuzzy Logic of Race and Gender in the Mismeasure of Asian American Women’s Health Needs*, 65 U. CIN. L. REV. 799, 820 (1997).

20. Grace Xueqin Ma, Ph.D., *Barriers to the Use of Health Services by Chinese Americans*, 29 J. ALLIED HEALTH 64, 68 (Summer 2000); see also Maloy et al., *supra* note 18, at 6.

21. The 2000 population census showed that 71.7% of foreign-born persons from Latin America are not citizens, and 52.9% of foreign-born persons from Asia are not citizens. POPULATION DIVISION, U.S. CENSUS BUREAU, TABLE 2.6 FOREIGN-BORN POPULATION BY WORLD REGION OF BIRTH, CITIZENSHIP AND YEAR OF ENTRY: MAR. 2000, available at <http://www.census.gov/population/socdemo/foreign/p20-534/tab0206.pdf>.

22. INST. OF MED., *supra* note 12, at 11.

23. *Id.*

24. See LILLIE-BLANTON & ALFARO-CORREA, *supra* note 8, at 18; INST. OF MED., *supra* note 12, at 89.

25. LILLIE-BLANTON & ALFARO-CORREA, *supra* note 8, at 14.

urban areas.²⁶ Additionally, many non-Native health care providers refuse to serve Native Americans because of uncertainty about reimbursement.²⁷

The lack of accessible medical providers is exacerbated by two obstacles: (1) difficulty in maintaining health care facilities within the community and, (2) difficulty in training sufficient numbers of physicians of color, who are the health care providers that typically provide health care to people of color.

(i) Health Care Facilities

The main reason minority communities have difficulty maintaining health care facilities within their boundaries is economics—their clientele cannot afford to pay for the services provided. Consider, for example, the June 25, 2001, closing of D.C. General Hospital, located in the southeastern quadrant of the District of Columbia, an area that is characterized by poverty and poor health status. Southeast D.C. has the highest concentrations of low-income and Black residents in the city, and is plagued by high incidences of heart disease, infant mortality, and cancer.²⁸ Of the eleven hospitals located in the District of Columbia, D.C. General was one of three located in southeast D.C.²⁹

For years there were rumblings from Congress and some quarters of the District Government about closing the hospital as a cost-cutting measure, in spite of the fact that the hospital saw over half of the trauma cases in the District and provided the bulk of uncompensated care (36%) to D.C. residents.³⁰ The crux of the financial problem was that the hospital was treating a significant number of patients who were uninsured, the hospital

26. Roubideaux, *supra* note 15, at 4; INST. OF MED., *supra* note 12, at 67.

27. Pfefferbaum et al., *supra* note 6, at 248.

28. Barbara A. Ormond et al, URBAN INSTITUTE, *Health Care for Low-Income People in the District of Columbia*, at 2 (Dec. 1, 1999), http://www.urban.org/UploadedPDF/dc_lowincome.pdf.

29. Barbara A. Ormond & Randall R. Bovbjerg, URBAN INSTITUTE, *The Changing Hospital Sector in Washington, D.C.: Implications for the Poor*, 11, 13 (1998) (testimony before D.C. City Council, Committee on Human Services), available at <http://www.urban.org/Template.cfm?Section=ByAuthor&NavMenuID=63&template=/TaggedContent/ViewPublication.cfm&PublicationID=6924>. The 1995 report of the Mayor's Blue Ribbon Panel on Health Care Reform Implementation found that the more affluent parts of the city have more than three times the number of primary care physicians found in the poorer neighborhoods. Barbara A. Ormond et al., *supra* note 28, at 6.

30. Steve Vogel, *If I Was Shot, This is Where I'd Want to Go*, WASH. POST, Jan. 4, 1998 at 19; Ormond & Bovbjerg, *supra* note 29, at 15.

was mismanaged, and the facility was poorly maintained and obsolete.³¹ Additionally, there was evidence that the services D.C. General provided to its uninsured patients could be purchased at half the cost from private hospitals and clinics in other parts of the District.³² In light of these circumstances and factors, the closing of D.C. General was inevitable.³³

When these communities have sought legal recourse to keep health care providers, like hospitals, from closing or moving to seemingly more prosperous areas like the suburbs, they have largely been unsuccessful.³⁴ Typically, aggrieved community

31. Vogel, *supra* note 30; Avram Goldstein, *D.C. General Sends Off its Last Patient; Tomorrow's Shutdown, and Resulting Health System, a Major Gamble for City and Mayor*, WASH. POST, June 24, 2001, at A1. Other causes of the D.C. General shut-down included a drop in Washington's population, the reduction of hospital use generally because of the arrival of managed care, rising costs, budget deficits, and an out-of-date physical plant that would have required \$110 million to renovate.

