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Using Civil Rights Law to Undermine Profitability of Ongoing Racial Segregation in Health Care

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Abstract

In 2008, New York Lawyers for the Public Interest filed a civil rights complaint with the New York State Office of the Attorney General on behalf of its client, Bronx Health REACH. This complaint asserts that 3 prestigious New York City (NYC) health care organizations' outpatient clinics maintain systems of care that are separate, unequal, and segregated by race. This article considers health care segregation's past, present, and future; specifically examines 1990s and 2000s-era civil rights complaints in NYC; and offers strategies to improve equity and outcomes in NYC that can be applied in health networks nationwide.

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Yesterday

To think about segregated health care now, one has to remember the past.^{1,2} Between the ending of the Civil War in 1865 and the Civil Rights Act of 1964, there was a long interregnum.³ During the Reconstruction period from 1865 to 1877, the US government passed constitutional amendments to end slavery,⁴ guarantee equal protection,⁵ and protect voting rights based on race and color.⁶ But the White response to emancipation was insurrection. From 1881 to the 1960s, US states and localities passed reactionary laws restricting the rights of people of color in every facet of ordinary life—education, work, and, of course, health care.^{7,8} In the medical field, the influential **Flexner Report** of 1910 paved the way for improving medical education—but only for White patients and White doctors. The report put it bluntly: “A well-taught negro sanitarian will be immensely useful; an essentially untrained negro wearing an MD label is dangerous.”^{9,10}

Around the same time, the brilliant sociologist W.E.B. Du Bois edited a 1906 study entitled *The Health and Physique of the Negro American*.¹¹ He noted that in hospitals “in the South they have separate wards or distinct institutions”¹¹ and that, in the North, it wasn't much better. In the Colored Hospital and Home in New York City, for example, Black patients could be admitted but could not be treated by Black doctors.^{11,12,13} But segregation ran deeper still. Du Bois' study was a detailed examination of the equality of

Black people and White people and rejected the notion that the former were inferior to the latter.

The Conference [for the Study of the Negro Problems at Atlanta University on May 29, 1906] does not find any adequate scientific warrant for the assumption that the Negro race is inferior to other races in physical build or vitality. The present differences in mortality seem to be sufficiently explained by conditions of life; and physical measurements prove the Negro a normal human being capable of average human accomplishments.¹¹

While it might seem shocking, “inferiority” appears in a different guise today, in this century. Historically, it was assumed that race was “a reliable proxy for genetic difference”¹⁴ and that people of color “experienced greater genetic susceptibility to disease.”¹⁵ We now know that racial health disparities are not genetic and inherent but caused by social factors and contingent, and there is a growing movement of health care professionals, researchers and academics, and lawyers and communities who are running against the current of inequitable care based on race.

Today

Bronx Health REACH (REACH) and New York Lawyers for the Public Interest (NYLPI) have taken a stand against segregated care. Founded in 1999, REACH comprises community- and faith-based organizations and health care clinicians with a mission to end racial and ethnic disparities in the Southwest Bronx.^{16,17} NYLPI is a public interest law firm with lawyers and organizers working on behalf of the communities that care about health justice, disability rights, and environmental justice in New York City.¹⁸ The Southwest Bronx—mostly Black and Brown families—has poor health outcomes compared to New York City as a whole on every metric: infant mortality, premature death, life expectancy, and chronic conditions.¹⁹ Perhaps unsurprisingly, people of color in New York City have a high uninsured rate. The New York City Department of Health and Mental Hygiene reported that, in 2012, 19% of Black adults, 31% of Hispanic adults, and 20% of Asian and Pacific Islander adults were uninsured compared to 12% of White adults.²⁰

In 2008, NYLPI (with which I was affiliated at the time), on behalf of the client, REACH, filed a civil rights complaint with the New York State Office of the Attorney General against 3 prestigious New York City hospitals—New York-Presbyterian, Mount Sinai, and Montefiore—each of which is a short subway or bus ride away from the Southwest Bronx.²¹ The assertion was that these hospitals maintained 2 separate and unequal systems of outpatient clinics, sorting patients based on payer source and resulting in disparate treatment of patients based on race and national origin. It was the existence of such unequal segregated care that gave rise to the separate-but-equal clause of the Hill-Burton Act and Title VI of the Civil Rights Act of 1964, which conditioned hospital federal funding on nondiscrimination.^{22,23}

