

# Tragedy and Remedy: Black Reparations for Racial Disparities In Health<sup>1</sup>

Kevin Outterson<sup>2</sup>

## Introduction

The tragedy of American health care is the stubborn persistence of racial disparities in Black health,<sup>3</sup> one hundred and forty years after Emancipation, and more than four decades after the passage of Title VI.

Biomedical research into racial disparities in health is distracted by an etiological reductionism which overlooks the underlying history of slavery, racism and segregated health care. The epidemiological model of research is ill-equipped to adequately diagnose the health effects of race, controlling for variables such as income and education which themselves bear the legacies of racism in America. Biomedical research can also fall prey to the dangers of racialized research, reinforcing stigma through medical profiling based on race. Biomedical research has a race problem.

Black reparations could provide a remedy for the historical crimes of slavery and discrimination, but is considered a fringe political and legal issue. The primary legal objection to Black reparations is remoteness of the injury – the crimes were long ago, all of the defendants and plaintiffs are dead, and the statutes of limitation have run. Lawsuits raising broad claims for Black reparations are invariably dismissed without reaching the merits. In July 2005, the African-American Slave Descendants Litigation was dismissed without reaching the merits. The Black reparations movement has a law problem.

This Article attacks both problems by connecting Black reparations with racial disparities in health.<sup>4</sup> When reparational analysis is applied to Black health disparities, some important research problems are resolved. Reparational analysis avoids the errors of etiological reductionism and racialized research by focusing upon the underlying causes of racial disparities, and connecting it with centuries of American history.

---

<sup>1</sup> This Article is based upon presentations at numerous academic venues over the past five years, including presentations at the University of Cambridge (Hughes Hall) and the DePaul/Operation PUSH symposium on racial disparities in health. I want to thank Adjoa Aiyetoro, Co-Chair of the N'COBRA Litigation Committee and Co-Chair of the Reparations Coordinating Committee, for her inspiration on the issue of Black reparations. Michele Goodwin was successful in persuading me to finally write this Article for publication. The Hodges Research Fund supported this research.

<sup>2</sup> Associate Professor, West Virginia College of Law. LL.M. University of Cambridge; J.D. Northwestern University. [Kevin.Outterson@mail.wvu.edu](mailto:Kevin.Outterson@mail.wvu.edu).

<sup>3</sup> While many racial categories exhibit health disparities in the United States, this Article focuses on the Black experience.

<sup>4</sup> Professor Randall appears to be the only legal scholar to have examined the intersection to any significant degree. See Vernellia R. Randall, *Eliminating the Slave Health Deficit: Using Reparations to Repair Black Health*, 11 POVERTY & RACE 3 (2002) [hereinafter Randall, *Deficit*]. Professor Randall's article focuses on describing potential reparational remedies for Black health disparities, without the theoretical work undertaken herein.

Likewise, the legal prospects for Black reparations may improve in the narrower context of Black health disparities. Racial disparities in Black health are rooted in a long history of oppression and state-supported health care discrimination. These practices continued deep into the 20<sup>th</sup> Century, and are not wholly absent today. Black health disparities are not remote, but survive to the present day with remarkably deadly effect. Black children born in 2005 continue to suffer much shorter life expectancies than their white counterparts. Black health disparities may provide a firmer foundation for Black reparations, less susceptible to charges of remoteness.

This project may also breathe some reality into the critical race theory reparations literature, responding to Richard Delgado's call for reparations scholarship which moves beyond mere discourse to practical, structural changes in society. Health is not a peripheral social concept, but is a key indicator of how society is structured and its resources allocated. If you want to know something about inequality in a society, look at its health outcomes. Eliminating American racial disparities in health is both a practical goal and a revolutionary step in social justice.

## **I. Racial Disparities in Black Health**

### **A. The Tragedy of American Health Care**

In 1999 Congress instructed the Institute of Medicine to prepare a report on racial disparities in health.<sup>5</sup> The study committee performed a literature review of articles in the PUBMED and MEDLINE databases published in peer-reviewed journals from 1992 to 2002. To be selected, the articles must have addressed racial differences in health care while controlling for access and a range of other potential confounding variables.<sup>6</sup> Over 100 studies were selected and summarized in the *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, and a larger group of 600 studies were identified in a companion article covering the last 30 years.<sup>7</sup> Many of these studies have been cited in law review articles concerning racial discrimination in health care, Title VI enforcement, and related topics.<sup>8</sup>

---

<sup>5</sup> Consolidated Appropriations Act, Pub. L. No. 106-113, 113 Stat. 1501 (1999); Institute of Medicine, *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* 30 (Brian D. Smedley, et al., eds., 2003) [hereinafter *UNEQUAL TREATMENT*].

<sup>6</sup> Such as patient preferences, racial differences in disease severity or presentation, and geographic availability of specific services or procedures. *UNEQUAL TREATMENT*, *supra* note 5, at 38. Controlling for access generally reduces the extent of racial disparities since access is a confounding variable for many racial minorities. See *infra* section II for a critique on the use of confounding variables in disparity research.

<sup>7</sup> *UNEQUAL TREATMENT*, *supra* note 5, at 39; H. Jack Geiger, *Racial and Ethnic Disparities in Diagnosis and Treatment: A Review of the Evidence and a Consideration of Causes*, in *UNEQUAL TREATMENT*, *supra* note 5, at 417.

<sup>8</sup> See, e.g., Heather K. Auschleman, *The White World of Nursing Homes: The Myriad Barriers to Access Facing Today's Elderly Minorities*, 8 *ELDER L.J.* 367 (2000); Ian Ayres, et al., *Unequal Racial Access to Kidney Transplantation*, 46 *VAND. L. REV.* 805 (1993); M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 *YALE J. HEALTH POL'Y L. & ETHICS* 95 (2001); Rene Bowser, *Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities*, 7 *MICH. J. RACE & L.* 79 (2001);

The first finding of *Unequal Treatment* is a wake up call to our ‘color-blind’ society:

Racial and ethnic disparities in healthcare exist. These disparities are consistent and extensive across a range of medical conditions and healthcare services, are associated with worse health outcomes, and occur independently of insurance status, income, and education, among other factors that influence access to healthcare. These disparities are unacceptable.<sup>9</sup>

None of this should be surprising. For as long as records have been kept, studies have reported racial differences in health care access and health status in the United States.<sup>10</sup> In 1985, the *Report of the Secretary’s Task Force on Black and Minority Health* clearly noted:

[The] continuing disparity in the burden of death and illness experienced by Blacks and other minority Americans as compared with our nation’s population as a whole. That disparity has existed ever since accurate federal record keeping began – more than a generation ago. And although our health charts do itemize steady gains in the health of minority Americans, the stubborn disparity remained – an affront to both our ideals and to the ongoing genius of American medicine... [this report] can – it should – mark the beginning of the end of the health disparity that has, for so long, cast a shadow on the otherwise splendid American track record of improving health.<sup>11</sup>

---

Gwendolyn Roberts Majette, *Access to Health Care: What a Difference Shades of Color Make*, 12 ANN. HEALTH L. 121 (2003); Barbara A. Noah, *Racial Disparities in the Delivery of Health Care*, 35 SAN DIEGO L. REV. 135 (1998); Randall, *Deficit*, *supra* note 4, at 3; Vernellia R. Randall, *Slavery, Segregation and Racism: Trusting the Health Care System Ain’t Always Easy! An African American Perspective on Bioethics*, 15 ST. LOUIS U. PUB. L. REV. 191 (1996) [hereinafter Randall, *Trusting*]; Sidney D. Watson, *Race, Ethnicity and Quality of Care: Inequalities and Incentives*, 27 AM. J.L. & MED. 203 (2001) [hereinafter, Watson, *Race, Ethnicity and Quality of Care*]; Sidney D. Watson, *Race, Ethnicity and Hospital Care: The Need for Racial and Ethnic Data*, 30 J. OF HEALTH & HOSP. L. 125 (1997) [hereinafter Watson, *Race, Ethnicity and Hospital Care*]; and Michael S. Shin, *Comment: Redressing Wounds: Finding a Legal Framework to Remedy Racial Disparities in Medical Care*, 90 CALIF. L. REV. 2047 (2002).

<sup>9</sup> UNEQUAL TREATMENT, *supra* note 5, at 79.

<sup>10</sup> See, e.g., Paul Farmer, *INFECTIONS AND INEQUALITY: THE MODERN PLAGUES* (1999) (social inequalities often determine the distribution and clinical outcomes of diseases such as AIDS and tuberculosis); M.L. Engelman Lado, *INEQUALITY IN THE DISTRIBUTION OF HEALTH CARE: CLOSING THE GAP* (1992); Robert M. Mayberry, et al., *RACIAL AND ETHNIC DIFFERENCES IN ACCESS TO MEDICAL CARE: A SYNTHESIS OF THE LITERATURE* (The Henry J. Kaiser Family Foundation, Oct. 1999); M.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 BROOKLYN LAW REVIEW 239-73 (1994) (describing studies of racial health disparities at pages 239-247 and examples of post-desegregation methods used by hospitals to adjust their “payor mix” to reduce the number of poor patients, often racial minorities, at pages 248-252); B.A. Noah, *Racial Disparities in Health Care*, 35 SAN DIEGO LAW REVIEW 135-78 (1998); Watson, *Race, Ethnicity and Quality of Care*, *supra* note 8, at 203-24 (discussing racial disparities as serious medical error, requiring education and cultural shift in medicine).

<sup>11</sup> Department of Health, Education and Welfare, *REPORT OF THE SECRETARY’S TASK FORCE ON BLACK AND MINORITY HEALTH* (1985) *quoted in Hearings on the Health Care Fairness Act of 1999: Testimony*

The Kerner Commission<sup>12</sup> in 1968, and the United States Commission on Civil Rights in 1963 found racial discrimination and segregation in health care:

[T]he evidence clearly shows that Negroes do not share equally with white citizens in the use of such [health care] facilities. As patients and medical professionals, they are discriminated against in their access to publicly supported health facilities. Commission investigation also shows that the federal government, by statute and administration, supports racial discrimination in the provision of health facilities.<sup>13</sup>

The 1948 report to President Truman from the National Health Assembly detailed the discriminatory barriers to Black health,<sup>14</sup> as did Gunnar Myrdal's *An American Dilemma* in 1944.<sup>15</sup> The Assistant Surgeon General in 1915 identified the root causes of racial disparities in mortality as socio-economic and remediable.<sup>16</sup> In 1903, W.E.B. Du Bois wrote *The Souls of Black Folk*, illustrating the many struggles of life 'within the Veil' of American racism,<sup>17</sup> followed in 1906 by *The Health and Physique of the Negro American*.<sup>18</sup> In 1869, the Freedmen's Bureau pleaded the great health and other needs of the newly freed Black population.<sup>19</sup>

Racial disparities in health have been studied *ad nauseam*, while the patients continue to die. More studies are in the pipeline.<sup>20</sup> The tragedy of American health care is that

---

*Before the Subcomm. on Health and Environment, House Commerce Committee, 106th Cong. 26 (May 11, 2000) (statement of David Satcher, Surgeon General) available at [www.hhs.gov/asl/testify/t000511a.html](http://www.hhs.gov/asl/testify/t000511a.html).*

<sup>12</sup> REPORT OF THE NATIONAL ADVISORY COMMISSION ON CIVIL DISORDERS (the Kerner Commission) 269, 271-72 (Bantam Books 1968) ("fewer doctors, dentists, and medical facilities are conveniently available to Negroes – especially to poor families – than to most whites. This is a result both of geographic concentration of doctors in higher income areas in large cities and of discrimination against Negroes by doctors and hospitals").

<sup>13</sup> 1963 REPORT OF THE UNITED STATES COMMISSION ON CIVIL RIGHTS.

<sup>14</sup> The National Health Assembly, AMERICA'S HEALTH: A REPORT TO THE NATION (1949) [hereinafter AMERICA'S HEALTH].

<sup>15</sup> Gunnar Myrdal, AN AMERICAN DILEMMA: THE NEGRO PROBLEM AND MODERN DEMOCRACY (1944).

<sup>16</sup> John W. Trask, *The Significance of the Mortality Rates of the Colored Population of the United States*, 6 AM. J. PUB. HEALTH 254, 259 (1916).

<sup>17</sup> W.E.B. Du Bois, THE SOULS OF BLACK FOLK *passim* (1903).

<sup>18</sup> W.E.B. Du Bois, ed., THE HEALTH AND PHYSIQUE OF THE NEGRO AMERICAN 76-90 (The Atlanta University Publications No. 11) (1906).

<sup>19</sup> *Report of the Commissioner Bureau Refugees, Freedmen &c, October 20, 1869* in U.S. WAR DEPARTMENT: ANNUAL REPORT, 1868-69, VOL. I, p. 502.

<sup>20</sup> Annual reports on racial disparities in health are produced by the Agency For Healthcare Research and Quality (*National Healthcare Disparities Report*), and the National Institutes of Health (*Strategic Research Plan to Reduce and Ultimately Eliminate Health Disparities*). Elaine K. Swift, ed., GUIDANCE FOR THE NATIONAL HEALTHCARE DISPARITIES REPORT 1 (2002) (available at <http://www.ahrq.gov>); National Institutes of Health, STRATEGIC RESEARCH PLAN TO REDUCE AND ULTIMATELY ELIMINATE HEALTH DISPARITIES: FISCAL YEARS 2002-2006 (draft, Oct. 6, 2000). The Centers for Disease Control and Prevention sponsors research in racial and ethnic approaches to community health, also known as the REACH 2010 program. Centers for Disease Control and Prevention, PROGRAM ANNOUNCEMENT 01123: RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH 2010 (2001) at <http://www.cdc.gov/od/pgo/funding/01123.htm>.

while racial disparities in health are not new, they remain newsworthy, stubbornly persisting for centuries right up to the present day.

## **B. Black Health In America**

Andrew Hacker and Cheryl Harris suggested that one way to test the persistence and magnitude of racism is to ask white students how much money it would take for them to choose to become Black.<sup>21</sup> I ask a similar question of my students in Health Law. When white students understand the health dimensions of that choice, they generally refuse at any price.

Black mortality rates are significantly higher than white rates in seven of the ten leading causes of death, resulting in more than 73,000 excess Black deaths per year.<sup>22</sup> If being Black was a separate cause of death, it would rank sixth in the United States, ahead of diabetes, influenza and pneumonia, Alzheimer's, nephritis, suicide, septicemia, chronic liver disease, homicide, and HIV.<sup>23</sup> Black infant mortality in the United States is more than triple the European rate, and significantly higher than infant mortality in Bulgaria, Costa Rica, Estonia, Greece, South Korea, Lithuania, and Oman, among many others.<sup>24</sup> Black men's life expectancy at birth is currently 5.7 years less than white men's; the female disparity is 4.3 years.<sup>25</sup> Table 1 demonstrates the historical record of this disparity from 1900 to the present:

---

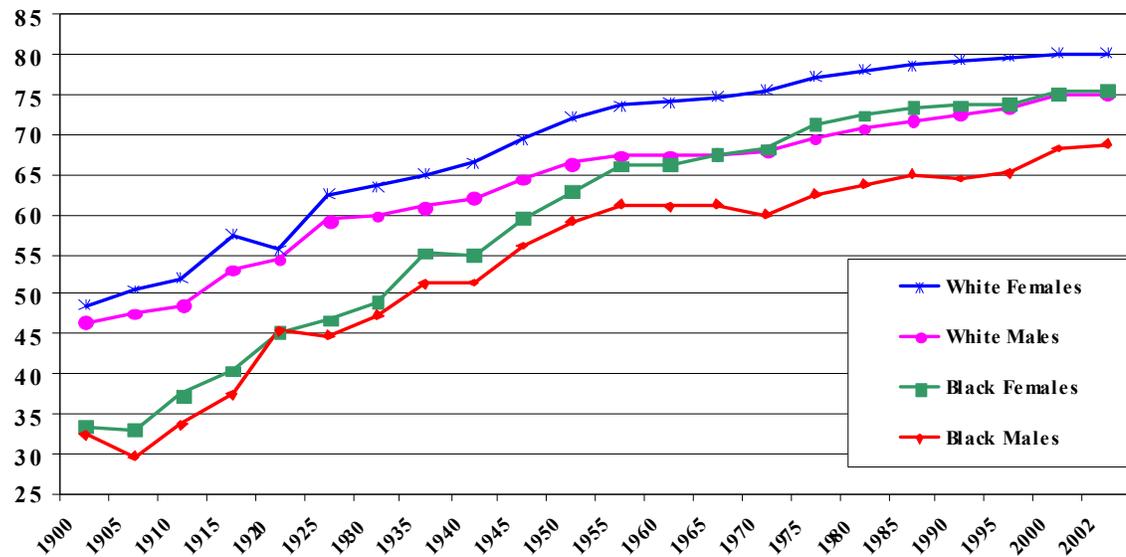
<sup>21</sup> Cheryl I. Harris, *Whiteness As Property*, 106 HARV. L. REV. 1709, 1758-59 (1993) citing Andrew Hacker, TWO NATIONS: BLACK AND WHITE, SEPARATE, HOSTILE, UNEQUAL 31-2 (1992).

<sup>22</sup> 53 National Vital Statistics 5 (Oct. 12, 2004) (Table C) (causes of death). Louis W. Sullivan, *The Role of Historically Black Colleges and Universities in Addressing Disparities in Health Status and Health Care in the United States*, Address at National NBCU Week, Session II, page 6 (Sept. 16, 2002) (excess Black deaths).

<sup>23</sup> 17 National Vital Statistics Reports, 9 (March 7, 2005) (Table E). Significant regional variations are present across the US. See, e.g. Michele L. Casper, et al., WOMEN AND HEART DISEASE: AN ATLAS OF RACIAL AND ETHNIC DISPARITIES IN MORTALITY 78-79, 200-201 (2d ed., 2000); Elizabeth Barnett, et al., MEN AND HEART DISEASE: AN ATLAS OF RACIAL AND ETHNIC DISPARITIES IN MORTALITY 72-73, 194-95 (2001) available at <http://www.cdc.gov/nccdphp/cvd/>.

<sup>24</sup> The U.S. Black infant mortality rate in 2002 is 14.4. National Center for Health Statistics, HEALTH, UNITED STATES, 2004 (Table 22) (2002 is the latest year for which complete data is available). The infant mortality rates for the following countries or group of countries is taken from the World Bank World Development Indicators database: Bulgaria (12); Costa Rica (8); Estonia (8); European Monetary Union (4); Greece (4); Hungary (8); Korea, Rep. (5); Lithuania (8); Oman (10); and Poland (6). World Bank, WORLD DEVELOPMENT INDICATORS DATABASE (2003 data) (available at <http://devdata.worldbank.org/>).

<sup>25</sup> 53 National Vital Statistics Reports 3-4, 33-34 (Tables A and 12) (Nov. 10, 2004).

**Table 1. Life Expectancies At Birth<sup>26</sup>**

Even as general population health improves, most racial differences have remained stubbornly persistent. While racial gaps in health care access narrowed in the period 1968 – 1978,<sup>27</sup> during the expansion of Medicare and Medicaid,<sup>28</sup> the gaps in life expectancy at birth (LEAB) remained. The racial disparity in LEAB remains roughly unchanged over the last century. Whites have achieved any given life expectancy more than a generation before Blacks. Black LEAB remains about a generation behind, relatively unchanged from the 1930s:

<sup>26</sup> National Vital Statistics Report, Vol. 51, No. 3, Table 12 (Dec. 19, 2002). Data prior to 1929 is from death-registration states only. Black data prior to 1970 is not available; data shown from 1900-1969 is from the non-white population. For an innovative account of the change in Black life expectancy 1900 to 1940, see Werner Troesken, *WATER, RACE, AND DISEASE* 10 (2004) (arguing that municipal water and sewer systems were provided on a non-discriminatory basis during this period, resulting in remarkable reductions in water-borne disease).

<sup>27</sup> Lu Ann Aday, *Achieving Equity of Access to the American Health Care System: An Empirical Look at Target Groups*, in UNITED STATES COMMISSION ON CIVIL RIGHTS, *CIVIL RIGHTS ISSUES IN HEALTH CARE DELIVERY* 266 (1980) [hereinafter *CIVIL RIGHTS ISSUES IN HEALTH CARE DELIVERY*] (“The gaps between whites and nonwhites with respect to both potential and realized access indicators have narrowed considerably over the past 25 years. The preceding analysis suggests that racial inequities do persist along certain access dimensions, however, even when income differences are controlled.”); Karen Davis & Cathy Schoen, *HEALTH AND THE WAR ON POVERTY: A TEN-YEAR APPRAISAL* 26 (1978) (“Although the gap between the health of the poor and that of others narrowed in the decade 1965-75, it has not disappeared.”).

