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HOSPITAL FLIGHT FROM MINORITY COMMUNITIES: HOW OUR EXISTING CIVIL RIGHTS FRAMEWORK FOSTERS RACIAL INEQUALITY IN HEALTHCARE

Brietta R. Clark*

Hope has two beautiful daughters. Their names are anger and courage; anger at the way things are, and courage to see that they do not remain the way they are.

-St. Augustine

On November 24, 2004, the fate of “Killer King” seemed undeniable. “Killer King” is the nickname given to the Martin Luther King Jr. Hospital, affiliated with Charles Drew Medical Center (the King/Drew Medical Center) and located in the Watts area of Los Angeles, California. On this day, the busiest trauma center in Los Angeles County, the *lifeline* of the Watts community, was closed indefinitely. It was considered the community’s lifeline because it served one of the “most violence-prone neighborhoods in the county, and is credited with saving the lives of countless victims of gunshots, stabbings, and serious traffic accidents.” Closing the trauma center ignited fears that the rest of the hospital would be taken away too.¹

The County justified the closure on the grounds that the lapses in quality of care were too grave to continue without significant reform.² In fact, Killer King received its name in the community

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¹ See Mitchell Landsberg & Jack Leonard, *King/Drew’s Trauma Unit Ordered Shut*, L.A. TIMES, Nov. 24, 2004, at C1.

² See Tracy Weber, Charles Ornstein, & Mitchell Landsberg, *Part 1: Deadly Errors and Politics Betray a Hospital’s Promise*, L.A. TIMES, Dec. 5, 2004, at C1 [hereinafter *King/Drew Article Part 1*] (Prior to the County’s decision to close the trauma center, King/Drew had lost private accreditation for three of its training programs and was on the verge of losing overall hospital accreditation); Charlie Leduff, *Watts Symbol of Hope Becomes Center of Conflict*, N.Y. TIMES, Mar. 28, 2004, at 24, available at http://www.racesci.org/in_media/NEW/watts.htm (the

because it was notorious for constantly making severe errors that cost patients' lives.³ Despite these clear lapses in quality, the community fought the closure. It rushed to protect King/Drew from what it perceived to be a "government attack."⁴ It is clear from the community's response that any government involvement is viewed as a threat to their rights and access to care, not a means of protection. There is no faith that government action will result in better care; there is only fear that such actions are thinly veiled attacks on one of the few institutions in our health care system willing to serve minorities.⁵ So the community has rallied to King/Drew's side to protect the hospital they see as the killer of its own people. Why? Because some care is better than no care at all. The community sees King/Drew as their only hope. They do not trust the health care system, the legal system, or the political system to protect them.

This fear is neither atypical nor irrational in light of one of the most visible, yet ignored, problems for minority communities – hospital closures and relocations. Increasingly, hospitals, private and public, have closed or terminated services in areas populated by minorities, while relocating services to more affluent, predominantly white neighborhoods. These closures have primarily occurred in urban areas with the greatest need and least resources. Remaining hospitals willing to care for minorities or the poor are either located far enough away that timely care is effectively foreclosed or they are already overburdened and understaffed. In fact, as early as 1979, the New York Times identified hospital closings and relocations as "possibly the most searing of the losses in the continuing pattern of inner-city disintegration...."⁶ Nonetheless, treatment of hospital flight from minority communities as a "civil rights" issue has had a checkered past.

The most visible cause of racial inequality in health care was the overt exclusion of minorities from hospitals and the segregation of blacks and whites in hospital wards. Through the 1950s and 60s, some

county temporarily seized control over key administrative positions and the federal government threatened to pull Medicaid and Medicare funding because of severe lapses in quality).

³ See Landsberg & Leonard, *King/Drew*, *supra* note 1. King/Drew spent \$20.1 million on malpractice payouts during fiscal years 1999-2003 and was the subject of recurring negative media attention of lives lost to medical mistakes. *Id.*

⁴ Mitchell Landsberg et al., *Reaction to King/Drew Plan Loud and Clear*, L.A. TIMES, Nov. 16, 2004.

⁵ *See id.*

⁶ Roger Wilkins, *Loss of Hospitals in Central Cities Said to Cause Array of Problems*, N.Y. TIMES, Sept. 17, 1979, at D11.

states enacted anti-discrimination laws to prohibit intentional race discrimination, and in 1964, the Civil Rights Act was enacted at the federal level. The Civil Rights Act prohibited discrimination on the basis of race, ethnicity, and national origin by recipients of federal funding.⁷ While the federal prohibition was viewed by some as a powerful symbol of racial equality, many minority communities were skeptical. These communities were acutely aware of the limits of a law applied to facially discriminatory actions, but that did not guarantee true equality in the distribution of resources. Minority communities in Los Angeles were vocal about these concerns, as they suffered from a lack of adequate health, employment, and educational resources, despite state anti-discrimination laws.⁸ In health care, for example, minority communities knew that antidiscrimination protection was limited if public resources were not used to build and maintain hospitals in their communities. Ironically, King/Drew was borne out of this struggle for true equality in health care, and its construction in 1972 was supposed to be a symbol of the promise of racial equality.⁹

Despite this skepticism, health care and civil rights advocates initially believed that Title VI of the Civil Rights Act was a powerful tool to address these resource inequities and to ensure equal access to health care.¹⁰ Title VI's prohibition on race discrimination applies to recipients of federal funding, which practically gave the federal government significant power over private and local public entities.¹¹ The federal government's direct construction and operations funding of hospitals, tax subsidies for nonprofit health care facilities, and its indirect subsidization of health care facilities via the Medicare and Medicaid insurance programs, gave the government expansive reach into both the private and public mechanisms for health care delivery.¹² The government also created an Office of Civil Rights (OCR)

⁷ *See id.*

⁸ *See* GERALD HORNE, FIRE THIS TIME: THE WATTS UPRISINGS & THE 1960s, at 10-11, 45-63 (1995).

⁹ Leduff, *supra* note 2, at 24.

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

¹¹ *See id.*

¹² At first, this was not necessarily the case. Title VI was enacted before the creation of the Medicare and Medicaid system, and Hill-Burton funding was not seen as important enough leverage to force compliance. *See* DAVID BARTON SMITH, HEALTH CARE DIVIDED: RACE AND HEALING A NATION 91-94 (1999).

dedicated to the enforcement of federal civil rights laws and established a process through which complaints of discriminatory actions would be investigated and remedied. OCR was a visible symbol of the government's purported commitment to the elimination of race discrimination. Finally, the federal government promulgated what appeared to be very patient protective regulations in that the regulations expressly prohibited the use of criteria or methods, or choice of site locations that have discriminatory effect.¹³ This appeared to give minority communities the ability to use the courts to prevent hospital closures where federal and local government failed to intervene.

Despite this promise, Title VI has not prevented the massive hospital closures and removal of critical services from minority communities. King/Drew's metamorphosis from a symbol of hope to "Killer King" is merely one example of many in a patchwork of private and public health care that has failed racial and ethnic minorities.¹⁴ Indeed, the community's vocal mistrust of government and fear that King/Drew is their best and only hope for health care is the most compelling indictment of our traditional civil rights framework and its failure to remedy the racial inequality in access to health care. When we look at the problem of hospital relocations and closures, like King/Drew, we see pieces of a complex and very frustrating puzzle. A story is revealed, not simply about the discrete problems of racial inequality in access to quality health care and the health and economic consequences for individuals and the community at large, but of the more fundamental problems of our notion of civil rights. This story illuminates the disconnect between the legal construct developed and the reality that minority communities face as victims of this system. Consequently, this legal construct has had the perverse effect of undermining the promise of Title VI in preventing the unequal distribution of hospital resources, by making it almost impossible to prevent even the most racially harmful hospital closures and relocations. Even beyond the harmful effects in any individual challenge, the principles of equality and civil rights that have become crystallized through the hospital relocation cases have infected our discourse and impeded our ability to honestly critique the cause of racial disparities that still exist in our health care system today.

In Part I, I provide a background of the hospital closure problem, exploring the trends, effects, and reasons for the growing numbers of hospital closures in minority communities. Studies of

¹³ 45 C.F.R. § 80.3(b)(2) (2004).

¹⁴ See *infra* Part I.

hospital restructuring reveal that they do indeed disproportionately affect minority communities and are caused in large part by an underfunding of indigent health care and government action that encourages such closures. Moreover, despite common assumptions that closures help, or are necessary to, conserve health care resources and reduce excess bed capacity, the patterns of hospital closures suggest the opposite – that such closures further strain our health care resources by driving up the cost of hospital care and leaving Medicaid and uninsured patients without access to early preventive and routine care.

In the next three parts of this Article, I critique our existing civil rights framework to show how certain structural and ideological foundations of this framework have undermined our fight for true equality in health care. I consider each piece of the Title VI puzzle that is critical to enforcement: the funding upon which the federal government's power is based, the administrative mechanisms created to enforce Title VI, and the scope of the rights granted to private plaintiffs and their ability to use courts to enforce these rights where federal and local governments have failed to prevent discriminatory actions. In Part II, I explore more deeply the effects of such funding decisions, showing how the government has consistently and consciously made funding decisions that foster racial inequality, creating a health care system that is incompatible with racial equality. In Part III, I show how the government has visibly undermined its purported commitment to civil rights by deliberately structuring the administrative arm responsible for civil rights enforcement in ways that render it utterly ineffective and by abandoning its facilities planning responsibility to ensure racial equality in health care. In Part IV, I explore the third piece of the puzzle -- the role of the courts through civil rights litigation to show how courts have created doctrinal barriers that make it impossible to win Title VI challenges to hospital closures.

In Part V, I address the implications for this failure, beyond the effects in any individual case of closure. I argue that our existing Title VI framework circumscribes our civil rights discourse in ways that discourage an honest critique of the hospital closure problem and stymies our vision for meaningful reform. One important consequence of this framework is the tendency to ignore or significantly underestimate the government's role in creating and maintaining an inherently discriminatory structure for health care delivery. For example, while there is some acknowledgement of intersection of race and economics in the discourse, it is used to engender sympathy for

government and private actors who are draining resources from minority communities. As a result, there is a lack of public outrage about the government's role in fostering race discrimination, and no demand for a radical restructuring of the health care system that is essential to achieving racial equality. This framework enables the continuous draining of hospital resources from minority communities that not only threatens their access to health care, but engenders feelings of mistrust, helplessness, and anger.

This is where the quote from St. Augustine becomes relevant. I believe that as legal advocates, we have a responsibility to harness the anger within communities that suffer the greatest burdens under this system and the anger we should all feel at this conscious and sustained neglect by our government, and use it to advocate for a fundamental redefinition of our notion of equality in health care. Moreover, legal advocates have a duty to use legal tools in creative ways to increase awareness and to empower communities to drive needed health care reform. In Part VI, I offer some suggestions toward this end. My suggestions include both short and long term ideas for minimizing disparities, incorporate traditional and nontraditional legal tools, and consider even unpopular approaches for reform. If we can use our anger constructively and have the courage to engage in what is sure to be a long and difficult fight for equality, I have hope that our notion of civil rights, at least as applied to health care access, will finally evolve.

I. HOSPITAL FLIGHT FROM MINORITY COMMUNITIES

Hospital relocations and closures are a nationwide problem and one that is longstanding.¹⁵ The implications for racial minorities' access to

¹⁵ See *Urban Hospital Closings in the Face of Racial Change Before the Subcommittee on Health, Committee of Ways and Means, 96th Cong.* 195 (1980) (statement of Alan Sager) [hereinafter Sager, *Testimony*]. See also Mitchell F. Rice, *Inner-City Hospital closures/Relocations: Race, Income Status, and Legal Issues*, 24 SOC. SCI. MED. 889, 896 (1987). "Nationally, dozens of hospitals close or relocate each year. For example, over the three years, 1975-1977, 231 hospitals closed or relocated according to data collected by the AHA. This means about 80 hospitals per year"; "[b]etween 1976 and 1980 there were 296 hospitals registered with the American Hospital Association that closed." *Id.* at 896. During the last decade, hospitals nationwide lost 103,000 staffed beds and 7,800 medical/surgical beds, and 370 emergency departments disappeared between 1994-1999. See Stephanie Mencimer, *Rich Man, Spore Man: If the Elite want to Survive Bioterrorism, They'll Have to Make Sure the Poor Do, Too*, WASHINGTON MONTHLY, Dec. 1, 2001, at 34 (describing how in the last five years California has closed more than 23 hospitals and 40 emergency rooms; Massachusetts lost 24 percent of its hospital beds between

health care became visible during the 1980s as a result of civil rights litigation brought to prevent the growing number of private and public closures.¹⁶ During this time, social scientists and policy analysts began focusing on this problem by studying the patterns of hospital reconfiguration, analyzing their causes and impact on health care delivery.¹⁷ These studies confirmed what civil rights advocates and minority communities already knew: private hospitals were leaving minority communities, and those with the least resources, in order to relocate to more affluent, predominantly white communities. At the same time, public hospitals, upon which minorities and the poor relied heavily, were falling victim to closure by local governments trying to conserve resources.¹⁸

1988-1998; in a one-week period in Boston, the city's 17 major hospitals were operating at an unheard of 96.2 occupancy rate, with emergency rooms closed to ambulances on a regular basis; in Cleveland, four of the region's leading hospitals last year were in bankruptcy, the high-level trauma center at Mt. Sinai was closed and in May metro Cleveland's 22 emergency rooms were simultaneously closed to ambulances for almost 10 percent of the month due to lack of space). See also Mary Chris Jaklevic, *Trouble in the City; Mergers, Medicare and Managed Care Combine to Force Closing of 38 Urban Hospitals*, MODERN HEALTHCARE, Jan. 8, 2001, at 52.

¹⁵ Julie Piotrowski, *How Secure is the Safety Net? Public Hospitals Learn to Survive in an Increasingly Tight Market by Closing, Building, Replacing and Sometimes Converting*, MODERN HEALTHCARE, Feb. 25, 2002, at 34. Between 1979-1982, 70 public hospitals across the United States closed. See ALAN SAGER, *THE RECONFIGURATION OF URBAN HOSPITAL CARE: 1937 - 1980*, reprinted in CITIES AND SICKNESS: HEALTH CARE IN URBAN AMERICA 55 (Ann Lennarsan Greer & Scott Greer eds., 1983) [hereinafter SAGER, RECONFIGURATION]. While public hospitals accounted for one-third of all hospital beds in 1950, by 1985, they only accounted for one-seventh. *Id.* See generally FRANK A. SLOAN ET AL., UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES (1986); HARRY F. DOWLING, CITY HOSPITALS: THE UNDERCARE OF THE UNDERPRIVILEGED (1982).

¹⁶ Julie Piotrowski, *How Secure is the Safety Net? Public Hospitals Learn to Survive in an Increasingly Tight Market by Closing, Building, Replacing and Sometimes Converting*, MODERN HEALTHCARE, Feb. 25, 2002 at 34. Between 1979 and 1982, 70 public hospitals across the United States closed. See SAGER, RECONFIGURATION, supra note 15, at 55. While public hospitals accounted for one-third of all hospital beds in 1950, by 1985, they only accounted for one-seventh. See *id.* See generally FRANK A. SLOAN ET AL., UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES (1986); HARRY F. DOWLING, CITY HOSPITALS: THE UNDERCARE OF THE UNDERPRIVILEGED (1982).

¹⁷ See Rice, supra note 15; Sara McLafferty, *The Geographical Restructuring of Urban Hospitals: Spatial dimensions of Corporate Strategy*, 23 SOC. SCI. & MED. 1079 (1986) (study of hospital closures in New York).

¹⁸ See LAURIE KAYE ABRAHAM, MAMA MIGHT BE BETTER OFF DEAD: THE FAILURE OF HEALTH CARE IN URBAN AMERICA 111 (1993).

These studies provide support for the story that minority communities have shared through their own narratives, political action, and law suits alleging race discrimination in violation of Title VI. They demonstrate why this problem cannot be understood by simply looking at an isolated instance of one hospital's decision to close or relocate services and comparing the immediate effects of closure with the hospital's or local government's purported justifications. Closures must be considered in light of hospitals' role in the larger public-private patchwork used to deliver health care in this country. They must be considered as part of a trend created and furthered by federal and local action, as well as conscious inaction. Finally, they make clear that we can not simply accept claims of fiscal concern and economic pressure as sufficient justifications for such closures.

A. Harmful Effects of Hospital Closures¹⁹

Alan Sager has performed the most comprehensive study of hospital restructuring to date, reviewing the patterns of hospital restructuring from 1937-1980 in eighteen cities of the Northeast and Midwest.²⁰ His study documented significant correlations between race and the location of hospital closings or removal of services. Specifically, Sager found that "[a]s the minority proportion of the neighborhood around the hospital increases, so does the proportion of hospitals closing or relocating...."²¹ This conclusion was supported by another study of hospital restructuring that documented an even stronger racial correlation between the likelihood of closures and the racial makeup of the in-patient population of the hospital.²² Social scientists have also observed an important correlation between the location of closures and the socioeconomic status of the community affected by closure. For example, both Sager and Sara McLafferty have noted the trends of hospital closures or the termination of services within areas of predominantly lower socio economic status (SES), with high portions

¹⁹ Throughout the article, I will use the term hospital closures generically to include the closure of an entire hospital, the termination of certain hospital departments (such as the closure of King/Drew's trauma center), or the termination and exclusive relocation of hospital services to a different geographic location..

²⁰ Sager, *Testimony*, *supra* note 15.

²¹ See Sager, *Testimony*, *supra* note 15, at 388. For example, in neighborhoods 0-25% black in 1970, only 14.2% of the 1937 hospitals had closed or relocated by 1977, while almost half of the hospitals (46.9%) had disappeared in neighborhoods that were 76-100% black in 1970. *Id.*

²² See *id.*; Rice, *supra* note 15, at 891. SAGER, RECONFIGURATION, *supra* note 15, at 55.

of Medicaid and uninsured patients, and the relocation of those services to high SES areas.²³ The correlation of race and SES to hospital closures is critical to understanding the magnitude of the effects of closure for minority communities with the least resources and greatest need.

The magnitude of the harm suffered by minority communities may not be immediately obvious because our health care system is a complex patchwork of private and public actors without clearly defined duties. The effects of closure depend in large part on the availability and willingness of other hospitals to help fill the community's needs. In theory, closure of a facility will not adversely affect care, if there are other facilities in the community that can adequately provide needed care in a timely manner. However, a number of factors, including overt and covert racial bias, economic discrimination, and overcrowding of public hospitals, undermine the ability or willingness of other hospitals to adequately fill this need. Moreover, hospital closures can trigger a domino effect that threatens longer term access and quality of care for remaining hospitals, and the maintenance of a quality primary care network of providers for minority communities.²⁴

1. Disruption in Inpatient, Outpatient, and Emergency Services

The most obvious effect of closure is a disruption of hospital services to residents in the affected community, such as inpatient acute care, outpatient services, and emergency room or trauma services.²⁵ The increased travel time and distance for residents needing emergency care can mean the difference between life and death. The SES factor compounds the negative effects of hospital closures because residents of these communities are often exposed to extraordinarily high rates of violent crimes (i.e., shootings and stabbings) or are more likely to suffer from a serious or life-threatening illness at the point they enter the health care system due to a lack of insurance or ability to pay for preventive care.²⁶

²³ See McLafferty, *supra* note 17.

²⁴ See Rice, *supra* note 15, at 892-93. See generally Sager, *Testimony*, *supra* note 17; ABRAHAM, *supra* note 18, at 60-76.

²⁵ See Rice, *supra* note 15, at 893-94; SAGER, RECONFIGURATION, *supra* note 15, at 55.

²⁶ See ABRAHAM, *supra* note 18, at 60-76, 111 (The "trauma center is indispensable in a neighborhood where so many residents are literally torn apart by violence).

Even in nonemergency cases, the increased time and distance faced by minority communities has a demonstrable impact on their access to health care.²⁷ A common scenario is that services are relocated from a lower SES, predominantly minority community to a more affluent, primarily white community located a great distance away. This effectively forecloses care where affordable private or public transportation is not available.²⁸ Second, even where public transportation exists, the added time for travel and cost can create barriers too difficult for residents of these communities to overcome, given their already precarious balancing of work, childcare, and other care giving responsibilities.²⁹ For patients who speak limited English and depend on friends or family to accompany them to the doctor for translation, the extra time involved may make it more difficult or even impossible to coordinate times for appointment.³⁰ To the extent that people in the affected communities are discouraged or prevented from accessing early treatment, this increases the likelihood that patients will be sicker by the time they finally do enter the health care system.³¹

This disruption in access to hospital care is made worse by the unreliability of remaining voluntary or public hospitals to provide patients with timely and medically appropriate care.³² Despite Title

²⁷ Studies show that increased travel time is associated with marked reductions in the use of out-patient hospital care. See Sager, *Testimony, supra* note 15, at 396.