32. Paul Offner, *Politics and the Public Hospital in our Capital*, 10 HEALTH AFF. 176, 177 (2001).

33. In previous years at least two other hospitals - Greater Southeast and Southern Maryland - closed their trauma departments because they were financial drains to the hospital. Vogel, *supra* note 30.

34. NAACP v. Med. Ctr. Inc., 657 F.2d 1322, 1340 (3d Cir. 1981) (no Title VI violation found even though the court accepted plaintiffs' assertion that a hospital relocation and reorganization plan would subject the African American plaintiffs to inferior health care and disproportionate travel burdens, because the plan served a legitimate goal where the hospital at issue was in danger of losing accreditation and would not be able to receive Medicaid or Medicare funds, its surgical residency program was on probation, its facility was aging and not in compliance with Delaware licensing law, and moving was necessary because the Delaware population had shifted to the suburbs, necessitating a move of its facility to prevent threat from a competitor); Bryan v. Koch, 627 F.2d 612, 621 (2d Cir. 1980); Jackson v. Conway, 620 F.2d 680, 682 (8th Cir. 1980) (upholding the trial court decision that the plaintiffs had not provided sufficient evidence to demonstrate disparate impact even though the distance of obtaining acute care inpatient services and weekend emergency room services and certain outpatient services had increased for a substantial, but uncertain percentage of north side St. Louis area residents). *But see* Latimore v. County of Contra Costa, 1996 WL 68196 (9th Cir. 1996). This is one of the few cases in which a group of indigent minorities in need of health care services were partially successful using Title VI in an attempt to equalize access to health care between the county's predominately-white Central county residents and minority residents. The District Court initially entered a preliminary injunction in favor of the potential minority patients, which barred the county from expending funds on reconstructing a hospital located in a predominately white neighborhood. *Id.* at **1. The District Court found that "the county's alleged failure to provide 'equal access' to hospital services caused delays in treatment, exacerbation of illnesses and ultimately, increased health care costs," constituted hardships that outweighed the defendant's projected financial losses. *Id.* at **2. The Court of Appeals later dissolved the injunction because the county took some initial steps to equalize access. Specifically, the county (1) increased the availability of hospital services in the east and west part of the county by contracting with hospitals and expanding clinic hours in those portions of the county; (2) quadrupled the number of shuttles to the hospital in the richer neighborhoods,

members assert an action against the hospital under Title VI of the Civil Rights Act of 1964 in an attempt to block the hospital's pending move. Title VI provides, "no person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance."³⁵ The Supreme Court has held that the Title VI statute prohibits only intentional discrimination.³⁶ However, the regulations enforcing the statute go even further and specifically prohibit recipients from determining the site or location of a facility:

with the effect of excluding individuals from, denying them the benefits of, or subjecting them to discrimination under any programs to which this regulation applies, on the ground of race, color, or national origin, or with the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of [Title VI] or [its implementing regulations].³⁷

Unfortunately, due to a recent Supreme Court case, *Alexander v. Sandoval*, the regulations will not be as powerful a tool in eradicating discrimination based on discriminatory effects because private litigants, including advocacy organizations, can no longer bring a private right of action under the regulations.³⁸ Private litigants can only bring suits for intentional discrimination under Title VI and its implementing regulations.³⁹ *Sandoval* does not prevent the Office of Civil Rights from bringing discriminatory effects cases under the Title VI regulations.⁴⁰ Additionally, while the regulations are still valid, several justices on the Supreme Court have also questioned the validity of the regulation prohibiting discriminatory impact.⁴¹

Courts analyzing Title VI regulation claims use a burden-shifting model, which requires that the plaintiffs make a *prima facie* showing that the relocation of the hospital discriminatorily

from 10 to 42 per weekday, and (3) publicized the increased access through an informational campaign. The Ninth Circuit found these measures sufficient to constitute a substantial change in circumstances that altered the balance of hardships necessary to support continued enforcement of the preliminary injunction. *Id.*

35. 42 U.S.C.A. § 2000(d) (2002).

36. *Alexander v. Sandoval*, 532 U.S. 275, 280 (2001).

37. 45 C.F.R. § 80.3(b)(3) (2002).

38. *Sandoval*, 532 U.S. at 293.

39. *Id.* at 285-86.

40. *See id.* at 288-89.