<sup>28</sup> Richard Cooper, et al., *Improved Mortality Among U.S. Blacks, 1968-1978: The Role of Antiracist Struggle*, 11 INT’L J. OF HEALTH SERVICES 511 (1981).

**Table 2. Racial Disparity in Life Expectancy at Birth (LEAB)<sup>29</sup>**

Year of birth	Black LEAB	Year same LEAB was first reached by whites	Disparity in years
2002	72.3	1975	27
2000	71.9	1970	30
1990	69.1	1950	40
1980	68.1	1949	31
1970	64.1	1933	37
1960	63.6	1933	27
1950	60.8	1921	29
1940	53.1	1912	28
1930	48.1	1901	29

For Black men, the disparity in LEAB is even greater, for much of the gains in Black health have been among women. At current rates of change, these disparities may persist for many generations, even as absolute health improves for most groups.

\* \* \* \*

The analysis and conclusions in this first section are relatively uncontroversial, acknowledged by both the Left and the Right.<sup>30</sup> This Article now leaves the safe waters of consensus for controversies over causation and remedies. The next section describes the search for a biomedical “cause” of Black disparities in health. The dominant approaches are critiqued as *etiological reductionism* and *racialized research*.

## II. Racial Research on Health Disparities

### A. Etiological Reductionism: Searching For Micro Causes in a Macro World

Scientific research attempts to identify causes rather than just associations. Biomedical scientists search for the precise causal or *etiological* pathways of disease and health status. This model has worked well in many infectious diseases categories such as influenza, malaria and AIDS, as well as chronic diseases such as cancer and diabetes.<sup>31</sup> But etiological reductionism can be misleading when applied to race and health.

<sup>29</sup> Author’s analysis of statistics from National Vital Statistics Report, Vol. 51, No. 3, Table 12 (Dec. 19, 2002); see also Rashi Fein, *An Economic and Social Profile of the Negro American*, 94 DAEDALUS 815 (1965) (similar time lag studies in LEAB, infant mortality rate, educational attainment, and other measures). Fein also notes that time lag studies understate the permanent disparity: “if the Negro in 1965 is where the white was in 1945, this does not mean that the Negro considers himself as well off as the white considered himself twenty years ago.” *Id.* at 818.

<sup>30</sup> See William H. Frist, *Overcoming Disparities in U.S. Health Care*, 24 HEALTH AFFAIRS 445 (March/April 2005) (U.S. Senate Majority Leader); and Edward M. Kennedy, *The Role of the Federal Government in Eliminating Health Disparities*, 24 Health Affairs 452 (March/April 2005) (ranking Minority Member on the Senate Health, Education, Labor, & Pensions Committee).

<sup>31</sup> Examples of this kind are chronicled in many scientific histories. See, e.g., Randy Shilts, *AND THE BAND PLAYED ON: POLITICS, PEOPLE, AND THE AIDS EPIDEMIC* (1987); John M. Barry, *THE GREAT INFLUENZA: THE EPIC STORY OF THE DEADLIEST PLAGUE IN HISTORY* (2004).

Researchers generally consider socio-economic status (SES) factors such as income and education as *confounding variables*, to be adjusted for and controlled in any experiment to determine if any residual impact of race remains. But in the United States, Blacks suffer disparities in most SES variables such as income, wealth, education, insurance, occupation, and housing. If race (or racism) is *prior*, then all of these SES variables are co-morbidities or simultaneous symptoms rather than confounding variables. Black disparities of all types may point to a deeper social problem. The cause may be macro rather than micro, obscured by methodology.

For example, assume a study is undertaken to determine the cause of large health differences between Group X and the general population. Group X is a minority racial group, and suffers much higher morbidity and mortality rates. Members of Group X are overwhelmingly poor, lack health insurance, are disproportionately unemployed, live in unsanitary housing, are poorly educated and otherwise occupy the lowest quintile of any socioeconomic indicator, all resulting from persistent racial discrimination. Adjusting for all of these variables may well show that Group X suffers no racial health disparities, or may show only very minor disparities. Aggressive adjustment for confounding variables may obscure the relationship between health and race, “treat[ing] race-associated differences as nuisance confounders rather than as important clues to be mined.”<sup>32</sup>

The Institute of Medicine study committee recognized this methodological issue, even as they followed their Congressionally-mandated definition of disparity:

To a great extent, attempts to separate the relative contribution of these factors risks presenting an incomplete picture of the complex interrelationship between racial and ethnic minority status, socioeconomic differences, and discrimination in the United States. For example ... racial and ethnic housing segregation is a by-product of both historic and contemporary racism and discrimination, as well as socioeconomic differences (itself the legacy of poorer opportunities for many minority groups). The committee therefore stresses that attempts to “parcel out” access-related factors from the quality of healthcare for minorities remains an artificial exercise, and that policy solutions must consider the historic and contemporary forces that contribute to access to and quality of healthcare.<sup>33</sup>

Almost all of the rigorous studies examined in *Unequal Treatment* demonstrated reduced disparities after controlling for SES variables, although most still found remaining racial disparities.<sup>34</sup> The annual *National Healthcare Disparities Report* issued by the Agency for Healthcare Research and Quality generally reports racial disparities in health

---

<sup>32</sup> Camara Phyllis Jones, “Race,” *Racism, and the Practice of Epidemiology*, 154 AM. J. OF EPIDEMIOLOGY 299, 302 (2001); see also Paula Braveman, et al., *World Health Report 2000: How It Removes Equity from the Agenda for Public Health Monitoring and Policy*, 323 BRIT. MED. J. 678 (2001) (supporting broader reporting of health disparities by social inequality).

<sup>33</sup> UNEQUAL TREATMENT, *supra* note 5, at 32 (mandate), 34-35 (quote).

<sup>34</sup> UNEQUAL TREATMENT, *supra* note 5, at 42.

measures without adjustment for SES, although it does occasionally present multivariate analyses which adjust for age, gender, household income, education, insurance and residence location.<sup>35</sup> The *2004 National Healthcare Disparities Report* recognized that race, health and SES indicators are highly correlated in American society, but nevertheless adjusted for SES in a few categories.<sup>36</sup> Any attempt to adjust for SES will underreport the true scope of the tragedy of Black health in America.

The alternative to etiological reductionism is to treat Black disparities in health and SES as co-morbidities rather than confounding variables. This approach is similar to that taken by Dr. Paul Farmer. He does not shrink from the “biosocial realities” of health disparities, but includes all available data, “linking molecular epidemiology to history, ethnography, and political economy.”<sup>37</sup> To Farmer, “inequality itself [has] become a pathogenic force.”<sup>38</sup>

## B. The Paradox of Racialized Research

Many sophisticated critiques of race come from the biomedical sciences, debunking a genetic basis for race. Current evidence suggests the genetic variation within races is greater than the variation between races.<sup>39</sup> This profound result undermines broad racial classification by genetics, and clearly establishes race as primarily a social construct.

Weak scientific foundations do not make race irrelevant. Hitler’s racial beliefs may have been unscientific, but they did construct social reality for millions of people. Race has an undeniably place in our history. Many social characteristics are utilized as variables; to exclude any social variable *a priori* is improper and particularly so in the case of race.<sup>40</sup>

---

<sup>35</sup> Agency for Healthcare Research and Quality, 2004 NATIONAL HEALTHCARE DISPARITIES REPORT 7, 10, 12-13 (March 2005, 2<sup>nd</sup> printing) (available at [www.qualitytools.ahrq.gov](http://www.qualitytools.ahrq.gov)).

<sup>36</sup> *Id.*, at 12-13. In 2005, U.S. government researchers continue to refine methodological issues in health disparities research, but fail to discuss this problem of over adjustment. See National Center for Health Statistics, *Methodological Issues in Measuring Health Disparities*, Vital and Health Statistics (Series 2, Number 141) (July 2005).

<sup>37</sup> Paul Farmer, *INFECTIONS AND INEQUALITIES: THE MODERN PLAGUES* 5 (1999).

<sup>38</sup> *Id.*, at 16, 37-58.

<sup>39</sup> Richard S. Cooper, et al., *Race and Genomics*, 348 N. Engl. J. Med. 1166, 1167 (2003) [hereinafter Cooper, *Race and Genomics*]. For a helpful summary of the literature, see Sharona Hoffman, *Is There a Place for “Race” as a Legal Concept?*, 36 Ariz. State L. J. 1093, 1116-22 (2004).

<sup>40</sup> Paula Braveman, et al., *Health Inequalities and Social Inequalities in Health*, 78 BULL. WORLD HEALTH ORG. 232 (2000); Esteban Gonzalez Burchard, et al., *The Importance of Race and Ethnic Background in Biomedical Research and Clinical Practice*, 348 N. ENGL. J. MED. 1170, 1171 (2003) (emphasizing the value of racial and ethnic data, including genetic differences due to geographic origin); Judith B. Kaplan & Trude Bennett, *Use of Race and Ethnicity in Biomedical Publication*, 289 J. AM. MED. ASS’N 2709 (2003) (describing three major challenges to the use of race in biomedical research and suggesting guidelines); Sandra Soo-Jim Lee, Joanna Mountain & Barbara A. Koenig, *The Meanings of “Race” in the New Genomics: Implications for Health Disparities Research*, 1 YALE J. HEALTH POL’Y, L. & ETHICS 33, 53-59 (2001) (race is an improper variable in biomedical research but may have a continuing place in social science); Steven P. Wallace, et al., *The Consequences of Color-Blind Health Policy for Older Racial and Ethnic Minorities*, 9 STAN. L. & POL’Y REV 329, 338 (1998) (“[I]t is crucial that we be race-sensitive as we devise health and aging policy...we need to better understand the distribution of health needs...The health and economic problems of older minorities are rooted in historic practices of discrimination.”).

The paradox of racialized research is that race is a dangerous and unscientific category, but must remain as a variable in social science research in order to measure its tragic legacy. The use of race as a variable in biomedical research is more problematic. Recent research into drugs targeting particular racial or ethnic groups may lead to racial medical profiling.<sup>41</sup>

Genetic heterogeneity within and between races does not exclude the possibility of specific genetic conditions which occur in some populations. These genotypes must not be confused with race. For example, people with the CYP3A5\*1 allele are more susceptible to hypertension, and a disproportionate number of people with this allele consider themselves to be Black.<sup>42</sup> But many Black people do not carry the allele; and some people with the allele are not Black. It would be a gross mistake to label the CYP3A5\*1 allele a 'Black' genotype, or hypertension as a Black disease, even though both are more prevalent in Blacks. Scientists are using 'Black' as shorthand for 'people with CYP3A5\*1' when what is really needed is an inexpensive test for the presence of the allele. Professor Sharona Hoffman recently described similar examples of genetic conditions which are mistakenly characterized as racial, including Tay-Sachs and sickle cell anemia.<sup>43</sup> The absence of pharmacogenomics<sup>44</sup> leads to racialized medicine.

The fear of racialized medicine is not unfounded. NitroMed recently won FDA approval to market a new fixed-dose combination drug for Black heart disease, BiDil (hydralazine + isosorbide dinitrate). The African-American Heart-Failure Trial (A-HeFT) found BiDil to be effective in reducing heart failure mortality amongst the study participants.<sup>45</sup> Critics have raised questions about whether studies like these are proper. A more recent study on ACE inhibitors found that equalizing access to health insurance resulted in Blacks having a slightly higher survival rate than white patients, suggesting that access, not genetics or culture, is the cause of the disparity.<sup>46</sup> One possible explanation for

---

<sup>41</sup> For a review study summarizing the various racially-denominated pharmacological recommendations in heart failure, see J.S. Taylor & G.R. Ellis, *Racial Differences in Responses to Drug Treatment: Implications for Pharmacotherapy of Heart Failure*, 2 AM. J. CARDIOVASCULAR DRUGS 389-99 (2002). For recent discussions on racial profiling in medicine, see Erik Lillquist & Charles A. Sullivan, *The Law and Genetics of Racial Profiling in Medicine*, HARV. C.R.-C.L. L. REV. 391 (2004); Rene Bowser, *Race as a Proxy for Drug Response: The Dangers and Challenges of Ethnic Drugs*, 53 DEPAUL L. REV. 1111 (2004); Rene Bowser, *Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities*, 7 MICH. J. RACE & L. 79 (2001); and Rene Bowser, *Racial Bias in Medical Treatment*, 105 DICK. L. REV. 365 (2001).

<sup>42</sup> H. Ho, et al., *Association Between the CYP2A5 Genotype and Blood Pressure*, 45 HYPERTENSION 294-8 (Feb. 2005) ("the CYP3A5\*1 allele may be associated with hypertension that is more refractory to treatment in this [black] ethnic group"). This latter study suffers from the self-identification error, described immediately below.

<sup>43</sup> Hoffman, *supra* note 39, at 1142-43 (describing the medical dangers of considering Tay-Sachs and sickle cell anemia as Jewish and African-American diseases, respectively).

<sup>44</sup> Pharmacogenomics is the branch of medicine which uses individualized genetic profiles to determine optimal pharmaceutical therapy.

<sup>45</sup> Stephanie Saul, *Maker of Heart Drug Intended for Blacks Bases Price on Patients' Wealth*, N.Y. TIMES July 8, 2005.

<sup>46</sup> Lindsey Tanner, *Access To Care Is Called Key In Study On Race and Health*, BOSTON GLOBE A2 (May 21, 2003). **[find the underlying study]** Critics question whether these studies are properly designed and performed. Cooper, *Race and Genomics*, *supra* note 39; Lee, Mountain & Koenig, *supra* note 40, at 53-59.

BiDil's success is an allele which was prevalent within the study population, but not within the general US population. Some Blacks lack this allele, and will gain no advantage from BiDil. Others will have the allele, but will never be prescribed BiDil because they are not Black. Again, racialized medicine is no substitute for pharmacogenomics.

One methodological weakness in racialized research is patient self-identification as Black. Studies typically rely upon the individuals studied to self-identify race.<sup>47</sup> Since the concept of race is socially constructed, this self-identification is necessarily an amorphous genetic category. The use of race as a variable introduces a coding consistency issue, particularly when multiple data sets are used. Several studies have demonstrated racial misclassification in health care.<sup>48</sup> If the study intends to measure a social impact (such as discrimination), then self-reporting may be the best practice. But if the study intends to measure a genetic variation within a population, self-reporting introduces data errors. A tenth-generation American citizen with significant ancestry from European and Native American populations might still self-identify as Black. Others with similarly ancestry but passing for white might not self-identify as Black. Recent immigrants from other countries might have different notions of Black. Brazilians have highly specific notions of race, with categories differing in some degree from our own.<sup>49</sup> Knowing the significant genetic heterogeneity within Blacks, it is dangerous and misleading to use Black as a proxy for a genetic allele. The best practice would be to know the actual genetic background of the individuals in the BiDil study, without racial labels. If all of the responsive Blacks in the study were 10<sup>th</sup> generation Americans living in Mississippi, the study may not accurately predict effectiveness with a first generation Black immigrant from England, or Tiger Woods, or anyone else lacking the specific allele.

When biomedical researchers express results racially, the result may be medical racial profiling.<sup>50</sup> Doctors are being told that BiDil works wonders with Blacks, but is ineffective with whites. Perhaps it will be malpractice to prescribe BiDil to someone

---

<sup>47</sup> The BiDil study (A-HeFT) relied upon racial self-identification. Anne L. Taylor, *The African-American Heart Failure Trial (A-HeFT): Rationale and Methodology*, 9 J. of Cardiac Failure S216, S217 (Suppl. 2003). Recruitment of patients for the trial was through the National Medical Association and the Association of Black Cardiologists, which probably adds a layer of provider identification. Id. at S218.

<sup>48</sup> Michele L. Casper, et al., *WOMEN AND HEART DISEASE: AN ATLAS OF RACIAL AND ETHNIC DISPARITIES IN MORTALITY 21-22* (2d ed., 2000) (misreporting of race on death certificates, primarily for American Indians and Alaska Natives, Asian and Pacific Islanders, and Hispanics, but not Blacks); R. A. Hahn, et al., *Identifying Ancestry: The Reliability of Ancestral Identification in the United States by Self, Proxy, Interviewer, and Funeral Director*, 7 EPIDEMIOLOGY 75 (1996); J. S. Kaufman, *How Inconsistencies in Racial Classification Demystify the Race Construct in Public Health Statistics*, 10 EPIDEMIOLOGY 101 (1999); J. J. Kelley, et al., *Race/Ethnicity Misclassification of Persons Reported with AIDS*, 1 ETHNICITY & HEALTH 87 (1996); H. M. Rosenberg et al., *Quality of Death Rates by Race and Hispanic Origin: A Summary of Current Research*, VITAL AND HEALTH STATISTICS, SER. 2, NO. 128 (National Center for Health Statistics, 1999) (discussing the quality of racial and Hispanic origin designations on death certificates); and David R. Williams, *Race/Ethnicity and Socioeconomic Status: Measurement and Methodological Issues*, 26 INT'L J. HEALTH SERV. 483 (1996).

<sup>49</sup> See, e.g., Jefferson M. Fish, *Mixed Blood*, in *THE BRAZIL READER: HISTORY, CULTURE, POLITICS* 391 (Robert M. Levine & John J. Crocitti, eds.) (1999).

<sup>50</sup> See Hoffman, *supra* note 39 at 1141-44; Lillquist & Sullivan, *supra* note 41; and Bowser, *supra* note 41.

who appears to be white, and equally erroneous to fail to prescribe it for someone who appears to be Black.<sup>51</sup> BiDiI requires providers to identify race in order to plan a course of treatment. The person ceases to be a patient, and becomes a Black patient. Or perhaps a person who passes for white is not identified as Black, despite having the proper genotype. Racialized research contributes to medical racial profiling, despite the best intentions of the researchers and physicians.<sup>52</sup>

Racialized medicine intersects with etiological reductionism in disturbing ways. One recent study in the Proceedings of the National Academy of Science examined the role of patient education on outcomes in diabetes and HIV, positing that well educated patients would achieve higher self-management of complex clinical regimes.<sup>53</sup> The results for HIV demonstrated a statistically significant correlation between years of schooling and adherence to the complex treatment protocol, on a level similar to the effect of being black or female.<sup>54</sup> Similar effects were found in diabetes and other diseases.<sup>55</sup> Patient compliance has been used to legitimize withholding complex treatments from the less well educated.<sup>56</sup> The danger here is when being Black stands as a proxy for noncompliant.

### C. Collecting Higher Quality Racial Data

Data issues abound in race and health. Race is socially constructed and contestable, especially at the margins. Some researchers have called for more aggressive and consistent collection of racial data to promote research quality.<sup>57</sup> Aetna recently began

---

<sup>51</sup> Not to mention the dozens of other races which confront providers treating heart disease.

<sup>52</sup> Michelle van Ryn, *Paved with Good Intentions: Do Public Health and Human Service Providers Contribute to Racial/Ethnic Disparities in Health?*, 93 AM. J. PUB. HEALTH 248 (2003); Lillquist & Sullivan, *supra* note 41; Bowser, *supra* note 41.

<sup>53</sup> Dana P. Goldman & James P. Smith, *Can Patient Self-Management Help Explain the SES Health Gradient?*, 99 PROC. NAT'L ACAD. SCI. 10929 (2002). For a study with similar results, see Richard Ippolito, *Education Versus Savings As Explanations for Better Health: Evidence from the Health and Retirement Study*, GEORGE MASON LAW & ECONOMICS RESEARCH PAPER NO. 03-04, available at Social Sciences Research Network Electronic Library, [www.ssrn.com](http://www.ssrn.com), abstract 377862.

<sup>54</sup> Goldman & Smith, *supra* note 53, at 10931.

<sup>55</sup> *Id.* at 10932-33. R.C. Kaplan, et al., *Race, Ethnicity, and Sociocultural Characteristics Predict Noncompliance With Lipid-Lowering Medications*, 39 PREV. MED. 1249-1255 (Dec. 2004) ("higher noncompliance among minority patients persisted independently of these and other specific social, cultural, and economic factors"); Susan L. Furth, *Effects of Patient Compliance, Parental Education and Race on Nephrologists' Recommendations for Kidney Transplantation in Children*, 3 AM. J. OF TRANSPLANTATION 28-34 (2003).