²⁸ ABRAHAM, *supra* note 18, at 44-59. For the indigent with serious, disabling conditions, such closures are devastating. Abraham chronicles one family's struggle through the health care system in Chicago. One of the central figures was Mrs. Jackson, who was sixty-nine years old at the beginning of Abraham's research and suffered from a number of disabling conditions that kept her from being able to use public transportation. She could not private transportation to get to routine medical appointments or to seek care when a problem developed. Abraham takes us through a number of instances in which they alternated between waiting until her condition became serious enough to "justify" the ambulance coming or calling 911 and lying to them in order to get the ambulance to take her to the hospital anyway. See also *Wilmington v. NAACP*, 491 F. Supp. 290, 302-03 (D.C. Del. 1980) [hereinafter *Wilmington II*] (plaintiffs' claims that the proposed hospital closures and relocation of services to a suburban hospital would have a disparate impact on racial minorities in violation of Title VI and persons with disabilities under the Federal Rehabilitation Act); *Bryan v. Koch*, 627 F.2d 612 (2nd Cir. 1980) (alleging that closure of a public hospital would violate the disparate impact prohibition under Title VI and the Americans with Disabilities Act); *Rodde v. Bonta*, 357 F.3d 988 (9th Cir. 2004).

²⁹ See ABRAHAM, *supra* note 18, 146-66.

³⁰ See, e.g., *Wilmington II*, 491 F. Supp. at 302-03; *Rodde*, 357 F.3d at 988.

³¹ See ABRAHAM, *supra* note 18, 44-76.

³² See generally Sager, *supra* note 15; Vernellia R. Randall, *Racist Health Care: Reforming an Unjust Health Care System to Meet the Needs of African-Americans*, 3

VI's prohibition on race discrimination, many hospitals have continued to overtly discriminate against racial and ethnic minorities or have used economic proxies to disguise intentional discrimination.³³ For example, in a speech given by the Director of the OCR in 1999, he cited a number of overt Title VI violations by hospitals, including a New York hospital with segregated maternity wards, a hospital in McAllen, Texas, that clothed its security officers in uniforms resembling the Border Patrol, and a South Carolina hospital that had a policy in effect of not giving epidurals to non-English speaking women.³⁴ Even where there is no evidence of overt racial discrimination, however, hospitals regularly engage in overt and covert discrimination against Medicaid recipients and the uninsured, which disproportionately harms minorities.³⁵ Finally, in cases where there are hospitals located within a reasonable distance and willing to serve residents in the affected communities, these hospitals are often overburdened and/or provide substandard care so that residents are still effectively prevented from accessing timely and quality medical care.³⁶

2. Long Term Threats to Primary Care Services & Quality of Care

A less obvious effect of hospital closures is the disruption in primary care services, due in part to "physician flight" following the hospitals that leave the inner city. Sager identified this pattern as part of the larger trend of the de facto segregation of inner-city communities. This "physician flight" began as an outgrowth of the typical de facto residential segregation that took off during the 1970s and 80s as physicians followed their patients who moved to the suburbs. Initially,

HEALTH MATRIX: J. L. MED. 127 (1993) [hereinafter Randall, *Racist Health Care*]; Lisa M. Enfield & David P. Sklar, *Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem*, 13 AM. J. L. & MED. 561 (1988).

³³ See *infra* Part II.A. For example, many for-profit hospitals do not believe that they have a duty to provide indigent care because they subsidize such care as taxpayers. See Rice, *supra* note 15, at 894. Moreover, despite the charitable obligations undertaken by nonprofit hospitals, there is evidence that they discourage indigent care in many instances.

³⁴ See Thomas Perez, Director, Office for Civil Rights, Department of Health and Human Services, Remarks at the New England Regional Minority Health Conference (Apr. 13, 1999). In every case the OCR entered into a settlement with the hospital. There were no instances in which funding was terminated. See *id.*

³⁵ See generally Sidney D. Watson, *Race, Ethnicity and Quality of Care: Inequality and Incentives*, 27 AM. J. L. MED. 203 (2001). See also ABRAHAM, *supra* note 18, at 72-74; Randall, *supra* note 32, at 148-152.

³⁶ See Rice, *supra* note 15, at 894; ABRAHAM, *supra* note 18, at 93-133.

physicians would maintain two practices – one in the suburbs and one in the city; gradually, however, physicians maintained fewer hours at their city location, until they decided to close it altogether.³⁷ Hospital closures further encourage the departure of primary care physicians in minority communities because these hospitals are a critical base for the physicians' practice.³⁸ This creates a vicious cycle as physicians with hospital-based practices leave the community, causing affected residents to become even more dependent on the few remaining public or private hospitals and further straining remaining hospitals' ability or willingness to provide a safety net for the poor.³⁹ These effects are evident through the increasing dependence of minority communities on hospital emergency rooms and public hospitals for routine and other non-emergency care:

[F]or a large number of minority and low-income individuals more often than not the public hospital's emergency department services as an entry point into the health system. It is not unusual for the public hospital to act as the primary care center, preventive care center, trauma center and the intensive care center for the indigent patient such as the feverish baby, the shooting victim, the high risk pregnancy, the premature neonate....” With this kind of activity and care the public hospital's emergency department has become the ‘family doctor’ of inner city communities.⁴⁰

Public hospitals have historically been the safety net for poorer residents and primarily minority communities for all types of care, in large part because of racial bias and/or financial discrimination by physicians and private hospitals.⁴¹ Thus, the combination of public and private emergency room closures has compounded the problem of access to all types of care for minority communities.

Another long term effect of private hospital closures and relocations is the ultimate deterioration, or what has been commonly

³⁷ *See id.*

³⁸ *See SAGER, supra* note 15, at 90. *See also Rice, supra* note 15, at 891.

³⁹ *See SAGER, supra* note 15, at 90.

⁴⁰ *See id.*; Dowling, *supra* note 16, at 187; ABRAHAM, *supra* note 18, at 65, 95 (“hospital outpatient departments are used much more commonly by poor minorities than others”).

⁴¹ *See Randall, Racist Health Care, supra* note 32, at 148-52. *See also* Dowling, *supra* note 16, at 187; Rice, *supra* note 15, at 894.

termed “ghettoization,” of the remaining hospital facility.⁴² Social scientists and health advocates have documented the problem of relocating critical services and physician resources out of communities that need it the most, leaving them with facilities that are not adequately maintained or served by physicians and local planning entities.⁴³ The result is a gradual deterioration of the facility plant and quality of care delivered to the affected communities. Hospital closures set into motion a chain of events that threaten minority communities’ immediate and long term access to primary care, emergency and nonemergency hospital care, and results in a substandard quality of care provided by the few deteriorating or overburdened facilities that remain.

3. Psychological Effects

I began with a discussion of King/Drew because it highlights one of the most devastating effects of hospital closures – the psychic harm that results to minority communities from the disproportionate closures and reduction of services in minority communities. There are at least two dimensions of this harm that may not be immediately obvious. First, psychological harm results when there is a violation of an expectation of access to care, which can arise from the removal of care that is already being provided.⁴⁴ For more affluent communities, hospital closures will not necessarily trigger this effect because the expectation of access to care is not significantly disrupted. For residents of these communities, hospital stays are not typically considered part of everyday life. Interactions with hospitals are rare, while relationships with primary care physicians, nursing homes, and rehabilitation centers are much more significant.⁴⁵ When a hospital stay is necessary, people in these communities typically have a choice of where to go. The trend shows hospitals competing for these “markets” so there typically will not be a shortage of providers willing to treat these patients. In order to fully grasp the psychological dimension of hospital closures on minority communities, however, it is critical to understand the different experience of minority communities that depend on these hospitals for

⁴² See, e.g., Rice, *supra* note 15, at 892 (describing the deterioration of the inner city facility in Gary, Indiana, after a partial relocation of services to the suburbs); Sager *Testimony*, *supra* note 17, at 390-92. See generally ABRAHAM, *supra* note 18.

⁴³ See DAVID BARTON SMITH, HEALTH CARE DIVIDED: RACE AND HEALING A NATION (1999); ABRAHAM, *supra* note 18.

⁴⁴ See Rice, *supra* note 15, at 893.

⁴⁵ See generally ABRAHAM, *supra* note 18.

their survival and are often left with little if any effective alternatives for care as a result of such closures.

Affected communities are acutely aware of their dependence on hospitals for their lives. Losing services so vital to the community triggers the ultimate fear of survival. We hear this fear in the King Drew community's outrage when the County decided to close King/Drew's trauma unit, *the busiest trauma unit in the city*. Vast numbers of people with life threatening conditions would have to travel at least an extra ten or fifteen minutes to the next closest ER, a distance that could mean the difference between life and death. Moreover, the ability and willingness of the other hospitals to treat the sickest and poorest of the Watts community is questionable. Closure of King/Drew's trauma center literally meant cutting the community's lifeline. Recently, Jesse Jackson captured the intensity of this fear in his statements on behalf of the Watts community, protesting closure of the trauma center:

People here are so emotional because they feel threatened....People are scared. There are car wrecks on the freeway – they're scared. Most of these folks don't have insurance – they're scared. They've made AK-47s and Uzis legal again – they're scared....This hospital was born from that kind of pain.”⁴⁶

Another source of psychological harm is the violation of expectation about the level of care received relative to others. Such expectations arise from the promise of equality guaranteed through federal and local antidiscrimination laws and from local mandates about the minimal level of care required for all communities.⁴⁷ While minority communities are ever conscious of the racial and economic disparities in society generally, hospital closures reify this disparity in immediate and powerful ways that exacerbate feelings of racial stigma. This is particularly the case where a private or public entity is not just closing a hospital, but is terminating services or closing a facility as part of a larger plan to relocate services to predominantly white communities that are more affluent and do not have as a great a need. Relocations and closures are a signal to affected communities that those in charge of doling out public resources have given up on the

⁴⁶ See *Reaction to King/Drew Plan Loud and Clear*, *supra* note 4.

⁴⁷ See, e.g., CAL WELF. & INST. CODE §17000 (2001) (creating an obligation by the County to provide adequate indigent care).

community – that newer facilities in affluent areas will be given priority in the allocation of scarce resources. This sends a clear message to minority communities that they are less valuable and less deserving of certain resources than the white communities.⁴⁸ Once again, commentary on King/Drew reflects the racial stigma attached to hospital closures:

Community activists, who fought so hard for the hospital's creation, are [] consumed with the fear that it could be closed. * * * Strong willed and fiercely protective ... a coterie of African America leaders, most now in their 70s and 80s, [] defend King/Drew with the same intensity that they once devoted to the civil rights movement. To them it is part of the same struggle.

Some vividly recall how things used to be, when they had to find a ride to the main county hospital some 15 miles away. It was a long trip if you didn't have a car – and most people didn't. "Twenty-five dollars sick" meant you were in bad enough shape to pay for a cab across town.

Many remember the case of Leonard Deadwyler, a black man who in 1966 was rushing his pregnant wife from their home in Watts to County General Hospital ... in Boyle Heights when police stopped him for speeding. An officer approached his car and shot him to death. The shooting was determined to have been an accident, but many saw it as a racist killing.

⁴⁸ Justice Thurgood Marshall has recognized that such psychological harm and racial stigma can result from facially neutral action. *See City of Memphis v. Greene*, 451 U.S. 100, 138 (Justice Marshall dissenting from a majority opinion rejecting a Section 1983 and Thirteenth Amendment challenge to a street closing in Memphis that created a barrier between a white residential community and a bordering community that was predominantly black). In his dissent, Justice Marshall described the nature of the stigma that can result from such actions:

Until the closing of West Drive, the most direct route for those who lived on or near Springdale St. was straight down West Drive. Now the Negro drivers are being told in essence: "You must take the long way around because you don't live in this 'protected' white neighborhood."

Justice Marshall made clear that "valuing inconvenience lightly ignores the plain and powerful symbolic message of the 'inconvenience.'"

They also remember how the voters of Los Angeles County, mostly white, refused to pay for King/Drew's construction, forcing Supervisor Kenneth Hahn to find money elsewhere. Even now, threats to trim the hospital's budget revive fears that whites are trying to take it away.⁴⁹

It is clear from the protests of the Watts community that any government action to terminate certain services at the hospital is viewed as a threat to their rights, not a means of protection. There is no faith that government action will result in better care; there is only fear that such actions are thinly veiled attacks on one of the few institutions willing to serve minorities in a health system that continues to exclude and dehumanize people of color.⁵⁰ It is difficult to communicate the dehumanizing effects suffered as a result of these closures. Narratives, such as those presented in *Mama Might be Better Off Dead*, by Laurie Abraham, and sporadic newspaper articles about communities' protests of proposed closures help to present this picture from the community's perspective. However, I will offer two examples based on recent testimony by an emergency room physician at a Los Angeles town hall meeting.

California has been particularly hard hit by a health care crisis in recent years, with more than 70 hospital emergency room and trauma centers closed since 1990, creating a shortage of health care facilities and professionals. The problem of hospital closures and overburdened emergency rooms, while receiving little media attention, is considered a major crisis by physicians, health advocates, and patients. About a year ago, a proposition was proposed to raise funds to reimburse emergency rooms and physicians in California who treat indigent patients. In his testimony in favor of this proposition, an emergency room physician recalled a woman who had a miscarriage was forced to wait in the hospital waiting room for hours with her fetus in a Tupperware dish before she could be seen. He also testified about the lack of physician specialists willing to serve on call for emergency rooms in these urban settings. He recalled a boy who came into the emergency room with a serious head injury, but could not be helped properly. The physician said he could not find the proper specialist at any of the other local ERs, and the boy was not able to get the emergency treatment he needed. These patients and their families could not access needed care

⁴⁹ See *King/Drew Article Part 1*, *supra* note 1.

⁵⁰ See *Reaction to King/Drew Plan Loud and Clear*, *supra* note 2.

in a timely manner because of a shortage of physicians and overburdened emergency rooms, due in large part to the closures of hospitals and draining of resources in the most vulnerable communities. These were not atypical occurrences.

The emergency room physician did not have words to express the humiliation and helplessness he knew the woman experienced who had the miscarriage. Nor could he effectively communicate the frustration and hopelessness the boy's parents experienced as they watched him suffer preventable injuries because he could not get the necessary care in time. Minority communities experience this frustration, helplessness, and dehumanizing feeling each time they encounter barriers to access, but such feelings are intensified as they watch critical hospital services leave their communities. Ironically, California law acknowledges the psychic dimension of the harm that can result where such barriers to care exist. For example, it requires that "Every county and city shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident [when] such persons are not supported [by other means],⁵¹ and that "aid shall be administered and services provided *promptly and humanely, with due regard for the preservation of family life, and without discrimination.....*"⁵² Unfortunately, this mandate has not prevented the dehumanizing effects of hospital flight on minority communities.

B. Why Are Hospitals Leaving?

In 1978, the American Hospital Association published an article summarizing the results of a survey done of administrators of closed or relocated hospitals to ascertain the primary reasons for closure.⁵³ They surveyed 231 hospitals that closed or relocated during the years 1975-1977. Of 231 hospitals, the reasons for closure or relocation were broken down as follows: 27% reported financial reasons for closure or relocation, 23% were replaced by a new facility, 14% closed due to low occupancy rate; 13% closed because they were outdated facilities; and 10% closed due to inadequate supply of physicians.⁵⁴ These are consistent with the reasons offered by defendants in legal challenges brought to prevent closure. In every case, defendants give economic

⁵¹ CAL. WELF. & INST. CODE § 17000.

⁵² CAL. WELF. & INST. CODE § 10000.

⁵³ *See id.*

⁵⁴ *See id.*

justifications for closure.⁵⁵ Fiscal reasons are heavily relied upon by local governments deciding to close public hospitals or allowing private hospitals to relocate services from minority communities.⁵⁶ Secondarily, criteria such as occupancy rate and quality of the facility are cited as important considerations.⁵⁷

These justifications have created the perception that the benefits of hospital closures typically outweigh any disadvantages. This perception is based on the assumption that such closures actually reduce excess bed capacity, improve quality of care, and help save scarce public resources that will benefit society at large. Studies of hospital restructuring have called such assumptions into question. For example, Sager demonstrated that although the rate of closures was increasing, the pattern of hospital relocations and closures did not reduce overall bed capacity. This is because while some hospitals were closing, others were expanding their bed capacity.⁵⁸ Moreover, the location of the bed reductions did not correlate to communities with existing overcapacity; rather, minority communities and lower SES communities with the highest need for hospital beds tended to experience the greatest loss.⁵⁹

Trends in the types of hospitals closed and expanded over time provided further evidence that the pattern of restructurings were more likely to drive up the cost of health care, rather than enable the government to conserve resources. For example, Sager found that smaller community hospitals were more likely to close, while larger

⁵⁵ See, e.g., *Wilmington II*, 491 F. Supp. 290, 302-03, 340; *Bryan*, 627 F.2d at 614; *Mussington v. St. Luke's Roosevelt Hospital Center*, No. 92-89618 (S.D.N.Y. filed Dec. 11, 1992) (complaint). *Mussington* was ultimately dismissed on procedural grounds. *Mussington v. St. Luke's Roosevelt Hospital Center*, 824 F. Supp. 427 (S.D.N.Y. 1993).

⁵⁶ See., e.g., *McLafferty*, *supra* note 17, at 1085. For example, in an article about the trends of hospital restructuring, McLafferty studied the geographical restructuring of hospitals in New York City in the late 1960s and early 70s and found that the state actively encouraged the closure of 29 hospitals during this time. *Id.* Public reports had linked excess hospital bed capacity to rapid increases in medical costs. *Id.* [T]he state proposed a plan to reduce excess bed capacity by closing 30 hospitals in New York City. *Id.* All of the targeted hospitals were small and their names were published in a much publicized 'hit list'. *Id.* Although direct action was taken in only a few cases, inclusion on the hit list became a self-fulfilling prophesy that undermined consumer and physician confidence in the hospitals. *Id.* All but one of the listed hospitals ultimately closed. *Id.*

⁵⁷ See, e.g., *Wilmington II*, 491 F. Supp. at 302-303, 340; *Bryan*, 627 F.2d at 614; *Mussington*, 824 F. Supp. at 427.

⁵⁸ See SAGER, *supra* note 15, at 88.

⁵⁹ See *id.*

hospitals, especially teaching facilities and hospitals located in higher SES communities, were often expanded or renovated substantially.⁶⁰ Sager argued that this can result in an overall increase in health care costs for two reasons. First, these patterns suggest that patients are being shuffled from smaller community hospitals that are typically better suited to providing the kind of care needed, and at relatively low cost, to larger, more expensive facilities that are less focused on delivering the kind of care most needed by the affected communities.⁶¹ Second, to the extent that hospital closures disrupt access to preventive and early treatment for underserved communities, patients enter the health care system when they are sicker and in need of more expensive medical treatment:

It seems clear that the observed pattern of reconfiguration is not moving us toward some desirable stable state of fewer, stronger, and more appropriately sized and located institutions able to serve their cities' patients. Rather, public hospital bed reductions and the closing of less costly voluntary hospitals (both serving high proportions of minority and Medicaid-funded patients) will oblige surviving hospitals – if they have room – to choose between denying care to displaced patients and admitting them, possibly lessening their own chances of remaining open.⁶²

Despite the fact that hospital closures have not remedied purported fiscal concerns about conserving scarce resources, there are powerful economic incentives for hospitals' to flee predominantly minority, low SES communities. First, because many physicians have relocated their practice to suburban areas, there is a shortage of physicians willing to use the hospitals in these urban communities as their patient base.⁶³ Physician referrals are critical to a hospital's ability to attract private pay patients, and so this shortage of physicians has resulted in a decrease in the number of private pay patients using these hospitals. On the other hand, demographic changes have resulted

⁶⁰ Basic secondary care is usually not the focus of many of these hospitals, so even routine care is much more expensive in these hospitals. See SAGER, *supra* note 15, at 89-90.

⁶¹ See Sager, *Testimony*, *supra* note 15, at 400.