41. *Id.* at 281-82.

impacts minorities.⁴² If plaintiffs meet this burden, the burden shifts to the defendants to show that the disproportionate impact is a matter of necessity, or that the relocation is manifestly related to the facility's legitimate goals. The plaintiffs may rebut the defendant's necessity claim by showing that other less discriminatory relocation alternatives exist.⁴³

Bryan v. Koch exemplifies the typical unsuccessful Title VI action challenging a hospital's closure decision.⁴⁴ There, despite the court's finding that the plaintiffs sufficiently established that the closure of a hospital disproportionately impacted African Americans and Latinos, the Second Circuit ultimately held that there was no Title VI violation. If a Title VI violation were found, it would have allowed the court to block the closure of the hospital. Specifically, in *Bryan*, the Sydenham Hospital was located in central Harlem, New York City, and 98% of its patients were African American or Latino.⁴⁵ The City argued that it needed to close Sydenham to reduce expenditures and increase efficiency within the municipal hospital system.⁴⁶ In particular, it argued that Sydenham was the smallest hospital within the system, operated under a large deficit, had an obsolete facility in need of costly renovation, and was thirty minutes away from other hospitals that offered comparable services and accepted Medicaid patients.⁴⁷ The majority opinion rejected the plaintiffs' argument that less discriminatory alternatives existed, such as hospital mergers, regionalization of services, increasing Sydenham's service, or increasing Medicaid reimbursement.⁴⁸ The court focused solely on whether Sydenham was the most appropriate hospital to close among the seventeen municipal hospitals.⁴⁹

Justice Kearse, who dissented in part, criticized the majority's decision because it did not carefully scrutinize the city's decision-making process, nor its decision.⁵⁰ Judge Kearse stated:

No one would contest the fact that the City must assign priorities among competing economic demands and evaluate po-

42. *Bryan v. Koch*, 627 F.2d 612, 618 (2d Cir. 1980).

43. *Id.* at 618-19.

44. *Id.*

45. *Id.* at 614.

46. *Id.* at 617.

47. *Id.* at 618.

48. *Id.* at 618-19.

49. *Id.* at 619.

50. *Id.* at 625-26 (Kearse, J., concurring in part and dissenting in part).

litical and economic alternatives. But in my view, when a recipient of federal moneys makes a decision to use those moneys in a way which has disparate racial impact Title VI requires that the recipient show, at the very least, that its decision was the product of a rational decision-making process. The City has made no such showing here as to its decision to close Sydenham.⁵¹

According to Judge Kearse, the city's decision to close Sydenham was not the product of a rational decision-making process, because there was no consideration of cost saving techniques other than closure of a hospital within the city's hospital system.⁵² Additionally, Judge Kearse found that the evidence showed that the hospitals in the surrounding area (allegedly adequate alternatives to Sydenham hospital) would not be able to treat the number of patients left by Sydenham's closure.⁵³ The facts showed that the hospital beds at these nearby hospitals were full, and that these hospitals would not accept uninsured or underinsured patients if these beds were otherwise occupied.⁵⁴

(ii) Minority Health Care Professionals

Not only do minority communities have difficulty retaining health care facilities, but they also have difficulty finding health care professionals willing to provide health care services. Studies show that "minority doctors open practices in minority neighborhoods in far greater numbers (nearly three-to-one) than do whites."⁵⁵ However, there is a shortage of minority physicians, and their rate of enrollment in medical schools is declining. In the United States, for most minority groups there is a disparity between the percentage of practicing minority physicians and the percentage of minorities within the population. For example, in 1998, Blacks, Hispanics, and American Indian/Alaska Natives constituted less than 6% of medical school graduates, yet these three groups made up 28% of the U.S. popula-

51. *Id.* at 621.

52. *Id.* at 625.

53. *Id.* at 626.

54. *Id.* at 627-28.

55. John Zicconi, *What Color Should Medicine Be?*, 12 *UNIQUE OPPORTUNITIES, THE PHYSICIAN'S RES.* 26, 32 (2002); Vera B. Thurmond & Darrell G. Kirch, *Impact of Minority Physicians on Health Care*, 91 *S. MED. J.* 1009, 1010 (1998), <http://www.sma.org/smj1998/novsmj98/thurmond.pdf>; PUB. HEALTH SERV. HEALTH RES. & SERV. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERV., *MINORITY PHYSICIANS: A PROFILE 3* (Sept. 1993).

tion.⁵⁶ Additionally, recent court challenges to the use of race as an admission criterion to colleges and universities, such as the case of *Hopwood v. Texas*,⁵⁷ adversely impacted the numbers of minorities enrolling in medical school. For example, between 1994 and 1996, enrollment of African American students in medical schools declined 8.7%, and enrollment of African Americans in Texas' public medical schools alone dropped 54%.⁵⁸ This trend is likely to exacerbate the existing disparity between minority physicians and the number of minorities within the United States population.