<sup>56</sup> See L. M Bogart et al., *Factors Influencing Physicians' Judgments of Adherence and Treatment Decisions for Patients with HIV Disease*, 21 MED. DECISION MAKING 28 (2001); L.M. Bogart et al., *Impact of Medical and Non-Medical Factors on Physician Decision Making for HIV/AIDS Antiretroviral Treatment*, 23 J. ACQUIRED IMMUN. DEFIC. SYNDR. 396 (2000) [**check original**]. Global drug companies withheld life-saving AIDS drugs from poor people until systems could be put in place to assure patient compliance with the regimes. Barton Gellman, *A Turning Point That Left Millions Behind; Drug Discounts Benefit Few While Protecting Pharmaceutical Companies' Profits*, WASH. POST, Dec. 28, 2000, at A1.

<sup>57</sup> See, e.g. Marian E. Gornick, *Vulnerable Populations and Medicare Services: Why Do Disparities Exist?* 47-48 (2000) [hereinafter Gornick, *Vulnerable Populations*]; Watson, *Race, Ethnicity and Hospital Care*, *supra* note 8, at 125; Nancy Moss & Nancy Krieger, *Measuring Social Inequalities In Health; Report on*

collecting racial data in hopes of reducing racial disparities in health.<sup>58</sup> A modification in Medicare reimbursement methodologies in the 1980s created new data sets which exposed previously unexamined racial disparities in Medicare.<sup>59</sup> Collecting racial data is necessary if racial disparities are to be identified, but the continued legal reification of race may prolong racial stereotypes.<sup>60</sup> As the prior section demonstrates, continued collection of race data may be most troubling in biomedical research, as opposed to the social sciences. In particular, race is to be avoided as a proxy variable for something which can be measured directly, such as genotypes or patient compliance.

The federal government does not routinely collect racial data in health care,<sup>61</sup> despite calls from many health policy scholars to do so.<sup>62</sup> Health care racial difference studies frequently utilize data from government programs such as Medicare, Medicaid, or the Veterans' Administration, but racial data is not collected in the clinical encounters.<sup>63</sup> In 1994, HCFA (now CMS) adopted a uniform claims form that collects a mountain of data, but excluded race. HCFA defended the practice in a lawsuit by minority groups pressing for collection of the racial data.<sup>64</sup> To obtain racial data, researchers must match social security numbers to the Social Security Administration files.<sup>65</sup> Historically, self-reported race was collected on each application for a social security number, but the Enumeration at Birth program no longer collects racial and ethnic data.<sup>66</sup> As a result, the ability to match to the social security files for race is deteriorating over time, particularly among the young. The lack of racial data hinders civil rights enforcement.<sup>67</sup> The federal

---

*the Conference of the National Institutes of Health*, 110 Public Health Reports 302 (1995) (suggesting better collection of data on both race and socio-economic status).

<sup>58</sup> Ron Winslow, *Aetna Is Collecting Racial Data To Monitor Medical Disparities*, Wall St. J. A1 (Mar. 5, 2003).

<sup>59</sup> Marian E. Gornick, *Disparities in Medicare Services: Potential Causes, Plausible Explanations, and Recommendations*, 28 Health Care Financing Rev. 23, 33-34 (Summer 2000) [hereinafter, Gornick, *Disparities in Medicare Services*]; Gornick, *Vulnerable Populations*, *supra* note 57, at 25-35.

<sup>60</sup> Hoffman, *supra* note 39 at 1141-44; Lillquist & Sullivan, *supra* note 41; and Bowser, *supra* note 41.

<sup>61</sup> David R. Williams & Toni D. Rucker, *Understanding and Addressing Racial Disparities in Health Care*, 21:4 Health Care Financing Review 75, 79 (Summer 2000). One survey gave the misleading impression that racial data was being routinely collected in health care. Mara Youdelman with Steve Hitov, *RACIAL, ETHNIC AND PRIMARY LANGUAGE DATA COLLECTION: AN ASSESSMENT OF FEDERAL POLICIES, PRACTICES AND PERCEPTIONS, VOL. 2: THE CURRENT FEDERAL LANDSCAPE IN HEALTH CARE REGARDING THE COLLECTION AND REPORTING OF DATA ON RACE, ETHNICITY AND PRIMARY LANGUAGE: A SURVEY OF THE STATUTES, REGULATIONS, POLICIES, PRACTICES AND DATA COLLECTION VEHICLES* i, i-iv, 18-84 (National Health Law Program, Oct. 2001). A careful review of the survey reveals that racial and ethnic data are not collected for clinical encounters in Medicare or Medicaid, nor in HEDIS, a major reporting format for managed care.

<sup>62</sup> *See, e.g.*, David Barton Smith, *Health Care Divided: Race and Healing a Nation* 322-23 (1999) [hereinafter Smith, *Health Care Divided*].

<sup>63</sup> Williams & Rucker, *supra* note 61, at 79.

<sup>64</sup> *Madison-Hughes v. Shalala*, 80 F.3d 1121 (6<sup>th</sup> Cir. 1996).

<sup>65</sup> Susan L. Arday, et al., *HCFA's Racial and Ethnic Data: Current Accuracy and Recent Improvements*, 21 HEALTH CARE FINANCING REV. 107, 108-09 (2000).

<sup>66</sup> Youdelman, *supra* note 61, at 33-34, n. 120.

<sup>67</sup> United States Commission on Civil Rights, *The Consequences of Government Race Data Collection Bans on Civil Rights*, Briefing held May 17, 2002, available at [www.usccr.gov/pubs](http://www.usccr.gov/pubs); David Barton Smith, *Addressing Racial Inequities in Health Care: Civil Rights Monitoring and Report Cards*, 23 J. OF HEALTH POL., POL'Y & L. 75, 92-101 (1998) [hereinafter Smith, *Addressing Racial Inequalities*].

government repeatedly failed to require more specific data for Title VI enforcement in health care.<sup>68</sup> Government collection of racial data continues to be a political issue. California recently rejected Proposition 54, Ward Connerly's effort to ban the collection of racial data by the state in public education, public contracting and public employment.<sup>69</sup> While Proposition 54 would not have affected medical research directly, it should be seen as part of a larger program over many decades to constrict the available data on racial differences, as if ignoring the problem will make it disappear.

It should also be noted that many of the data sources used in disparity studies do not include certain institutionalized populations, including correctional facilities such as jails and prisons.<sup>70</sup> This gap in the data is significant, since prison populations exhibit both racial differences and poor health, a pattern that was noted as early as 1844.<sup>71</sup> According to the U.S Department of Justice, twelve percent of Black men aged 20 to 34 were in jail or prison on June 30, 2002.<sup>72</sup> Approximately 818,900 Black men and 65,600 Black women were in jail or prison on June 30, 2002.<sup>73</sup> The rate of incarceration of Blacks greatly exceeds the white rate: for Black men, the rate is 7.4 times the white male rate; for Black women, the rate is 5.1 times the white female rate.<sup>74</sup> Prison populations have increased 400% since the 1970s.<sup>75</sup> As for health, prison populations are sicker than the general population on an age-adjusted basis and have significant access and quality issues.<sup>76</sup> These circumstances have combined to understate racial health disparities by excluding significant Black populations which are now in prison and in poor health.

\* \* \* \* \*

This Article now leaves questions of etiology behind, with the suspicion that Black disparities in both health and SES may share a common cause, grounded in American history. The next section examines the history of racism in American health care, paying particular attention to the role of governments as state actors in endorsing or permitting racial disparities in health care, and the continuity of Black health disparities from slavery to the present day. These themes become important when we turn to Black reparations.

---

<sup>68</sup> Smith, Health Care Divided, *supra* note 62, at 173, 185, 322-23.

<sup>69</sup> Editorial, *The Color of California*, Wall St. J. A8 (Aug. 4, 2003).

<sup>70</sup> See Debra L. Blackwell & Luong Tonthat, Summary Health Statistics for the U.S. Population: National Health Interview Survey, 1998 2 (National Center for Health Statistics, Ser. 10, No. 207, Oct. 2002).

<sup>71</sup> Benjamin H. Coates, *On the Effects of Imprisonment on the African Races*, 4 N.Y.J. Med. 91, 92 (Jan. 1844).

<sup>72</sup> Paige M. Harrison & Jennifer C. Karberg, *Prison and Jail Inmates at Midyear 2002*, BUREAU OF JUSTICE STATISTICS BULLETIN 1, 11 (April 2003) available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/pjim02.pdf>.

<sup>73</sup> *Id.*

<sup>74</sup> *Id.* at 11, Table 14.

<sup>75</sup> Fox Butterfield, *Prison Rates Among Blacks Reach a Peak, Report Finds*, N.Y. Times, Apr. 7, 2003, at A12.

<sup>76</sup> See generally Scott Burris, *Prisons, Law and Public Health: The Case For a Coordinated Response to Epidemic Disease Behind Bars*, 47 U. MIAMI L. REV. 291 (1992); Amy Petre Hill, *Death Through Administrative Indifference: The Prison Litigation Reform Act Allows Women to Die to California's Substandard Prison Health Care System*, 13 HASTINGS WOMEN'S L.J. 223 (2002); Ira P. Robbins, *Managed Health Care in Prisons as Cruel and Unusual Punishment*, 90 J. CRIM. L. & CRIMINOLOGY 195 (1999).

The combination of still-living plaintiffs and state action may result in a Black reparations lawsuit which can survive a motion to dismiss. Readers intimately familiar with the history of Black health in America may wish to skim forward to Section IV.

### III. Tragedy in History: Black Health in America

The history of Black health in America is cruel and shocking. From the inception of the Atlantic slave system until quite recently, medicine treated Blacks in a grossly inferior manner. Rare were the medical voices asserting the innate equality of Blacks.<sup>77</sup> Racial disparities in health arose in the context of slavery and were reinforced by state action in segregation and discrimination.<sup>78</sup> Roma Stewart notes the connection:

Some disparities are the vestiges of historical patterns of racial segregation. In Louisiana, for example, separate hospitals were built for blacks. Race, not ability to pay, determined which hospital was accessible to which patient. Until 1964 the Federal Government made grants and loans to segregated hospitals under the Hill-Burton Act. Further, until the mid-1960s, black physicians were not given staff privileges at some nonpublic hospitals. The vestiges of this system when combined with subtle discriminatory practices of today, perpetuate health care access problems for black Americans.<sup>79</sup>

The following section focuses on the acts of governments and nonprofit organizations to create and perpetuate tragedy of Black health disparities, as a foundation for the reparations issues to be discussed in Section IV below.

#### A. The Slave Health System

Good farmers take care of their livestock, providing care and enlisting the assistance of a veterinarian as the situation warrants. So too with human chattel property.<sup>80</sup> Protecting the health of their slaves was a major economic issue for the slave owner.<sup>81</sup>

<sup>77</sup> Nancy Krieger, *Shades of Difference: Theoretical Underpinnings of the Medical Controversy on Black/White Differences, 1830-1870*, 17 Int'l J. Health Serv. 259 (1987) [hereinafter Krieger, *Shades of Difference*].

<sup>78</sup> Several authors have examined this connection at length. See W. Michael Byrd & Linda A. Clayton, AN AMERICAN HEALTH DILEMMA: RACE, MEDICINE, AND HEALTH CARE IN THE UNITED STATES, VOLS. I (BEGINNINGS TO 1900) (2000) & II (1900 TO 2000) (2002) [hereinafter Byrd & Clayton, DILEMMA] (exhaustive two-volume review of the history of Black health); Smith, HEALTH CARE DIVIDED, *supra* note 62 (an excellent book-length treatment); Nancy Krieger, *The Ostrich, the Albatross, and Public Health: An Ecosocial Perspective – Or Why an Explicit Focus on Health Consequences of Discrimination and Deprivation Is Vital for Good Science and Public Health Practice*, 116 PUBLIC HEALTH REPORTS 419 (2001); Randall, *Trusting*, *supra* note 8; Randall, *Deficit*, *supra* note 4; and Watson, *Race, Ethnicity and Quality of Care*, *supra* note 8, at 203.

<sup>79</sup> Roma J. Stewart, *Health Care and Civil Rights*, in CIVIL RIGHTS ISSUES IN HEALTH CARE DELIVERY; A CONSULTATION SPONSORED BY THE UNITED STATES COMMISSION ON CIVIL RIGHTS 322-23 (United States Commission on Civil Rights, 1980).

<sup>80</sup> William Dosite Postell, THE HEALTH OF SLAVES ON SOUTHERN PLANTATIONS (1951) (finding slaves to be as healthy as the general antebellum population); Smith, HEALTH CARE DIVIDED, *supra* note 62, at 11-12; Todd L. Savitt, MEDICINE AND SLAVERY: THE DISEASES AND HEALTH CARE OF BLACKS IN ANTEBELLUM VIRGINIA 150 (1978) [hereinafter Savitt, MEDICINE AND SLAVERY] (“Virginians often

Todd Savitt studied the slave health care system in antebellum Virginia, finding several layers of care. Most effective were the sanitary and public health measures,<sup>82</sup> often supported as necessary for white health due to physical proximity.<sup>83</sup> This concept was later known as “germs have no color line.”<sup>84</sup>

In addition to public health and sanitation, the master or overseer provided care in routine cases. Domestic medicine could be effective in some cases.<sup>85</sup> For serious cases of illness or injury, the slave owner hired physicians, either on an annual contract or on a fee for service basis.<sup>86</sup> In the mid-nineteenth century, the services of a physician did not necessarily improve health. Prior to the discovery of the germ theory and anesthetic, modern (allopathic) medicine could be dangerous and was not very effective.<sup>87</sup> Effective antebellum therapies included smallpox vaccination,<sup>88</sup> hernia repair,<sup>89</sup> and quinine.<sup>90</sup> Many other therapies were useless or dangerous, such as bleeding and purging.<sup>91</sup>

---

displayed concern for the health of blacks in bondage. The reasons were threefold: slaves represented a financial investment which required protection; many masters felt a true humanitarian commitment toward their slaves; and whites realized that certain illnesses could easily spread to their own families if not properly treated and contained.”); Walter Fisher, *Physicians and Slavery in the Antebellum Southern Medical Journal*, J. OF THE HIST. OF MED. 36-49 (Jan. 1968); Felice Swados, *Negro Health on the Antebellum Plantations*, 10 BULL. HIST. MED. 460, 460-472 (1941) (detailing the deficiencies of plantation health care). Apologists of slavery tended to exaggerate the medical benefits of the slave health system. See, e.g., L.C. Allen, *The Negro Health Problem*, 5 AM. J. PUB. HEALTH 194-195 (1915) (“It is undoubtedly true that the negro race has deteriorated physically and morally since slavery times...There was no more healthy race of people to be found anywhere in the world than the slaves of the South before the Civil War”) [hereinafter L.C. Allen, *Problem*]. For a more balanced conclusion, see Postell, *supra* this note, at 164.

<sup>81</sup> Frederick Law Olmsted, THE COTTON KINGDOM: A TRAVELLER’S OBSERVATIONS ON COTTON AND SLAVERY IN THE AMERICAN SLAVE STATES 439-440, 449 (Arthur M. Schlesinger, ed., Modern Library 1969) (1861) (quoting a Mississippi planter as encouraging better health care for slaves, in the economic interests of the planters); Postell, *supra* note 80, at 22, 50-52 (accord, and also suggesting that planters responded to morality in providing health care to slaves); but see Frederick Douglass, NARRATIVE OF THE LIFE OF FREDERICK DOUGLASS, AN AMERICAN SLAVE 153-59 (Houston A. Baker, Jr. ed., Penguin Books 1982) (1845).

<sup>82</sup> Savitt, MEDICINE AND SLAVERY, *supra* note 80, at 57-73

<sup>83</sup> Savitt, MEDICINE AND SLAVERY, *supra* note 80, at 208, 221-22.

<sup>84</sup> Vanessa Northington Gamble, GERMS HAVE NO COLOR LINE: BLACKS AND AMERICAN MEDICINE, 1900-1940 (1989) [hereinafter Gamble, GERMS].

<sup>85</sup> Postell, *supra* note 80, at 102 (comparing various treatment regimes).

<sup>86</sup> Savitt, MEDICINE AND SLAVERY, *supra* note 80, at 165-71, 191.

<sup>87</sup> Kevin Outterson, *Healthcare, Technology & Federalism*, 103 W. VA. L. REV. 503, 507-11 (2001); Savitt, *Medicine and Slavery*, *supra* note 80, at 167 (“The main virtue of most irregular health systems was their relative harmlessness, especially when compared with traditional approaches.”).

<sup>88</sup> Savitt, *Medicine and Slavery*, *supra* note 80, at 220; Outterson, *supra* note 87, at 507-11 (2001).

<sup>89</sup> Savitt, *Medicine and Slavery*, *supra* note 80, at 135.

<sup>90</sup> Savitt, MEDICINE AND SLAVERY, *supra* note 80, at 155-56.

<sup>91</sup> Postell, *supra* note 80, at 50-128.

Unsurprisingly, traditional medical approaches flourished surreptitiously within Black communities, parallel to allopathic medicine.<sup>92</sup> Black suspicion of the medical establishment began in slavery, but was reinforced by the exclusion of Blacks from the medical establishment and the use of Blacks in medical training and experiments in the nineteenth and twentieth centuries.<sup>93</sup> Understanding this history might inform the current literature on patient compliance.<sup>94</sup> Todd Savitt noted the pattern of reticence to submit to the master's medicine:

Beyond the master's and overseer's eyes, back in the slaves' cabins, some Virginia blacks took medical matters into their own hands. When under the surveillance of whites, slaves usually (but not always) accepted their treatments. Some even administered them in the name of the master. But others developed or retained from an ancient African heritage their own brand of care, complete with special remedies, medical practitioners, and rituals. The result was a dual system of health care, the two parts of which constantly conflicted with each other.<sup>95</sup>

The slave health system was paternalistic and primarily served the interests of the master, but it provided some limited health care and retirement benefits to slaves.<sup>96</sup> By comparison, free Blacks arranged and paid for their own health care. Free Blacks suffered appalling health, with a mortality rate approximately double the white rate.<sup>97</sup> Freedom did not necessarily mean equal health, so long as the other social conditions of life were unequally distributed. At Emancipation, all would be swept away and free Blacks would be abandoned to the marketplace to purchase or contract for whatever health care they could afford from whoever would be allowed to serve them.<sup>98</sup>

## B. From the Civil War to the New Deal, 1861 - 1933

Crises in public health often accompany war; the Civil War was no exception. Despite the end of legal slavery, Blacks suffered terribly from malnutrition, poverty and lack of

---

<sup>92</sup> Edward H. Beardsley, *A HISTORY OF NEGLECT: HEALTH CARE FOR BLACKS AND MILL WORKERS IN THE TWENTIETH-CENTURY SOUTH* 30-35 (1987) [hereinafter Beardsley, *NEGLECT*]; Postell, *supra* note 80, at 59; Savitt, *MEDICINE AND SLAVERY*, *supra* note 80, at 149, 171-84.

<sup>93</sup> See, e.g., Savitt, *MEDICINE AND SLAVERY*, *supra* note 80, at 281-307; Walter Fisher, *Physicians and Slavery in the Antebellum Southern Medical Journal*, *J. OF THE HIST. OF MED.* 36, 45-49 (Jan. 1968) (Black bodies were used in southern medical schools for training and experimentation); Smith, *HEALTH CARE DIVIDED* at 24-27; W. Montague Cobb, *Surgery and the Negro Physician: Some Parallels in Background*, 43 *J. OF THE NAT'L MED. ASS'N* 145, 147-49 (1951).

<sup>94</sup> See Section II.B *supra*.

<sup>95</sup> Savitt, *MEDICINE AND SLAVERY*, *supra* note 80, at 171.

<sup>96</sup> The practice of keeping aged slaves on the plantation, coupled with laws forbidding manumission of the aged and infirm, operated as a form of retirement benefit after the slaves were no longer able to work. Savitt, *MEDICINE AND SLAVERY*, *supra* note 80, at 201-07. Postell goes further and concludes that slave health was equal to the general antebellum population. Postell, *supra* note 80, at 164.