⁶² See SAGER, *supra* note 15, at 88.

⁶³ See Sager, *Testimony*, *supra* note 15, at 394-95.

in an increase in patients less able to pay for care, either because they are unable to get private or public insurance or because they receive Medicaid (which does not provide adequate reimbursement).⁶⁴ Thus, hospitals have faced a changing in-patient population that resulted in significant reductions in patient revenue. Consequently, the problem of hospital closures is caused by both an underfunding of health services for the poor and an inadequate supply of physicians.⁶⁵

While some hospitals experience severe revenue reductions that force them to consider alternatives for economic survival, it is not necessarily the case that these hospitals are on the brink of financial disaster or even close to it. Rather, many hospitals have begun acting like typical corporations in a competitive market; that is, hospitals are increasingly considering strategies to maximize their profits to ensure their long term survival, such as relocation to more affluent markets. Another common strategy has been to renovate facilities and expand technological capability to attract more physicians with a wealthier patient base. While this may enhance quality of care for the most affluent, it has actually increased the cost of care generally and depleted resources that should be directed to communities in need.⁶⁶ Finally, social scientists and health policy analysts have attributed these trends to the failure of local and federal government to create a sustainable health care financing system and to the government's shift away from active facilities planning to a largely unregulated industry that allows market competition to determine hospital restructuring patterns.⁶⁷ In some cases, local governments have actively encouraged or facilitated closures and relocations that were clearly driven by market competition, but that harmed communities in dire need of hospital resources.⁶⁸

⁶⁴ See *id.* at 395. See also ABRAHAM, *supra* note 18, at 94 (describing how “many Chicago institutions fled the [trauma] network during the late 1980s citing heavy losses incurred from treating severely injured patients who tend to be uninsured or covered by Medicaid.”). As discussed further in the next part, this problem was caused in large part by the lack of universal health insurance system, barriers minorities faced in getting employment that would provide private insurance and the inadequate funding of Medicaid.

⁶⁵ See Rice, *supra* note 15, at 891-92 (citing studies establishing a direct link between hospitals' financial stress and care to the poor); McLafferty, *supra* note 16, at 1079.

⁶⁶ See SAGER, *supra* note 15, at 88.

⁶⁷ See McLafferty, *supra* note 17, at 1079; Rice, *supra* note 15, at 890.

⁶⁸ See McLafferty, *supra* note 17, at 1080.

C. Hospital Flight as a Civil Rights Issue

In response to the increasing flight of hospitals from predominantly minority, urban communities, civil rights and health care advocates partnered to bring Title VI legal challenges to prevent public and private closures. Title VI was believed to be a powerful weapon in the fight against racial disparities in distribution of hospital resources for three reasons. First, the federal funding requirement meant that Title VI obligations reached into almost every aspect of health care delivery because of the federal government's extensive funding of private and public hospitals. Second, an Office of Civil Rights (OCR) was created and charged with the enforcement of federal civil rights laws in all areas. Finally, pursuant to authority granted in Title VI, the agency overseeing health care administration, the Department of Health, Education, and Welfare (DHEW) used its power to promulgate regulations that explicitly prohibited recipients of federal funding from using criteria or methods of administration that have discriminatory effects⁶⁹ or from choosing a "site or location of a facility" that would have such effects.⁷⁰ Thus, Title VI prohibited precisely the kind of racial inequality that resulted from hospital relocations and closures, without proof of intentional racial bias. Moreover, it empowered DHEW, through the OCR, to actively prevent such discriminatory effects, and it appeared to give communities a private right of action under Title VI to prevent closures where the government failed to do so.

Yet Title VI was not the weapon advocates hoped it would be. While the failures of civil rights laws to remedy problems of discriminatory effects is not new or unique to health care, the hospital closure problem is particularly useful for critiquing our traditional civil

⁶⁹ Specifically, the regulations provide that "[a] recipient [of federal funding], in determining the types of services. . . or facilities which will be provided under any such program. . . or the situations in which, such services. . . or facilities will be provided under any such program, or the class of individuals to be afforded an opportunity to participate in any such program, may not...utilize criteria or methods of administration which the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color, or national origin." 45 C.F.R. § 80.3(b)(3).

⁷⁰ 45 C.F.R. § 80.3(b)(3). The regulations go even further by noting that recipients may not choose "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 the Act or this regulation."

rights framework, as well as, for understanding more specifically the problem of racial inequality in health care. In order to flesh this out, I will examine all three parts of the civil rights framework critical to preventing discriminatory closures: (1) federal legislation providing significant health care subsidies for public and private health care providers; (2) the federal government's administrative power to oversee state hospital planning and to ensure Title VI compliance in the distribution of health care resources; and (3) the judiciary's role as providing a check on the federal and state actors, as well as private hospitals, attempting to restructure hospital services in discriminatory ways. In Parts II – IV of this article, I will show how in each of part, the government has not only failed to live up to the promise of Title VI, it has made decisions that have fostered racial inequity in the distribution of hospital resources and demonstrated, at a minimum, a conscious disregard for the effects on minorities' access to care.

II. CIVIL RIGHTS & FEDERAL FUNDING: THE ROLE OF HEALTH CARE FINANCING IN EXACERBATING RACIAL DISPARITIES

[I]t is possible to view hospital closings and relocations as partial symptoms, first of deficiencies in physician availability and distribution (both geographically and by specialty) and second, of an underfunding of health services of the poor... But we need to ask the questions, Why wasn't there enough money? Why replace the hospital? Why did occupancy rates fall? Why was the physical plan outdated? Why weren't there enough doctors?⁷¹

The primary reason Title VI was viewed by patients' advocates and civil rights lawyers as a powerful weapon to deal with the problems of health care access was because of the extensive federal funding reaching into almost every aspect of health care delivery. The government's direct construction and operations funding to hospitals, indirect subsidization of health care facilities via Medicare and Medicaid, and tax subsidies for nonprofit health care facilities gave the government expansive reach into both the private and public mechanisms for health care delivery. In theory, the government could

⁷¹ See Sager, *Testimony*, *supra* note 15, at 390.

regulate almost every type of provider, from physicians to nursing homes to private and public hospitals. This also gave it the power to oversee and challenge any discriminatory allocation of resources by states and local government planning of health care facilities. Thus, in order to critique the successes and failures of civil rights law, we must consider the patterns of funding and government activity in this area.

A. Overview of the Healthcare System

In order to understand the critical role federal funding plays in determining equitable access to hospital care, one must be familiar with the structure of our healthcare system and the private/public patchwork of health insurers and providers used to provide care. It is helpful to think of our health care delivery system in terms of two components. One is the direct provision of care through the construction of health care facilities and employment of professionals, such as physicians and nurses. The other is through an insurance system that guarantees reimbursement to health care providers. Both are critical to ensuring access to care. Without insurance, most individuals are practically barred from accessing all but the most emergent care because of extraordinary cost. If health care facilities and providers are not distributed equitably, entire communities may be foreclosed from accessing care in a timely manner.

There is no national health insurance system in this country and no cognizable legal duty of the federal government to provide health care for all citizens.⁷² Instead there is a patchwork of private and public health care, as well as, limited local and federal mandates to provide health care for certain groups of people. The U.S. health delivery system relies heavily on private insurance that people are expected to obtain through their employment, school, individually, or some other association.⁷³ Many people are uninsured, either because they are not eligible for insurance, employers do not offer it, or the insurance is prohibitively expensive.⁷⁴ For people who cannot obtain private health insurance, they must rely on the public "safety net."

There are significant gaps within the health care safety net because of this patchwork of private and public health care delivery.

⁷² *Maier v. Roe*, 432 U.S. 464, 469 (1977) ("[t]he Constitution imposes no obligation on the [government] to pay ... any of the medical expenses of indigents.")

⁷³ Stephen H. Long, *Public versus Employment-related Health Insurance: Experience and Implications for Black and Nonblack Americans*, in *HEALTH POLICIES AND BLACK AMERICANS 200-01* (David P. Willis ed., 1989).

⁷⁴ *See id.*

Much of the role of direct care provision and the doling out of resources is left to the states. Many states have enacted laws that obligate local entities to ensure health care access for its indigent citizens, although such laws typically do not define the minimum level of care required nor do they require local governments to provide this care directly.⁷⁵ While public hospitals are one means to satisfy this obligation, courts allow local governments to rely heavily on private health care providers, facilities, and managed care plans to provide the requisite care.⁷⁶ Gaps remain because while public hospitals have a duty to provide care regardless of one's ability to pay, private providers, such as hospitals, nursing homes, outpatient centers, health clinics, and physicians, do not.⁷⁷ There are limited exceptions. For example, federal law requires hospitals that participate in the Medicare program and have an emergency room to provide a screening and stabilizing treatment for anyone who comes to the emergency room, regardless of their insurance status or ability to pay.⁷⁸ However, this law does not create a duty to provide nonemergency care. Many hospitals are also tax-exempt, which means they receive state and federal tax benefits in exchange for some community benefit or charitable purpose they serve. Although this federal charitable requirement has been interpreted to embody a free care requirement, this interpretation has been significantly undermined.⁷⁹ States vary in

⁷⁵ See, e.g., CAL. WELF. & INST. CODE § 17000.

⁷⁶ See, e.g., CAL. HEALTH & SAFETY CODE § 1442.5 (2000) (“...the county shall provide for the fulfillment of its duty to provide care to all indigent people, either directly through county facilities *or indirectly through alternative means*”) (emphasis added).

⁷⁷ See *id.*

⁷⁸ An important, but narrow, exception to this rule is that hospitals with emergency rooms have a legal duty to screen all patients for emergency conditions and then provide stabilizing care, regardless of ability to pay. EMTALA requires all hospitals that operate an emergency room and participate in Medicare and Medicaid to provide a screening examination to everyone who comes to the emergency room, and if an emergency medical condition is discovered, it must be stabilized before the patient can be transferred to another facility. This applies to all patients, regardless of insurance coverage or ability to pay. See Enfield & Sklar, *supra* note 32 (discussion of the Emergency Medical Treatment and Active Labor Act of 1986).

⁷⁹ See 26 U.S.C. § 501(c)(3) which exempts entities “organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes....” While early revenue rulings suggested that hospitals must devote some of its revenue to the care of indigent as a condition of tax exemption, subsequent rulings seem to dilute this standard. See, e.g., Rev. Rul. 83-157 (1983) (upholding tax exempt status for a hospital that did not operate an emergency room and usually referred indigent patients to another hospital).

the degree to which they are willing to define and enforce a free care requirement as a condition of tax-exempt status.⁸⁰

Although the federal government relies heavily on state administration, planning, and design of health care delivery, it is extensively involved in health care delivery through its subsidization of states' health care programs, direct funding and tax subsidies to private and public hospitals, and through limited social insurance programs that help certain categories of the extremely poor, disabled, and elderly.⁸¹ Thus, the federal government is in fact a powerful financial partner of the states and private health care providers. Through its spending power, the government has the means and the obligation to ensure that recipients of federal funding and subsidies provide care in a nondiscriminatory manner. However, a canvass of the system of health care financing reveals that the government has created a health care financing system that exacerbates racial disparities, while simultaneously abdicating its legal obligation to ensure that funds are distributed equitably. To illustrate the government's active and passive role in fostering racial disparities, I will use two examples: the federal government's decisions in structuring and financing the Medicare and Medicaid programs and its creation and administration of Hill-Burton funding to hospitals.

B. Social Insurance: The Medicare & Medicaid Programs

The Medicare and Medicaid programs were enacted in 1965 and 1967, respectively. Enactment of Medicare and Medicaid is credited with helping to transform the U.S. health care system by encouraging access for people who otherwise were not eligible for private insurance.⁸² Medicare, in particular, is seen as playing a critical role in the movement to eliminate racial segregation through Title VI. In fact, the threat of exclusion from Medicare was initially used to force Title VI compliance, enabling the successful desegregation of more than 1000

⁸⁰ See, e.g., *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265 (Utah 1985).

⁸¹ See *infra* Part II.B & II.C.

⁸² See Watson, *supra* note 35, at 1; SMITH, *supra* note 43, at 141. See also KAREN DAVIS ET AL., *Health Care for Black Americans: The Public Sector Role*, in HEALTH POLICIES AND BLACK AMERICANS 213 (David P. Willis ed., 1989) (noting that Medicare and Medicaid, coupled with primary care programs, improved access and health status for millions of Americans).

hospitals in the first few years of the Act's life.⁸³ Despite this promising start, the government subsequently made choices that undermined the promise of both programs for racial minorities.

On June 30, 1966 President Johnson announced that Medicare would begin the next day and "for the first time, nearly every older American will receive hospital care – *not as an act of charity, but as the insured right of a senior citizen.*"⁸⁴ What was not acknowledged, however, was that because eligibility for Medicare was tied to payment into the social security program, some older and disabled workers were excluded, especially minorities.⁸⁵ This is because many jobs that tended to be disproportionately populated by minorities, such as cleaning workers, did not pay into the social security system. Moreover, the pervasive history of employment discrimination against minorities effectively excluded them from many of the jobs that would have provided these benefits.⁸⁶ By 1976, the racial differences in enrollment of minorities and nonminorities narrowed significantly,⁸⁷ but racial and ethnic disparities in access to care persist.⁸⁸ One reason for the disparities is that Medicare beneficiaries remain liable for significant out-of-pocket costs in the form of coinsurance, deductibles,

⁸³ See SMITH, *supra* note 43, at 141. See also Watson, *supra* note 35, at 210 (describing how Medicare and Medicaid helped narrow the racial and class divide that previously existed).

⁸⁴ See SMITH, *supra* note 43, at 115-16, 141-42.

⁸⁵ See ABRAHAM, *supra* note 18, at 37, 53-57.

⁸⁶ See *id.* at 53 (explaining that some jobs that tend to be disproportionately populated by minorities are excluded from the system). See also Long, *supra* note 73, at 203-04 (citing statistics that show black are more likely to be covered by public insurance than non-blacks).

⁸⁷ See DAVIS, *supra* note 82, at 226-228. Medicare was originally divided into two parts. Part A covers hospital, nursing home, and home health services; and Part B covers physician, outpatient hospital, home health and some ambulatory services, but Part B is voluntary: "Part A covers all eligible persons. Those covered under Part A may voluntarily enroll in Part B by paying a premium. Nearly all beneficiaries enrolled in Part A participate in Part B. Participation in Part B has increased overtime, particularly for blacks and other minorities...The improvement in coverage of blacks under Part B has been attributed to the growth of the state buy-in program under the Medicaid program. This program permits states to pay the Part B premiums, coinsurance, and deductibles for those aged and disabled on welfare." *Id.* at 227-28.

⁸⁸ See DAVIS, *supra* note 82, at 231-32. For example, disparities persist in the use and reimbursement of services among whites and blacks. Moreover, there are differences in the rates of physician services used, which has been attributed to minorities greater use of outpatient departments for primary care services. There is also inequality in the distribution of benefits for skilled nursing care. See *id.*

and excluded services. To the extent African-Americans are more likely to have lower incomes, such cost sharing acts as a barrier to necessary health care.⁸⁹

Medicaid helped fill in some of the gaps, however the structure and financing of the Medicaid program presented other problems. Medicaid eligibility was limited to only certain categories of persons, like pregnant women, children, and the disabled, and only the extremely poor of these individuals.⁹⁰ The consequences of the eligibility lines drawn for Medicare and Medicaid meant that minorities, the working poor, men and single women tended to be left out of the system.⁹¹ These groups were expected to obtain their own insurance through employment, school, or the private insurance market, despite the fact that these areas were largely unregulated and many employees were either ineligible due to work status or were effectively priced out of the market because of exorbitant insurance rates. Once again, African-Americans and Latinos were more likely than whites to fall through these gaps due to unemployment or employment in jobs that did not offer insurance.⁹²

There were also significant differences in the administration and financing of Medicare and Medicaid that fostered racial inequality. Medicare is a federal program that has typically been pretty easy for patients and providers to negotiate.⁹³ Coverage determinations and provider reimbursements have generally been timely and health care providers have viewed Medicare patients as valuable clients from a business perspective.⁹⁴ Medicaid, on the other hand, is a joint federal/state program in which the federal government delegates program administration and benefit determination to the states, with little or no federal oversight.⁹⁵ In practice, Medicaid has been a bureaucratic nightmare for patients and providers alike. Because

⁸⁹ See DAVIS, *supra* note 82, at 233-34.

⁹⁰ See ABRAHAM, *supra* note 18, at 44-59.

⁹¹ For example, in 1989, only 36% percent of people under 65 with incomes below the federal poverty level were covered by Medicaid. See ABRAHAM, *supra* note 18, at 70-71.

⁹² African-Americans and Latinos, in particular, are more likely than nonminorities to be uninsured due to unemployment or employment in jobs that typically do not offer health insurance. See Randall, *Racist Health Care*, *supra* note 32, at 171.

⁹³ See DAVIS, *supra* note 82, at 226.

⁹⁴ See generally ABRAHAM, *supra* note 18.

⁹⁵ *Id.* The federal government delegates most responsibility for program administration and benefit determination to the states, with little or no federal oversight. See ABRAHAM, *supra* note 18. See also DAVIS, *supra* note 82, at 220.

Medicaid eligibility depends on financial need, it was initially conceived and structured as an extension of the public welfare system – with overburdened and inexperienced welfare workers responsible for health plan administration.⁹⁶ This resulted in inaccurate and/or delayed eligibility and coverage determinations that often prevented or discouraged patients from getting needed services.⁹⁷ In fact, some states' procedures were so confusing and arbitrary, that they were forced, through litigation, to reform.⁹⁸

Medicare has also historically been funded much more generously than Medicaid. Medicaid reimbursement is universally seen as woefully inadequate, and its financing is always in danger.⁹⁹ This coupled with the structural difficulties in program administration create powerful incentives for health care providers to refuse to treat or severely limit their treatment of Medicaid patients, which disproportionately affects minorities.¹⁰⁰ These problems have also impacted the quality of health care delivered to Medicaid versus Medicare beneficiaries in significant ways. As more physicians and hospitals limited their Medicaid and indigent patients through exclusions or by leaving communities with higher rates of Medicaid patients, only a limited pool of providers willing to serve Medicaid patients remain.¹⁰¹ This often results in substandard providers delivering the bulk of care to Medicaid populations and creates a second-class health care system for the Medicaid and indigent population.¹⁰²

⁹⁶ *See id.*

⁹⁷ *See generally* ABRAHAM, *supra* note 18. In her chronicle of one family's difficulties in negotiating the public health system, Abraham described how the family didn't know that medical transportation was covered by Medicaid and another public program until a social worker informed them, causing them to miss important doctor's appointments because of a lack of affordable transportation. Even the social workers employed to assist people in getting proper insurance and health care have difficulty getting accurate information from Medicaid workers about patients' eligibility and covered medical supplies. *See id.*

⁹⁸ *See id.* at 52. The system was so bad at one point that Public Aid was forced to change its spend down procedures because of a number of lawsuits requiring the program to be administered more fairly.

⁹⁹ *See id.*

¹⁰⁰ *See* Watson, *Inequality and Incentives*, *supra* note 35; ABRAHAM, *supra* note 18, 60-76 (describing the problem of Medicaid mills).

¹⁰¹ *See* DAVIS, *supra* note 82, at 225-26.

¹⁰² *See id.*; ABRAHAM, *supra* note 18; Watson, *Inequality and Incentives*, *supra* note 35.

Despite the fact that the gaps in health access between different races and classes were narrowed as a result of Title VI and Medicare, it should not have been surprising that within two years of Title VI enactment, “racial divisions were widening again.”¹⁰³ Numerous health advocates and policy analysts have attributed this fostering of the racial divide in large part to the problems of the Medicaid program.¹⁰⁴ In essence, the government undermined its own tools for change by creating a two-tiered system of care and by creating categorical exclusions that would clearly harm minorities disproportionately.

C. Hill-Burton Funding

In 1946, there was a push by the administration and several legislators for a national insurance system.¹⁰⁵ Although this was not successful, a much more limited program of federal assistance in health care was provided through the Hospital Survey and Construction Act, also known as the Hill-Burton Act.¹⁰⁶ Through this Act, the federal government supported states and private hospitals by subsidizing hospital construction and expansion. Significant funding was distributed to hospitals throughout the 1940s-60s as a result.¹⁰⁷

At the insistence of those who pushed for a more comprehensive insurance program, Congress attached two conditions to the receipt of Hill-Burton funds. The first was an anti-discrimination clause (also known as the community service requirement) which provided that hospitals agree to make their facilities “available to all persons residing in the territorial area of the applicant without discrimination on account of race, creed or color.”¹⁰⁸ The second

¹⁰³ See SMITH, *supra* note 43, at 143.