The medical school enrollment of minorities in the 1990s increased and peaked in 1995 with an enrollment rate of 12.4%.⁵⁹ This increase was due in part to affirmative action programs,⁶⁰ which most medical schools implemented in the 1970s in order to increase the number of minority physicians.⁶¹ According to Michael Scotti, the Vice President of the American Medical Association's professional standards division, affirmative action programs significantly increased the numbers of women and Asians in medical schools, but did little to increase the number of African Americans and Hispanics.⁶² In 2000, while African Americans made up 12.3% of the United States population, they made up only 7.4% of students enrolled in medical school.⁶³ The medical school enrollment rate for Native Americans was 0.8%, in contrast to their United States population percentage of 0.9%,⁶⁴ and the rate for Mexican Americans and Puerto Rican-Mainlanders, who represent 8.5% of the population, was 3.3%.⁶⁵ Asian Americans, on the other hand, are not

56. MINORITY GRADUATES OF U.S. MEDICAL SCHOOLS: TRENDS, 1950-1998, ASS'N OF AM. MED. COLL. REPORT 14 (2000).

57. *Hopwood v. Texas*, 78 F.3d 932 (5th Cir. 1996). This decline in minority enrollment in medical school is consistent with the decline that resulted from the first Supreme Court case to discuss affirmative action programs in higher education, *Regents of the Univ. of Cal. v. Bakke*, 438 U.S. 265 (1978). INST. OF MED., *supra* note 12, at 98; MINORITY PHYSICIANS: A PROFILE, *supra* note 55, at 5; Thurmond & Kirch, *supra* note 55, at 1011.

58. INST. OF MED., *supra* note 12, at 98.

59. *Id.*; Zicconi, *supra* note 55, at 26.

60. Other notable efforts include the Association of American Medical Colleges "Project 3000 by 2000," which sought to achieve parity in medical schools for under-represented minority groups; INST. OF MED., *supra* note 12, at 98; Thurmond & Kirch, *supra* note 55, at 1012.

61. Thurmond & Kirch, *supra* note 55, at 1011.

62. Zicconi, *supra* note 55, at 32.

63. *Id.* at 29.

64. *Id.*

65. *Id.*

underrepresented in the medical profession. In 2000, Asian Americans were 3.7% of the U.S. population, yet represented 19.8% of medical school graduates.⁶⁶

Despite the disparities between the number of minorities enrolling in and graduating from medical school, and the number of minorities within the United States population, voluntary efforts to rectify these disparities have faced legal challenges. The first and only Supreme Court challenge to a medical admissions program designed to increase the number of minority applicants was *Regents of the University of California v. Bakke*.⁶⁷ In *Bakke*, the medical school operated a two-track admission policy, with a general admissions track, and a special admissions track for disadvantaged minority students.⁶⁸ According to the University, the special admissions system was designed to (i) reduce the historic deficit of traditionally disfavored minorities in medical schools and in the medical profession, (ii) counter the effects of societal discrimination, (iii) increase the number of physicians who will practice in communities currently underserved; and (iv) obtain the education benefits that flow from an ethnically diverse student body.⁶⁹ A white male whose application to medical school was rejected challenged the legality of the school's special admissions program under the Equal Protection Clause of the Fourteenth Amendment.⁷⁰

The Equal Protection Clause provides that no state shall "deny to any person within its jurisdiction the equal protection of the laws."⁷¹ The Supreme Court rendered a splintered plurality opinion, with Justice Powell providing the swing vote to affirm the California Supreme Court's finding that the University's admissions program was unconstitutional, and to reverse the California Supreme Court order enjoining the University from giving any consideration to race in the admissions process. However, writing for the Court, Justice Powell did state that race may be one of a number of factors considered by the school in considering applications.⁷² While Justices Brennan,

66. *Id.*; ASS'N OF AM. MED. COLL. REPORT, *supra* note 56, at 5 (stating that in 1998, Asian Americans were 4% of the United States' population, yet represented over 18% of medical school graduates).

67. *Regents of the Univ. of Cal. v. Bakke*, 438 U.S. 265 (1978).

68. *Id.* at 272.

69. *Id.* at 305-06.

70. *Id.* at 276-77.

71. U.S. CONST. amend. XIV, § 1.

72. *Bakke*, 438 U.S. at 297, 315-18.

White, Marshall, and Blackmun supported the use of race in the admissions process, they did so for different reasons.⁷³

Prior to May 14, 2002, only one federal Court of Appeals followed Justice Powell's rationale in *Bakke* when determining the constitutionality of a professional school's use of race in its admissions policy.⁷⁴ In *Smith v. University of Washington*, the Ninth Circuit held that a "properly designed and operated race-conscious admissions program . . . would not be in violation of Title VI or the Fourteenth Amendment."⁷⁵ The court declined to follow other admission cases that found violations of the Fourteenth Amendment. The Ninth Circuit followed *Marks v. United States* and stated that the holding from a fragmented decision of the Supreme Court should be viewed as the position taken by those members concurring in the judgments on the narrowest grounds.⁷⁶ Additionally, the Supreme Court has stated that "if precedent of this Court has direct application in a case, yet appears to rest on reasons rejected in some other line of decisions, the Court of Appeals should follow the case which directly controls, leaving to this Court the prerogative of overruling its own decisions."⁷⁷

Since *Bakke*, several federal courts of appeal have found race-based admissions programs to be unconstitutional.⁷⁸ These

73. *Id.* at 326.