<sup>97</sup> G. Emerson, *Medical Statistics*, 17 *AM. J. OF THE MEDICAL SCIENCES* 3, 35 (Nov. 1831); Coates, *supra* note 71, at 92 *citing* Emerson, *id.* at 35-38. Black mortality within prisons was higher still. Coates' figures are for Philadelphia, since national data on antebellum Black health were not available.

<sup>98</sup> Savitt, *MEDICINE AND SLAVERY*, *supra* note 80, at 207-17 (discussing antebellum health care for free Blacks); Smith, *HEALTH CARE DIVIDED*, *supra* note 62, at 12-13.

access to land, capital, employment, education and health care.<sup>99</sup> In terms of health care, southern Blacks may have been worse off after the Civil War: they lost the paternalistic slave health care system and very little was available to replace it.<sup>100</sup> A slave owner suffered financially if a slave died or missed work due to illness or injury. Antebellum landlords with Black contract laborers did not have similar financial incentives.<sup>101</sup> White physicians, formerly paid by slave owners, were not eager to serve Blacks who were unable to pay for health care after the war.<sup>102</sup> At the dawn of the era that modern medicine was becoming more effective, Blacks were shut out from many of its benefits, with disastrous effects.<sup>103</sup> By 1900, the average Black life expectancy at birth was 30 to 35 years, 15 years less than the white LEAB.<sup>104</sup>

When freedmen signed labor contracts with plantation owners after the Civil War, the contracts generally excluded any medical care coverage or required the freedmen to pay for it.<sup>105</sup> Alternative sources of health care were meager. The federal government and Northern philanthropists provided some charity care and limited public health programs; Blacks paid for other health care with their own resources.

### *Charity Care and Public Health*

---

<sup>99</sup> Leon F. Litwack, *BEEN IN THE STORM SO LONG: THE AFTERMATH OF SLAVERY* (1979) [hereinafter Litwack, *STORM*].

<sup>100</sup> Todd L. Savitt, *Politics in Medicine: The Georgia Freedmen's Bureau and the Organization of Health Care, 1865-1866*, 38 *CIVIL WAR HIST.* 45, 64 [hereinafter Savitt, *Politics in Medicine*]; see also Martin Abbott, *THE FREEDMEN'S BUREAU IN SOUTH CAROLINA, 1865-1872* 48-51, 66-69, 138-43 (1967) (some labor contracts overseen by the Freedmen's Bureau provided for health care); Howard N. Rabinowitz, *RACE RELATIONS IN THE URBAN SOUTH, 1865-1890* 128-31 (1978); Marshall S. Legan, *Disease and the Freedmen in Mississippi During Reconstruction*, 28 *J. HIST. MED. AND ALLIED SCIENCES* 257-67 (1973); and Alan Raphael, *Health and Social Welfare of Kentucky Black People, 1865-1870*, 2 *SOCIETAS* 143-47 (1972). Although Abbott (and others) note the presence of health care provisions in labor contracts, he does not describe whether the freedmen were required to pay for the care when the crop was harvested. *C.f.* Louis S. Gerteis, *FROM CONTRABAND TO FREEDMAN: FEDERAL POLICY TOWARD SOUTHERN BLACKS 1861-1865* at 73, 86, 104, 127, 163 (1973) (employers charged for medical care). In addition, the contracts charged freedmen for absence from work, even if due to sickness, at the customary rate of 50 cents per day. The plantation owner after slavery probably did not have clear economic incentives to maximize the health of his Black workers.

<sup>101</sup> Postell, *supra* note 80, at 22, 50-52; see also the sources cited in note 100, *supra*.

<sup>102</sup> See Postell, *supra* note 80, at 66 (noting that before the war, the plantation owner always was responsible for paying the physician's bill).

<sup>103</sup> *UNEQUAL TREATMENT*, *supra* note 5, at 103-05; Ann Hallman Pettigrew & Thomas F. Pettigrew, *Race, Disease and Desegregation: A New Look*, 24 *PHYLON* 315, 333 (1963); Postell, *supra* note 80, at 80, 143, 151 (describing the apparent increase in Black morbidity and mortality after the Civil War); Savitt, *Politics in Medicine*, *supra* note 100, at 63. Cutler and Meara found that most gains in mortality in the early 20<sup>th</sup> century resulted from public health and economic measures, while medical care began to significantly reduce mortality by mid-century. David M. Cutler & Ellen Meara, *CHANGED IN THE AGE DISTRIBUTION OF MORTALITY OVER THE 20<sup>TH</sup> CENTURY 1-4* (Nat'l Bur. Econ. Research, Working Paper 8556, Oct. 2001).

<sup>104</sup> Pettigrew & Pettigrew, *supra* note 103, at 333; National Vital Statistics Reports, Vol. 51, No. 3 Table 12 (Dec. 19, 2002).

<sup>105</sup> Savitt, *Politics in Medicine*, *supra* note 100, at 61-62; but see the discussion of Abbott in note 100, *supra*.

Private charities were significantly involved in health care in the decades surrounding the Civil War, particularly for children and sanitary public health programs.<sup>106</sup> As the Civil War progressed, slaves who reached Union lines required some protection. Rather than permit uncontrolled Black refugee migration to the North, and to avoid hindering military operations, the Army settled them into camps in Union-controlled southern states.<sup>107</sup> In these camps and other Union-controlled areas, charities such as the American Missionary Association and the various Sanitary Commissions provided education and assistance, including public health care programs.<sup>108</sup>

In the midst of the Civil War, the War Department and the Treasury Department organized relief and contract labor programs for “contraband” Blacks escaping slavery.<sup>109</sup> The goal of these efforts was to put Blacks back to work, for the Union.<sup>110</sup> At the end of the war, federal assistance to former slaves was transferred to the Freedmen’s Bureau, established by Congress on March 3, 1865.<sup>111</sup> The efforts of the Medical Department of the Freedmen’s Bureau, while heroic in aspiration, were chaotically organized and ineffective in meeting the crushing needs.<sup>112</sup> Hospitals and other institutions were established across the South.<sup>113</sup> Five Black hospitals were established in Georgia by the Freedmen’s Bureau, but the lack of supplies, personnel and adequate facilities crippled efforts.<sup>114</sup> When beds were available at all, they were occupied by two or three patients simultaneously.<sup>115</sup> The head of the Freedmen’s Bureau wrote in 1869 that only 1 out of

---

<sup>106</sup> Robert H. Brenner, *THE PUBLIC GOOD: PHILANTHROPY AND WELFARE IN THE CIVIL WAR ERA* 14-34 (1980).

<sup>107</sup> Brenner, *supra* note 106, at 98-99; Gerteis, *supra* note 100, at 24 (Federal policy encouraged contraband slaves to remain in the South); Charles J. Stille, *HISTORY OF THE UNITED STATES SANITARY COMMISSION* (Philadelphia: J.B. Lippincott & Co. 1866).

<sup>108</sup> Brenner, *supra* note 106, at 91-110; Gerteis, *supra* note 100, at 20, 121.

<sup>109</sup> Gerteis, *supra* note 100, *passim*.

<sup>110</sup> Gerteis, *supra* note 100, at 60, 83, 151 (1973).

<sup>111</sup> An Act to Establish a Bureau for the Relief of Freedmen and Refugees, 13 Stat. 507 (1865).

<sup>112</sup> Savitt, *Politics in Medicine*, *supra* note 100, at 45; Abbott, *supra* note 100, at 135 (concluding that the Bureau’s work in South Carolina was “a qualified failure,” hamstrung by meagre resources, daunting needs and southern opposition). Louis Gerteis viewed the Freedmen’s Bureau as still-born from inception, given the record of the contract labor system for contraband during the Civil War. Gerteis, *supra* note 100, at 185 (“Under the circumstances, the Freedmen’s Bureau, which paid lip service to the idea of creating a class of independent black farmers, could do little more than preside over the liquidation of wartime labor programs while facilitating the restoration of antebellum property rights and institution of a contract labor system throughout the South. Denying the Bureau any real power and discarding the agricultural programs begun during the war, Congress replaced programs of government protection and support with hollow promises of land for freedmen and poor whites.”).

<sup>113</sup> Brenner, *supra* note 106, at 116-17, n 11; Abbott, *supra* note 100, at 48-51 (describing significant medical care provided in South Carolina by the Bureau).

<sup>114</sup> A letter from one of the physicians is instructive: “Many of my patients ... died from the Want of comfort and clothes: Some of them entirely Naked. Last week the weather was very inclement ... at which time I was not able to be Supplied with wood and five of my patients died from sudden chills.... I have not been able to give my female patients a change, even of chemise, since they are under me. Some are now laying all the time in Bed from want of covering their Frames. Notwithstanding repeated requisitions [for supplies] made by me.” Savitt, *Politics in Medicine*, *supra* note 100, at 55 (letter of Dr. D’Alvigny, Jan. 8, 1866).

<sup>115</sup> Savitt, *Politics in Medicine*, *supra* note 100, at 55.

200 freedmen received assistance, generally the very poorest.<sup>116</sup> The health work of the Freedmen's Bureau only lasted for three years; afterwards impoverished former slaves could look only to local governments or charities for access to health care.<sup>117</sup> The institutional legacy of the Freedmen's Bureau was the Freedmen's Hospital and Asylum in Washington, D.C., which today is the Howard University Hospital,<sup>118</sup> one of the few remaining historically Black hospitals.<sup>119</sup>

After Reconstruction, charities and public health agencies demonstrated little interest in Black health, with a few exceptions.<sup>120</sup> Many public health efforts for Blacks were stained with racism and social Darwinism: Blacks were described as a race in decline; Black extinction would solve the race problem.<sup>121</sup> Black health was important primarily to avoid the spread of communicable diseases to whites, as if Blacks were merely an epidemiological vector like rats or mosquitoes.<sup>122</sup> At the 1914 General Session of the American Public Health Association, the Health Officer from Savannah, Georgia warned:

There are 5,000 or more negroes in this city who are parasites and their removal would lower the death-rate and reduce crime; therefore, it is recommended that some remedy be applied by enacting building laws preventing the congestion of negroes and the elimination of the depreddating class.<sup>123</sup>

The dominant white ideology was disdainful of making important long term investments in Black health.<sup>124</sup> One example was the publication in 1896 of Frederick L. Hoffman's RACE TRAITS AND TENDENCIES OF THE AMERICAN NEGRO, which argued that Blacks were

---

<sup>116</sup> Brenner, *supra* note 106, at 125 citing *Report of the Commissioner Bureau Refugees, Freedmen &c, October 20, 1869* in U.S. WAR DEPARTMENT: ANNUAL REPORT, 1868-69, VOL. I, p. 502.

<sup>117</sup> Savitt, *Politics in Medicine*, *supra* note 100, at 60-61.

<sup>118</sup> Brenner, *supra* note 106, at 142-43, n 91.

<sup>119</sup> *The Crisis of the Disappearing Black Hospitals*, EBONY 23 (March 1992).

<sup>120</sup> Paul B. Cornely, *Segregation and Discrimination in Medical Care in the United States*, 46 AM. J. PUB. HEALTH 1074, 1075 (1956). One of the most ardent charities in support of Black health was the Julius Rosenwald Fund, but even this leading light only allocated \$1.5mm to Black health in the period 1928-1942. Edwin R. Embree, *Two Years of Progress in Advancement of Health of the Negro Reported by Julius Rosenwald Fund*, 10 NAT'L NEGRO HEALTH NEWS 31 (Oct.-Dec. 1942). Embree was the scion of a famous abolitionist family. Edwin R. Embree, BROWN AMERICANS (1943).

<sup>121</sup> Gamble, GERMS, *supra* note 84, at introduction; Beardsley, Neglect, *supra* note 92, at 129-30.

<sup>122</sup> Gamble, GERMS, *supra* note 84, at introduction. For a remarkably racist speech delivered before the 1914 General Session of the American Public Health Association, see L.C. Allen, *Problem*, *supra* note 80, at 194 ("Disease among the negroes is a danger to the entire population. Communicable diseases find their favorite propagating grounds in the dirty negro sections of our cities, and in unsanitary negro homes in the country."). A similar speech at the same session warned: "recognize the negro as a potent factor in the transmission of disease...you will suffer. The negro of the lower class is thrown into domestic contact with you and he furnishes 80 per cent. of your household help. You cannot keep pace with modern sanitation unless you care for him." William F. Brunner, *The Negro Health Problem In Southern Cities*, 5 AM. J. PUB. HEALTH 183, 189 (1915). Racist ideology may have assisted in promoting public health measures such as municipal water and sewer systems, which could not be easily denied to Blacks. Troesken estimates that at least 25% of the reduction in Black mortality from 1900 to 1940 was due to the introduction of water and sewer systems. Troesken, *supra* note 26, at 208.

<sup>123</sup> Brunner, *supra* note 122, at 185 (1915); for a contrary contemporary view, see Trask, *supra* note 16.

<sup>124</sup> Nancy Krieger, *Shades of Difference*, *supra* note 77, at 259.

physically and mentally inferior and would not survive long in North America.<sup>125</sup> Hoffman was not a fringe author, but a statistician for Prudential Insurance Company; the volume was published by the American Economic Association. This hugely popular book reflected and encouraged an apathetic approach to meeting the health needs of Blacks, a view that largely held sway for a century after Emancipation.<sup>126</sup> Tuberculosis is a prominent example of the neglect of Black public health, particularly in the South.<sup>127</sup> Estimates in the 1920s suggested that effective control of tuberculosis would have extended the average Black life span by five years.<sup>128</sup> Southern public health agencies failed to serve the pressing needs of Black citizens:

[T]he final group with responsibility for the welfare of black Southerners – the region’s state and local public health directors – did little to challenge patterns of segregation or to address black needs. As constituted guardians of the health of the whole citizenry, these public servants bore greatest responsibility for the health of the black population. Yet the fact remains that until the infusion of federal money and larger purpose into Southern public health operations in the New Deal era, they failed their black patrons by a wider margin than any other group.<sup>129</sup>

---

<sup>125</sup> Hoffman’s book was reprinted in March 2004, with an introduction by Paul Finkelman. Frederick L. Hoffman, *RACE TRAITS AND TENDENCIES OF THE AMERICAN NEGRO* (Paul Finkelman, introduction, The Lawbook Exchange, Ltd. 2003) (1896). 1896 also marked the publication of the first of many statistical studies on the American Negro by Atlanta University with more sanguine prospects for Black survival. Thomas N. Chase, ed., *MORTALITY AMONG NEGROES IN CITIES* (Atlanta University Publications, No. 1) (1896; 2<sup>nd</sup> abridged ed., 1903). The series was later supervised by Du Bois.

<sup>126</sup> Byrd & Clayton, *DILEMMA*, *supra* note 78, at 35-65; Smith, *HEALTH CARE DIVIDED*, *supra* note 62, at 8-24 (discussing the scope and effect of scientific racism on Black health). Similar views were expressed in medical journals prior to the Civil War. See Samuel A. Cartwright, *Report on the Diseases and Physical Peculiarities of the Negro Race*, *NEW ORLEANS MEDICAL AND SURGICAL J.* 89 (May 1851) (articulating biological and theological differences requiring slavery). For a thorough review of Black health in the South during the first thirty years of the twentieth century and the role of public health for Blacks, see Beardsley, *NEGLECT*, *supra* note 92, at 11-41, 128-55.

<sup>127</sup> See H.M. Green, *Hospitals and Public Health Facilities for Negroes*, 1928 *PROC. OF THE NAT’L CONF. OF SOC. WORK* 179-180 (1928). For a collection of medical articles from the period 1900 to 1940 on Black health, particularly tuberculosis, see Gamble, *GERMS*, *supra* note 84. Public health efforts amongst Blacks in Northern cities were more effective. Beardsley, *NEGLECT*, *supra* note 92 at 26-27.

<sup>128</sup> C.S. Johnson, *Negro Health In Light of Vital Statistics*, 1928 *PROCEEDINGS OF THE NATIONAL CONFERENCE OF SOCIAL WORK* 173-75 (1928). Johnson also notes that even with the great racial disparities in health status in the United States, substantial progress had been made when compared to many European countries. For example, he notes that the Black infant mortality rate in the mid-1920s was less than the overall infant mortality rate in Austria, Belgium, Bulgaria, France, Germany, Italy, Rumania, Hungary and Spain. *Id.* at 175. See also Gamble, *GERMS*, *supra* note 84; Troesken, *supra* note 26, at 10, 208 (substantial progress in municipal water and sewer systems for both whites and Blacks greatly improved public health).

<sup>129</sup> Beardsley, *NEGLECT*, *supra* note 92 at 128; see also Cornely, *supra* note 120, at 1080, but see generally 10 *NAT’L NEGRO HEALTH NEWS* (Jan.-Mar. 1942) (This periodical emphasizes the advanced made in public health for Blacks. It was originally published by Tuskegee, and was later adopted by the United States Public Health Service).

### *Market-Based Health Care*

In the decades surrounding the Civil War, health care was a relatively free market, mostly unencumbered by regulation.<sup>130</sup> Blacks with financial resources purchased health care services in the marketplace. Other Blacks aspired to provide those services as doctors or other health professionals. Both of these options were frustrated by racism. Racism forced Blacks to resort to a segregated medical system to serve their health needs.

After the Civil War, hospitals became an increasingly important site for medical care,<sup>131</sup> but hospital discrimination excluded Black patients altogether, or relegated them to clearly inferior segregated wards. Many hospitals were not available to Blacks in the first half of the twentieth century.<sup>132</sup> Almost a quarter of hospitals in 1922 practiced complete exclusion of Blacks,<sup>133</sup> in addition to the hospitals practicing racial segregation. According to a 1928 survey, “each white citizen of the United States has fourteen times as good a chance at proper hospital care as has the Negro.”<sup>134</sup> In 1930, the number of hospital beds per person available to Blacks was one-fourteenth the white rate.<sup>135</sup> A 1956 survey found only 5.8% of southern hospitals to be integrated.<sup>136</sup> When segregated hospitals were available to Blacks, they were often used for training white physicians, residents and interns.<sup>137</sup> The Veteran’s Administration built a Black hospital in Tuskegee rather than accept integration of World War I veterans.<sup>138</sup> Post-acute and sub-acute institutions also excluded Blacks.<sup>139</sup>

<sup>130</sup> Outterson, *supra* note 87, at 510-15.

<sup>131</sup> Charles E. Rosenberg, *THE CARE OF STRANGERS: THE RISE OF AMERICA’S HOSPITAL SYSTEM* (1987).

<sup>132</sup> Cornely, *supra* note 120, at 1074-75 (discussing racial discrimination in health care 1930-1949, both North and South); Du Bois, *supra* note 18, at 93-95 (hospital segregation as of 1906).

<sup>133</sup> Rosemary Stevens, *IN SICKNESS AND IN WEALTH: AMERICAN HOSPITALS IN THE TWENTIETH CENTURY* 137 (1989) [hereinafter Stevens, *IN SICKNESS AND IN WEALTH*].

<sup>134</sup> Green, *supra* note 127, at 179. Dr. Green compared the 6,807 U.S. hospitals with 853,318 beds to the 210 hospitals “available to [Negroes]” with 6,780 beds. *Id.* It is unclear how he accounts for segregated wards in white hospitals.

<sup>135</sup> Peter Marshall Murray, *Hospital Provision for the Negro Race*, 4 *BULL. AM. HOSP. ASS’N* 37 (1930) reprinted in Gamble, *GERMS*, *supra* note 84, at 109.

<sup>136</sup> Cornely, *supra* note 120, at 1079. Northern hospitals claimed to be 82.5% integrated, but this figure was likely to be highly inflated, given the Department of Health, Education and Welfare’s experience in Title VI compliance certification a decade later. See Michael Meltsner, *Equality and Health*, 115 *UNIV. OF PENN. L. REV.* 22, 31-38 (1966).

<sup>137</sup> See Green, *supra* note 127: “Many cities, especially in the South, provide wards, usually in the basement of their city hospitals, for Negro patients. A few northern cities admit Negro patients to their free wards along with their white paupers. These institutions invariably exclude Negro physicians. Here the Negro patients (North and South) are used largely as clinical material for training interns of another race, a practice employed by no other civilized country in the world.” See also Myrdal, *supra* note 15, at 635 (description of segregation and racial exclusion practices in hospitals in the United States in the early 1940’s); Stevens, *IN SICKNESS AND IN WEALTH*, *supra* note 133, at 137.