¹⁰⁴ See Watson, *Inequality and Incentives*, *supra* note 35, at 217-218 (“[a]lmost from the beginning, Medicaid reimbursement lagged behind both Medicare and private insurance rates, and most private hospitals and physicians refused to treat or severely restricted their Medicaid patients. As a result, Medicaid patients -- who are disproportionately minority -- still cluster in public hospitals and the few private hospitals -- some formerly all Black that welcome them.”). See also Randall, *Racist Health Care*, *supra* note 32; ABRAHAM, *supra* note 18.

¹⁰⁵ See SMITH, *supra* note 43.

¹⁰⁶ 42 U.S.C. § 291 (2000).

¹⁰⁷ See SMITH, *supra* note 43.

¹⁰⁸ See SMITH, *supra* note 43. The statute provided that “[t]he Surgeon General, with the approval of the Federal Hospital Council and the Secretary of Health, Education, and Welfare, shall by general regulations prescribe -- (e) that the State plan shall provide for adequate hospitals, and other facilities for which aid under this part is available, for all persons residing in the State, and adequate hospitals (and such other facilities) to furnish needed services for persons

requirement, known as the free care requirement, provided that the hospital make available “a reasonable volume of hospital services to persons unable to pay” with an exception provided in cases where it is not financially feasible.¹⁰⁹ Once again, despite apparent promise, the government undermined its own purported commitment to improving access to health care for everyone.

The most obvious example of this is found in the text of the original legislation. The government expressly sanctioned racial segregation by recipients of Hill-Burton funds by including a qualifying clause in the antidiscrimination provision that permitted hospitals to provide “separate but equal” facilities for nonwhites.¹¹⁰ Ultimately, this provision was challenged in 1963 and found unconstitutional in *Simkins v. Cone*,¹¹¹ commonly referred to as the *Brown* of health care.¹¹² The facts of *Simkins* also illustrate the extent to which significant public funding had already been disseminated to hospitals that overtly excluded or segregated minorities. In *Simkins*, plaintiffs brought a constitutional challenge against two hospitals that denied staff privileges to black physicians and refused to treat black patients on account of their race.¹¹³ The facts revealed that the hospitals received significant government funding from their participation in the

unable to pay therefore. Such regulations may also require that before approval of an application for a project is recommended by a State agency to the Surgeon General for approval under this part, *assurance shall be received by the State from the applicant that (1) the facility or portion thereof to be constructed or modernized will be made available to all persons residing in the territorial area of the applicant; and (2) there will be made available in the facility or portion thereof to be constructed or modernized a reasonable volume of services to persons unable to pay therefore, but an exception shall be made if such a requirement is not feasible from a financial viewpoint.* 42 U.S.C. §291c(e) (emphasis added).

¹⁰⁹ See *id.*

¹¹⁰ A qualifying statement was added to the anti-discrimination clause that read:

“but an exception shall be made in cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group.” SMITH, *supra* note 43, at 47 (citing former 42 U.S.C. § 291e(f); 42 C.F.R. § 53.112).

This was the only federal legislation explicitly permitting racially exclusionary services throughout the 1900s. See SMITH, *supra* note 43, at 47.

¹¹¹ *Simkins v. Cone*, 323 F.2d 959 (1963).

¹¹² See SMITH, *supra* note 43, at 91-94.

¹¹³ *Simkins*, 323 F.2d at 962. One of the hospitals actually admitted a few select black patients, on special conditions not applied to white patients. See *id.*

Hill-Burton program.¹¹⁴ The government had allocated over \$1 million in Hill-Burton funding to one hospital, which constituted approximately 15% of its construction expenses, and almost \$2 million dollars to the other, which constituted about 50% of the cost of its construction projects.¹¹⁵ The court held first that there was sufficient state action because of the intermeshing of state and federal programs used to allocate resources for the promotion of health care access.¹¹⁶ In light of this finding of state action, the court held that the separate but equal provision of Hill-Burton violated the equal protection clause, and thus directed the district court to enjoin the defendant hospitals from further discrimination against black patients and physicians.¹¹⁷

Although both *Simkins* and Title VI prohibited race discrimination, minorities were still being excluded or segregated from whites on economic grounds. The link between race and economic discrimination was clear as early as the 1950s in those states that enacted antidiscrimination laws that prohibited the exclusion or segregation of minorities by hospitals. For hospitals that wanted to avoid Title VI or state antidiscrimination law prohibitions, economic proxies were used to exclude minorities, sometimes quite transparently. For example, many hospitals required preadmission deposits that effectively excluded Medicaid and uninsured patients, but applied the deposits selectively to minorities.¹¹⁸ In other cases, hospitals constructed private rooms or wings of hospitals to separate the privately insured and affluent patients from those who were indigent or received Medicaid.¹¹⁹ This had the visible effect of, and in some cases

¹¹⁴ See *id.* The defendant hospitals were also tax-exempt and thus subject to state and federal charitable care requirements, See *id.*

¹¹⁵ See *id.* at 962-63.

¹¹⁶ See *id.*

¹¹⁷ See *id.*

¹¹⁸ See Randall, *Racist Health Care*, *supra* note 32. For example, in Smith's book he documents the reputation that one hospital had in 1967 refusing to treat black people: "The parking lot was known sarcastically as the 'black obstetrical unit.' A number of babies had been born in the parking lot, because the mothers did not have the deposit needed to get admitted....[At the same hospital, an investigation showed that "in a number of cases, poor white people got "vouched for" and did not have to pay an admission deposit, but poor black people did not ever seem to get the same treatment." SMITH, *supra* note 43, at 168-69.

¹¹⁹ In another accounting of the problems of health care in Chicago, Laura Abraham's research revealed pervasive racial segregation disguised as economic discrimination:

As late as the 1970s, racial segregation had not been eliminated at Chicago hospitals. Medical students at Rush-Presbyterian-St. Luke's

was intended to, create a de facto segregation of black and white patients within hospitals.¹²⁰

Thus despite Title VI, the Hill-Burton antidiscrimination and free care mandates were critical for preventing race discrimination by hospitals. The nondiscrimination and free care requirements provided a powerful tool for combating race discrimination disguised by economic proxies because it could be used to prevent the exclusion or segregation of Medicaid and uninsured recipients without having to prove a race-based motive. Indeed, in light of the federal government's role in structuring Medicaid and Medicare and its early discriminatory allocation of Hill-Burton funding, it had a legal and ethical obligation to use these requirements aggressively to ensure the equitable distribution of hospital resources. Moreover, the legacy of de jure discrimination against minorities in all sectors of the economy meant that minorities were overrepresented among the indigent and Medicaid populations, and economic proxies used to disguise intentional race discrimination were pervasive. Nonetheless, the government abdicated its obligation to allocate funding equitably and to ensure that the recipients of these funds complied with the free care and nondiscrimination requirements. For example, the government continued to allocate public funds to facilities that discriminated against minorities, overtly and covertly, forcing advocates to seek help from the courts.¹²¹ In fact, the government ignored the free care provision altogether until civil rights advocates discovered it in the 1970s.¹²²

In 1970, in *Cook v. Ochsner*,¹²³ a class action suit was brought against ten New Orleans hospitals that received Hill-Burton funding. The plaintiffs were Medicaid recipients and minority residents whose

Medical Center protested in 1973 that black obstetric patients, those with good insurance as well as welfare recipients, were relegated to an old, deteriorating building, while white women gave birth in a modern wing of the hospital. *Hospital officials contended that only black Medicaid recipients were excluded from the new rooms because Medicaid would reimburse only for the cheapest accommodations. The students countered that the price differential existed solely to promote segregation since the charges for the new and old room were only a few dollars apart.*

ABRAHAM, *supra* note 18, at 118.

¹²⁰ See Rice, *supra* note 15, at 894.

¹²¹ See SMITH, *supra* note 43, at 47.

¹²² See SMITH, *supra* note 43, at 47.

¹²³ *Cook v. Ochsner Foundation Hospital*, 61 F.R.D. 354 (1972). See SMITH, *supra* note 43, at 170.

incomes were below the recognized poverty level.¹²⁴ The defendants included several hospitals that received federal Hill-Burton funding on the condition that they would provide a reasonable volume of free services to the indigent and make their services available to all in the community, but had an explicit policy of refusing or discouraging treatment of Medicaid patients.¹²⁵ The claim was later amended to add the U.S. Secretary of Health, Education, and Welfare and the Louisiana Director of State Department of Hospitals for abdication of their legal obligations to ensure compliance under the Hill-Burton Act.¹²⁶ Originally, plaintiffs sought to enjoin this discrimination under Title VI because of the racial effects of these policies, but the Title VI claim was eventually severed from the Hill-Burton claim.¹²⁷ The federal district ultimately ruled that the community service or nondiscrimination obligation prohibited hospitals from discriminating against Medicaid patients and forced the federal government to finally issue regulations regarding the free care requirement.¹²⁸ While this provided some guidance to hospitals and gave advocates a stronger tool with which to police noncomplying hospitals, the government never aggressively enforced these requirements.

In sum, the government, through policy choices about the structure and administration of federal funding programs for health care, effectively undermined its apparent commitment to racial equality in health care access in several ways.

¹²⁴ *Cook*, 61 F.R.D. at 355.

¹²⁵ *Cook*, 61 F.R.D. at 355. Plaintiffs also challenged the hospital practice of requiring admission by a private physician as having discriminatory effects. *See id.*

¹²⁶ *Cook*, 61 F.R.D. at 356.

¹²⁷ *See SMITH*, *supra* note 43, at 47. Allegations of violation of the free care requirement were ultimately settled by consent decree in July 1972.

¹²⁸ *See Cook*, 61 F.R.D. at 356-358. DHEW promulgated regulations directing that hospitals providing uncompensated service “at a level not less than the lesser of 3 percent of operating costs or 10 percent of all Federal assistance” for that fiscal year will be “deemed in presumptive compliance” with the free care requirement. 42 C.F.R. § 53.111(h)(7) (2004). *See also Cook v. Ochsner*, 559 F.2d 968, 973 (1977) (upholding the validity of these regulations). The court also interpreted DHEW’s regulations at § 53.111(a) as creating a twenty-year limitation on the free care requirement. *See id.* at 973 (affirming the validity of this limitation); *see also SMITH*, *supra* note 43, at 169-71.

III. ADMINISTRATIVE FAILURES IN TITLE VI ENFORCEMENT & THE RETREAT FROM FACILITIES PLANNING

The federal government has reserved a powerful administrative role for itself in Title VI enforcement and as the overseer of state facilities planning in the distribution of hospital resources, more generally. Despite this reservation of power, the federal government undermined its purported commitment to Title VI enforcement in two key ways. First, through a series of actions that ranged from “deliberate sabotage” to “shameful neglect,” the government rendered the OCR ineffective in civil rights enforcement. Moreover, the federal government not only delegated its facilities planning power almost completely to local entities, it made a conscious decision to further shift from a model of active regulatory control of hospital distribution (the facilities planning model) to one that would allow free market competition to essentially determine the distribution of hospital resources. Both decisions had predictable adverse effects on minorities’ access to care.

A. The Impotence of the OCR

In its three decades of operation, an agency that had originally defined its role as an advocate and prosecutor had been transformed largely into a passive arbiter of disputes that avoided taking sides. In the process, it was transformed from a central, driving force into an increasingly isolated, decaying part of the federal bureaucracy.¹²⁹

As mentioned in the previous Part, the federal government initially was aggressive in using the threat of exclusion from Medicare to eliminate the overt segregation and exclusion of minorities from hospitals receiving public funds. The federal agency responsible for overseeing the administration of health care financing was originally the Department of Health, Education, and Welfare (DHEW), which has been reorganized and is now the Department of Health and Human Services (HHS). Pursuant to the authority granted under Title VI, DHEW promulgated regulations that expressly prohibited the use of criteria, methods, or choice of site location that would

¹²⁹ See *id.* at 356.

disproportionately affect racial minorities.¹³⁰ Title VI enforcement was vested in the Office of Civil Rights, which was charged with the processing of all complaints of discriminatory practices.¹³¹ Through DHEW and the OCR, the federal government appeared to have a powerful administrative arm through which to police public and private hospital restructuring. This power was never fully actualized, however. Despite the obligation to investigate complaints of discrimination prohibited by the regulations, the federal agencies charged with this responsibility were not equipped to adequately respond to complaints. Minority communities falling victim to private and public closures were forced to seek help from the courts, and once again, a court order was required to force the government to fulfill its legal obligations.

In *NAACP v. Wilmington*,¹³² a Title VI challenge was brought against the Wilmington Medical Corporation (WMC) to prevent a plan involving a closure of two hospitals in an urban community that was predominantly minority and the relocation of key services exclusively to a new location in a predominantly white, affluent area.¹³³ Plaintiffs challenged the restructuring plan on the grounds that it would have a disproportionately harsh effect on racial and ethnic minorities.¹³⁴ Upon receiving a copy of the lawsuit filed by plaintiffs, however, the U.S. Secretary of DHEW failed to investigate or initiate any proceedings to halt the relocation.¹³⁵ In fact, DHEW had expressly approved of the relocation through a process created under the Social Security Act and unrelated to the specific question of Title VI compliance.¹³⁶

¹³⁰ 45 C.F.R. § 80.3(b)(2).

¹³¹ 28 C.F.R. § 42.408 (a) (2005).

¹³² *Wilmington I*, 426 F. Supp. 919 (D.C. Del. 1977) [hereinafter *Wilmington I*].

¹³³ *Id.* at 921-922. The plaintiffs also alleged violations of the Federal Rehabilitation Act because the plan would disproportionately impact the elderly and disabled persons. *See id.* at 922.

¹³⁴ *See id.*

¹³⁵ *See id.* at 924.

¹³⁶ *See id.* at 922. The court explains that “[t]he significance of § 1122 approval reflects the narrow Congressional purpose of encouraging state and local health planning efforts [by ensuring hospitals] that the Secretary will not later withhold federal funds under Medicare, Medicaid, and programs for maternal and child health services because the capital component of the hospital charges is the result of an unnecessary capital expenditure. If WMC had not applied for §1122 approval or if its §1122 application had been rejected, it simply ran the risk of not being fully reimbursed for services provided to federally assisted patients.” *See id.* at 922. Before they could accomplish the plan, however, they sought approval for the federal government under section 1122 of the Social Security Act (42 U.S.C. s 1320a-1). In reality, the process for approval is delegated to local planning agencies, with final approval required by DHEW/HHS. *See id.*

Ultimately, the court had to force the OCR to investigate and collect information necessary to assess the effects of the plan.¹³⁷ At the conclusion of the investigation, the court issued a temporary injunction preventing closure.¹³⁸ As discussed further in the next Part, the relocation was eventually allowed to proceed based on assurances provided by the defendant designed to minimize the effects of closure.¹³⁹

Despite the courts' initial policing of the OCR, its record of Title VI enforcement is still shameful.¹⁴⁰ As recently as 1999, a report by the United States Commission on Civil Rights (the Commission) not only confirmed many of the longstanding complaints lodged by patients' advocates, it also issued a scathing indictment that concluded that the structure and operations of HHS/OCR have actually exacerbated racial disparities in health care.¹⁴¹ The Commission concluded that "the timid and ineffectual enforcement efforts of [OCR] have fostered, rather than combated, the discrimination that continues to infect the Nation's health care system."¹⁴² The Commission found a number of faults with OCR's operations: the failure to develop Title VI guidelines and adequate policy directions; lack of a thorough pre-award review process to ensure that prospective recipients of federal financial assistance were in compliance with the law; infrequent post award audits or onsite compliance reviews; growing complaint backlog; and lack of an effective and comprehensive system for monitoring corrective action commitment.¹⁴³ Despite regulations giving DHEW the power to prohibit acts that had discriminatory effects, no strategy or tools were implemented to enable the OCR to proactively police hospital restructuring or monitor the discriminatory effects that might occur.

The most compelling part of this report, however, was the conclusion about the cause of these flaws in OCR operations: the underfunding and understaffing of the agency and inherent structural

¹³⁷ See *id.* at 925.

¹³⁸ See *id.*

¹³⁹ The Court found this compromise acceptable under Title VI, which will be discussed further in the next section, but plaintiffs did not consider this a success.

¹⁴⁰ See *id.*

¹⁴¹ See Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare System: Reinvigorating the Role of the Federal Government in the Aftermath of Alexander v. Sandoval*, 3 YALE J. HEALTH POL'Y L. & ETHICS 215 (2003).

¹⁴² See *id.*

¹⁴³ See *id.*

defects in OCR's relationships to the agencies that controlled the administration of public funds. In short, OCR's flaws were really an indictment of Congress' policy choices. Congress has never provided adequate funding or staff for effective civil rights enforcement.¹⁴⁴ As *Wilmington* demonstrated, the OCR suffered from a lack of personnel with the relevant expertise to be able to gather and assess data properly in order to determine any harmful effects that would occur.¹⁴⁵

The Commission also attributed much of the OCR's impotence to the decision to lump all civil rights enforcement under one body and segregate civil rights enforcement based on Title VI from the administrative bodies that had the actual power to grant and revoke federal funding.¹⁴⁶ Lumping all civil rights enforcement under one body meant that health care got short shrift in lieu of the more visible and contentious issues surrounding school desegregation.¹⁴⁷ More importantly, though, establishing OCR as a separate agency from those administering federal funds essentially ensured that OCR would have no real enforcement power since the power of Title VI enforcement lies in its threat to withhold significant public funding. This choice has been characterized as "a deliberate attempt on the part of some members of Congress to eviscerate civil rights enforcement efforts."¹⁴⁸

Indeed, it is the adversarial relationship between OCR and other agencies administering funds which has not only impeded civil rights enforcement, but which sends a strong message that the government never intended to take its commitment to remedy disparate effects

¹⁴⁴ As early 1966, each division of DHEW only had a "token skeleton" staff to handle civil rights matters, and only a small skeleton staff operated out of the Office of Civil Rights. SMITH, *supra* note 43, at 183. See Marianne Engelman Lado, *Unfinished Agenda: The Need for Civil Rights Litigation to Address Race Discrimination and Inequalities in Health Care Delivery*, 6 TEX. F. ON C.L. & C.R. 1 (2001) (noting that "the dreadful financial and operational conditions within OCR are a fixture on the landscape of government enforcement and not a recent development."). Despite the obvious effect this has on enforcement, the problem hasn't changed. For example, in its 1999 report, the Commission criticized the fact that OCR's budget represented just .0054 percent of the entire HHS budget and that OCR had no separate budget for Title VI enforcement. See SMITH, *supra* note 43, at 125.

¹⁴⁵ See *Wilmington I*, 426 F. Supp. at 924.

¹⁴⁶ See SMITH, *supra* note 43, at 183 ("[i]nitially, Title VI was the responsibility of the assistant secretary of DHEW, with each operating division [such as Public Health Services] responsible for carrying out day-to-day enforcement.... In October 1967...DHEW reluctantly responded to pressures from these appropriation committees and reorganized the Title VI program, centralizing it into a single unit.")

¹⁴⁷ See SMITH, *supra* note 43, at 183.

¹⁴⁸ SMITH, *supra* note 43, at 183.

seriously. At each point that the OCR has tried to take a more aggressive role in the monitoring of racial disparities, it was hindered.¹⁴⁹ For example, early on, OCR officials called for the collection of race data as a critical tool for Title VI oversight, but HCFA resisted.¹⁵⁰ In fact, the federal Health Resources Administration, which actively worked to reduce excess hospital bed capacity through hospital closings, was unwilling to press for the analysis of racial segregation in patterns of local use of hospitals to try to understand the effects of its policies and whether these decisions served their purported goals of ensuring equal access.¹⁵¹ The OCR also fought for a prominent role in policing Title VI through the aggressive enforcement of Hill-Burton's free care requirement. Although it was able to influence standards ultimately promulgated, it was never given the power necessary to really enforce them.¹⁵²

B. Government Shift from Facilities Planning to Market Competition

Throughout the 1960s and 70s, the link between racial equality and aggressive facilities planning became clear. In fact, on March 14, 1980, Alan Sager, Ph.D. and Assistant Professor of Urban and Health Planning, gave a statement to U.S. House of Representatives, Health

¹⁴⁹ See Rosenbaum & Teitelbaum, *supra* note 141, at 237-38.