74. *Smith v. Univ. of Wash. Law Sch.*, 233 F.3d 1188, 1201 (9th Cir. 2000). On May 14, 2002, in a 5-4 decision, the Sixth Circuit reversed the district court's decision barring the University of Michigan Law School from using an applicant's race as a factor in its admissions decisions. *Grutter v. Bollinger*, 288 F.3d 732 (6th Cir. 2002), *cert. granted*, 2002 U.S. LEXIS 8677 (U.S. Dec. 2, 2002) (No. 02-241). The Sixth Circuit held that educational diversity is a compelling interest and that the law school's admissions policy was narrowly tailored. *Id.* at 742, 747. Thus, the policy was consistent with the Equal Protection Clause of the 14th Amendment and Title VI of the Civil Rights Act of 1964. This case creates a split in the federal circuits, with the Sixth and Ninth circuits holding that the use of race in admissions for professional schools is constitutional, and the Fifth and Eleventh circuits finding such use unconstitutional. *See infra* note 65. This shift in support of racially and ethnically conscious admissions policies may be what is needed to encourage universities to recommit to developing affirmative action programs, which in turn will increase the number of minority professionals.

75. *Smith*, 233 F.3d at 1201.

76. *Id.* at 1199 (relying on *Marks v. United States*, 430 U.S. 188, 193 (1977)).

77. *Id.* at 1200 (quoting *Rodriguez de Quijas v. Shearson/Am. Express, Inc.*, 490 U.S. 477, 484 (1989)).

78. *Johnson v. Bd. of Regents of the Univ. of Ga.*, 263 F.3d 1234, 1248 (11th Cir. 2001) (expressly refusing to decide whether diversity was a compelling interest, but invalidating the University of Georgia's admissions program because it was not narrowly tailored); *Hopwood v. Texas*, 78 F.3d 932, 947-48 (holding that student diversity was not a compelling interest that warranted the use of race as an admissions criteria

courts have either rejected the notion that diversity in the student body is a compelling interest and found that the use of race as an admission criterion is *per se* violative of the Fourteenth Amendment, or have found that the admissions program at issue was not narrowly tailored to survive strict scrutiny.⁷⁹

Additionally, several states have passed legislation barring the use of race in admissions policies. In 1996, California voters passed Proposition 209, which bars the use of race in public education policies.⁸⁰ Thereafter, in 1998, voters in the State of Washington passed Initiative Measure 200, which provides, "the state shall not discriminate against, or grant preferential treatment to, any individual or group on the basis of race, sex, color, ethnicity, or national origin in the operation of . . . public education."⁸¹ These initiatives further limit the use of affirmative action programs designed to increase the numbers of minority physicians. The effect of court challenges and legislative initiatives on medical school enrollment of minority students is devastating. In 1998, two years after the passage of Proposition 209 in California, the enrollment of underrepresented minorities in California medical schools declined 32% from the mid-1990s.⁸²

C. Cultural Sensitivity and Communication

Another aspect of accessibility is cultural sensitivity. Studies show that "racial concordance of patient and provider is associated with greater patient participation in care processes, higher patient satisfaction, and greater adherence to treatment."⁸³ As discussed previously, while studies show that physicians of color generally provide care to people of color, they are underrepresented in the health care profession, and their numbers are insufficient to meet the health care needs of people of

because it reinforces stereotypes, stigmatizes the applicant, and undermines the goal of the 14th Amendment to make race irrelevant in government decision making); *Grutter v. Bollinger*, 137 F. Supp. 2d 821 (E.D. Mich. 2001).

79. *Johnson*, 263 F.3d at 1248; *Hopwood*, 78 F.3d at 947-48.

80. California voter initiative Proposition 209, approved Nov. 5, 1996. This proposition became Article 1, Section 31 (a) of the California Constitution. The provision provides as follows: "The state shall not discriminate against, or grant preferential treatment to, any individual or group on the basis of race, sex, color, ethnicity, or national origin in the operation of public employment, *public education*, or public contracting." CAL. CONST. art. I, 31(a) (emphasis added).