<sup>138</sup> Stevens, *IN SICKNESS AND IN WEALTH*, *supra* note 133, at 127. Thirty years later, a proposal to build a second Black VA hospital was defeated, an early limited victory for hospital integration. Vanessa Northington Gamble, *MAKING A PLACE FOR OURSELVES: THE BLACK HOSPITAL MOVEMENT, 1920-1945* 186 (1995).

<sup>139</sup> Brenner, *supra* note 106, at 182-83; Smith, *HEALTH CARE DIVIDED*, *supra* note 62, at 236-75 (long term care).

These forms of segregation were supported by Supreme Court opinions eviscerating the Fourteenth Amendment's Equal Protection Clause. Beginning in the 1870's, the Supreme Court embraced a 'color blind' jurisprudence in numerous cases gutting civil rights, including *Virginia v. Rives*,<sup>140</sup> *Gibson v. Mississippi*,<sup>141</sup> *The Civil Rights Cases*,<sup>142</sup> *Plessy v. Ferguson*,<sup>143</sup> *Hodges v. United States*,<sup>144</sup> and *Corrigan v. Buckley*.<sup>145</sup> As I concluded in an *amicus* brief for the University of Michigan affirmative action cases:

These cases are the oration of Brutus, praising the one he has slain; they were the federal pillars of white supremacy for nearly a century, shamelessly professing 'color blind' equality while turning a blind eye to the harsh reality of life as an African American during Jim Crow.<sup>146</sup>

The Black response to health care segregation constructed a parallel Black system, which at its peak in the 1920s and 1930s numbered perhaps 200 Black hospitals.<sup>147</sup> These hospitals did not embrace segregation, but were a defensive response to American racism. Black medical institutions and professionals were largely insulated from white interference, permitting advocacy for Black issues without fear of economic reprisal.<sup>148</sup> In theory, a separate but equal system of health care would not be dangerous for Blacks. Truly equal systems would not suffer disparities. But white supremacy, particularly after Reconstruction, denied equality and doomed Blacks to an inferior health care system for generations.<sup>149</sup>

---

<sup>140</sup> *Virginia v. Rives*, 100 U.S. 313 (1879) (upholding a facially color blind Virginia juror selection system which had the effect of excluding all Blacks).

<sup>141</sup> *Gibson v. Mississippi*, 162 U.S. 565 (1896) (upholding the juror qualification provision of the infamously racist Mississippi Constitution of 1890).

<sup>142</sup> *The Civil Rights Cases*, 109 U.S. 3 (1883) (finding the Civil Rights Act of 1875 unsupported by the Civil War Amendments).

<sup>143</sup> *Plessy v. Ferguson*, 163 U.S. 537 (1896) (upholding "equal, but separate" public accommodation on Louisiana railroads).

<sup>144</sup> *Hodges v. United States*, 203 U.S. 1 (1906) (private conspiracy to forcibly prevent African Americans from working, solely on the basis of race and color).

<sup>145</sup> *Corrigan v. Buckley*, 271 U.S. 323 (1926) (racially restrictive covenants).

<sup>146</sup> See Kevin Outterson, et al., Brief Amici Curiae of the National Coalition of Blacks For Reparations in America (N'COBRA) and the National Conference of Black Lawyers (NCBL) In Support of Respondents (filed with the U.S. Supreme Court in *Grutter v. Bollinger* (2003) and *Gratz v. Bollinger* (2003)) available at Social Science Research Network Electronic Database, [www.ssrn.com](http://www.ssrn.com), abstract 392060, posted June 3, 2003). For an economic and philosophical critique of color blind jurisprudence, see Glenn C. Loury, *THE ANATOMY OF RACIAL INEQUALITY* (2002). For a narrative and doctrinal treatment, see andre douglas pond cummings [ ].

<sup>147</sup> Gamble, *MAKING A PLACE*, *supra* note 138, at 183 (listing 169 Black hospitals in 1929); Smith, *HEALTH CARE DIVIDED*, *supra* note 62, at 16-21; Edward T. Morman, *Book Review*, 70 *BULL. OF HIST. OF MED.* 335 (1996) (reviewing Vanessa Northington Gamble, *MAKING A PLACE FOR OURSELVES: THE BLACK HOSPITAL MOVEMENT, 1920-1945* (1995)); Cornely, *supra* note 120, at 1078-80; *The Crisis of the Disappearing Black Hospitals*, *EBONY* 23 (March 1992).

<sup>148</sup> Smith, *HEALTH CARE DIVIDED*, *supra* note 62, at 38 ("Black physicians and dentists made up the backbone of local chapters of the NAACP.").

<sup>149</sup> See, e.g., Josiah C. Nott, *Caucasian and Negro Races*, 30 *BOSTON MED. SURG. J.* 244 (1844) (Blacks are a different species, not suited to non-tropical regions, which explains higher morbidity and mortality rates); Stevens, *IN SICKNESS AND IN WEALTH*, *supra* note 133, at 9, 50 (social stratification is a primary characteristic of American hospitals).

Racism also forced the creation of segregated Black medical professions.<sup>150</sup> Paul Starr chronicled the rise of medicine as a profession from the 1850s, and the growing power of the American Medical Association,<sup>151</sup> but Black physicians were largely excluded from the AMA and its constituent societies. Black physicians were generally denied admitting privileges to hospitals, even to segregated wards. Denial of admitting privileges hurt Black physicians financially; some Black physicians (such as surgeons) needed a hospital in order to practice at all. The mechanism of exclusion was a requirement that the physician hold membership in the all-white county AMA medical society. This permitted a hospital to maintain the facade of equal opportunity into the 1960s while allowing the local medical society to enforce discrimination.<sup>152</sup>

Overt discrimination against Black physicians in the South persisted well into the 1960's, with the AMA issuing non-binding proclamations of non-discrimination, but refusing to challenge discriminatory practices by its local and state constituent medical societies.<sup>153</sup> In June, 1963, the Medical Committee for Civil Rights issued "An Appeal to the AMA" which challenged the AMA to: (1) speak out against segregation and discrimination; (2) terminate any state or local medical societies which continued to practice racial exclusion; (3) oppose Hill-Burton "separate but equal" funding; and (4) oppose the re-credentialing of any non-integrated hospital.<sup>154</sup> The AMA failed to act decisively until the passage of the Civil Rights Act of 1964 and Medicare in 1965. For example, the first Black member of the Chattanooga and Hamilton County Medical Society was Dr. Hiram B. Moore in 1964.<sup>155</sup> Admission to the Society was required before gaining hospital admission privileges at Chattanooga's two hospitals, publicly-owned Erlanger and the

---

<sup>150</sup> The segregated medical professional organizations included physicians (American Medical Association and National Medical Association), dentists (American Dental Association and National Dental Association) and hospitals (American Hospital Association and National Hospital Association (1923)); the parallel nursing organizations (American Nurses' Association and the National Association of Colored Graduate Nurses) effectively merged after a long history of working together to combat segregation. Smith, *HEALTH CARE DIVIDED*, *supra* note 62, at 42-43. In 1971, Black nurses re-founded a separate association, the National Black Nurses Association. Gamble, *MAKING A PLACE*, *supra* note 138, at 195. *See also* Dietrich C. Reitzes, *NEGROES AND MEDICINE* 3-12 (1958) (describing data showing increased access for Black physicians, particularly in the North); Cornely, *supra* note 120, at 1078 ("at the present time [1956] not one state or county dental society is opened to Negro dentists ... who [are] barred from even joining his national organization, the American Dental Association").

<sup>151</sup> Paul Starr, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982).

<sup>152</sup> Cornely, *supra* note 120, at 1077-78 (discussing role of AMA and its constituent societies in denying hospital admission privileges to Black physicians); *see generally* Beardsley, *NEGLECT*, *supra* note 92, at 79-80; Byrd & Clayton, *DILEMMA*, *supra* note 78, at 35-65; Smith, *HEALTH CARE DIVIDED*, *supra* note 62, at 13-21, 32-39, 68-74 (1999); Reitzes, *supra* note 150, at 331-32, tables 67-69 (summarizing the extent of health care discrimination in the 1950s in fourteen cities across the nation); and Cobb, *supra* note 150, at 150.

<sup>153</sup> The AMA passed weak resolutions in 1950 and 1952, but did nothing to prevent its local and state medical societies from excluding Blacks from membership, with full knowledge that such membership was necessary to be appointed to the medical staffs of most hospitals. Herbert M. Morais, *THE HISTORY OF THE NEGRO IN MEDICINE* 152, 153, 175, 224 (1970).

<sup>154</sup> Morais *supra* note 153, at 162. Beardsley highlights some token moves by the AMA and its societies in the 1950's, but fails to explain why the Medical Committee for Civil Rights was still demanding desegregation from the AMA in 1963. *See* Beardsley, *NEGLECT*, *supra* note 92, at 252.

<sup>155</sup> Morais *supra* note 153, at 178.

private Memorial Hospital.<sup>156</sup> Similar conditions prevailed in Chicago in 1963.<sup>157</sup> The residual effects of this legacy still remain: a recent study found that Black doctors still report greater difficulty obtaining hospital admissions than white physicians, even after controlling for a wide range of practice and environmental characteristics.<sup>158</sup>

Blacks also developed a separate medical education system. Under AMA pressure, access to the medical profession increasingly required a college degree followed by medical school; both avenues were less available to Blacks.<sup>159</sup> The nursing profession faced similar barriers. Of the 1800 accredited nursing schools in the mid-1920's, only 58 admitted Black students.<sup>160</sup> Black colleges were the natural response,<sup>161</sup> including the two leading Black medical schools, Howard in Washington and Meharry in Nashville. Prior to the 1960's, the vast majority of Black physicians were trained in Black medical schools, but Blacks were barely 1% of all medical students in training.<sup>162</sup> The first southern medical school to admit Blacks was the University of Arkansas in 1948.<sup>163</sup> It was not until 1966-67 that the last southern medical schools admitted a Black medical student.<sup>164</sup> In 1950, Blacks were 10% of the population, but only 2.2% of all physicians,<sup>165</sup> and only 133 Blacks graduated from medical school, mostly from Meharry and Howard.<sup>166</sup> Over the last decade, the number of Black graduates from medical school has declined,<sup>167</sup> despite the fact that Blacks are underrepresented as physicians<sup>168</sup> and medical school faculty members.<sup>169</sup> Since the end of legal segregation, the Black physician deficit has been reduced somewhat, but with these rates it may take a long time to reach equality.

\* \* \* \*

By the beginning of the twentieth century the pattern was firmly set: official neglect of Black health needs, unmitigated by the former property interest; discrimination against

<sup>156</sup> Morais *supra* note 232, at 178.

<sup>157</sup> *Morris v. Chicago Hospital Council*, \_\_\_ F. Supp. \_\_\_, (N.D. Ill. 1964), 9 Race Rel. Rep. 1838 (1964-1965).

<sup>158</sup> J. Lee Hargraves, et al., *Minority Physicians' Experiences Obtaining Referrals to Specialists and Hospital Admissions*, 3(3) MEDSCAPE GENERAL MEDICINE 1 (2001) available at [www.medscape.com/viewarticle/408160](http://www.medscape.com/viewarticle/408160) (also reporting that Hispanic physicians were more likely to report problems in obtaining a specialist referral; 58% of Hispanic physicians were educated outside the U.S., compared with 11% of white physicians).

<sup>159</sup> Cobb, *supra* note 93, at 150-51; Du Bois, *supra* note 18, at 95-109.

<sup>160</sup> A. Roberts, *Nursing Education and Opportunities for the Colored Nurse*, 1928 PROCEEDINGS OF THE NATIONAL CONFERENCE OF SOCIAL WORK 183-85 (1928).

<sup>161</sup> Brenner, *supra* note 106, at 212-13.

<sup>162</sup> Cornely, *supra* note 120, at 1074-77; see also Reitzes, *supra* note 150, at 3-43 (statistical review of Black physicians, medical students and applicants, published in 1958).

<sup>163</sup> Cornely, *supra* note 120, at 1075.

<sup>164</sup> Beardsley, Neglect, *supra* note 92, at 255; Sullivan, *supra* note 25, at Session II, page 14.

<sup>165</sup> Reitzes, *supra* note 150, at xxvii.

<sup>166</sup> *A JBHE Check-Up on Blacks in U.S. Medical Schools*, *Journal of Blacks in Higher Education* (July 18, 2005) (available at [www.jbhe.com/features/47\\_medicalschoools.html](http://www.jbhe.com/features/47_medicalschoools.html)).

<sup>167</sup> Id.

<sup>168</sup> Hargraves, *supra* note 158, at 8, Table 1.

<sup>169</sup> *Journal of Blacks in Higher Education*, *supra* note 166.

Black health institutions and providers in a separate and unequal system; government deferral to racist professional organizations; and ‘color-blind’ interpretations of the Equal Protection Clause to deny a Constitutional remedy.

### C. The New Deal Generation, 1933-1964

The Depression wrecked economic havoc on Black communities. Employment discrimination meant that Blacks were the last to be hired and the first to be fired, and trade unions generally excluded Blacks to protect white privilege.<sup>170</sup> To some extent, the New Deal responded to these needs, a remarkable achievement given the tenuous position held by Blacks in American society at the time.<sup>171</sup>

#### 1. A New Deal For Blacks<sup>172</sup>

FDR and several of his close advisors cautiously advanced some programs for Blacks. Actions included appointments of Blacks to federal offices,<sup>173</sup> and employment in the Works Progress Administration and other federal programs.<sup>174</sup> In an early model for Title VI, President Franklin Delano Roosevelt signed Executive Order 8802 mandating non-discrimination in some government contracts.<sup>175</sup> The impetus was Philip A. Randolph’s threatened march on Washington in 1941.<sup>176</sup> In health care, Public Health Service grants to states improved Black health<sup>177</sup> and the Public Works Administration embarked on a program of hospital construction which made an additional 8,000 beds available to Blacks.<sup>178</sup> Social Security was passed without explicit racial tests for participation or benefits, although the exclusion of agricultural and household workers disproportionately affected Blacks.<sup>179</sup> In contrast to unbridled white supremacy, the New Deal provided some benefits to Blacks on a basis of near equality, providing the first significant federal assistance since the Freedmen’s Bureau.<sup>180</sup> Black advances were modest overall. Most of the relief programs accommodated the southern planting and harvesting schedule, suspending operations in order to encourage adequate field labor.<sup>181</sup>

<sup>170</sup> Michael .K. Honey, **Southern Labor and Black Civil Rights: Organizing Memphis Workers** (1993).

<sup>171</sup> John Brueggemann, *Racial Considerations and Social Policy in the 1930s: Economic Change and Political Opportunities*, 26 SOC. SCI. HIST. 139 (2002)

<sup>172</sup> Harvard Sitkoff, **A NEW DEAL FOR BLACKS: THE EMERGENCE OF CIVIL RIGHTS AS A NATIONAL ISSUE: THE DEPRESSION DECADE** (1978).

<sup>173</sup> Arthur M. Schlesinger, Jr., **THE AGE OF ROOSEVELT: THE POLITICS OF UPHEAVAL** 435 (1960).

<sup>174</sup> See Brueggemann, **supra note 171**, at 143-47; C.S. Johnson, *The Negro*, 47 AMERICAN JOURNAL OF SOCIOLOGY 855, 857 (1942).

<sup>175</sup> See Sitkoff, **supra note 172**, at 321-22; Johnson, **supra note 174**, at 860.

<sup>176</sup> Sitkoff, **supra note 172**, at 314-321.

<sup>177</sup> Beardsley, **NEGLECT, supra note 92**, at 156-85.

<sup>178</sup> See Johnson, **supra note 174**, at 857; see also Myrdal, **supra note 15**, at 345, n. 35.

<sup>179</sup> Bruggemann, **supra note 171**, at 150, 164.

<sup>180</sup> Johnson, **supra note 174**, at 855; Sitkoff, **supra note 172**; see, e.g., *Over Million Negro Youths Receive School Lunches*, 11 NAT’L NEGRO HEALTH NEWS 15 (Jan.-Mar. 1943) (assistance provided on conditions of equality).

<sup>181</sup> Bruggemann, **supra note 171**, at 144-45.

Civil rights laws were not passed and many examples of segregation remained in long-term federal projects and organized labor.<sup>182</sup>

In Gunnar Myrdal's landmark 1944 study, segregation and discrimination still characterized American health care.<sup>183</sup> Facilities for Blacks, North and South, remained "qualitatively inferior;" and rural hospital facilities were "totally inadequate almost everywhere in the South, especially for Negroes."<sup>184</sup> Civilian health needs were largely on the sideline during the Second World War,<sup>185</sup> but in the immediate post war years various health care proposals were floated in Congress.<sup>186</sup> In January 1948, President Truman requested a report on the nation's health status. The result was the National Health Assembly, which produced an official report entitled *America's Health: A Report to the Nation*.<sup>187</sup> The report identified disparities in Black health and called for dramatic government action.<sup>188</sup> This view did not carry the day; the National Health Assembly did not recommend an end to health care segregation or embrace a national health system.<sup>189</sup> The American Medical Association and the American Hospital Association had previously endorsed a more limited, decentralized proposal fashioned by Senators Lister Hill (D-AL) and Harold Burton (R-OH). The Hill-Burton program provided federal money for state-supervised hospital and medical facility construction, including racially segregated facilities.<sup>190</sup> By providing the funds without guarantees of nondiscrimination, the Hill-Burton program entrenched segregation in a new generation of facilities.

## 2. The Hill-Burton Program: American Apartheid in Health Care

The federal government supported a racially segregated health care system through hospital construction grants under the 1946 Hill-Burton Act,<sup>191</sup> eventually providing more than \$3 billion in federal funds.<sup>192</sup> Between 1949 and 1962, about 30% of all

<sup>182</sup> Bruggemann, *supra* note 171, at 145-149, 159.

<sup>183</sup> See Myrdal, *supra* note 15, at 323 ("There are only a few hospitals in the United States, such as Harlem Hospital in New York City, where Negro and white doctors work together in a system of absolute equality.").

<sup>184</sup> See Myrdal, *supra* note 15, at 344-45.

<sup>185</sup> Stevens, IN SICKNESS AND IN WEALTH, *supra* note 133, at 208-13.

<sup>186</sup> Morais, *supra* note 153, at 158-61; Stevens, IN SICKNESS AND IN WEALTH, *supra* note 133, at 213-16.

<sup>187</sup> *America's Health*, *supra* note 14. The Chairman of the National Health Assembly, Oscar R. Ewing, also published his personal report to President Truman, Oscar R. Ewing, *THE NATION'S HEALTH: A TEN-YEAR PROGRAM* (1948). The primary difference between the two reports is that *The Nation's Health* called for national health insurance whereas the official report did not.

<sup>188</sup> *America's Health*, *supra* note 14, at 200-01.

<sup>189</sup> *America's Health*, *supra* note 14, at 150 ("The committee brought in a recommendation that discrimination and segregation is out of line with democratic principles and should be abolished not only in the institutions of higher learning but also throughout the general educational system. No agreement, however, could be reached on this subject either in general or with reference to medical education.").

<sup>190</sup> Smith, *HEALTH CARE DIVIDED*, *supra* note 62, at 46-47; Stevens, IN SICKNESS AND IN WEALTH, *supra* note 133, at 216-19; Smith, *Addressing Racial Inequities*, *supra* note 67, at 81.

<sup>191</sup> Hospital Survey and Construction Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946). For a legislative history of Hill-Burton, see Congressional Quarterly, Inc., *Hill-Burton Hospital Survey and Construction Act, 1946*, in CONGRESS AND THE NATION 1945-1964 1122-23 (1965).

<sup>192</sup> Judith R. Lave & Lester B. Lave, *THE HOSPITAL CONSTRUCTION ACT: AN EVALUATION OF THE HILL-BURTON PROGRAM, 1948-1973* 5 (1974).

hospital construction projects were assisted under Hill-Burton.<sup>193</sup> Two provisions of the Hill-Burton program are of interest here: (a) the “community service” and “uncompensated care” requirements; and (b) the Hill-Burton provision embracing segregation in health care.