¹⁵⁰ See *id.*

¹⁵¹ See SMITH, *supra* note 43.

¹⁵² Smith provides a first hand account of the barriers to the aggressive use of Hill-Burton funding in health care planning during the early 70s:

Hill-Burton had these two requirements, the community services and uncompensated-care requirements, that were really dormant. We waged an aggressive effort to have OCR become the primary enforcement agency and to revise the regulations on [what these requirements] entailed. Neither ... had been spelled out, and the department wasn't paying much attention to it. In conjunction with [the Health Resources Administration and HCFA] we developed the formula for free indigent care. It was a mechanical formula....On the community services side, where it had not been defined, the issues were much more contentious....We wanted community services defined in a way that would give it real meaning: forcing facilities to provide access to Medicaid and uninsured populations. In the end, we got pretty much what we wanted on uncompensated care, and we got a lot of good language on community services, but virtually no enforcement. What we really lost out on was giving it any teeth.

Sub-committee of the Ways and Means Committee, entitled "Urban Hospital Closings in the Face of Racial Change."¹⁵³ Sager made certain recommendations for dealing with the hospital closure problem based on his study of hospital closures. He advised them of his findings: Hospital closures were a problem for minority communities and the poor, in particular. Inadequate funding of health services for the poor, coupled with economic pressures of hospitals to focus on profit, encouraged closures of some facilities and expansion of others. These closures not only had the effect of decreasing minority access to care, but probably increased the financial burdens to Medicare and Medicaid, further stressing our public fisc, and thus, the scarce resources used as a safety net. As a result of these findings, Sager concluded that greater economic controls and active facilities planning were essential to achieving a more equitable distribution of hospital resources.

Indeed, through its spending power, the federal government has the ability to oversee state planning to ensure that resources are equitably distributed. This power extends beyond just oversight of Title VI compliance. For example, the statute creating Hill-Burton funding for hospitals required states to submit a plan for approval as a condition of receiving such funds that would assure an adequate distribution of resources by the state:

The Surgeon General, with the approval of the Federal Hospital Council and the Secretary of Health, Education, and Welfare, shall by general regulations prescribe . . . that the State plan shall provide for adequate hospitals, and other facilities for which aid under this part is available, for all persons residing in the State, and adequate hospitals (and such other facilities) to furnish needed services for persons unable to pay therefore.¹⁵⁴

Despite the reservation of administrative power by the federal government to ensure Title VI compliance in the distribution of hospital resources, it neglected this power and made policy decisions that have exacerbated the problem of hospital flight and revealed a conscious neglect of the devastating effects such closures have on minority communities. For example, during the 1980s, the federal government retreated from a facilities planning model, shifting to a model of free market competition that could only exacerbate problems

¹⁵³ See Sager, *Testimony*, *supra* note 15.

¹⁵⁴ 42 U.S.C. §291c(e).

of racial disparities.¹⁵⁵ Moreover, during this time President Regan cut Medicaid and other federal spending significantly, while the economy suffered from a recession, accompanied by high unemployment.¹⁵⁶ This resulted in more people becoming uninsured or relying on public insurance, at a time when the public funding was being reduced, putting greater strain on hospitals that served disproportionate numbers of the uninsured and Medicaid beneficiaries. As already noted, in a competitive market, hospitals are forced to search out richer markets and consider corporate strategies that will maximize profits. This profit maximizing goal in the face of the increasing economic strain resulting from constant cuts in Medicare and Medicaid, and further cuts in resources allocated to the public safety net, encouraged hospital flight from urban and predominantly minority communities. In the face of increasing public and private hospital closures and the federal government's abdication of its facilities planning responsibility, minority communities and civil right advocates turned to the courts for help.

IV. Civil Rights Litigation: The Unfulfilled Promise of Title VI

As far as establishing national precedents or changing the behavior of federal planning and civil rights agencies, the results from the hospital relocation lawsuits were abysmal from the perspective of the civil rights advocacy groups.¹⁵⁷

As seen in Parts II and III, civil rights litigation has been instrumental in forcing government accountability at certain levels: it forced the government to set standards defining express legal obligations, as in *Ochsner*; it forced the government to comply with express requirements to investigate complaints of Title VI violations, as in the first phase of *Wilmington*; and it prevented cases of intentional discrimination by recipients of federal funding, as in *Simkins*. Thus, civil rights litigation has been successful where there is evidence of intentional discrimination and/or a complete abdication by the government of action explicitly required by law. While *Simkins*, *Ochsner*, and the first phase of *Wilmington* reflect some progress in fighting race

¹⁵⁵ See McLafferty, *supra* note 17, at 1080.

¹⁵⁶ See Long, *supra* note 73, at 206-08.

¹⁵⁷ See SMITH, *supra* note 43, at 181.

discrimination in health care, Title VI has not been as successful in the hospital closure cases.

Title VI challenges to hospital closures are different because they rely on the court taking seriously the disparate effects language in the regulations as it is practically impossible to show intentional discrimination by the bodies making closure or relocation decisions. Moreover, where such closures are sanctioned by the federal or local government, it requires the courts to step in and exercise independent judgment about the merits of the decision in contravention of government approval. Thus, the cases discussed above left open two critical questions: to what extent must the federal government actively use its facilities planning power to ensure the distribution of hospital resources in equitable ways; and to what extent are courts willing to serve as a check on the government's decisions in individual challenges to hospital closures.

In this Part, I will review the courts' decisions in this area to show how they have undermined Title VI enforcement by eviscerating the disparate effects protection promised under the regulations. Specifically, courts have done this by devaluing the harm alleged by plaintiffs and showing undue deference to defendants' justifications of closures. In order to flesh this out, I will look at two typical scenarios – public closure and private relocation. While my analysis will draw upon the decisions from a number of cases, I will focus my discussion on two key cases – *NAACP v. Wilmington*, the first Title VI challenge to a private hospital relocation to reach the courts, and *Bryan v. Koch*, a Title VI challenge to the closure of a New York public hospital. These cases illustrate that despite two very different approaches and degrees of protection provided plaintiffs by the *Bryan* and *Wilmington* courts, the ultimate result is the same – courts have created an almost insurmountable barrier for plaintiffs challenging hospital relocations.

A. Typical Scenarios of Hospital Closure/Relocation

1. Private Hospital Relocation in *NAACP v. Wilmington*

In *Wilmington*, plaintiffs brought a Title VI challenge to prevent the closure and relocation of hospitals owned by a private hospital corporation, Wilmington Medical Center, Inc (WMC).¹⁵⁸ WMC provided a major portion of the hospital care for New Castle County, Delaware.¹⁵⁹ In fact, WMC was the sole provider of tertiary care and

¹⁵⁸ *Wilmington II*, 491 F.Supp. at 290.

¹⁵⁹ *See id.* at 294-95.

almost the sole provider of obstetrical care.¹⁶⁰ Three nonprofit hospitals formed the center of its operations: the General Division, the Memorial Division, and the Delaware Division – all located within the City of Wilmington.¹⁶¹ It was the largest provider of free care for the indigent in New Castle County.¹⁶²

WMC decided that a massive capital expenditure program was required in order to modernize its facility, stay competitive in the health care market, and increase the quality and level of care it was delivering.¹⁶³ It adopted a plan entitled “Plan Omega,” in which the Memorial and General Divisions would be closed and the Delaware Division (hereinafter referred to as the “City Division”) would be renovated, reducing the number of beds for downtown Wilmington to 250.¹⁶⁴ As part of Plan Omega, a new sixty million dollar, 800 bed tertiary care facility would be built in the Stanton suburb of Delaware (the “Stanton or Suburban Division”).¹⁶⁵ A number of important and high-need services would be terminated at the Delaware Division and relocated exclusively at the new Stanton location, including obstetric, high-risk prenatal and specialty pediatric, gynecology, and hemodialysis.¹⁶⁶ Primary care clinics, on the other hand, would be consolidated at Delaware Hospital, as would psychiatry, dentistry, and some other services.¹⁶⁷

Phase I. In their initial complaint plaintiffs alleged that Plan Omega violated Title VI because it discriminated against the poor, ethnic and racial minorities.¹⁶⁸ Plaintiffs noted that the minority and elderly populations were heavily concentrated in the City Division, which also tended to be populated with a large number of low income patients without access to private or public transportation to the proposed suburban location.¹⁶⁹ Moreover, the communities in the City Division had a disproportionately higher need than residents of the

¹⁶⁰ *See id.*

¹⁶¹ *See id.*

¹⁶² *See id.* at 296.

¹⁶³ *See Wilmington II*, 491 F.Supp. at 302, 340.

¹⁶⁴ *See id.* at 298.

¹⁶⁵ *See id.*

¹⁶⁶ *See id.*

¹⁶⁷ *See id.*

¹⁶⁸ *See Wilmington II*, 491 F.Supp. at 298.

¹⁶⁹ *See id.* at 302-03. Seventy-two percent of the Black residents of New Castle lived downtown and in the other areas served by the City Division, but only 14% of Blacks lived in the areas served by the Suburban Division. The statistics are even more dramatic in comparing the racial makeup of the potential in-patient population for each Division. *See id.*

suburban location for many of the services, such as OB and cardiovascular services, which were being relocated exclusively to the Suburban location.¹⁷⁰ In short, certain services were being moved 9.35 miles further from the people who needed them the most, but would have no way of accessing them.¹⁷¹

The court ordered OCR to investigate and ultimately OCR agreed that the discriminatory effects of the proposed plan would violate Title VI.¹⁷² Despite these findings, federal funding was not terminated and DHEW/OCR did not inquire about less discriminatory alternatives; rather DHEW allowed WMC to continue with the Plan subject to certain assurances.¹⁷³ In particular, WMC agreed to provide “free and adequate transportation” for patients, visitors, and employees between the City and Suburban divisions.¹⁷⁴ WMC also had to make assurances that it would not allow either division to become “racially identifiable” and that it would direct resources for the complete renovation of the City Division in such a manner as to prevent the ultimate deterioration and neglect of the downtown location.¹⁷⁵

Phase II. The plaintiffs challenged this revised plan under Title VI as well.¹⁷⁶ First, plaintiffs argued that despite some mitigation of harmful effects, the increased distance and travel time would effectively discourage needed care by the poorer residents and minorities of Wilmington.¹⁷⁷ Moreover, plaintiffs were skeptical of the financial assurances made by defendants to maintain the facility and provide transportation.¹⁷⁸ Second, plaintiffs challenged the fundamental unfairness of the removal of such critical services from a high need, underserved community, especially in light of an alternative plan that would have less discriminatory effects.¹⁷⁹ In fact, the plaintiffs specifically identified a plan that had been rejected by WMC called Reverse Omega that would result in an 800 bed Delaware Division and 200 bed Southwest Division that would keep most of the beds in the community with the greatest need.¹⁸⁰ Finally, the plaintiffs

¹⁷⁰ *See id.* at 308.

¹⁷¹ *See id.*

¹⁷² *Wilmington I*, 426 F. Supp. at 921-22.

¹⁷³ *Wilmington II*, 491 F. Supp. at 299-302.

¹⁷⁴ *See id.* at 302.

¹⁷⁵ *See id.*

¹⁷⁶ *See id.* at 308-310.

¹⁷⁷ *See id.* at 308-309.

¹⁷⁸ *See Wilmington II*, 491 F. Supp. at 327-28.

¹⁷⁹ *See id.* at 310.

¹⁸⁰ *See id.*

alleged that WMC failed to show an important enough justification for its plan in light of the less discriminatory alternative.¹⁸¹

After a lengthy consideration of the plaintiffs' allegations and OCR findings, the court ultimately held that in light of the contract assurances and free transportation negotiated by DHEW, plaintiffs could not make out a prima facie case of Title VI violation.¹⁸² The Court went on to note that even if the plaintiffs could show a disparate impact, the defendant had established that the restructuring served a legitimate, bona fide interest because the less discriminatory plan could only be accomplished at significantly greater cost.¹⁸³

2. Public Hospital Closure in *Bryan v. Koch*

In *Bryan v. Koch*,¹⁸⁴ a Title VI challenge was brought to prevent New York City's decision to close Sydenham Hospital in Central Harlem, which served a population that was 98% minority (black and Hispanic).¹⁸⁵ The mayor had appointed and charged a special task force to "examine ways of reducing costly excess hospital capacity while maintaining access to high quality health services."¹⁸⁶ Ultimately, the task force recommended, and the city decided to replace some hospitals, reduce bed capacity at others, and to close two out of seventeen of municipal hospitals.¹⁸⁷ The closure of Sydenham was challenged on the grounds that it would have a significant adverse impact on blacks and Latinos.¹⁸⁸ Plaintiffs also sought a preliminary injunction to temporarily enjoin Sydenham's closure pending the outcome of the lawsuit or assurances by the city that the in-patient and emergency needs of the minority populations would otherwise be served.¹⁸⁹

In stark contrast to *Wilmington*, the facts about the potential impact of the closure are scarce because no OCR or HHS investigation

¹⁸¹ See *id.* at 339-45.

¹⁸² See *id.*

¹⁸³ See SMITH, *supra* note 43, at 179.

¹⁸⁴ *Bryan*, 627 F.2d at 612.

¹⁸⁵ See *id.* at 614.

¹⁸⁶ See *id.*

¹⁸⁷ See *id.*

¹⁸⁸ There were three lawsuits relating to this preliminary injunction. In two of them, the city and state of New York were defendants, as well as the State Health Department. The federal Department of Health and Human Services was also sued for failure to investigate the administrative complaint filed about the closure. See *id.* at 614-15.

¹⁸⁹ See *Bryan*, 627 F.2d at 614.

had been completed.¹⁹⁰ Nonetheless, the 2nd Circuit majority refused to issue an injunction temporarily preventing closure, despite the lack of data that should have been collected by OCR and that was necessary to assess the magnitude of harmful effects resulting from the closure.¹⁹¹ It affirmed the District Court's findings that there were only minimal effects on racial minorities¹⁹² and that the city's decision was justified by a nondiscriminatory reason – the government's fiscal concerns.¹⁹³

B. The Failure of Title VI in Preventing Hospital Closures

In making a *prima facie* case for a Title VI violation, the plaintiff must prove that an act, policy, or in this case site location, will have discriminatory effects. This requires not only statistics demonstrating that a particular race or ethnic minority will be disproportionately affected, but that a significant adverse effect will result. Proof of disparate effects merely shifts the burden to defendants to proffer evidence of a legitimate, nondiscriminatory reason for the decision. There are two key criticisms of the courts' application of Title VI to hospital relocations/closures: (1) the failure to properly value plaintiffs' harm; and (2) too much deference and weight given to defendants' justifications for closure.

1. Devaluation of Harmful Effects

Courts have devalued plaintiffs' allegations of harm in a number of ways. Some courts have been outwardly hostile to disparate effects claims, viewing intentional discrimination as the only basis for private relief under Title VI. *Bryan* provides the most obvious example of this. The District Court spent most of its opinion analyzing whether there was intentional discrimination and questioning whether plaintiffs had the right to use Title VI to seek injunctive relief without evidence of bad intent.¹⁹⁴ It devoted so little time to plaintiffs' allegations of disparate effects that the dissent in the appellate decision characterized the analysis as "a mere afterthought."¹⁹⁵ Even where courts appear to take the disparate effects test seriously in theory, they have applied the test in ways that devalue certain kinds of harm identified in Part I of this article. First, courts create an impossibly high burden for plaintiffs

¹⁹⁰ See *id.* at 620.

¹⁹¹ See *id.* at 616.

¹⁹² See *id.* at 617.

¹⁹³ See *id.* at 617-19.

¹⁹⁴ See *Bryan*, 627 F.2d at 624.

¹⁹⁵ See *id.*

to recover, essentially requiring them to show that the challenged action will result in complete foreclosure of access to care.¹⁹⁶ In *Wilmington*, for example, the court only seemed to view immediate disruptions in hospital care as significant. The court focused on two issues: (1) Will the relocation result in a foreclosure of plaintiffs' access to emergency and non-emergency services? (2) If transportation will be a barrier, how will this be fixed? Apparently, after their negotiations, DHEW and the defendants answered these questions to the court's satisfaction.

On the other hand, anything short of absolute and immediate foreclosure to hospital services is dismissed as insignificant or too remote. The indirect behavioral, long term, or psychic harms identified in Part I.A. of this Article have not been considered sufficiently burdensome to constitute a Title VI violation. For example, allegations that increasing the burden of time and distance would have the effect of discouraging timely routine and preventive care were never really addressed by the court. Moreover, the fundamental unfairness and racial stigma arising out of a plan to relocate services from minority areas with greater need, to a predominantly white area with much less need, was also largely ignored. Finally, plaintiffs' concerns about the ultimate "ghettoization" of the hospital leading to substandard care were characterized as a "fanciful scenario."

Courts also underestimate the magnitude of the harm from closure through uncritical acceptance of the mitigating factors offered by defendants. In *Wilmington*, to the extent that the court considered the plaintiffs concerns about the de facto segregation of care, the deterioration of the urban facility, and the racial stigma that would result from both, it seemed satisfied with the defendants' vague assurances not to let this happen and by DHEW's purported willingness to enforce these assurances.¹⁹⁷ The court's reliance on these assurances was particularly troublesome in light of the OCR's inadequate resources and of DHEW's initial neglect. *Bryan* provides the best example of the courts' underestimation of harm in its discussion of the City's claims that access to care will not be disrupted because other hospitals can provide catchment for patients previously served by Sydenham. The court focused only superficially on this claim and failed to deal honestly with the limited ability and willingness of these other hospitals to take more Medicaid and uninsured patients. Oddly, the court relied on the unproven assertion that existing hospitals were already treating a significant number of Medicare and Medicaid

¹⁹⁶ See, e.g., *Jackson v. Conway*, 476 F. Supp. 896 (E.D. Mo. 1979).

¹⁹⁷ *Wilmington II*, 491 F. Supp. at 299-302.

patients as evidence that they would continue to do so, which defies both common sense and experience.¹⁹⁸ First, in treating Medicaid and Medicare patients as synonymous in the eyes of providers, the court ignored the pervasive problem of Medicaid discrimination, a critical element of plaintiffs' effects argument. Moreover, even if it were true that these hospitals already treated significant numbers of Medicaid patients, experience shows that this would decrease, not increase, their willingness and ability to absorb more Medicaid patients.

2. Undue Deference to Defendants

In measuring the legitimacy and sufficiency of a defendant's justifications for actions that have discriminatory effects, there are three important issues to be addressed: what reason is important enough to overcome plaintiffs' showing of harm; is the defendant required to demonstrate that its decision was the least discriminatory alternative available or that other alternatives were considered in the decision-making process; and how closely should the defendant's reasons or processes be scrutinized.

In every challenge to a hospital closure or relocation, the defendant asserts an economic justification for the closure, and courts have been extremely deferential in finding such reasons legitimate.¹⁹⁹ In *Wilmington*, for example, the defendant paints a picture of a hospital fighting for its survival in a competitive market. In *Bryan*, the city justifies its action as a way to conserve resources in the midst of a budget crisis.²⁰⁰ Defendants will usually also assert quality of care justifications as well. In both *Wilmington* and *Bryan*, the hospital suffered quality of care problems as evidenced by the condition of the facility and problems with its accreditation. The defendants argued that the closure/relocation would enable them to improve the quality of care most efficiently by using the resources to construct newer and better facilities.²⁰¹

Courts have differed as to whether defendants must consider less discriminatory alternatives and the level of scrutiny to be applied to the defendants' decision-making process. *Bryan* provides an example of the most hands-off approach a court can take. In *Bryan*, the government failed to investigate the likelihood that the closure would reduce health care expenditures in light of the disruption to access that

¹⁹⁸ *Bryan*, 627 F.2d at 617 n.2.

¹⁹⁹ See Watson, *Reinvigorating Title VI*, *supra* note 107.

²⁰⁰ *Bryan*, 627 F.2d at 617.