81. WASH. REV. CODE § 49.60.400(1). This ballot initiative is very similar to California's Proposition 209.

82. INST. OF MED., *supra* note 12, at 98.

83. *Id.* at 12.

color.⁸⁴ Access difficulties are compounded by the fact that prospective patients may also refuse to visit health care providers who are racially or ethnically different from them.⁸⁵ Establishing a trusting and productive provider-patient relationship between persons who share different values, beliefs, and languages is difficult. Studies show that Native Americans are hesitant to use non-Native American providers.⁸⁶ In fact, Native Americans living in urban areas will often travel back to their reservations for health care treatment.⁸⁷ Additionally, Hispanic Americans who value family and holistic and personal health care may be less apt to go to bureaucratic providers that treat patients as objects.⁸⁸

Language barriers may also affect access to health care. Communication between patients and physicians is more problematic for Hispanics (33%), Asian Americans (27%), and African Americans (23%) than for Caucasians (16%).⁸⁹ For Asians and Hispanics, an inability to speak English coupled with a scarcity of multi-lingual health care providers poses a significant hardship on patients.⁹⁰ An inability to communicate can be a complete barrier to care, or it may cause misdiagnosis and inappropriate treatment of the patient's symptoms.⁹¹ A recent survey revealed the following communication problems among minority patients: "(1) the doctor did not listen to everything that the [patient] said, (2) the patient did not fully understand the doctor, or (3) the patient had questions during the visit but did not ask them."⁹²

Another barrier to receipt of health care is the patient's lack of awareness that care is needed. Oftentimes, formal educational resources do not portray people of color as patients.

84. Thurmond & Kirch, *supra* note 55, at 1010; PUB. HEALTH SERV. HEALTH RES. & SERV. ADMIN., *supra* note 55, at 3; LILLIE-BLANTON & ALFARO-CORREA, *supra* note 8, at 4.

85. Jane L. Delgado, Ph.D., *Meeting the Health Care Needs of Hispanic Communities*, 9 AM. J. HEALTH PROMOTION 300, 305-307 (1995).

86. Pfefferbaum et al., *supra* note 6, at 247.

87. *Id.*

88. Delgado, *supra* note 85, at 306.

89. COLLINS ET AL., *supra* note 11, at 14.

90. LILLIE-BLANTON & ALFARO-CORREA, *supra* note 8, at 12; Delgado, *supra* note 85, at 307; Ma, *supra* note 20, at 67; INST. OF MED., *supra* note 12, at 69-72. The 2001 Health Care Quality Survey revealed that less than one-half (48%) of the non-English speakers who said they needed an interpreter during a health care visit always or usually had one. COLLINS ET AL., *supra* note 11, at viii, 19.

91. INST. OF MED., *supra* note 12, at 14.

92. COLLINS ET AL., *supra* note 11, at vii; INST. OF MED., *supra* note 12, at 14.

Thus, people of color may not perceive themselves as persons needing treatment and may not seek preventative or appropriate care.⁹³ This is especially problematic, because studies show that patient education materials improve patients' knowledge about clinical encounters and their participation in health care decisions.⁹⁴

D. Discrimination

The final barrier to care is discrimination. Discrimination is the differential and negative treatment of individuals on the basis of race, ethnicity, gender, or other group membership.⁹⁵ In health care delivery there are three possible causes of discriminatory treatment: (1) bias or prejudice, (2) stereotyping, and (3) uncertainty in communication and clinical decision-making.⁹⁶ Prejudice is conscious behavior defined as an "unjustified negative attitude based on a person's group membership."⁹⁷ In contrast, stereotyping can be conscious or unconscious.⁹⁸ Stereotyping is the "process by which people use social categories (e.g., race, sex) in acquiring, processing, and recalling information about others."⁹⁹ Uncertainty in communication and clinical decision-making is a result of the dissonance that results from intergroup communication.¹⁰⁰ Here, physicians might provide less than appropriate treatment, because they must make diagnosis and treatment decisions in a short amount of time with limited or inaccurate information, including missing or misinterpreting patients' verbal and nonverbal communications.¹⁰¹

Discrimination in the health care system is merely a reflection of the discrimination that exists in American society. Racial discrimination persists in several important aspects of American life, such as mortgage lending, housing, employment, and criminal justice.¹⁰² Access to quality health care is no different. For example, a recent study published in the February 25, 1999 *New England Journal of Medicine* found that the race and sex of a

93. Telephone Interview with Mary Chung, President and CEO, National Asian Women's Health Organization (Feb. 2, 1999).

94. INST. OF MED., *supra* note 12, at 15.

95. *Id.* at 75.

96. *Id.* at 8, 127.

97. *Id.* at 129.

98. *Id.* at 135.

99. *Id.* at 133.

100. *Id.* at 138.

101. *Id.* at 127-137.