**a. The Failure To Enforce The Community Service and Uncompensated Care Requirements**

The Hill-Burton program required recipients such as hospitals to provide community services and uncompensated care in exchange for federal funds.<sup>194</sup> From the beginning of the Hill-Burton program until 1980, the Department of Health, Education and Welfare did little to actively enforce these requirements.<sup>195</sup> Private attempts began in the 1970s as legal service lawyers set up specialized programs in health law advocacy.<sup>196</sup> In *Cook v. Ochsner Foundation Hospital*, a private right of action was inferred for intended beneficiaries of the uncompensated care and community service regulations.<sup>197</sup> The Hill-Burton program was discontinued shortly thereafter. Had the federal government enforced Hill-Burton as written, Black access to health care would have improved. The first government survey of the social and racial composition of recipients of uncompensated care at Hill-Burton hospitals occurred in 1995, by which time they were unable to identify racial disparities in a program that had been discontinued for more than twenty years.<sup>198</sup>

The most significant government attempt to enforce a community benefit standard came from the Internal Revenue Service, which sporadically enforced charitable standards for tax-exempt hospitals. Federal tax exemption was an indirect federal subsidy to hospitals and generally led to state and local tax exemptions as well.

The Internal Revenue Service proceeded under Section 501(c)(3) of the Internal Revenue Code, as interpreted by Revenue Ruling 56-185.<sup>199</sup> The language of the Revenue Ruling is expansive and could have been of great help to Black health: the hospital “must not . . . refuse to accept patients in need of hospital care who cannot pay for such service” and “must not restrict the use of its facilities to a particular group of physicians and surgeons.” The 1956 Revenue Ruling also permitted some discretionary authority to

<sup>193</sup> Lave & Lave, *supra* note 192, at 16.

<sup>194</sup> P.A. Paul-Shaheen & H. Perlstadt, *Class Action Suits and Social Change: The Organization and Impact of the Hill-Burton Cases*, 57 IND. L.J. 385 (1982) (containing a good summary of the community service and uncompensated care cases as of 1982); Kenneth R. Wing, *The Community Service Obligation of Hill-Burton Health Facilities*, 23 BOSTON COLL. L. REV. 577 (1982) [hereinafter Wing, *Community Service*].

<sup>195</sup> Institute of Medicine, HEALTH CARE IN A CONTEXT OF CIVIL RIGHTS 14-15 (1981) [hereinafter IOM, CONTEXT OF CIVIL RIGHTS].

<sup>196</sup> Sylvia A. Law, *A Right to Health Care That Cannot be Taken Away: The Lessons of Twenty-Five Years of Health Care Advocacy*, 61 TENN. L. REV. 771, 778 (1994).

<sup>197</sup> *Cook v. Ochsner Foundation Hospital*, 319 F. Supp. 603 (E.D. La. 1970) (one of a series of published opinions involving Ochsner).

<sup>198</sup> U.S. Department of Health and Human Services, *HRSA Studies Hill-Burton Patient Demographics*, 110 PUB. HEALTH REP. 111-12 (1995). The full 31-page monograph is: U.S. Department of Health and Human Services, *The Demographic and Treatment Characteristics of the Hill-Burton Population* (1995).

<sup>199</sup> Rev. Rul. 56-185, 1956-1 C.B. 202-04.

“impose limitations on the extent to which [the hospital facilities] may be made available to all reputable and competent physicians in the area.”<sup>200</sup> In 1958, the Tax Court denied tax exemption to a physician clinic which provided charity care equal to only 2% to 5% of its revenues.<sup>201</sup> In 1969, a further Revenue Ruling removed the charitable care requirement and restated the community benefit standard to include operating an emergency room open to all without regard to ability to pay.

Language in both the 1956 and 1969 Revenue Rulings could support denying exemption to a hospital which racially discriminated against qualified doctors or against patients. The IRS did not make serious attempts enforce these provisions prior to the early 1980’s, when tax-exempt status was finally denied to the racially discriminatory Bob Jones University.<sup>202</sup> The IRS had the sole power to enforce these provisions; the Supreme Court dismissed a private suit to enforce Revenue Ruling 56-185 for lack of standing.<sup>203</sup>

The IRS could have vigorously enforced the charitable care and community benefit standard in the decades prior to the *Bob Jones* case. Their success in attacking racial discrimination in *Bob Jones* demonstrates what was possible, operating under a statute which was practically unchanged from 1939.<sup>204</sup> What was lacking was the will to enforce, not the text of a statute.

#### **b. Racial Exclusion and Segregation under Hill-Burton**

The federal government fully embraced segregated health care in Hill-Burton.<sup>205</sup> Under the program, federal and state governments assisted in the planning and construction of thousands of hospitals and other health facilities across the United States, most of which continued their existing patterns of discrimination and segregation untroubled by the receipt of federal funds.<sup>206</sup> The Hill-Burton Act delegated to the states the responsibility

---

<sup>200</sup> Rev. Rul. 56-185, 1956-1 C.B. 202-04.

<sup>201</sup> *Lorain Ave. Clinic v. Commissioner*, 31 T.C. 141 (1958).

<sup>202</sup> *See, e.g., Bob Jones University v. United States*, 461 U.S. 574 (1983) (denying tax exemption to racially discriminatory university).

<sup>203</sup> *Simon v. Eastern Kentucky Welfare Rights Organization*, 426 U.S. 26 (1976). For a discussion of this case, *see Smith, Health Care Divided, supra* note 62, at 171-72.

<sup>204</sup> *See* 26 U.S.C. §501(c)(3) (1954 Code); 26 U.S.C. §101(6) (1939 Code).

<sup>205</sup> Stevens, *IN SICKNESS AND IN WEALTH, supra* note 133, at 254 (“Sanctions for social stratification, built into the private voluntary hospital system, were endorsed (and furthered) by federal legislation. Through its policy of decentralization, Hill-Burton allowed for the segregation of patients by race and for the continuation of the multiclass system...hospitals in the South were able to continue white-only policies where they wished.”).

<sup>206</sup> Morais, *supra* note 153, at 152. It is important to distinguish various forms of segregation at this point. Many hospitals, perhaps a quarter, practiced racial exclusion altogether. Others admitted a limited number of Blacks, but relegated them to Black wards in the basement or in a separate building. Some cities operated two public hospitals, one white and one Black. Other hospitals were effectively all Black. Most Hill-Burton funds went to hospitals which were not racially exclusive, but rather practiced segregation. Some Hill-Burton funds went to build “separate but equal” facilities, 84 for whites only and 20 for Blacks. *See generally, Morais, supra* note 153, at 180-81 (“For more than a decade and a half, the ‘separate-but-equal’ clause of the [Hill-Burton] law was discretely kept in the background while nearly two billion dollars of federal funds were poured into the rebuilding of the American hospital system.”).

for developing plans for assessing the health facility needs of their populations. This process allowed the local white political structure to control the process.

Segregation and Hill-Burton program were fellow travelers from the inception of the program. Segregationist Senator Lister Hill (D-AL) carefully designed the statute to permit “separate but equal” facilities.<sup>207</sup> A provision requiring “non-discrimination” was interpreted to permit segregation.<sup>208</sup> Senator Burton (R-OH) lent his support and name to the program,<sup>209</sup> but left the Senate for the U.S. Supreme Court before Hill-Burton was enacted.<sup>210</sup> At the Supreme Court he joined in the unanimous 1954 opinion in *Brown v. Board of Education* striking down segregation in education,<sup>211</sup> although Burton considered allowing segregated schools to continue so long as they were “equal to those provided white pupils.”<sup>212</sup> Senator Hill later signed the Southern Manifesto pledging to “use all lawful means” to oppose and reverse *Brown*.<sup>213</sup> As a former Chairman, his portrait still hangs in the anteroom adjacent to the Hearing Room of the Senate Health, Education, Labor and Pensions Committee.

Of 7000 Hill-Burton projects funded before 1970, only 104 were racially exclusive, including 84 white facilities and 20 Black facilities.<sup>214</sup> Debates occurred within the Black community<sup>215</sup> and in white liberal groups<sup>216</sup> on whether to apply for Hill-Burton assistance for these “separate but equal” facilities.<sup>217</sup> In some cities, civil rights leaders opposed it as accommodation of segregation,<sup>218</sup> joined by older Black doctors with a vested interest in the segregated system.<sup>219</sup> In others, the facilities were welcomed as

<sup>207</sup> Smith, HEALTH CARE DIVIDED, *supra* note 62, at 46-47.

<sup>208</sup> Hospital Survey and Construction Act of 1946, Pub. L. No. 79-725, 60 Stat. 1040 (1946) *formerly codified at* 42 U.S.C. § 291e(f); 42 C.R.F. Sec. 53.112; 21 Fed. Reg. 9841 (Dec. 12, 1956); Smith, HEALTH CARE DIVIDED, *supra* note 62, at 46-47; Kenneth Wing, *Title VI and Health Facilities: Forms Without Substance*, 30 HAST. L.J. 137, 144-46 (1978) (reviewing history of the Hill-Burton non-discrimination regulations prior to Title VI).

<sup>209</sup> Mary Frances Berry, STABILITY, SECURITY AND CONTINUITY: MR. JUSTICE BURTON AND DECISION-MAKING IN THE SUPREME COURT 1945-1958 13 (1978).

<sup>210</sup> Berry, *supra* note 209, at 25. The Hill-Burton program was enacted in 1946. Hospital Survey and Construction Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946).

<sup>211</sup> 347 U.S. 483 (1954); Berry, *supra* note 209, at 123-25 (discussing Burton’s bench memo for oral argument in *Brown*); *id.* at 154-58 (Burton’s notes of the Court’s discussions in *Brown*).

<sup>212</sup> Berry, *supra* note 209, at 157 (quoting from one of Burton’s draft decrees for *Brown*).

<sup>213</sup> 102 Cong. Rec. 4459-4460 (1956).

<sup>214</sup> Morais, *supra* note 153, at 181.

<sup>215</sup> Gamble, MAKING A PLACE, *supra* note 138, at 186-90.

<sup>216</sup> Such as the largely white Physicians’ Forum, *see* Morais, *supra* note 153, at 152, 158.

<sup>217</sup> Many of these projects were for Black hospitals which had been founded in the early decades of the century, as an alternative hospital system in the face of racism. *See supra* Section III.B.

<sup>218</sup> *See* Beardsley, *Good-Bye To Jim Crow: The Desegregation of Southern Hospitals, 1945-70*, 60 BULL. HIST. MED. 367, 372 (1986) [hereinafter Beardsley, *Good-bye to Jim Crow*] *citing* 44 J. OF THE NAT’L MED. ASS’N 314 (1952) (describing the reversal by the Memphis chapter of the NAACP, ultimately opposing the construction of an all-Black Hill-Burton hospital). The presence of a Black hospital may have actually permitted segregationist practices to persist in the 1940s and 1950s. Reitzes, *supra* note 150, at 333-35 (case study of health care discrimination in fourteen major cities).

<sup>219</sup> Beardsley, NEGLECT, *supra* note 92, at 258.

vitaly needed improvements.<sup>220</sup> The National Medical Association opposed Hill-Burton “separate but equal” hospital construction,<sup>221</sup> but in 1940, W.E.B. Du Bois was not willing to sacrifice Black health while fighting for equality:

[W]hat Negroes need is hospital treatment now; and what Negro physicians need is hospital practice; and to meet their present need, poor hospitals are better than none; segregated hospitals are better than those where the Negro patients are neglected or relegated to the cellar....I am certain that for many generations American Negroes in the United States have got to accept separate medical institutions. They may dislike it; they may and ought to protest against it; nevertheless it will remain for a long time their only path to health, to education, to economic survival.<sup>222</sup>

Du Bois may have been correct to concede that “separate but equal” health facilities were better than nothing, no matter how inferior the facilities compared to white hospitals.<sup>223</sup> He did not agree, however, that these arrangements were just.<sup>224</sup> The integrationist view increasingly prevailed in the Black community, particularly after World War II as the deficiencies of the ‘Black medical ghetto’ were increasingly evident.<sup>225</sup>

The Hill-Burton program distinguished the 104 “separate but equal” facilities which practiced complete racial exclusion from more than 7000 “non-discriminatory” facilities which were permitted to segregate by ward, room or floor.<sup>226</sup> Hospitals in America both reflected and legitimized segregation.<sup>227</sup>

---

<sup>220</sup> Papers of the Nat’l Assn. for the Advancement of Colored People; Series A: Legal Department Files; Part 15: Segregation and Discrimination, Reel 5/19, frames 722-24 [hereinafter NAACP Legal Files] (March 28, 1941 letter to Walter White describing the proposed expansion of a hospital in Columbia Missouri which will increase the number and quality of segregated Black rooms); Hila Richardson & Samuel Wolfe, *Public General Hospitals: A Redefinition of Their Crisis*, in FIGHTING FOR THE PUBLIC HOSPITAL CONFERENCE APP. A (1980) (describing the history of the Homer Phillips Hospital in St. Louis); *id.* § D (relocation of white Memphis hospitals to suburbs, leaving a city subsidized hospital to care for a predominately Black population).

<sup>221</sup> Morais, *supra* note 153, at 152.

<sup>222</sup> W.E.B. Du Bois, DUSK OF DAWN 309 (1940). Du Bois’ practical approach here does not minimize the crime of segregation, much as the work of the Red Cross in World War II did not legitimize Nazi atrocities.

<sup>223</sup> Beardsley takes a similar view. Beardsley, NEGLECT, *supra* note 92, at 247, 256.

<sup>224</sup> See, e.g. his strongly worded opposition to the imposition of an all-white professional staff at the Tuskegee Hospital in 1923. W.E.B. Du Bois, *The Tuskegee Hospital*, in W.E.B. DU BOIS: WRITINGS 1201-04 (Nathan Huggins, ed., Library of America 1986) (1923) reprinted from THE CRISIS (July 1923). Du Bois noted prophetically that “[a]ny Negro in such a hospital... would be a subject of torture and murder rather than restoration of health.” *Id.* at 1204.

<sup>225</sup> Gamble, MAKING A PLACE, *supra* note 138, at 184-85.

<sup>226</sup> Morais, *supra* note 153, at 243. For example, the Dixie Hospital in Hampton, Virginia received over \$1,700,000 in Hill-Burton funds in 1956. The Dixie Hospital was not a “separate but equal” facility; indeed, it had certified that “the facility will be operated without discrimination because of race, creed or color.” *Smith v. Hampton Training School for Nurses*, 360 F.2d 577, 579 (4<sup>th</sup> Cir. 1966). In 1963, the Hospital fired several Black employees for eating in the white cafeteria. The Fourth Circuit ruled the firings illegal and ordered reinstatement with back pay, citing *Simkins v. Moses H. Cone Memorial Hospital*, 323 F.2d 959 (4<sup>th</sup> Cir. 1963). 360 F.2d at 580-82. A second example is the Wake Memorial Hospital in Raleigh, North Carolina, built with Hill-Burton funds in 1961. It also was not a “separate but equal” hospital, but placed Black patients in a segregated ward. White hostility was so great to even a

The General Counsel of the Department of Health, Education and Welfare issued guidelines for these “non-discriminatory” hospitals, which permitted segregation of patients by race, creed or color and denial of staff privileges to physicians on the basis of race, creed or color so long as everyone had access to the facilities built with Hill-Burton funds.<sup>228</sup> These rules remained in force until November 1, 1963 when they were suspended following the *Simkins v. Moses H. Cone Memorial Hospital* case discussed below.

Segregation and lack of access impacted Black health status. Even after controlling for poverty (an example of etiological reductionism), Blacks health disparities were significant.<sup>229</sup> In 1963, Black life expectancy was still seven to eight years shorter than whites.<sup>230</sup> Forty years later, the gap is distressingly similar.<sup>231</sup>

### c. The End of *De Jure* Racial Discrimination under Hill-Burton

In the early 1960’s Representative Adam Clayton Powell (D-NY) and Senator Jacob Javits (D-NY) attempted to block federal funds to projects which discriminated on the basis of race.<sup>232</sup> The next year the United States Civil Rights Commission recommended to President Kennedy that Hill-Burton funds no longer be available to segregated facilities.<sup>233</sup>

When the legal denouncement finally came, it was swift.<sup>234</sup> It began with the 1963 Fourth Circuit decision, *Simkins v. Moses H. Cone Memorial Hospital*,<sup>235</sup> reversing the District Court and finding that the Fifth and Fourteenth Amendment prohibited a private hospital from refusing to admit Black patients or to grant staff privileges to Black physicians and dentists. The key finding was that receipt of federal Hill-Burton funds provided the necessary state action to impose the Constitutional requirement. On November 1, 1963, the United States Public Health Service suspended the approval of

---

segregated hospital that Wake Memorial experienced a white boycott and grave financial difficulties in its early years. Beardsley, *Good-bye to Jim Crow*, *supra* note 218, at 369-70. Beardsley paints a generally sympathetic picture of the integration of southern hospitals by white administrators and Black physicians.

<sup>227</sup> Stevens, IN SICKNESS AND IN WEALTH, *supra* note 133, at 50 (“Hospitals, as social institutions, carried (and enhanced) prevailing assumptions about social class and racial divisions in the United States, not only legitimising written rules but also making informal practices visible – and thus sanctioning them in turn.”).

<sup>228</sup> Morais *supra* note 153, at 243-44.

<sup>229</sup> Leona Baumgartner, *Health and Ethnic Minorities in the Sixties*, 55 Am. J. Pub. Health 495 (1965).

<sup>230</sup> Pettigrew & Pettigrew, *supra* note 103, at 333.

<sup>231</sup> See *supra* section II. B.

<sup>232</sup> See Beardsley, *Good-bye to Jim Crow*, *supra* note 218, at 375; Smith, *Addressing Racial Inequities*, *supra* note 67, at 82.

<sup>233</sup> Morais, *supra* note 153, at 152.

<sup>234</sup> Some voluntary moves towards desegregation had occurred over the prior decades as well. See Beardsley, Neglect, *supra* note 92, at 245-71, 312 (claiming that white physicians provided key leadership in the process).

<sup>235</sup> *Simkins v. Moses H. Cone Mem'l Hosp.*, 323 F.2d 959 (4<sup>th</sup> Cir. 1963) (en banc, 3-2), *cert. denied*, 376 U.S. 938 (1964). For an excellent chapter on the history and context of *Simkins*, see Smith, HEALTH CARE DIVIDED, *supra* note 62, at 64-95.

new "separate but equal" Hill-Burton funding applications.<sup>236</sup> The United States Supreme Court denied review of *Simkins* on March 2, 1964. On May 18, 1964, the Public Health Service issued new regulations which prohibited discrimination throughout any facility which had received Hill-Burton funds and required an open medical staff.<sup>237</sup> Under the political cover of this case, Congress extended the Hill-Burton program for five more years in August 1964, but with the "separate but equal" clause removed and the community services requirement strengthened.<sup>238</sup>

The exorcism of racism from the Hill-Burton program quickly passed from the public forum. An otherwise comprehensive review of the Hill-Burton program in 1974 failed to even discuss this history of racial discrimination.<sup>239</sup>

*Simkins* is rightly celebrated for these achievements, but in the context of health care reparations it established another key legal principle: state action. Under the Hill-Burton program, state and federal governments actively supported racial discrimination, sufficient for a Fourteenth Amendment nexus.<sup>240</sup> This state action provides a clear defendant for a Black reparations claim.

#### **D. The Great Society: Title VI, Medicare, and Medicaid, 1964-1966**

In segregated communities with multiple health care providers, voluntary desegregation disadvantaged the first mover: in a two-hospital town, the hospital which desegregated first would suffer white flight and economic loss. For example, Wake Memorial Hospital in Raleigh, North Carolina was built with Hill-Burton funds in 1961. It was not a "separate but equal" hospital, and yet it featured segregated wards for Black patients. White hostility was so great to even a segregated hospital that Wake Memorial experienced grave financial difficulties as white patients fled to Raleigh's all-white hospitals. The white boycott of Wake Memorial demonstrated a preference for all-white racially exclusive hospitals over hospitals such as Wake with segregated wards.<sup>241</sup>

If one accepts that only the fear of being a first mover was hindering desegregation of southern hospitals,<sup>242</sup> then simultaneous regulatory action might be effective. President

<sup>236</sup> Morais, *supra* note 153, at 244.

<sup>237</sup> Morais, *supra* note 153, at 243. [review reg, to confirm whether entire facility or just federally funded portion]

<sup>238</sup> Morais, *supra* note 153, at 181-82; Smith, *Addressing Racial Inequities*, *supra* note 67, at 82.

<sup>239</sup> Lave & Lave, *supra* note 192.