²⁰¹ *Wilmington II*, 491 F. Supp. at 297-298; *Bryan*, 627 F.2d at 617 n.2.

would result and the potential shuffling of patients to more expensive facilities.²⁰² The government also failed to consider whether less discriminatory alternatives to closing the hospital existed, such as merger or consolidation.²⁰³ Although such failures undermine both the rationality and substantive legitimacy of the City's decision, the majority nonetheless deferred to the City. It seemed satisfied that there was some decision-making process, and it gave only token consideration to the form and criteria used to decide which hospital to close. In fact, the *Bryan* court explicitly ruled that Title VI does not "require[] consideration of alternatives beyond an assessment of all the municipal hospitals in order to select one or more for closing."²⁰⁴

While a somewhat more protective approach was used in *Wilmington*, it effectively led to the same result. The *Wilmington* court suggested that the defendant did have a duty to consider whether less discriminatory alternatives exist to meet the stated goals.²⁰⁵ As part of its analysis, the court found it relevant that a less discriminatory alternative had been considered and rejected by the defendant hospital corporation. Nonetheless, the court noted that the burden of persuasion remained on the plaintiff to prove that the defendant's justification was mere pretext or that the less discriminatory alternatives would be able to serve the defendant's purported goals.²⁰⁶ In its analysis, the court was quite deferential to defendants.

For example, despite the fact that a less discriminatory restructuring plan was available, WMC justified its rejection of this alternative based on its cost. The OCR never investigated the defendants' assertions about the cost differentials between the two plans, however.²⁰⁷ Moreover, during trial, plaintiffs introduced persuasive evidence that the defendants had significantly overestimated the cost of the alternative plan.²⁰⁸ While the court acknowledged the possibility that defendants overestimated the cost, it also found that plaintiffs' estimates were likely too low because of errors in assumptions made in its calculations.²⁰⁹ Rather than require defendants to provide accurate calculations to support their cost justifications, the

²⁰² *Bryan*, 627 F.2d at 625-28.

²⁰³ *See id.*

²⁰⁴ *Id.* at 619.

²⁰⁵ *Wilmington II*, 491 F. Supp. at 314-15.

²⁰⁶ *See id.*

²⁰⁷ *See id.*

²⁰⁸ *See id.* at 343-45.

²⁰⁹ *See id.*

court simply deferred to defendants' belief that the cost differential was significant enough to forego the less discriminatory alternative.²¹⁰

Such deference only makes sense if one is simply trying to ensure that there is no "bad motive" or intentional race discrimination, without regard to a balancing of the importance of the defendant's justification against the magnitude of the harm. The *Bryan* court admitted this focus on motive and gave only token consideration to the disparate effects claim. In the court's analysis of the magnitude of the harm, it admitted that it could not assess the accuracy of the city's claims that any harm would be mitigated by other hospitals in the area. The court was satisfied that the defendant's decision to close Sydenham "was made not only rationally, but with sufficient concern for likely consequences."²¹¹ This sounds like a classic test to determine whether a defendant's reasons are merely a proxy for bad motive; not an independent scrutiny of the reasons to determine whether they are important enough to overcome the evidence of disparate effects.

Thus, despite explicit regulatory protections against neutral actions that have discriminatory effects, evidence of significant short and long term disruptions in access to health care that result from discriminatory closures, and severe lapses by private and public actors in their decision-making process and economic justifications for closure, courts have applied Title VI in ways that have prevented any meaningful relief for plaintiffs. Courts have followed the path of disparate effects claims generally, by effectively foreclosing relief for plaintiffs absent proof of intentional discrimination.

C. The Implications of Blaming & the Devaluation of Plaintiffs' Harm

Complaints about courts' search for a "bad motive" or "blameworthy" defendant in civil rights challenges is not unique to health care. A common criticism levied at the courts in civil rights generally, and specifically, in the hospital closure cases is the failure to apply a legal standard that is faithful to the intent of Title VI and its implementing regulations. The implications of this construct are particularly dangerous in hospital relocation cases for the reasons identified in Parts I-III of this Article. The underfunding of health care for the indigent, the economic and racial disparities fostered through differential treatment of Medicare and Medicaid beneficiaries, and the significant gaps in the public-private patchwork delivery system make it

²¹⁰ *Wilmington II*, 491 F. Supp. at 343-45.

²¹¹ *Bryan*, 627 F.2d at 617 n.2.

impossible to identify any particular actor as “blameworthy” or as not reacting to real economic pressures created by this system. Indeed, we see the opposite occurring – courts are using these factors to shield defendants from responsibility, while at the same time ignoring these factors in assessing the magnitude of the harm that will be suffered by plaintiffs. This shielding obscures legitimate policy reasons for holding public and private hospitals more accountable to these underserved communities, even though they may not have evidenced bad motive deserving of blame.

While applying an improper legal standard obviously makes plaintiffs’ challenges much less likely to succeed, a closer look at the courts’ opinions in this area reveals a struggle that can not necessarily be fixed by tweaking the legal standards used. I believe that what is going on is the courts’ deeper frustration with what it perceives to be an impossible task – that is defining and enforcing the federal government’s obligation of racial equality within a health care system that has been created and maintained in a way that fosters economic and race discrimination and is, therefore, inherently incompatible with racial equality. This struggle is clearest in the apparently inconsistent treatment by courts of the economic elements of the hospital relocation problem: that is the problem of the underfunding of health care for the poor generally and how that informs the courts view of plaintiffs’ allegations of harm versus defendants’ justifications for closure.

1. Economics as a Shield from Blame

Measuring the harmful effects of the closure, as well as understanding the reasons underlying such closures, depends in large part on assumptions about other actors in the health care system. The impact of multiple actors and forces in this patchwork system make it impossible to find a blameworthy defendant. In fact, the opposite feeling is engendered –the tone overwhelmingly is one of sympathy for the defendant in challenges to both private and public hospital closures. In *Wilmington*, the court took seriously the defendant’s perception of the economic pressures created by WMC’s significant public function in a system where neither the federal nor state government ensures universal coverage, and where market competition for more affluent patients was seen as critical to long term survival.²¹² In *Bryan*, the court painted the picture of a city “struggling mightily” to provide health care for its citizens in the midst of a budget crisis and the

²¹² *Wilmington II*, 491 F. Supp. at 296.

described closure as one of the many “painful steps” it had undertaken.²¹³

The problem is that the federal government enables local governments and private actors to make decisions that do not appear to serve the purported financial concerns and that are made without any examination of, or concern about, whether affected communities will still have adequate access to care after the closure. In *Wilmington*, for example, the effects of closure, including the immediate disruption to hospital services due to lack of transportation between the city and suburban division, were not considered by the hospital or local or federal officials, prior the court forcing OCR to investigate. In *Bryan*, the city never considered other options to closure, did not investigate the willingness and or capability of other hospitals to help serve the affected community, and never sought assurances from these other hospitals that they would treat the indigent patients previously served by the public hospital being closed. Sadly, but predictably, one of the hospitals that the defendants argued would be available to ensure uninterrupted access to care for Harlem residents was later downsized as well.²¹⁴ In fact, Sydenham Hospital was merely one a number of hospital facilities lost by Harlem residents in the course of a “Manhattan-wide” plan for reduction in hospital bed capacity, where the reductions tended to occur in underserved communities with the greatest need and least resources.²¹⁵

Moreover, courts fail to appreciate the obligations arising out of the public-private and federal-state partnerships created as a result of the significant public subsidies used to support these hospitals. Two examples of this partnership, the Medicare/Medicaid and Hill-Burton programs were described in Part II. Another significant form of public subsidy, which occurs through tax-exemptions provided to nonprofit hospitals at the federal and state levels, was described at Part I.A. above. Despite the fact that hospitals have benefited significantly as a result of this partnership, and have corresponding obligations as a result, courts fail to hold hospitals accountable to the obligations they

²¹³ *Bryan*, 627 F.2d at 614.

²¹⁴ See Marianne L. Engelman Lado, *Breaking the Barriers of Access to Health Care: A Discussion of the Role of Civil Rights Litigation and the Relationship Between Burdens of Proof and the Experience of Denial*, 60 BROOK. L. REV. 239, 260-61 & nn.68-72 (1994). See also *Mussington*, 824 F. Supp. at 427 (dismissed on procedural grounds), *aff'd*, 18 F. 3d 1033 (2d Cir. 1994) (Title VI challenge brought to prevent the relocation of obstetric, neonatal intensive care, pediatric and other inpatient services out of the Harlem area).

²¹⁵ Lado, *Breaking the Barriers*, *supra* note 214, at 262 n.72.

voluntarily undertook as a condition of the benefits they receive. For example, courts cite to the provision of charitable care by defendants as further evidence of the degree of economic pressure that compels hospitals to consider relocation, generating sympathy for the defendants. They fail to account for, or compare the amount of charity care delivered by the defendant hospitals against the amount of public subsidies received through federal and state tax-exemptions, direct funding for construction, the amount of its endowment, or the amount of bad debt the hospital was able to write off on its taxes. In other words, no assessment is done to determine how much of the “charity care” is actually owed as a condition of the direct and indirect public benefits received by the hospital. Focus on “blaming”, therefore, obscures other characteristics of our health care delivery system that demand greater accountability by hospitals and increased enforcement by courts. Indeed, the fact that such hospitals are part of a larger patchwork of private and public actors should not lessen courts’ willingness to scrutinize the decision.

2. Ignoring Economics in Devaluing Plaintiffs’ Harm

In contrast to the courts’ willingness to consider economic factors that generate sympathy for defendants, courts have been much less willing to consider the impact of these economic realities in assessing the magnitude of the harm to minority communities. In *Wilmington*, we see this in the court’s casual dismissal of the plaintiff’s fear of the ultimate “ghettoization” of the hospital through the inevitable draining of hospital and primary care resources as a “fanciful scenario”. In *Bryan*, we see this through the court’s irrational assumptions about the ability and willingness of other hospitals to mitigate the effects of closure.²¹⁶ Scholars and civil rights advocates who have identified this problem of the court’s devaluation of the harm have made suggestions for reform based on one of two assumptions: either that the court is not willing to properly balance the plaintiffs harm against defendant’s justifications as manifested by the use of improper legal standards,²¹⁷ or

²¹⁶ Another example occurs in the *Ochsner* case where free care obligations under Hill-Burton and nonprofit law have been used by advocates in conjunction with Title VI to enforce civil rights. Rather than account the proven implications of indigent care obligations for racial equality, courts have treated such claims as discrete claims, forcing plaintiffs to confine fit their argument in one of two very narrow boxes.

²¹⁷ See, e.g., Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination – It Shouldn’t be so Easy*, 58 *FORD. L. REV.* 939, 975-78 (1990) [hereinafter *Watson, Reinvigorating Title VI*] (arguing that the defendant should bear the burden of showing that the challenged practice significantly furthers an important,

that courts have been unable to fully appreciate the harm because of a lack of fully developed sociological evidence about the type and magnitude of the effects of these closures for minority communities.²¹⁸

However, the *Wilmington* and *Bryan* opinions reveal that there may be an additional problem that is driving the courts' apparent disregard of these effects which can not necessarily be fixed by changing the legal standard or introducing more comprehensive evidence of harm. Rather than failing to appreciate these economic realities, courts seem to be responding to what they perceive is an impossible task precisely because of these economic realities: namely, the struggle with how to identify and remedy a civil rights violation premised upon an unequal allocation of resources when no clear minimal level of care or definition of equality is provided and where the federal government has itself sanctioned and exacerbated disparities in insurance coverage, which contribute to the hospital relocation problem.

Once again, *Bryan* provides the clearest example of this in its justification for its extremely deferential approach to hospital closure cases:

We are skeptical of the capacity and appropriateness of courts to conduct such broad inquiries concerning alternative ways to carry out municipal functions. Once a court is drawn into such a complex inquiry, it will inevitably be assessing the wisdom of competing political and economic alternatives. Moreover, such policy choices would be made without broad public participation and without sufficient assurance that the alternative selected will ultimately provide more of a benefit to the minority population.²¹⁹

While the *Wilmington* court seemed to take its task more seriously, it still openly struggled with the problem of how to measure equality in health care and what level of inequality is "justifiable" in light of certain economic realities. For example, in response to plaintiffs'

legitimate program objective, which cannot be substantially accomplished through less discriminatory means; also arguing that the defendant should be required to provide empirical evidence of the former assertion). See also Randall, *Racist Health Care*, *supra* note 32, at 190-92.

²¹⁸ See, e.g., Lado, *Breaking the Barriers*, *supra* note 214, at 266-68.

²¹⁹ *Bryan*, 627 F.2d at 619.

concerns about the unfairness and stigma created by relocating services from a high need minority community to a more affluent, predominantly white area, in the face of a less discriminatory option, the court answered, with an almost helpless tone it seemed, that equality of race does not mean equal resources and that equality does not mean *exactly* equal. Moreover, the court expressed the same concerns as the *Bryan* court that Title VI might be used to create a legal obligation to guarantee some standard of care that does not currently exist, and the court seemed to fear too much responsibility for setting this standard:

While the plaintiffs' evidence and the seriousness of the possible consequences of error might lead the Court, if it were a member of WMC's administration or board, to take a hard second look at the plan, the Court refuses to construe the civil rights statutes as a license for this Court to act as a financial overseer to those who provide services to minorities. It would especially hesitate to assume that role in a case such as this, where the sanctions available to the Court could be applied by the market place as effectively and certainly with more accuracy.²²⁰

The last part of this quote is particularly troublesome because it ignores overwhelming evidence that allowing the market, as opposed to aggressive facilities planning, to determine the distribution of hospital resources actually increases the likelihood of closures in minority communities. When faced with the challenge to second-guess government action and define what level of disparity violates Title VI, courts have essentially thrown up their hands and refused to scrutinize the government's resource decisions.

The first four Parts of this Article show that the problem of hospital relocations and closures present a complex and very frustrating puzzle. A story is revealed, not simply about the discrete problems of racial inequality in access to health care, but of the more fundamental problems of our notion of civil rights. The hospital relocation problem illuminates the disconnect between our Title VI legal construct and the reality that minority communities face as victims of an inherently unequal health care system. It also raises our awareness of the psychic harm these communities suffer as they experience feelings of

²²⁰ *Wilmington II*, 491 F. Supp., at 328.

helplessness, dehumanization and anger as critical hospital resources – the lifelines of their communities – are being taken away by local planning agencies and private hospitals subsidized by public funding, while the federal government and courts allow it to happen.

V. THROUGH THE LOOKING GLASS: THE REAL EFFECT OF OUR EXISTING CIVIL RIGHTS FRAMEWORK ON HEALTH CARE ACCESS

The *Brown* decision[s] invalidated ‘separate but equal,’ replacing it – as civil rights advocates urged – with ‘equal opportunity.’ But given the continued motivations for racism, society has managed to discriminate against blacks as effectively under the remedy as under the prior law – more effectively really, because discrimination today is covert, harder to prove, its ill effects easier to blame on its black victims.²²¹

Could the above quote about the effects of *Brown* be true for discrimination in health care? Have we indeed made it easier to discriminate by making it more difficult to fight discrimination? This is a harsh indictment of our current civil rights paradigm, but one which we see revealed through the hospital closure problem. Indeed this article was born out of a desire to understand how a problem as pervasive as hospital flight from minority communities is still largely ignored in the discussion of racial inequality in health care, and more specifically, whether the unfulfilled promise of Title VI could be revived to help plaintiffs fight racial inequality resulting from increasing numbers of private and public hospital closures. The organizers of the symposium where I presented this paper expressed this concern in a much simpler and more powerful way, entitling my panel: *Is Civil Rights Law Dead?* When this question is raised, the focus is usually on the litigation part of the civil rights framework, though, as Parts I-IV demonstrate, all three parts play an important role in understanding the failures of our civil rights framework.

In one of the few articles considering hospital relocations from a civil rights perspective, a civil rights advocate with experience litigating Title VI challenges to prevent hospital closures identifies three important purposes that such litigation can serve:

²²¹ *Wilmington II*, 491 F. Supp., at 328.

First, and, perhaps most importantly, as individual challenges to discriminatory or exclusionary practices, lawsuits bring relief to a plaintiff or group of plaintiffs. Second, suits build a record of discriminatory and exclusionary practices, a record that can be used by advocates to educate the public and to support legislative and administrative change....Third, collectively, these suits constitute a direct assault on the wall separating care for individuals of different racial or ethnic backgrounds and different income levels. This third point, in essence, suggests that enforcement of civil rights and access-oriented laws will help to undermine the viability of the current separation between the high-tech, quality care that wealthy, middle-class and predominantly white America has come to expect and the underfinanced, inadequate and delayed health services so often provided to the poor and many people of color."²²²

By all three measures, one might be tempted to argue that civil rights law as an effective tool for change is indeed dead. First, in almost every challenge to a hospital closure case that has been brought, plaintiffs have lost.²²³ The numbers of private and public closures plaguing underserved areas throughout the U.S, coupled with studies reporting the widening of race disparities in health status and access,

²²² Lado, *supra* note 214, at 254-56.

²²³ See *Mussington*, 824 F. Supp. at 427 (dismissed on procedural grounds); *Heath v. Charlotte-Mecklenburg Hosp.*, 681 F.2d 814 (4th Cir. 1982) (Circuit court vacated the district court's injunction blocking closure of a hospital serving the predominantly black community of Charlotte, North Carolina); *Bryan*, 627 F.2d at 612; *Wilmington II*, 491 F. Supp at 290; *U.S. v. Bexar County*, 484 F. Supp. 855 (W.D. Tex. 1980) (challenge to the proposed closure of inpatient maternity services of an inner-city public hospital serving predominantly low-income, Latino residents); *Jackson*, 476 F. Supp. at 896 (holding that the consolidation of hospital services did not foreclose plaintiffs' access to care). *But see Terry v. Methodist Hosp. of Gary*, Nos. H-76-373 and H-77154 (N.D. Ind) (consent decree entered into on June 8, 1979) (discussed in Lado, *Breaking Barriers*, *supra* note 214, at n.72 and SMITH, *supra* note 43, at 177-178). After a partial relocation of services led to a deterioration of the inner city facility, plaintiffs sued DHEW and the hospital and a consent decree was entered into in which major renovations would occur at the inner city facility. While this was an important challenge to the unequal distribution of resources, the fact that there was also evidence of overt racial segregation of room assignments probably weighed heavily in the plaintiffs' favor. *See id.*

suggest little effect on the disparities resulting from economics and race. Certainly, the protests of King/Drew's closure is one of many examples showing that minority communities do not perceive that civil rights laws have helped to guarantee equality in public resources.

Second, despite proven links between the underfunding of services for the poor as a cause of increased hospital closures, on the one hand, and the exacerbation of racial disparities and the increasing strain our health care resources that result from hospital closures, on the other, we still have not seen a coordinated or sustained movement for legislation that would ensure everyone adequate health insurance and access to quality health care. On the contrary, we continue to see government cuts in health care funding for the poor and other health policy decisions that result in increasing numbers of uninsured.²²⁴

Finally, the Supreme Court recently issued a ruling that jeopardizes even the small leverage communities gained from Title VI challenges to hospital closures.²²⁵ In *Alexander v. Sandoval*, the Supreme Court sent chills through the spine of the civil rights community when it held that Title VI does not provide a private right of action to enforce regulations that prohibit facially neutral actions which have disparate effects.²²⁶ In *Sandoval*, respondents brought a class action to enjoin the Alabama Department of Public Safety's decision to administer state driver's license examinations only in English.²²⁷ Respondents argued that the department's policy violated regulations promulgated pursuant to Title VI because it had the "effect" of

²²⁴ See generally Rosenbaum & Teitelbaum, *supra* note 141. The authors note another "egregious example of rules that foment discrimination.... [such as] a proposed rule issued by the Bush Administration in August 2001, that would reverse an earlier Medicaid managed care rule promulgated by the Clinton Administration. The earlier rule prohibited state agencies from maintaining contracts with Medicaid managed care organizations and entities that maintained segregated provider networks (i.e., separate networks based on source of payment). The intent of this earlier rule was to prevent participating entities from excluding members from certain portions of their network and (at least by logical extension), as a means of discouraging managed care entities from contracting with health providers that refuse to treat Medicaid patients). This type of exclusionary and segregating practice bears striking similarities to the older and well-documented practices involving segregated hospital floors, segregated medical staffs, and segregated nursing home wings, all of which unquestioningly violate Title VI." *Id.* at 236-37.

²²⁵ See generally *id.*

²²⁶ *Alexander v. Sandoval*, 532 U.S. 275 (2001). See also Rosenbaum & Teitelbaum, *supra* note 141, at 238-39.