102. *Id.* at 75-80.

patient independently influence how physicians manage cardiac care and the use of cardiac catheterization.¹⁰³ The hypothesis of this study was to evaluate how a patient's race and sex influenced a physician's recommendation for cardiac catheterization.¹⁰⁴ The study also controlled the effect of differing socioeconomic status on the physician's treatment decision to avoid challenges to the study, based upon the argument that socioeconomic status was the basis for differing treatment decisions between the races.¹⁰⁵

The conclusions of the *New England Journal of Medicine* study were supported by a study on physicians' perceptions about patients. This study, by van Ryn and Burke, surveyed physicians to assess their perceptions of white and African American patients following a hospital visit.¹⁰⁶ The study found that a patient's race and socioeconomic background influence physicians' perceptions.¹⁰⁷ According to the study, physicians rated African American patients "as less intelligent, less educated, more likely to abuse drugs and alcohol, more likely to fail to comply with medical advice, and less likely to participate in . . . [treatment] than white patients."¹⁰⁸

The van Ryn and Burke Study reveals that an obvious consequence of a physician holding negative perceptions about ethnic minorities is that the doctor is less likely to recommend treatments, or less likely to put effort into discerning the true nature of the patient's problems.¹⁰⁹ The study also shows that a physician's stereotypical expectations may cause the doctor to engage in behavior toward the patient that causes the patient to respond in a way that confirms the negative perception held by the health care provider.¹¹⁰

Health care professionals, like many individuals, are reluctant to believe that they themselves engage in discriminatory behavior. While minority communities have asserted for years that racial discrimination affects health care,¹¹¹ the health care profession as a whole has refused to believe or admit it. In 1998,

103. Schulman et al., *supra* note 4, at 618.

104. *Id.* at 619.

105. *Id.* at 624.

106. INST. OF MED., *supra* note 12, at 131.

107. *Id.*

108. *Id.*

109. *Id.*

110. *Id.* at 136.

111. See, e.g., W. Michael Byrd, & Linda A. Clayton, *An American Health Dilemma: A History of Blacks in the Health System*, 84 J. NAT'L MED. ASS'N 189 (1992).

two major reports by the United States Department of Health and Human Services, one of which was the Department's Response to the President's Initiative on Race, failed to acknowledge racial discrimination as a substantial cause of disparities in health care.¹¹² These reports merely listed (1) level of education, (2) environment, (3) income, and (4) type of occupation as substantial causes of the disparities. Similarly, the Institute of Medicine's recent report on *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, assumes without direct evidence that the vast majority of health care providers finds "prejudice morally abhorrent and at odds with their professional values."¹¹³ However, this assumption brings little comfort to minority patients when the survey also finds that well-meaning whites, not overtly biased or prejudiced, typically demonstrate "unconscious, implicit negative racial attitudes."¹¹⁴ Thus, from the minority patient's point of view, it does not matter whether the health care provider subconsciously or consciously engages in racial or ethnically discriminatory behavior, because the effect on the patient is the same: receipt of health care that does not meet the patient's needs.

III. INTERDISCIPLINARY SOLUTIONS

As discussed in Part II of this article, people of color encounter several barriers to accessing health care: inability to pay for health care, including a lack of adequate insurance; a shortage of health care providers; cultural insensitivity and miscommunication with health care providers; and discrimination. In an effort to remove these barriers to health care, there are four areas of study that should be examined and integrated: economics, business, law, and medicine. By partnering people from these four areas of expertise, a comprehensive strategy can be developed to eliminate the role that a patient's race and ethnicity plays in one's ability to access health care. Of course, to ensure that the solutions developed are practical and feasible in light of each unique culture, people of color should be integrally involved in developing the solutions.

112. U.S. DEP'T OF HEALTH & HUMAN SERVS., RACIAL & ETHNIC DISPARITIES IN HEALTH: RESPONSE TO THE PRESIDENT'S INITIATIVE ON RACE at ii (Feb. 21, 1998); NAT'L CTR. FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH AND HUMAN SERVS., HEALTH, U.S., 1998 WITH SOCIOECONOMIC STATUS AND HEALTH CHARTBOOK 23 (1998).

113. INST. OF MED., *supra* note 12, at 129.

114. *Id.* at 135.

Economists should be consulted, because they can provide objective data that can be used to make the case for equalizing access to health care for all Americans, regardless of ethnic and racial background. Specifically, economists can help quantify the cost to society if we fail to remove barriers to health care, as well as the cost to society to remove the barriers.

Business people should be consulted to help develop economic wealth in low-income minority communities so that the people will have the economic means to pay for health care services. Business people can design programs to attract industry to the communities, so that there will be better paying jobs with good employment benefits such as health insurance. They can also provide job training to the people in the minority communities, so that the people have the skills needed to acquire better paying jobs with benefits.

Business people can also help reduce the shortage of health care providers available to people of color and their communities. Business people can do this by designing business models and educational programs that show administrators of health care facilities and providers how to grow and operate a successful business that serves the uninsured, underinsured, and minority communities. First and foremost, it must be remembered that health care delivery is a business. As such, the facility or practice must adhere to basic business practices. The facility or practice must provide high quality services. Additionally, the facility or practice must market itself to patients that have the ability to pay for services, as well as to those who do not.