<sup>240</sup> *Simkins v. Moses H. Cone Mem'l Hosp.*, 323 F.2d 959, 965-68 (4<sup>th</sup> Cir. 1963); *but see* Beardsley, NEGLECT, *supra* note 92, at 257 (highlighting the benefits of Hill-Burton to Blacks).

<sup>241</sup> Beardsley, *Good-bye to Jim Crow*, *supra* note 218, at 369-70. Beardsley paints a generally sympathetic picture of the integration of southern hospitals by white administrators and physicians. For an example of hospital integration from Mobile, Alabama, *see* Smith, HEALTH CARE DIVIDED, *supra* note 62, at 230.

<sup>242</sup> This is generally the position taken by Beardsley. *See* Beardsley, NEGLECT, *supra* note 92, at 264-68, 271; Beardsley, *Good-bye to Jim Crow*, *supra* note 70, at 286. This view does not fully appreciate the value of the carrot: federal money through Medicare and Medicaid. Perhaps white hospital administrators wanted Black patients now that they brought federal money. The first-mover hypothesis also does not explain why physicians' offices and nursing homes did not join the desegregation parade in 1966, *see*

Johnson employed this approach.<sup>243</sup> From 1964 to 1966, virtually all forms of legal segregation ended in U.S. hospitals: the Jim Crow signs came down and patients were randomly assigned to hospital rooms. The carrot was the offer of federal money in Medicare and Medicaid, passed in 1965 and effective in 1966. The stick was Title VI of the Civil Rights Act of 1964.<sup>244</sup> One unintended consequence was the destruction of Black hospitals.<sup>245</sup>

Unlike Title VII, which operates under from the Commerce Clause and the Fourteenth Amendment, Title VI is authorized under the Spending Power.<sup>246</sup> Title VI is a condition accepted by vendors participating in federal programs such as Medicare and Medicaid. The Supreme Court has not articulated many Constitutional limitations upon the exercise of the Spending Power,<sup>247</sup> making Title VI potentially a more powerful and unconstrained force for non-discrimination than Title VII.<sup>248</sup>

In connecting Title VI with Medicare, President Johnson risked a boycott of the fledgling health care program.<sup>249</sup> The National Medical Association supported the linkage of Medicare and Title VI and rallied some Black support behind Medicare.<sup>250</sup> President Johnson addressed the Black health problem at a speech at Howard University on June 5, 1965.<sup>251</sup> The lure of federal funds, together with Johnson's political skills, ultimately convinced physicians and hospitals to participate in Medicare and Medicaid,<sup>252</sup> although physicians were exempted from the proscriptions of Title VI.<sup>253</sup>

---

Smith, HEALTH CARE DIVIDED, *supra* note 62, at 236-75, nor does it explain segregation or racial exclusion in one hospital towns. For an economic analysis of racial disparities, see Loury, *supra* note 146.

<sup>243</sup> James M. Quigley, *Hospitals and the Civil Rights Act of 1964*, 57 J. OF THE NAT'L MED. ASS'N 455 (Nov. 1965) (emphasizing the efficacy of instant desegregation of hospitals and the threat of enforcement).

<sup>244</sup> Civil Rights Act of 1964, Title VI, §§ 601 et seq., 42 U.S.C. §§ 2000d-2000d-7 (2003). [check cite]. For a thorough review of the legislative history of Title VI with regard to health care, see Mitchell A. Horwich, Note, *Title VI of the 1964 Civil Rights Act and the Closing of a Public Hospital*, 1981 DUKE L.J. 1033 (1981). For an interesting account of the passage of Title VI, see Smith, HEALTH CARE DIVIDED, *supra* note 62, at 98-106.

<sup>245</sup> Gamble, MAKING A PLACE, *supra* note 138, at 191-93; Smith, HEALTH CARE DIVIDED, *supra* note 62, at 195; *The Crisis of the Disappearing Black Hospitals*, EBONY 23 (March 1992).

<sup>246</sup> For a short discussion of the Constitutional basis for Title VI, see United States Commission on Civil Rights, FEDERAL TITLE VI ENFORCEMENT TO ENSURE NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS 25-27 (June 1996).

<sup>247</sup> For a recent symposium devoted to the Spending Power, see 4 CHAPMAN L.R. (2001).

<sup>248</sup> For an attempt to encourage a more robust interpretation of Title VI vis a vie Title VII, see Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination – It Shouldn't Be So Easy*, 58 FORDHAM L. REV. 939-78 (1990) [hereinafter Watson, *Reinvigorating Title VI*]; see also Smith, HEALTH CARE DIVIDED, *supra* note 62, at 182.

<sup>249</sup> See Watson, *Race, Ethnicity and Quality*, *supra* note 8, at 214; Lado, *supra* note 10, at 245.

<sup>250</sup> Hearings on H.R. 6675 Before the S. Fin. Comm., 89th Cong. 323-28 (1965) (statement of Dr. W. Montague Cobb, President of the National Medical Association). [check cite and text]

<sup>251</sup> President Lyndon B. Johnson, *To Fulfill These Rights*, Address at Howard University (June 5, 1965) [cite to Vital Speeches or Pres. Papers]; see also Lyndon B. Johnson, *Forward to the Issue*, 94 DAEDALUS 743 (1965).

<sup>252</sup> Smith, *Addressing Racial Inequities*, *supra* note 67, at 82-83 (“Title VI was a sleeper section in the chaotic passage of the Civil Right Act...Although *Simkins* was used as an example to justify Title VI, the impact of the passage of the Medicare and Medicaid legislation the following year was unanticipated”);

Enforcement of Title VI got off to a good start when the Department of Health, Education and Welfare asked hospitals to certify under Medicare that they did not practice segregation or discrimination.<sup>254</sup> The Title VI regulations at first blush appear well suited to end discrimination in federal health care benefits or services. Prohibited practices include outright denials, segregation, and discrimination, including providing a benefit “which is different, or is provided in a different manner, from that provided to others...”<sup>255</sup> The regulation covers both intentional discrimination as well as disparate impact.<sup>256</sup> Over 3,000 hospitals agreed to change their practices to comply with the law.<sup>257</sup> Formal racial exclusion in medical schools also ended with Title VI.<sup>258</sup>

These great victories deserve to be celebrated; they also demonstrate the power that could have been utilized decades earlier to tie receipt of federal WPA and Hill-Burton funds to desegregation, along the lines of President Roosevelt’s Executive Order. Rather than absolving the government from responsibility for health care segregation, the events of 1964-1966 demonstrate the opportunity cost of decades of willful neglect. Premature celebration also ignores the aspects of Medicare and Medicaid which continue to disadvantage Blacks.<sup>259</sup>

A stranger to the jurisprudence of Title VI might be forgiven in assuming it to be a formidable weapon against racial disparities in health care; the actual state of affairs stands as a grim reminder of the limits of the legislative power in the absence of active enforcement and a supportive judiciary. Federal enforcement of Title VI has been soundly criticized as ineffective.<sup>260</sup> In 1980, the United States Commission on Civil Rights reported that:

---

Watson, *Race, Ethnicity and Quality of Care*, *supra* note 8, at 212-13; Joanne Silberner, National Public Radio, Weekend Edition (Jul, 31, 1999) (transcript on file with author).

<sup>253</sup> [cite reg]; IOM, CONTEXT OF CIVIL RIGHTS, *supra* note 195, at 24; Smith, *Addressing Racial Inequities*, *supra* note 67, at 85; Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 Am. J. L. & Med. 191-220 (1995) (describing difficulties in recruiting physicians to participate in Tennessee’s Medicaid Waiver program, Tenn-Care).

<sup>254</sup> Smith, HEALTH CARE DIVIDED, *supra* note 62, at 128-42; IOM, CONTEXT OF CIVIL RIGHTS, *supra* note 195, at 24.

<sup>255</sup> 45 C.F.R. 80.3(b)(1).

<sup>256</sup> 45 C.F.R. 80.3(b)(1), (2).

<sup>257</sup> IOM, CONTEXT OF CIVIL RIGHTS, *supra* note 195, at 24 (1981); Beardsley, NEGLECT, *supra* note 167, at 264 (widespread voluntary compliance by hospitals).

<sup>258</sup> Morais, *supra* note 153, at 173.

<sup>259</sup> While this particular topic is beyond the scope of this article, see Smith, HEALTH CARE DIVIDED, *supra* note 62, at 172-73, 176-83, 199-200, 217-35, Table 6.15 (Medicare and Medicaid cost-based reimbursement permitted hospital relocations from poor neighborhoods to the suburbs; the index of dissimilarity in Medicare continues to be high, particularly in the North).

<sup>260</sup> IOM, CONTEXT OF CIVIL RIGHTS, *supra* note 195, at 153; Smith, HEALTH CARE DIVIDED, *supra* note 62, at 164-68, 173-76, 317-19; United States Commission on Civil Rights, FEDERAL TITLE VI ENFORCEMENT TO ENSURE NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS 1-10 (June 1996) (“the Commission found that the Federal agencies were not enforcing Title VI effectively...the deficiencies identified in 1974 have persisted for 20 years...the Department of Justice has neglected its responsibility...” *Id.* at 4.); Marianne Engelman Lado, *Unfinished Agenda: The Need for Civil Rights Litigation to Address Race Discrimination and Inequalities in Health Care Delivery*, 6 TEX. FORUM CIV. LIB. & CIV. R. 1 (2001); Smith, *Addressing Racial Inequities*, *supra* note 67, at 75; Sydney Dean Watson,

[The Federal government] brought enforcement proceedings only rarely under Title VI, especially since 1970 .... The record of achievement in elimination of discrimination is bleak ... no recipient of Federal health funds has had its funds terminated since 1973.<sup>261</sup>

An optimist might find the lack of enforcement actions encouraging, assuming that segregation and discrimination had been eliminated in 1966 and no violations were left to enforce. Alternatively, the difficulties faced by the Office of Civil Rights in enforcing Title VI are to be expected: with the elimination of *de jure* segregation, the low-hanging fruit had been picked. Remaining discriminatory practices are much more difficult to root out, either structural (as in the case of Medicaid's low reimbursement) or floundering upon the difficulty of proving discriminatory intent and the identification of the causative "facially neutral policy."<sup>262</sup> One lesson from Title VI is that new legal norms do not quickly translate into social change: "[T]he more visible symbols of Jim Crow disappeared quickly, but the underlying structural patterns were more resistant to change."<sup>263</sup> The persistence of racial disparities in health in 2005, nearly four decades after the abolition of formal health care segregation, is a testament to deeply engrained patterns and speaks of the need for a remedy other than mere legal neutrality.<sup>264</sup>

Gregg Bloche suggests that Americans are no longer tolerant of direct discrimination, but are less concerned once racism is mediated through the marketplace.<sup>265</sup> I find the same polarity in Title VI and Title VII litigation (direct discrimination v. disparate impact) and affirmative action (particularized showing of discrimination v. statistical underrepresentation of minorities). Attacking the intentional, *de jure* forms of racial discrimination permits the nation to profess color-blind formalism, without descending into the marketplace to eradicate discrimination root and branch.

This section has outlined the main avenues of government participation in the segregation of health care. In a few situations, governments acted responsibly, demonstrating what could be done to extend greater health care access to Blacks. For the most part, governments either passively permitted segregation or actively supported and financed racially segregated health care.

---

*Minority Access and Health Reform: A Civil Right to Health Care*, 22 J. L., MED. & ETHICS 127 (1994); Wing, *supra* note 208, at 137.

<sup>261</sup> United States Commission on Civil Rights, CIVIL RIGHTS ISSUES IN HEALTH CARE DELIVERY: A CONSULTATION SPONSORED BY THE UNITED STATES COMMISSION ON CIVIL RIGHTS ix (1980).

<sup>262</sup> See Lado, *supra* note 260; Smith, *Addressing Racial Inequities*, *supra* note 67, at 87-92; Watson, *Reinvigorating Title VI*, *supra* note 326, at 939-77.

<sup>263</sup> Smith, *Addressing Racial Inequities*, *supra* note 67, at 79.

<sup>264</sup> In 1966, Michael Meltzer warned that mere legal neutrality would not eradicate racism in health care: "The treatment accorded to Negroes by southern medical facilities ... reflects a striking contradiction between law and practice, a variance which exemplifies the historic method of accommodating Negro claims to equality: incorporation of egalitarian principles into legal norms, and administrative tolerance of actual inequality." Meltzer, *supra* note 136, at 22. For a thoughtful, recent critique of mere racial neutrality, see Loury, *supra* note 146.

<sup>265</sup> Bloche, *supra* note 8, at 95, 98.

\* \* \* \* \*

Before plunging into Black reparations, a brief review of what has been established thus far:

1. Overwhelming evidence exists of significant racial differences in American mortality, health status and health care access, with Blacks coming out on the short end of the stick in almost every category. Current studies may actually underreport the magnitude of the disparities due to over-adjustment for confounding variables and inadequate data.
2. Racial disparities in Black health were not created in a vacuum. The history of health care in the United States demonstrates that Blacks have been relegated to a vastly inferior health care system for almost all of their time in America, wrecking havoc with Black health.
3. State and federal governments and charitable institutions such as hospitals actively supported this two-tiered health system from the founding of the Republic until at least 1966. Title VI has never been adequately enforced throughout its four decades. The racial divide continues in programs such as Medicaid. Many opportunities to improve Black health have been neglected.

The next sections examine whether Black reparations and racial disparities in health may be cross-pollinated to resolve some of the problems endemic to each.

#### IV. Black Reparations

The Black reparations movement proclaims that a debt is owed for the crimes of slavery and Jim Crow.<sup>266</sup> From the beginning, some have focused upon the strategy of litigation, working within the system,<sup>267</sup> whilst others, including the adherents of Critical Race

---

<sup>266</sup> The seminal legal writings include Boris I. Bittker, *THE CASE FOR BLACK REPARATIONS* (1973) (applying civil rights law to Jim Crow); Derrick A. Bell, Jr., *Dissection of a Dream*, 9 HARV. C.R.-C.L. L. REV. 156 (1974) (a critique of Bittker's law-based approach to reparations); Mari J. Matsuda, *Looking to the Bottom: Critical Legal Studies and Reparations*, 22 HARV. C.R.-C.L. L. REV. 323 (1987); Vincene Verdun, *If The Shoe Fits, Wear It: An Analysis of Reparations to African Americans*, 67 TULANE L. REV. 597 (1993); Rhonda V. Magee, *The Master's Tools, From the Bottom Up: Responses to African-American Reparations Theory in Mainstream and Outsider Remedies Discourse*, 79 Va. L. Rev. 863 (1993); Robert Westley, *Many Billions Gone: Is It Time to Reconsider the Case for Black Reparations?*, 40 B.C.L. Rev. 429 (1998); and Eric K. Yamamoto, *Racial Reparations: Japanese American Redress and African American Claims*, 40 B.C.L. Rev. 477 (1998). For an influential popular account, see Randall Robinson, *THE DEBT: WHAT AMERICANS OWE TO BLACKS* (2000). For two recent books collecting essays on Black reparations, see *SHOULD AMERICA PAY?: SLAVERY AND THE RAGING DEBATE OVER REPARATIONS*, 209, 210 (Raymond A. Winbush, ed., 2003) [hereinafter *SHOULD AMERICA PAY?*] and *WHEN SORRY ISN'T ENOUGH: THE CONTROVERSY OVER APOLOGIES AND REPARATIONS FOR HUMAN INJUSTICE* (Roy L. Brooks, ed., 1999) [hereinafter *WHEN SORRY ISN'T ENOUGH*]. For a particularly interesting book on broader themes of repairing historical injustice, see Elazar Barkan, *THE GUILT OF NATIONS: RESTITUTION AND NEGOTIATING HISTORICAL INJUSTICES* (2000).

<sup>267</sup> Examples include Bittker, *supra note 266*; Verdun, *supra note 266*; the plaintiffs in *Cato v. United States*, 70 F.3d 1103 (9<sup>th</sup> Cir. 1995) and *In re African-American Slave Descendants Litigation*, 2005 WL

Theory (CRT), looked more to the transformative power of reparations to remake society.<sup>268</sup>

This Article straddles this divide, proposing a litigation strategy while responding to Richard Delgado's call for critical scholarship which leads to real structural reforms.<sup>269</sup> Any attempt to remedy health disparities cannot be limited to mere legal fictions of equality. Token efforts will always be confronted with the troublesome facts of 73,000 excess Black deaths per year and the continuing gap in Black life expectancies.<sup>270</sup> Correcting racial disparities in health is a worthy goal because success will require massive structural changes in society. As a litigation strategy, focusing on racial disparities in health seems a much more likely strategy than the current crop of suits.

### A. Barriers to Litigating Black Reparations

The practical barriers to a successful Black reparations lawsuit are well known to any first year law student taking Civil Procedure.<sup>271</sup> All of the broadly-focused suits have foundered on Rule 12 motions to dismiss, citing lack of standing, expiration of the statute of limitations, failure to state a claim, sovereign immunity, and proximate causation.<sup>272</sup> The celebrated Farmer-Paellman 'corporate reparations' suits, consolidated in the

---

1561509 (N.D. Ill. July 6, 2005) (MDL No. 1491); and the formation of the N'COBRA Litigation Committee in 1997 and the Reparations Coordinating Committee in 2000, *see* Adjoa A. Aiyetoro, *The National Coalition of Blacks for Reparations in America: Its Creation and Contribution to the Reparations Movement*, in *SHOULD AMERICA PAY?*, *supra* note 266 at 209, 210. Many legal authors have written in this vein. Some of the better recent articles include Adjoa A. Aiyetoro, *Formulating Reparations Litigation Through the Eyes of the Movement*, 58 N.Y.U. ANN. SURV. AM. L. 457 (2003) [hereinafter Aiyetoro, *Reparations Litigation*]; Alfred L. Brophy, *Reparations Talk: Reparations for Slavery and the Tort Law Analogy*, 24 BOSTON COLLEGE THIRD WORLD LAW JOURNAL 81 (2004) (indeed this entire symposium issue is well done); Charles J. Ogletree, Jr., *Repairing the Past: New Efforts in the Reparations Debate in America*, 38 HARV. C.R.-C.L. L. REV. 279 (2003) (the best of several reparations articles by Ogletree); Alfreda Robinson, *Corporate Social Responsibility and African American Reparations: Jubilee*, 55 RUTGERS L. REV. 309 (2003); and Yamamoto, *supra* note 266.

<sup>268</sup> Many of the early articles on reparations emphasize this approach, including Bell, *supra* note 266; Matsuda, *supra* note 266; Magee, *supra* note 266; and Westley, *supra* note 266. Later examples (including scholars who do not necessarily follow CRT) include Roy L. Brooks, *Toward a Perpetrator-Focused Model of Slave Redress*, 6 African-American Law and Policy Report 49 (2004) (critiquing the tort model); Jeffery M. Brown, *Deconstructing Babel: Toward a Theory of Structural Reparations*, 56 Rutgers L. Rev. 463 (2004) (discussing recent reparations proposals which are not litigation oriented); Richard Delgado, *Crossroads and Blind Alleys: A Critical Examination of Recent Writing About Race*, 82 Texas L. Rev. 121 (2003) (book review essay) (calling for CRT to return to concerns for practical structural change rather than mere discourse); Kim Forde-Mazrui, *Taking Conservatives Seriously: A Moral Justification for Affirmative Action and Reparations*, 92 Cal. L. Rev. 683 (2004).

<sup>269</sup> *See* Delgado, *supra* note 268 at 150.

<sup>270</sup> *See supra* Section I.B.

<sup>271</sup> *See* Bob Carlson, *Why Slavery Reparations Are Good For Civil Procedure Class*, 47 Saint Louis Univ. L.J. 139 (2003).

<sup>272</sup> *See, e.g., Cato v. United States*, 70 F.3d 1103 (9<sup>th</sup> Cir. 1995) and *In re African-American Slave Descendants Litigation*, 2005 WL 1561509 (N.D. Ill. July 6, 2005) (MDL No. 1491). These issues have been well-identified, particularly since the *Cato* opinion in 1995. *See, e.g.,* Eric K. Yamamoto, *Racial Reparations: Japanese American Redress and African American Claims*, 40 B.C.L. Rev. 477 (1998); Aiyetoro, *Reparations Litigation*, *supra* note 267, at 464-472; Brophy, *supra* note 267, at 86-93; Keith N. Hylton, *A Framework For Reparations Claims*, 24 Boston College Third World L.J. 31, 36-44 (2004).