²²⁷ See *Guardians Ass'n. v. Civil Serv. Comm'n of New York City*, 463 U.S. 582 (1983).

discriminating against non-English speakers on the basis of national origin. The Court distinguished between the statutory language and regulations, viewing the regulatory obligations set forth as simply expanding administrative agency power, but not creating an independent private right of action.²²⁸ The decision was particularly shocking in light of the fact that only two years before, the Commission issued its scathing report documenting the OCR's "shameful neglect" and structural deficiencies that undermined its efficacy, proving the importance of courts as a check on government accountability.²²⁹

After seeing how all three parts of our Title VI framework combine to essentially shield defendants from any accountability and foreclose plaintiffs' relief in hospital relocation cases, however, perhaps the question should not be whether civil rights law is dead. Perhaps the question should be whether the assumptions underlying our existing health care system and civil rights framework, assumptions very much alive and well, serve to foster racial disparities, while public and private actors hide behind a mask of legitimacy created through superficial Title VI protections.²³⁰ As devastating as the effects of individual hospital closure or relocation cases are, the assumptions underlying the legal principles developed in these cases seem to infect our discourse about civil rights and equality in health care in far more insidious ways. Defects in the existing structure of antidiscrimination law can impede the struggle for true equality in light of the function law serves in society as not only "reflect[ing] dominant societal moral positions, but also serv[ing] as part of the process of forming or crystallizing such positions."²³¹ Ironically, though health care is one of

²²⁸ *Alexander*, 532 U.S. at 275. Previously it had made such a distinction for money damages, but had not done so for injunctive relief.

²²⁹ See Rosenbaum & Teitelbaum, *supra* note 141, at 231.

²³⁰ DERRICK BELL, *FACES AT THE BOTTOM OF THE WELL: THE PERMANENCE OF RACISM* 104 (1992). Indeed, in individual cases, defendants point to any process undertaken to evaluate the closure decision as evidence of good faith, and then rely administrative and judicial decisions in their favor as proof that their actions are substantively legitimate and consistent with goals of racial equality. Plaintiffs, on the other hand, are left feeling frustrated and angry at the process, as well as fearful of the disruption in access to care certain to result. See, e.g., Smith, *supra* note 43, at 180 (describing the defendant hospital's characterization of the result in the challenge to a hospital relocation).

²³¹ Alan David Freeman, *Legitimizing Racial Discrimination Through Antidiscrimination Law: A Critical Review of Supreme Court Doctrine*, 62 MINN. L. REV. 1049, 1051 (1978) ("Given a view that law serves largely to legitimize the existing social structure and, especially, class relationships within that structure, the ultimate constraints are outside the legal system. But if law is to serve its legitimating

the least talked about areas in civil rights jurisprudence, the hospital relocation problem provides one of the clearest examples of these dangerous effects.

In their rejection of Title VI challenges to hospital closures, courts have crystallized several assumptions that infect our current discourse in ways that impede meaningful reform. First, the search for a “bad motive” or blaming in place of a true disparate effects test diverts our attention from the lapse in government accountability and its conscious neglect of racial inequality. Second, ignoring the intersection between race and economics so critical to defining and addressing the inequitable distribution of hospital resources affirms an ideology inherent in the structure of our health, political, and judicial system that is incompatible with racial equality in health care. That is, it affirms an ideology that sanctions economic discrimination and market competition as a fair way to regulate the distribution of health care resources. This discourages an honest critique of the forms and effects of race discrimination in our health care system, which, in turn, impedes our ability to identify and construct the kind of creative and radical approaches needed to reform the system. Finally, the affirmation of these principles also creates process-oriented barriers to the development of an empowered, community-driven reform effort. It encourages divisiveness by focusing our attention on points of conflict, rather than common interests that should be used to build powerful coalitions across many different groups.

A. Implications of a Blaming Paradigm

The effects of a “blaming” framework extend beyond the individual cases that plaintiffs have lost, infecting our discourse about equality in health care in dangerous ways. This is evident in the contrast between our willingness to express outrage at overt acts of racism and our lack of outrage about the government’s active role in creating a system that is patently incompatible with racial equality. In 2002, Trent Lott made the infamous statement apparently expressing support for Thurmond’s segregationist platform back in 1948. There was an outpouring of anger and calls from the black community demanding his resignation. More recently, Bill Bennett, the former Education Secretary, made the comment that “if we abort every black baby, the crime rate would go down.” Once again, public outrage was clear. These isolated

function those ultimate constraints must yield up just enough autonomy to the legal system to make its operations credible for those whose allegiance it seeks as well as those whose self-interest it rationalizes.”).

statements, while having little, if any, effect on the plight of minorities, are obvious examples of the kind of racial bias that we abhor as a society and, thus, are easy targets for “blame” and calls for punitive measures. By contrast, there has been a notable lack of outrage about, and attention paid to, the federal government’s role in creating and maintaining a health care system that fosters race discrimination. Despite the fact that, the government, through its legislative, administrative, and judicial arms, has made choices at critical junctures that have knowingly undermined civil rights enforcement and revealed a conscious disregard for the health and psychic effects on minorities, criticism of the government’s responsibility for this problem is muted in mainstream discourse.

This muting effect may be due in part to the reality that health care has traditionally not been treated as a priority among the list of civil rights issues to be addressed.²³² Issues that impact minority communities on a day-to-day basis, such as education, employment, and conflict with criminal law enforcement get the most attention. Health care does not rise to the same level of importance as these other problems until a hospital closure makes it visible and minority leaders become actively involved in ways that energize and give voice to the community’s concerns. Another reason for this muting effect may be the localization of hospital conflicts. The federal government has successfully shifted the focus of these disputes to the local level through the delegation of its facilities planning to local agencies. Hospital closure conflicts, as currently framed, pit local communities against local hospital providers or local government officials making the closure decision. The courts, in applying a traditional intent-based analysis, look narrowly at this point of conflict and ask whether the decision maker has a bad intent. This framework causes us to ignore the importance of the relationship between the federal and local government in facilities planning, and more specifically, the history of conscious disregard of disparate effects on minorities at every level. Rather, local actors are painted as victims - and this image is largely reflected in our public discourse as well. The framework that has been absorbed into our discourse equates legal responsibility with blame; without the kind of incendiary statements given above that obviously

²³² See, e.g., SMITH, *supra* note 43, at 183 (explaining why the shift to a centralized OCR at the end of 1967 resulted in a preoccupation with the more visible issue of school desegregation, while health care received little attention).

merit blame, society is reluctant to hold the hospitals or government actors accountable.²³³

Diverting attention from the government's own responsibility allows it to continue acting in ways that are hostile to racial equality.²³⁴ For example, in 2001, the Institute of Medicine released the results of its report proving that significant disparities still exist between whites and minorities, both in terms of access to health care and health status.²³⁵ Rather than responding constructively and thoughtfully to the findings, government officials attempted to water-down the racial implications of the report's findings.²³⁶ Moreover, despite the documented links between an underfunding of health care for the poor and the problem of urban and physician flight from minority communities,²³⁷ there is no government reform effort underway to fix the current gaps in health care funding. Despite demonstrated links between racial disparities in access to care, the structural and operational defects identified in the OCR, and the federal government's failure to use its facilities planning power to prevent the unequal allocation of health care resources, Congress has yet to provide adequate resources for the OCR or to become more involved in facilities planning.²³⁸ Despite calls by leading health law scholars,²³⁹

²³³ See generally KOFI BUENOR HADJOR, *ANOTHER AMERICA: THE POLITICS OF RACE AND BLAME* (1995).

²³⁴ The blaming framework created under our civil rights framework essentially requires proof of intentional and conscious bias, which does not appear to be satisfied by showing a conscious or reckless disregard of the harmful effects on a particular racial group. Nonetheless, attempts to describe government action as "racist" yields one of two reactions: either government actors take a defensive posture that ends any discussion until one can in fact prove the actor's bad motive; and/or those actors defending the government label such critics crazy or conspiracy theorists. Thus, communities are in a Catch 22 because courts will not take plaintiffs seriously if they cannot prove intentional discrimination by a discrete actor; however, in order to be taken seriously in the larger discourse, we must speak in sterile terms about the system, its *unintended* effects on race, and then fashion a response accordingly.

²³⁵ See Robert Steinbrook, *Disparities in Health Care – From Politics to Policy*, 350 *NEW ENG. J. MED.* 1486 (2004); Gregg Bloche, *Health Care Disparities – Science, Politics, & Race*, 350 *NEW ENG. J. MED.* 1568 (2004).

²³⁶ See Steinbrook, *supra* note 235, at 1486; Bloche, *supra* note 235, at 1568.

²³⁷ See, e.g., Lynn M. Olson et al., *Children in the United States with Discontinuous Health Insurance Coverage*, 353 *NEW ENG. J. MED.* 382 (2005).

²³⁸ See, e.g., U.S. COMMISSION ON CIVIL RIGHTS, U.S. COMMISSION ON CIVIL RIGHTS REPORT: FUNDING FEDERAL CIVIL RIGHTS ENFORCEMENT (2005) (noting that in the past 10 years, OCR has never received the level of staffing it requested from Congress and that as staff has decreased, the pending inventory of claims has increased). The report also noted that "[i]n 2003, OCR closed fewer complaints than

health policy analysts,²⁴⁰ and civil rights advocates²⁴¹ for broader reform that would require race data collection and the aggressive use of financial incentives to encourage providers to minimize disparities, there have been no meaningful steps taken toward this end.²⁴² In fact, the government continues to cut Medicaid and resist suggestions for comprehensive health care reform that would provide more support for vulnerable populations.²⁴³

At the same time, the federal government has tried to shift responsibility for these disparities to other actors in the system. For example, the OCR website contains information about the government's concern and plan for remedying disparities by focusing on research initiatives to investigate the role of genetics or cultural factors in prevalence of disease and success of treatment. It also highlights funding provided for community education efforts to determine how minority communities' own behavior or mistrust may impede their willingness to access care. I do not want to trivialize the importance of understanding how patients' and providers' biases can impact health care delivery. For example, some community groups are very active in working with underserved communities to address this issue.²⁴⁴ Some physicians have also initiated important, self-critical

in the preceding year, which more than likely will result in the highest number of backlogged complaints since 1994." *Id.* at 34.

²³⁹ See generally Watson, *Inequalities and Incentives*, *supra* note 35; Watson, *Reinvigorating Title VI*, *supra* note 217.

²⁴⁰ See generally SMITH, *supra* note 43; DAVIS, *supra* note 82, at 244; ABRAHAM, *supra* note 18.

²⁴¹ See generally Lado, *supra* note 214.

²⁴² Recently I hosted a managed care CLE program where we had representatives from the Centers for Medicare and Medicaid Services and the Department of Managed Healthcare. In response to my question about whether either department had plans to require the collection of race data or incorporate financial incentives to police managed care plans, both representatives were sincerely concerned and thoughtful about the problem, but unfortunately the answer was no. A Los Angeles Assemblyman was also on the panel because he had been working on a proposal that would guarantee coverage for Californians through a model similar to the one used for automobile insurance. He claimed to have a thoughtful proposal to help solve the health care problem in California, yet he had no response to my question about tools for monitoring racial disparities.

²⁴³ Robert Pear, *Medicaid Commission Formed to Tame Program's Growth*, N.Y. TIMES, July 9, 2005, at A11.

²⁴⁴ In California, the California Black Women's Health Project and Asian and Pacific Islander American Health Forum are two examples of grass roots organizations that are proactive in educating minorities communities about their health care rights.

studies yielding evidence of subconscious bias based on race and gender.²⁴⁵

While such initiatives should be encouraged, they are not substitutes for the government's responsibility to ensure equality in the distribution of resources. Unlike the providers who are willing to challenge their own biases or communities with scarce resources willing to learn how to take an active role in their health care, the government refuses to take ownership of its responsibility in creating and perpetuating this problem. In light of the already large credibility gap that exists, any government action that purports to address racial disparities, but fails to acknowledge its own responsibility in fostering racial disparities and encouraging hospital closures, is suspect and will only generate further mistrust among minority communities.

B. The Segregation of Economics & Race

The failure of the court to acknowledge the critical role that economics plays in assessing the magnitude of the harm resulting from hospital closures in minority communities is also reflected in our broader discourse. Sager's study of the hospital relocation problem led him to the conclusion that "[u]rban hospital reconfiguration has manifested and exacerbated problems that can be solved by legislating health insurance coverage for all Americans." The links between the underfunding of health care, on the one hand, and poor health status, less health care access, and hospital closures in minority communities, on the other hand, should make it clear that legislating universal access to health care is a necessary, though not sufficient, step toward solving the problem of racial disparities. A system based on economic inequity in health care is incompatible with racial equality.

Despite these links, there is a lack of public outrage about the fundamental inequities in the system or demand for fundamental economic reform in health care that would guarantee universal coverage, even by the minority communities most severely affected by hospital closures. I am not arguing that the affected communities or civil rights advocates are unaware of the intersection of race and economics or that they do not understand the importance that resources play in the fight for equality. Indeed, King/Drew proves otherwise. However, what is visible in the vocal and angry protest of a particular hospital closure has been missing in the mainstream discourse. There

²⁴⁵ Kevin A. Schulman et al. *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*, 340 NEW ENG. J. MED. 618 (Feb. 25, 1999).

does not appear to be wide support for a sustained, powerful, proactive movement to redefine health care equality in this country in a way that meaningfully embodies a resource component.

A couple of reasons for this were suggested above, however, there may be an even more powerful reason highlighted by this tension between race and economics. At a fundamental level, and despite our recognition of the critical link between race and economics, we seem to struggle in the same way that courts struggle in Title VI challenges to define what is fair; that is, does society really embrace a notion of complete equality? Our own schizophrenia in this struggle has surfaced when political leaders have criticized the underlying economic structure of our system and demanded a universal health care system that guaranteed access for everyone. Such leaders have either been undermined, dismissed, or vilified for their attempts at fundamental economic reform. Society's own complicity in this regard is highlighted in a book entitled, *The System*, in which the authors discuss Clinton's failed attempts at health care reform. The authors recount advice given to President Clinton by Jay Rockefeller, someone considered a formidable advocate for universal health care. Rockefeller assessed the public psychology of the issue:

Cost control is the reform Americans most need, want and are willing to pay for....Peace of mind follows cost control. Voters fear losing coverage from loopholes, job changes, layoffs or catastrophic illness. Reform that makes insurance more affordable helps allay this fear, but voters want stronger safeguards. Fear, much more than compassion, drives support for universal guarantees of coverage. * * *

[The statement that] Americans deserve or have a right to health care is a dead-end approach. Although many Americans may initially react positively to this statement, overtime it can make them uneasy. Before long they will be asking: How would we pay for all that care for all those people? Won't it require a huge new government bureaucracy? Is every American deserving?²⁴⁶

²⁴⁶ See HAYNES JOHNSON & DAVID S. BRODER, *THE SYSTEM: THE AMERICAN WAY OF POLITICS AT THE BREAKING POINT* 92-93 (1996). Indeed this seems consistent with treatment of past leaders who attempted true economic reform in health care, often

Indeed, as we saw in Part II, the question “*Who is deserving?*” seems to underlie the inequitable structure of our social insurance system.²⁴⁷ We have been taught that economic discrimination is fair based in large part on the myth that we live in a meritocracy where hard work and productivity will be rewarded with material resources.²⁴⁸ The logical corollary: those without resources to access quality health care must not have contributed their fair share. This ideology only reinforces our willingness to underestimate the government’s responsibility for the barriers to access suffered by poorer, predominantly minority communities. In a civil rights discourse that relies on blaming, we are subconsciously, if not consciously, required to blame someone: if not the government or the hospitals who are acting rationally to maximize profits in a competitive healthcare market, then the affected communities who failed to acquire the necessary resources to ensure their access to health care.²⁴⁹

C. Impediments to Coalition Building & Community Empowerment

This framework has other potentially destructive effects in our struggle for equality. First, by defining civil rights violations in such narrow terms and distracting us from the critical goal of enacting meaningful economic reform, the existing framework can create divisiveness that impedes coalition building critical for this reform.²⁵⁰ For example, the focus on race-based motives in this context can pit different racial groups against each other as they compete for scarce resources. This triggers competition among vulnerable groups for scarce resources in a system where government action and inaction is the real threat to the limited safety net we have. In this kind of environment, antidiscrimination claims to resources may be viewed as claims for special protection to a substantive right that is not guaranteed to all. Indeed, courts have expressed this precise concern in justifying their reluctance to use Title VI to second-guess government policy decisions about how resources should be allocated.

being labeled as “communists” and Anti-American in order to demonize them. *See id.*

²⁴⁷ *See Smith, supra* note 43, at 23-31.

²⁴⁸ *See id.*

²⁴⁹ *See generally* HADJOR, *supra* note 233.

²⁵⁰ *See generally* MANNING MARABLE & LEITH MULLINGS, *The Divided Mind of Black America: Race, Ideology and Politics in the Post-Civil Rights Era*, in BEYOND BLACK AND WHITE: TRANSFORMING AFRICAN-AMERICAN POLITICS (1995).

Second, this focus on blaming can cloud our ability to identify other groups as potential partners in health care reform. For example, once we redefine the focus as one of fundamental economic reform, we can identify other groups who are currently vulnerable to the gaps in the public safety net, such as people with disabilities, the elderly, women, and increasingly the middle class generally. Thus broadening the focus of our reform effort allows us to broaden our coalition base. The blaming framework can also perpetuate divisiveness among groups that have traditionally been seen as hostile to minority communities' interests, but who, in fact, have more in common as potential partners in the fight for real health care reform. As I will develop more in the final section, patients and health care providers have a significant common interest in reforming the health care financing system. If we only consider the problem from the point of conflict that arises between patients, physicians, and hospitals in response to hospital closure decisions, communities may fail to see how hospitals and physicians can be powerful partners in a proactive fight for more comprehensive coverage that could help prevent the problems that lead to such closures in the first place.

Finally, because the existing Title VI framework has not provided the promised protection to minority communities, it has engendered mistrust and feelings of isolation that can lead to feelings of hopelessness and discourage potentially beneficial public-private partnerships. Encouraging communities' reliance on the existing civil rights enforcement structure in light of the obvious and pervasive defects in all three parts of this structure is tacitly enabling a system that is inherently discriminatory and incapable of providing meaningful remedies. To talk about civil rights in health care and the hospital relocation problem, without addressing the fundamental reforms necessary and without giving communities real tools to force government accountability only reinforces these feelings of helplessness, mistrust, and anger. This, in turn, can undermine the psychological and emotional empowerment necessary for effective grass roots advocacy in the fight for equality in health care.

VI. COURAGE & HOPE

I have spent most of this article showing how the hospital closure problem reveals serious defects in our current civil rights framework, which should trigger frustration and anger among scholars and advocates on behalf of the communities who have been failed by the

promises of Title VI. As shown above, our current civil rights approach perpetuates the false separation between race and economics in defining the problem, reinforces a health care system that is incompatible with racial equality, and defers almost completely to government agencies that have vacillated between overt sabotage and shameful neglect of their civil rights duties. The hospital relocation problem leads not only to racial disparities in health care access; it also reveals the dehumanizing and stigmatizing effects that result from the failure of civil rights laws to prevent hospital flight from minority communities. This has created feelings of hopelessness and anger among minority communities who feel betrayed by the political, judicial, and health care systems. As legal advocates, I believe we have a duty to harness this anger and use it to empower communities to fight to redefine our notion of civil rights in health care. To that end, I want to spend this last part using lessons from the hospital relocation problem to argue for a more comprehensive and creative plan of action, and to explain why I have hope for the future, despite the significant systemic and ideological barriers that must be overcome.

One of the simplest and most poignant observations about the problems of King/Drew is by Assemblyman Mark Ridley-Thomas who concluded that the problems of King/Drew are “Most fundamentally [due to the lack] of resolve to address the issue creatively and forthrightly.”²⁵¹ And this is where courage comes into play. Once we define the problem honestly, this dictates the kinds of reforms necessary for real change. While there are currently examples of discrete groups working on creative ways to improve access for targeted populations, one of the biggest problems is the lack of a comprehensive approach that bridges the different communities and areas in need and that empowers communities to attack the root of the problem. Health and civil rights advocates have a critical role to play in reforming our current ideological and structural framework for civil rights in health care by forming bridges across populations (race, gender, orientation, class); facilitating creative private and public partnerships; utilizing traditional and nontraditional forms of advocacy; and challenging even the most entrenched principles of our judicial and political system that impede court willingness to check the government’s abdication of authority. In this final part, I want to suggest some guiding principles in our ongoing attempts to do this.

²⁵¹ Mitchell Landsberg, *Why Supervisors Let Deadly Problems Slide*, L.A. TIMES, Dec. 9, 2004, at A1.