A prerequisite to developing a successful business model to operate a facility or practice that serves the needs of racial and ethnic minorities is to overcome the assumption that only certain people, instead of all people, deserve high quality health care that is provided in the best environment possible. This means that the staff is knowledgeable, friendly, and service oriented. It also means that the facilities are aesthetically pleasing and well maintained.

It is imperative that facilities and practices located in poorer neighborhoods are operated to attract patients from all economic levels. This will ensure that the facility or practice receives reimbursement at all levels, high, middle, and low, instead of only low to non-existent reimbursement. A facility or practice simply cannot continue to operate with little to no revenue. Only facilities and practices that receive adequate reimburse-

ment can routinely maintain their physical structure and equipment, comply with accreditation standards (facilities, operations, and residency programs), and provide appropriate compensation to the health care staff to attract and keep a highly qualified and caring staff.

Lawyers can help define what legal remedies exist to removing barriers to care, as well as the success and failures of those remedies. For example, lawyers can help eliminate discrimination and increase the number of health care providers accessible to people of color. Lawyers can help minority communities use Title VI of the Civil Rights Act of 1964 to combat intentional and unintentional discrimination that impedes access to care. For intentional discrimination, lawyers can bring suit on behalf of patients that are discriminated against. For unintentional discrimination that results in an adverse impact on minority communities, lawyers can help advocacy groups pressure the Office of Civil Rights of the Department of Health and Human Services to more actively monitor facilities that receive federal funds to ensure compliance with Title VI of the Civil Rights Act and to pursue complaints of discrimination by patients. Lawyers can also help minority communities combat unintentional discrimination that results in an adverse impact on the community by helping the community negotiate with the administrators and owners of health care facilities to avoid, eliminate, and reduce business decisions and practices that create barriers to health care. For example, if a health care facility decides to relocate, lawyers can help develop and present alternative plans to the administrators and owners for achieving their same goals.

Lawyers can also help reduce the shortage of health care providers that treat people of color by assisting educational institutions in their attempts to increase the number of providers that traditionally serve people of color—underrepresented minority health care providers. Lawyers can help these institutions design race-conscious admissions programs consistent with the dictates of the Equal Protection Clause of the Fourteenth Amendment and Title VI of the Civil Rights Act. Lawyers can also help advocacy groups lobby against future anti-affirmative action legislation that prohibits efforts by educational institutions that actively seek to increase the number of underrepresented health care providers.

Physicians and other health care providers should be consulted to help develop courses to train providers to be culturally

sensitive, and to encourage providers to serve communities that have provider shortages. To make health care providers culturally sensitive, diversity training should become an integral part of their training. These courses should be offered throughout the health care provider's professional development: during the educational training; the practical training, such as residency programs; and upon completion of training through continuing education. These courses should be designed to expose and eradicate conscious and subconscious prejudicial and stereotypical thinking about racial and ethnic minority groups. It is also important that health care providers be routinely educated about the need to provide health care to patient populations that consistently suffer from health care provider shortages and the nobility of providing services to these communities.

Health care providers can also identify the unique health care problems of various ethnic and racial populations. Once the problems have been identified, the providers can then assist in the development of best practices to prevent and treat the problems. One example of a prevention technique is to better educate the respective ethnic and racial populations on the health issues disproportionately affecting them. Educational information should include the warning signs and symptoms of diseases, as well as information on healthy lifestyles, well-balanced diets, getting well-baby check-ups and physicals, etc. Health care providers can also facilitate prevention and treatment of disease by educating communities on how to select the appropriate health insurance when a patient has a choice of insurance plans. As already stated, the communities being assisted should be consulted in the development of preventative and treatment solutions to ensure that the solutions developed, although well intended, are not misguided in light of cultural differences.

In conclusion, developing solutions to improve access to health care for people of color requires the development of a health care system that adequately responds to the needs of a socially and culturally diverse population. Looking at the barriers to health care faced by several racial and ethnic groups—African Americans, Asians Americans, Hispanic Americans, and Native Americans—reveals the true prominence that color and ethnicity play in accessing health care in the United States. Understanding this dynamic is critical to developing an effective

solution, because effective solutions can only be developed once the problem is clearly defined.

To form a comprehensive solution that removes the barriers to health care encountered by people of color requires a close examination of the barriers encountered by each group. Developing a comprehensive solution is ideal because it promotes an integrated, collective response that efficiently deploys resources to eradicate access issues. Additionally, taking an interdisciplinary look at the problem (economics, business, law, and medicine) is likely to result in an approach that is not only practical and feasible, but also economical.