Northern District of Illinois, were dismissed on July 6, 2005 on that basis.<sup>273</sup> Richard Delgado suggests the possibility that litigation may be a ‘dead end’ strategy for Black reparations.<sup>274</sup> Continued losses on Rule 12 motions is an unlikely path to success. Racial disparities in health may provide a better foundation for successful litigation.

## 1. Standing

Legal slavery in the United States ended with the ratification of the 13<sup>th</sup> Amendment to the Constitution on December 6, 1865,<sup>275</sup> 140 years ago. “Surely all applicable statutes of limitation have run,” opponents of reparations say, and federal judges tend to agree.<sup>276</sup> Related objections include appeals to “not get mired down in old history” or statements that all slaves and slave owners are long dead. The *remoteness* of the injury gives rise to challenges based on both standing and the statute of limitations.

Reparations plaintiffs have not succeeded with claims of ‘derivative’ standing by descendants of slaves.<sup>277</sup> A more promising line of approach is to focus on more recent acts of racial oppression, the ‘Jim Crow’ strategy.<sup>278</sup> Challenges to racial disparities in health is one such strategy, with millions of living citizens who suffer remarkably well documented health disparities, reaching from slavery to the present day. Standing should not be a barrier when the class is Black Americans currently suffering from racial disparities in health, or alternatively, living Americans who received care during the period of legal segregation in health care.

Focusing on racial disparities in health also sidesteps difficult issues on tracing descent from slaves. If slavery and its aftermath can be shown to have damaged the health of living Blacks, of any ancestry, then a plaintiff class is clearly identified. Several million persons living in the United States today have been directly harmed by substandard health. Much of this tragedy resulted from official strategies of neglect or indifference.

With regard to immigration, if Blacks had seamlessly merged into America’s immigrant “melting pot,” then Black reparations might not have relevance today. But slaves were not immigrants; they arrived in chains. For the vast majority, the Statute of Liberty did not greet (or mock) them upon arrival; their fate was the auction blocks of Charleston, New Orleans, or even the Nation’s capitol. For racial disparities in health, the proposed

---

<sup>273</sup> *In re African-American Slave Descendants Litigation*, 2005 WL 1561509 (N.D. Ill. July 6, 2005) (MDL No. 1491).

<sup>274</sup> Delgado, *supra* note 266, at 502.

<sup>275</sup> Ratification was completed on December 6, 1865, when the legislature of the twenty-seventh State (Georgia) approved the amendment, there being then 36 States in the Union. On December 18, 1865, Secretary of State Seward certified that the Thirteenth Amendment had become a part of the Constitution. 13 Stat. 774 (1985).

<sup>276</sup> *See, e.g., In re African-American Slave Descendants Litigation*, 2005 WL 1561509 (N.D. Ill. July 6, 2005) (MDL No. 1491); *Cato v. United States*, 70 F.3d 1103 (9<sup>th</sup> Cir. 1995).

<sup>277</sup> *Id.*

<sup>278</sup> Examples include the successful suit by Black farmers for government discrimination in lending and the pending RCC suit concerning the 1921 Tulsa Race Riot. *See* Brophy, *supra* note 267, at 90-103; David Lyons, *Reparations and Equal Opportunity*, 24 B.C. THIRD WORLD L.J. 177 (2004); Ogletree, *supra* note 267, at 281, 298-307.

plaintiff class is not selected by race or descent from slaves. The plaintiff class was selected by the governments and health care organizations which marginalized the needs of Blacks. The plaintiff class would include a 1950's immigrant from Jamaica who was relegated to a second-class Black health care system, as well as the descendants of Virginia slaves.

Jim Crow strategies also improve the process of identifying defendants. Opponents of reparations frequently say "I never owned a slave," "My family never owned slaves,"<sup>279</sup> or "All slave owners are now dead." The issue is most acute if Black reparations are to be assessed against individuals, based on descent. If the injury occurred much more recently, living defendants will be easier to find. Moreover, if a defendant is a legal entity (government or corporation) with continuity to the injury period, then this objection loses force. Many of the potential defendants for a health disparities case are governments and corporations (charitable or for profit) which can be shown to have participated in the creation and continuation of the Black health tragedy described above.

While it may seem unfair to expect current shareholders or taxpayers to pay for the sins of the fathers, the legal principle is well established that corporate liability follows the entity, without regard to the changing composition of the pool of shareholders or citizen taxpayers. Furthermore, in the case of governmental liability, Black reparations are likely to be paid only as part of a larger political settlement of the issue, providing democratic context to the action.

Other Jim Crow strategies are possible. Alfreda Robinson suggests the convict labor system, particularly in Alabama.<sup>280</sup> While legal slavery ended in 1865, oppressive labor systems such as peonage and convict leasing sprung up to replace slavery with little improvement in the basic living conditions of southern Blacks.<sup>281</sup> Other examples include the recent suit against the 1921 Tulsa Race Riot<sup>282</sup> and the successful suit against the federal government for discriminatory lending practices against Blacks.<sup>283</sup>

In the rush to pursue Jim Crow strategies, let us remember Richard Delgado's call for structural change.<sup>284</sup> One has to ask whether the Black farmers' suit has achieved much lasting change in social structures. The Tulsa suit can serve as valuable teaching tool, but is probably not a model for replication. The remedy for racial disparities in health is not a sum of money; the remedy is equality of health outcomes. Achieving that equality would require revolutionary changes in American society.

## 2. Statutes of limitation

<sup>279</sup> *But see*, Edward Ball, *Slaves in the Family* (1998).

<sup>280</sup> Alfreda Robinson, *Corporate Social Responsibility and African American Reparations: Jubilee*, 55 RUTGERS L. REV. 309 (2003).

<sup>281</sup> *See, e.g.*, Leon F. Litwack, *Trouble In Mind* (1999) [hereinafter Litwack, *Trouble*]; Litwack, Storm, *supra* note 99.

<sup>282</sup>

<sup>283</sup>

<sup>284</sup> *See* the discussion in the text accompanying notes 269-270, *supra*.

Several legal scholars had suggested theories of equitable tolling of the statutes of limitation,<sup>285</sup> but none were persuasive for Judge Norgle in his July 2005 ruling against Black reparations.<sup>286</sup> The Jim Crow strategy responds to this issue by bringing the injury into the present (or at least into the recent past).

Professor Brody has also noted that justifications for statutes of limitation are ‘under-theorized’ in the reparations context.<sup>287</sup> The strength of the policy justifications upholding the statute of limitations depends to some degree on the type of defendant. Compelling cases for the statute of limitations can be made when the defendant is a human individual, or when the passage of time has rendered a defense impossible. It is less clear that governments which supported the system through state action should be so protected, or that justice requires the statute of limitation to apply when the defense is not able to demonstrate prejudice. For these reasons, this present study - and my prior examination of slave taxes<sup>288</sup> - focuses upon *government* responsibility. When the defendant is a government, the defense of the statute of limitations converges with sovereign immunity, a concept which is discussed below. When the defendant is a corporate entity, the seeds of the statute of limitations may find more fertile soil. A corporate defendant today may bear little resemblance to their eighteenth century legal ancestors; although this would not be true in the case of entities such as Yale and Brown. The ability to marshal evidence to defend against the charges may have been severely compromised by the passage of time. However, it should be noted that these objections have been overcome in assessing corporate liability for crimes during World War II, despite the passage of at least sixty years.

### 3. Sovereign immunity

In every successful reparation program of the last 30 years, the issue of sovereign immunity was effectively waived or remedied by an enabling statute. For example, in the Civil Liberties Act of 1988, President Reagan authorized an apology to Japanese-Americans for internment in World War II, while President George H. W. Bush signed the bill which appropriated the \$1.1 billion dollars necessary to make the \$20,000 reparation payment to internees and some descendants.<sup>289</sup> In each of the Holocaust-era reparation commissions, governments participated without resort to the statute of

---

<sup>285</sup>

<sup>286</sup> *In re African-American Slave Descendants Litigation*, 2005 WL 1561509 (N.D. Ill. July 6, 2005) (MDL No. 1491).

<sup>287</sup> Brophy, *supra* note 267, at 93.

<sup>288</sup> Kevin Outterson, *Slave Taxes*, in SHOULD AMERICA PAY?, *supra* note 266, at 135, reprinted in THE PROCEEDINGS OF THE CAMBRIDGE TAX HISTORY CONFERENCE (2004).

<sup>289</sup> See Commission on Wartime Relocation and Internment of Civilians Act, Pub. L. No. 96-317 (1980) (established study commission for persons of Japanese ancestry who were interned by the U.S. government during World War II) (for background, see *Korematsu v. United States*, 323 U.S. 214 (1944); *Hirabayashi v. United States*, 320 U.S. 81 (1943); and *Yasui v. United States*, 320 U.S. 115 (1943)). The Report of the Commission on Wartime Relocation and Internment of Civilians led to the passage of the Civil Liberties Act of 1988, Pub. L. No. 100-383 (1988) (Congress accepted the findings of the Commission) and subsequent appropriations. Mitchell T. Maki et al., *Achieving the Impossible Dream: How Japanese Americans Obtained Redress* (1999).

limitations. In addition, sovereign immunity does not shield many of the private parties complicit with racial discrimination in health care.

## **B. Reparational Analysis of Racial Disparities in Health**

Reparational analysis modifies some of the methodologies and assumptions in the epidemiological literature on racial disparities in health. In research design, reparational analysis reduces the need to adjust for confounding variables which are themselves associated with a history of racial injustice. For Blacks, income, wealth, education, housing, and employment have all suffered under parallel histories of racial oppression. No matter how the strands are twisted and knotted, racism was a major cause of disparities in each of these variables. The reparation principle reverses the decision to adjust for SES, and will result in finding larger racial disparities than are now reported.

As a policy making tool, reparational analysis is more holistic, reminding us that many factors influence health other than health care: if the causes of ill health are structural (residential segregation, wealth disparities, inadequate investment in public health), then the remedies must also run broadly and deeply. Some of the most challenging work on health disparities takes this approach,<sup>290</sup> connecting the health care system to other social factors such as racial segregation, education, employment and public health.<sup>291</sup> Reparational analysis also provides an additional justification for investments in public health, addressing a likely market failure involving a key opportunity good.

In the law, reparations moves beyond the atomistic search for intentional individual discrimination, to focus on disparate impact and institutional discrimination. The absence of *de jure* discrimination has done little to reduce racial disparities in health. Waiting many generations for the ship to right itself is not a morally tenable option. Focusing on institutional discrimination through class actions may involve the law in the process more meaningfully. Medicaid cannot continue to offer second-class care with limited provider participation. Racial data must be collected to illuminate the scope of the problem and to guide remedial and enforcement efforts. Title VI cannot continue to be a dead letter.

Reparational analysis also avoids the tyranny of presentism.<sup>292</sup> The Black reparations movement connects modern racial disparities in health with the historical record. As Williams and Rucker stated:

---

<sup>290</sup> Paul Farmer is a champion of taking the broader view. Farmer, *supra* note 105. David Williams has written extensively on the larger social and economic issues connected to Black health. *See, e.g.* Williams & Collins, *supra* note 63, at 405. David Smith reaches broadly similar conclusions in *Health Care Divided*. Smith, *Health Care Divided*, *supra* note 62, at 325. *See also* Barnett, *supra* note 29, at 16-17 (“A holistic alternative to the lifestyle approach to heart disease prevention focuses on broad improvements in local social environments, recognizing that the social environment provides the context within which individuals are exposed to structural risk factors...”).

<sup>291</sup> Williams & Rucker, *Understanding*, *supra* note 53, at 78.

<sup>292</sup> Ken Booth, *Three Tyrannies*, in Tim Dunne & Nicholas J. Wheeler, eds., *Human Rights in Global Politics* 31 (1999).

[W]e can only regard these [racial health disparity] findings as surprising if we take an ahistorical and decontextualized view of the data... Throughout the history of the United States, non-dominant racial groups have, either by law or custom, received inferior treatment in major societal institutions. Medical care is no exception.<sup>293</sup>

This approach has many implications. For example given the history of political under-representation and agency indifference, relying on agencies in a *Chevron*<sup>294</sup> mode is ill advised. As *Alexander v. Sandoval*<sup>295</sup> and its expected progeny further restrict private right of action under Title VI, the situation becomes clear. Reparational analysis suggests the need for a private right of action, placing the case in front of a life-tenured federal judge, rather than relying on majoritarian democratic politics as mediated through agency positions, regulations and enforcement. The historical approach also avoids the tendency to blame the victim, as some would fault Black cultural preferences for health disparities, without understanding the history of medical abuse and neglect. The historical record also suggests that a remedy may take some time and require great resources, as the injury spans many generations. Finally, the historical approach reminds us of the history of racialized research, and its role in creating and supporting medical racial profiling. Modern forms of racialized research appear when race is utilized as a biological or genetic category, as opposed to its use as a social variable.

Finally, reparational analysis may facilitate the resolution of otherwise intractable issues, such as racial differences in the allocation of kidneys for transplant. The authors of an important article on this topic in the *Vanderbilt Law Review* appealed to something akin to the concept of reparations, although not by that name:

[R]esponding to this disparate racial access can be justified as an attempt to eliminate the effects of past discrimination. Kidney failure is associated with a number of other factors that may be exacerbated in black communities because of past discrimination – including poverty, stress, alcohol use, and poor medical care. To the extent that past discrimination has left blacks disproportionately poor and that poverty induces higher rates of kidney failure, these lingering effects of discrimination also supports society's corrective concern. At a minimum, we believe it is incumbent on society not to ignore the equitable claims of blacks in favor of other possibly less pressing equitable claims...<sup>296</sup>

Other examples include affirmative action in education, which could be supported on reparational grounds independent of Justice O'Connor's diversity rationale.<sup>297</sup>

---

<sup>293</sup> Williams & Rucker, *Understanding*, *supra* note 53, at 76 ("Many observers are surprised and perplexed by these findings [of persistent racial disparities in health]. However, we can only regard these findings as surprising if we take an ahistorical and decontextualized view of the data.").

<sup>294</sup> *Chevron U.S.A. v. Natural Res. Def. Council*, 467 U.S. 837 (1984).

<sup>295</sup> *Alexander v. Sandoval*, 532 U.S. 275 (2001).

<sup>296</sup> Ian Ayres, et al., *Unequal Racial Access to Kidney Transplantation*, 46 VAND. L. REV. 805, 842 (1993).

<sup>297</sup> See, e.g., Kevin Outterson, et al., Brief Amici Curiae of the National Coalition of Blacks For Reparations in America (N'COBRA) and the National Conference of Black Lawyers (NCBL) In Support of Respondents (filed with the U.S. Supreme Court in *Grutter v. Bollinger* (2003) and *Gratz v. Bollinger*

Two final questions with reparational analysis of racial disparities in health must be mentioned. The first is very practical. Programs to eliminate health care disparities are moving forward, with support from both sides of the aisle in Congress.<sup>298</sup> The Senate Majority Leader, Bill Frist (R-TN), is the sponsor and leading proponent of some of these programs to reduce racial disparities in health, but is probably not an ardent supporter of Black reparations. Why undermine Republican support for the program by linking it with Black reparations?

The second question is also political. Reparations creates a special warrant for groups that have been uniquely oppressed. If one accepts the general analysis that Blacks have been subjected to crimes against humanity, where does that leave other groups with racial disparities in health, but a less egregious history?

To the first question I would say that many reform programs move forward with multiple philosophical foundations, even contradictory foundations. The anti-slavery movement in the 19<sup>th</sup> Century united religious abolitionists and hard-nosed businessmen, cynical politicians and idealist. It ultimately did not matter that they supported the anti-slavery for different reasons.<sup>299</sup> As for the second question, the Black reparations movement does not oppose the elimination of all racial disparities in health. It merely stakes uniquely powerful claims for Black equality. Furthermore, successfully equalizing Black health in America would require such major social changes that the spillover effect for all other groups would be significant. This rising tide would lift all boats.

### **C. Racial Disparities In Health As A Warrant For Black Reparations**

Reversing the roles of object and subject, racial disparities in health contributes to resolving some of the difficult issues hindering Black reparations.

The first advantage is a clearly identified plaintiff class, at the very least those Blacks who were alive prior to the passage of Title VI; given the lackluster enforcement history of Title VI, the class could expand to the present day. Even Black children who are born in 2005 are known to suffer a life expectancy many years shorter than their white counterparts. Millions of Black American citizens are living members of the potential plaintiff class.

The defendant class is also clearly defined: state action by governments to support apartheid health care, together with the corporate institutions which actively participated. Focusing on racial disparities in health avoids the problem of remoteness, that sense that we should just forget about something that happened so long ago. This approach

---

(2003)) available at Social Science Research Network Electronic Database, [www.ssrn.com](http://www.ssrn.com), abstract 392060, posted June 3, 2003) (arguing that Black reparations is an independent ground for affirmative action in education).

<sup>298</sup> See the discussion in section III. D. *supra*.

<sup>299</sup> See Kevin Outterson, *Human Rights Before the Postmodern Critique* (unpublished LL.M. dissertation, Univ. of Cambridge, 2002).

confronts living persons and institutions, not just historical ancestors. The present-day disparities are substantial enough to justify significant remedial awards for the millions of living class members.

The health disparities research is also helpful in identifying the appropriate remedies. Opponents of reparations deride the notion of giving large sums of cash to Blacks, including people of mixed race or recent immigrants. Remedial programs in health will address racial disparities without cutting checks on the basis of skin color. The best remedy would be specific performance, making the changes necessary to equalize Black health. Even if the damages were limited to the cost of first-class health care for the balance of their lives, the monetary value of this award would run to hundreds of billions of dollars, similar to much broader Black reparation claims.<sup>300</sup> Black health disparities is a much more significant claim (in dollars) than other Jim Crow strategies, particularly single-event suits like the 1921 Tulsa Race Riot.

Professor Sidney Watson identified four prongs to any program to remedy racial disparities in health: health care financing (financial access); attracting sufficient providers to the inner cities (geographic access); combating discrimination (enforce Title VI); and developing a health care system which is responsive to the needs of the population (cultural competency).<sup>301</sup> Major structural changes will be required. Eliminating the second-class nature of Medicaid will require reimbursement of providers on the same basis as Medicare, and tying Medicare and Medicaid participation together. Massive changes in the system of educating providers would be required. Public health investments would be strongly supported, and not merely as a defense against terrorism. These and other remedies will not only improve Black health, but will have positive spillover effects to other minority groups and society as a whole.

### Conclusion

Many of the facts and relationships described in this article have been well known for many decades. In the introduction to a 1958 study of Black health care, Professor Everett C. Hughes wrote:

One of our most serious questions of social policy is, then, this: Shall we merely try hard to act as if race had never existed? Or shall we undertake to remove by

---

<sup>300</sup> Some “back of the envelope” estimates evidence the magnitude of a Black reparations claim: (1) unpaid labor: 20 million person/years @ \$30,000 (2003 dollars) yields \$600 billion; (2) the value of slaves as property in 1860: \$2 billion (1860 dollars) yields several hundred billion 2003 dollars; (3) free first-class health care for living Blacks who lived under segregation: at least 6 million Blacks for an average of 20 years of remaining life, at an average of \$3,000 per year incremental cost yields \$360 billion; and (4) the Japanese-American model: \$10,000 per person for a few years of confinement in modest conditions, compared to the Black experience with slavery and segregation: \$50,000 (2003 dollars) should have been given to each of 4 million freedmen, yielding \$200 billion.

<sup>301</sup> Sydney D. Watson, *Health Care in the Inner City: Asking the Right Question*, 71 N.C.L. REV. 1647, 1654 (1993).

special action the handicaps left over from our long history of racial discrimination?<sup>302</sup>

Racial disparities in health are an American tragedy, taking far more lives annually than AIDS and automobile accidents combined. These disparities were created in a history of slavery, segregation and white supremacy. Halting steps have been made towards amelioration, but current programs will require generations to close the gap; meanwhile, millions of Blacks suffer and 73,000 die prematurely each year. The joining of reparations and health disparities may dramatically improve Black health and partially redress one of the great crimes against humanity, moving from tragedy to remedy.

---

<sup>302</sup> Reitzes, *supra* note 150, at xxxi (introduction by Professor Everett C. Hughes, University of Chicago).