1. Be Willing to Challenge the Fundamental Ideology Underlying Our Current Notions of Civil Rights in Health Care and the Enforcement Structure of Title VI

Legal scholars have tended to craft solutions to the problem of racial disparities by identifying defects in our existing legal structure and trying to fix them. For example, a number of scholars have noted the importance of collecting racial data in order to monitor and ensure compliance with regulations concerning disparate effects; however, it is not clear how much help this would be in the face of judicial and administrative hostility to these kinds of claims. Indeed, *Wilmington* shows that even when courts were committed to reviewing such claims, the evidence of disparate effects could still be easily overcome. Legal scholars recognize this barrier and have also argued that the legal standards applied to such challenges should be altered to better accomplish the goals set forth in the Title VI statute and regulations. Thus, standards should be used that value both long and short term harms identified by plaintiffs and should factor in the reality of economic discrimination that undermines defendants' claims that other hospitals can mitigate any disruptions in access. Moreover, courts should scrutinize the defendant's decision-making process and reasons for closure more closely and shift the burden to defendants to show that no less discriminatory alternative exists.²⁵² However, this proposal does not take into account the fundamental struggle courts face in defining what level of disparity constitutes a Title VI violation in a health care system that fosters and sanctions disparities created through economic discrimination. The same economic factors that plaintiffs want courts to consider in measuring the magnitude of the harm, are also relevant to the court's perception of the economic pressures that incentivize the challenged closures, which make hospitals sympathetic defendants. Courts view inner city hospitals as having to bear a disproportionate burden of caring for the indigent – the federal government increasingly shifting more of the burden to local governments and federal and local government shifting responsibility to the private sector. One gets the picture of a game of hot potato, with the poor being dumped from place to place, no one willing to claim responsibility for providing a system of continuous and consistent quality care for everyone. Until we can change this aspect of the system, other reforms will have limited effect.

²⁵² See, e.g., Richard J. Zall, *Maintaining Health Care In the Inner City: Title VI and Hospital Relocations*, N.Y.U. L. REV. 271 (1980)

To that end, we must be willing to challenge certain ideological barriers to a meaningful reform of our health care and civil rights enforcement structure. Creating a system of universal health care is the obvious place to start. However, we know from studies of other countries that have universal health care that this is not sufficient to ensure racial equality. Universal access cannot eliminate racial disparities given the broader socioeconomic disparities within the U.S. that affect minority health status²⁵³ and the undisputed fact that some race disparities can be linked to race bias or other non-economic factors.²⁵⁴ Without some mechanism for identifying and correcting racial disparities in access and outcomes, a universal health care system will also have limited effect. Thus, a mandatory race data collection system designed to measure disparities in health access and outcome should be part of any health system implemented.

2. Short Term Solutions & The Role of Legal Advocates in Demanding Real Tools for Change

We can not and should not wait for the more fundamental health financing and civil rights reforms above to occur, in order to fight existing health care disparities. In the short term, communities can use their political leverage to prevent hospital closures. Legal advocates play a critical role in organizing and empowering communities to use this power to publicly shame and hold local officials accountable for decisions that adversely affect their communities. This approach has had varying degrees of success in California. One successful example occurred in the fight to keep Rancho Los Amigos open, a rehabilitation hospital whose closure would have disproportionately harmed disabled, indigent, and minority patients.²⁵⁵ Disability and health care advocates were able to secure an agreement by the County to keep it open for at least another three years. The outcome of King/Drew is still uncertain. There is clearly a lot of pressure on County officials to keep it open; however, this pressure was unable to prevent closure of its trauma center.

²⁵³ See, e.g., Randall, *Racist Health Care*, *supra* note 32, at 146-52.

²⁵⁴ See Steinbrook, *supra* note 235; Bloche, *supra* note 235. See also Randall, *Racist Health Care*, *supra* note 32, at 170.

²⁵⁵ *Rodde v. Bonta*, 357 F.3d 988 (9th Cir. 2003) (issuing preliminary injunction to prevent closure of the hospitals). See Western Law Center for Disability Rights website for updates on litigation. As of October 2005, the County announced a settlement to keep the hospital open. See Western Law Center for Disability Rights, <http://www.wlcdr.everybody.org> (providing a copy of the settlement agreement).

Legal advocates should also help communities use their power proactively to demand more comprehensive reforms at the local and federal levels that will help minimize existing pressures on hospitals in urban settings. Rather than wait until a hospital closure decision has been made to mobilize and fight, health care advocates and community leaders should work closely to identify potential trouble spots and to formulate plans for addressing the economic and quality of care concerns that often drive hospital closures.²⁵⁶ Such plans could then be presented to local government officials as less discriminatory alternatives that must be considered, rather than relying on the hospitals or the local government body that would probably not have considered or been required to look for less discriminatory options.²⁵⁷ Earlier intervention by community advocates can influence the distribution of public resources in ways that can relieve hospitals' financial stress before it becomes too great.

Moreover, advocates should use other legal tools, such as charitable trust, merger oversight, and state antidiscrimination laws to influence the pattern of hospital restructuring in minority communities. Successful models can be found in advocates' challenges to hospital mergers that have threatened reproductive health care. For example, in a few instances, community advocates, have used such laws to prevent mergers that would have resulted in the elimination of certain reproductive health services for women.²⁵⁸ In some cases, advocates used litigation, but in others, communities found that local public officials were sympathetic to the community's concerns and willing to use their discretion under the law to prevent disruption to health care access. In some cases, community action has prevented the proposed hospital closure or restructuring; in others, the community has been able to use its political and legal leverage to ensure that at least a

²⁵⁶ See Sager, *Testimony*, *supra* note 15, at 403-09 (offering several alternatives to closure that should be considered).

²⁵⁷ There is precedent for this. In New York, government officials initially refused to allocate additional resources to a hospital because they were concerned that the hospital would simply use the resources to expand and invest in greater technology in ways that would drive up health care costs. It was also concerned that resources were being diverted away from hospitals in communities with greater need. See McLafferty, *supra* note 17, at 1085.

²⁵⁸ See, e.g., Brietta Clark, *When Free Exercise Exemptions Undermine Religious Liberty and the Liberty of Conscience: A Case Study of the Catholic Hospital Conflict*, 82 OREG. L. REV. 625, 646-48 (2003).

portion of the resources would be redirected to maintain access to necessary health care for the affected community.²⁵⁹

Finally, minority communities should use their power to insist that any state or federal proposal for reform of the system includes a race data collection system. Opportunities for demanding these tools exist at every level. For example, as the Centers for Medicare and Medicaid Services (CMS) continually enact changes to their fee for service and managed care programs, race data collection should be required. In California, the Department of Managed Health Care is responsible for oversight of managed care plans, which have become critical players in our health care delivery system. Health advocates should empower communities to demand that any program for monitoring health plan quality and compliance include a mechanism for race data collection to help identify racial disparities. Although the collection of this data may not be immediately valuable as a litigation tool under our current civil rights enforcement structure, it can be very valuable if there is an alternative structure, preferably a community-based organization, that can gather, analyze, and use the data in proactive ways to facilitate reforms and police providers at the community level.

3. Community Education & Empowerment: Building Trust Across Different Communities

Both the short and long term legal reforms identified above require minority communities to become powerful politically and legally, and to be able to use their leverage proactively. This may seem like an unrealistic expectation for communities that are historically economically underserved and politically vulnerable. It is possible, however, and there are successful models for underserved communities becoming more active and powerful in driving important reform. Legal advocates are critical in this process and can facilitate community empowerment in a number of ways.

In my opinion, the most critical ingredient for community empowerment is trust – trust between the advocates and community, between different groups within the community, and between the community and the government officials responsible for protecting their interests. Legal advocates have an important role to play in restoring the trust that has been lost. In order to do this we must first acknowledge the mistrust that has been created by the inherent flaws of

²⁵⁹ See Freeman, *supra* note 231, at 1051.

our existing system. Communities need to be educated about why our legal structure is flawed and what that means for the kind of advocacy communities should use and the kind of reforms they should demand. For example, many people attribute the hospital closure problem to a conscious bias by the hospital or local decision maker, whether or not a bias, in fact, exists. Thus, they continue to frame the problem in terms of intentional discrimination, even though this obscures the bigger problems that lead to hospital and physician flight. Advocates need to educate underserved communities about the relationship between their race, ethnic, or community specific concerns and the broader problems of inadequate health care financing and facilities planning at the federal and local levels. We need to demonstrate that the very structure of our health care system is incompatible with racial equality and that an overhaul of our system is necessary to any reform and meaningful enforcement of civil rights protection.

Moreover, we have to help bridge different groups that have common interests and complementary perspectives to build a broader base and increase the political power and leverage of underserved communities in fighting for health care reform. Indeed, experience shows that plaintiffs have the greatest chance for success where such coalitions are formed. For example, in *Simkins*, the lawsuit was initiated by African-American physicians fighting on behalf of African-American patients who were excluded from white facilities and forced to incur dangerous delays at the few overburdened facilities willing to accept blacks. In California, increasingly provider-patients coalitions are being formed to assert their common interests in reforming the health care financing system. One successful example mentioned above was the fight to keep Rancho Los Amigos open. Another successful example occurred in California a few years ago. There was a ballot measure prohibiting the collection of race data that almost everyone agreed would impede the ability of the government to identify and remedy racial disparities in health care. A remarkably diverse coalition of different racial and ethnic groups, women's organizations, GLBT²⁶⁰ organizations, as well as health care providers and patients advocates, all came together to successfully defeat the measure.²⁶¹

In a less successful example, provider and patients' advocates came together to put an initiative on the ballot that would raise money

²⁶⁰ GLBT refers to Gay, Lesbian, Bisexual and Transgendered groups.

²⁶¹ Press Release, American Civil Liberties Union, Doctors, Educators, Civil Rights Leaders Across CA Vow to Defeat Dangerous "Race Information Ban" (Apr. 23, 2002), available at <http://www.aclu.org/news/2002/n042302b.html>.

through a new tax, a significant portion of which would be directed to hospitals and physicians who provide uncompensated emergency room care. A key argument for the measure was the relationship between physician and hospital flight and the uncompensated care disproportionately provided by these providers. Unfortunately, it did not succeed for a variety of reasons, including the failure to educate the community about how this measure would help ensure continued access.

Given the important link between universal care and fighting racial disparities, minority communities must reach out to other groups who would benefit from universal care as potential partners for reform. In some cases, the partnerships are obvious, as for example where closures will have a harsh impact on minorities and people with disabilities, these groups have partnered to fight such closures.²⁶² Certain disease specific measures, such as public health measures to fight HIV, also lead to atypical partnerships between the perceived mainstream black organizations and GLBT groups. However, these partnerships should not be atypical and should not only occur in response to a discrete public health or community access issue. We should build on the partnerships in broader and sustained ways to fight inequality in health care generally.

Increasingly, there are reports about how the middle class is also suffering the effects of our patchwork health care system, as employers continually reduce, or eliminate altogether, affordable employment based healthcare.²⁶³ Moreover, seniors are increasingly unsatisfied with the changes in Medicare and fear what further changes to a managed care system will bring. Studies also show that even those with insurance suffer because of limits on insurance and problems with hospitals that pursue them into bankruptcy for extraordinary medical bills that they couldn't cover.²⁶⁴ The time is ripe for tapping into the growing numbers of the middle class and seniors, minorities and non-minorities struggling through our health care maze as coalition partners in the fight for health care reform.²⁶⁵

²⁶² See *supra* Part VI.2 (providing a discussion of *Rodde v. Bonta*).

²⁶³ See Ezekiel Emanuel & Victor R. Fuchs, *Solved!*, WASHINGTON MONTHLY, June 1, 2005, at 20 (arguing that the very soon government will not be able to ignore the growing problem of gaps in the health care system and suggesting universal health care vouchers as a possible solution); Jane Gross, *The Middle Class Struggles in the Medicaid Maze*, N.Y. TIMES, July 9, 2005, at B1.

²⁶⁴ Watson, *Inequalities and Incentives*, *supra* note 35, at 16.

²⁶⁵ Lee Walczak & Richard S. Dunham, *Safety Net Nation: Why So Many Americans Aren't Buying Into Bush's Ownership Society*, BUS. WK., May 16, 2005, at 24-34.

Finally, despite the history of mistrust generated by both the federal and state government in minority communities, increasingly local governments and officials are becoming more responsive to communities' needs. They evidence a willingness to experiment or partner with communities to prevent disruption in access to health care. Oregon's experiment with universal healthcare on a local level is one example. As already noted above, attorneys general in several states have used their discretion and authority to prevent hospital mergers or consolidations that would deprive communities of needed reproductive health services.²⁶⁶ Other states have considered atypical partnerships to solve problems of health care shortages in the short term. For example, in California initiatives have been considered to facilitate the recruitment of physicians from other countries who are willing to work in underserved areas.²⁶⁷ Another recent example is the opportunity for American medical students to be trained essentially for free in Cuba on the condition that the physicians agree to work in underserved communities in the U.S., an opportunity that met much resistance from the Bush Administration.²⁶⁸ These can clearly be seen as unpopular partnerships for a variety of political reasons. While any proposals must be made after critically considering the access and quality of care implications, they should not simply be dismissed because of politics. We should not be thwarted from our long term goals for universal access with race-conscious tools for monitoring equality or our short term goals of increasing the number of health care providers in minority communities because of labeling or threats that such proposals are anti-American by government actors unwilling to provide adequate health care for all of its citizens.

²⁶⁶ See, e.g., Clark, *supra* note 258, at 646-48. Attorneys general, for example, have used their powers to enforce charitable trust and antidiscrimination laws in ways that ensured reproductive health services would not be terminated in hospital mergers.

²⁶⁷ See, e.g., Cal. A.B. 1045 (Mexico Physician Pilot Program designed to increase health care access to California's Latino population). The program has been opposed by the California Medical Association on quality of care grounds.

²⁶⁸ See Fitzhugh Mullan, *Affirmative Action, Cuban Style*, 351 NEW ENG. J. MED. 2680 (2004) (describing a program for U.S. citizens to study at the Latin American School of Medicine (ELAM) in Havana, a school sponsored by the Cuban government and dedicated to training doctors to treat the poor of the Western hemisphere and African).

4. Orient the Movement from Outside of the Current Political System: Grass Roots Advocacy & Community Based Organizations

The above examples highlight the importance of legal advocates working with health care advocates to design programs to minimize disparities or increase access in the short and long term. However, it is important that any meaningful proposal for change be initiated as a grass roots, community-based movement. In order to fundamentally restructure our existing system, change must come from people who can think creatively and radically about the best ways to create a race conscious, universal healthcare system, with meaningful legal protection to force government accountability. Leaders vulnerable to the kind of labeling and political pressures identified above are constrained in their vision and ability to honestly critique the current system. This results in the watering down of health care proposals for fear of isolating powerful constituencies.²⁶⁹ Moreover, a movement for this kind of change should be institutionalized in order to decrease its vulnerability to the localization, politics, or resources of any given community. Finally, community based organizations should play a prominent role in gathering and analyzing racial data about disparities in access and quality of care. To the extent, such organizations can proactively use this data to monitor health care providers, they can become a critical resource for community policing of providers that are performing poorly, at least until some public authority demonstrates the willingness and ability to aggressively enforce antidiscrimination mandates.

When I began this article I believed that I could find hope for a meaningful change in our system. Within the last few days, however, a hurricane devastated the Gulf Coast and left an indelible mark on the nation. We have watched as the poorest people of New Orleans,

²⁶⁹ See, e.g., ROBERT M. BALL, REFLECTIONS ON HOW MEDICARE CAME ABOUT, MEDICARE: PREPARING FOR THE CHALLENGES OF THE 21ST CENTURY 27-37, 29 (Resichauer, Butler & Lave eds., 1998) (stating that Medicare came about because the advocates of universal health insurance coverage were discouraged); NORMAN DANIELS, SEEKING FAIR TREATMENT: FROM THE AIDS EPIDEMIC TO NATIONAL HEALTH CARE REFORM 155-58 (1995) (describing Clinton's attempt "to seize a political middle ground between a single-payer ('big government'), public insurance scheme, on the one hand, and proposals that rely almost entirely on 'managed' market forces (and weak of absent government mandates), on the other); Vernellia R. Randall, *Does Clinton's Healthcare Reform Proposal Ensure Equality of Health Care for Ethnic Americans and the Poor?*, 60 BROOK. L. REV. 167 (1994) (explaining why the answer is no).

predominantly black, were abandoned by our federal government for days before finally sending help, and even then, not enough. We learned that the federal government cut funding for repairs in the levees that could have prevented some of the damage. We heard that this very scenario had been predicted and that engineers knew and even called attention to the fact that there would be no way to evacuate the poorest people living in the most dangerous areas because they did not have private transportation. Still, the government did not ensure that public transportation would be available in case of evacuation. (The similarity to the initial decisions in *Wilmington* to remove hospital services without making any provision for people in the city to be able to get to the new suburban location is telling). In other words, the government abandoned these communities in important ways before the hurricane hit. We have also seen the government try to divert our attention to the “looting” of people desperately trying to survive, and away from the obvious and ignoble government failures that have cost lives. It is hard to be hopeful now.

Nonetheless, I am encouraged by the fact that for the first time in a long time I hear uniform public outrage about these government lapses – lapses which show an utter disregard for the welfare and safety of the poorest and predominantly minority communities ravaged by this hurricane. Most importantly, people are talking about the racist dimensions of this neglect in powerful ways. Our public discourse is now completely overtaken by this intersection of race and class, in ways that had been previously muted. The collective anger and determination to hold the government accountable are precisely what we need in order to create the chance for real change. This tragedy is a surreal and unimaginable lens through which to truly understand the insidiousness of our existing structure and the government’s responsibility in fostering the inequality, mistrust, and dehumanization of our most vulnerable communities.

I want to be hopeful that despite the government’s abdication of its responsibility for Title VI enforcement, we will not accept the idea that civil rights is indeed dead. Rather, we should harness our anger and energy, and use them to prepare for a long and worthwhile fight to redefine civil rights in an honest and meaningful way.²⁷⁰ I am hopeful that communities of color will see that the connection between racial

²⁷⁰ See, e.g., Charles Abernathy, *When Civil Rights Go Wrong: Agenda and Process in Civil Rights Reform*, 2 TEMP. POL. & CIV. RTS. L. REV. 177 (1993) (identifying the over-reliance on the litigation and government-responsibility models as stymieing civil rights progress and suggesting alternative models for change).

inequality and economics can be used to give us power to reach out to, and form coalitions with, other groups suffering under the collapse of our patchwork delivery system. I am hopeful that the resurgence of community action in response to hospital closures can be maintained and strengthened in forward looking plans to radically restructure our system. I am hopeful that providers and patients can be true partners in this fight, as their mutual interests in adequate coverage and in the importance of race data becomes clear. I am hopeful that as we acknowledge the trust that has been undermined through the government's and courts' decisions, we will regain the communities' trust and empower them to effect real change. I am hopeful that change will come with increased community education and power used to forge creative public-private partnerships, where possible, or by shaming and fighting to remove public officials who are not responsive to demands for reform.

CONCLUSION

It is undisputed that Title VI helped reduce disparities created under a system of de jure segregation and exclusion. Moreover, we have seen that civil rights litigation has served as an important check at certain levels. However, this progress has been sharply circumscribed as seen through the problem of hospital flight from minority communities. The problem is that Title VI promised more. It promised that the courts and government agencies responsible for enforcing Title VI would ensure an equal allocation of resources. Unfortunately, Title VI has been used to create an artificial limit on our notions of what civil rights should mean in health care in this country and to mute our criticism of the government's responsibility for creating a health care system that is fundamentally incompatible with racial equality.

Through this article, I was also forced to engage in serious self-reflection about my own role as a health law advocate in this struggle. The opportunity I was given to present a preliminary version of this paper at this symposium, hosted by the DePaul University College of Law and Rainbow PUSH, only fanned the flames because the conference brought together academics, health providers, legislators, and most importantly, community members and activists. All came with a desire to find a solution to racial disparities in health care. I am mindful of Jesse Jackson's words at one point during the presentations by academics – he admonished us not to use our intelligence, expertise, and creativity merely to write law review articles that will serve as dust

collectors. He implored us to be active, to do something to help craft a real solution to this crisis. It is in the spirit of those words and the energy of the conference that I write this piece – hopefully not to be just another dust collector, but to encourage the use of our legal tools in creative and powerful ways.