First, there was precedent. In 1994, the New York State Department of Health and New York State Division of Human Rights began an investigation of Mount Sinai and Presbyterian hospitals when a number of maternity patients accused these hospitals of sorting patients in the maternity ward based on payer and, as a result, race.²¹ During the hearing of the investigation, the hospitals shared one interesting kernel of information: “They said their previous practice—which they have since abandoned—was intended to place Medicaid patients as close together as possible to provide more efficient care, since those patients did not have private physicians and relied on resident physicians in training for most of their care.”²⁴ Why, we asked, did Medicaid patients, primarily people of color, have access only to residents rather than fully trained attending physicians who

are more seasoned and can detect problems earlier and faster? And if this happened in inpatient hospitals, could the same thing occur in outpatient settings?

REACH's members seek treatment for diabetes, heart disease, and cancer at outpatient clinics, where community members experience frequent disruptions and uncertainties in accessing care, as well as poor quality and delivery of care. In developing our complaint, we focused on outpatient pathways to endocrine and cardiac care, given the prevalence of diabetes and heart disease in the community, and we conducted specialty surveys on the referral practices of 3 major teaching hospitals in or near the Bronx.²¹ Community members volunteering as testers were given a uniform script and scheduled to make calls to physician referral services on staggered shifts over a 2-month period.²¹ They asked for a referral for a relative whom they said would pay for care with Medicaid, private insurance, or out of pocket.

Testers took note of the following during each call: whether they were referred to a physician to receive an evaluation of their medical concern or instead to a clinic; the names and numbers of all physicians to whom they were referred; and the numbers of all clinics to which they were referred. In cases in which the caller was referred directly to the clinic, a follow-up call was made to determine the type of health professional who would treat the patient at that location (faculty physician, attending physician, fellow, resident, or medical student); whether the patient would have access to the physician for after-hours or weekend care or would be referred to the emergency department; and whether the physician would follow up with the patient's primary care physician.²¹ The result: testers who said that the relative about whom they were calling was on Medicaid uniformly were referred to clinics rather than faculty practices; were referred to residents rather than fully licensed faculty or attending physicians; were offered no access to help on the weekend or after hours other than the emergency room; and were offered no follow-up with their primary care physician.²¹

These findings are disconcerting because of the impact over time of segregated care on individuals and their bodies. In our complaint, we added stories from community members experiencing such care. Here is one vignette of a community member who learned that she had cancer:

Vanessa realized that her condition was allowed [to] disintegrate as much as it did because she was not able to get an accurate diagnosis and treatment early enough in the onset of the disease. Bouncing between her clinic and the emergency room, she was repeatedly told to simply eat healthier instead of being properly examined to determine if there was a more serious problem. Vanessa thinks her concerns were dismissed out-of-hand because there is a pervasive negativity among staff in clinics and emergency rooms toward Medicaid patients. She recalls that a nurse once told her: "well, you know you people ... with those, you know, managed care Medicais, you guys don't really take care of yourselves anyway... [and] that's how all of the doctors feel about you guys anyway, because ... if you really took care of yourself you wouldn't have managed care—you wouldn't have Medicaid."²¹

In other words, Medicaid is now a proxy for race and an indictment of Black and Brown communities in the health care setting. If you are a person of color who is not Asian, you are more likely to have Medicaid than if you are a White person, and people of color are treated as second tier in the hospital setting precisely because they have Medicaid rather than private insurance.²⁵ When Medicaid was first enacted in 1965, "Southern states were resistant to federal overreach due to immense changes brought by the civil rights legislation. A state-run program [with federally funded assistance] presented a solution, limiting federal involvement while allowing states to continue running health programs for low-income residents," often minimally and to the disadvantage of people

of color.²⁶ For example, studies examining nursing home segregation based on race and Medicaid have found that, on several metrics, Black residents lived in poorer-quality nursing homes than White residents and that nursing home care in southern and Midwestern states was de facto segregated.^{27,28} The result was stark differences in care that were palpable to patients like Vanessa.

Tomorrow

Our vision for the future is that medicine is integrated and equal. At the state level, the staff of then-Attorney General Andrew Cuomo showed an initial interest in our complaint but later reversed course and claimed that our complaint on “administrative difference”—for example, the difference between seeing a licensed doctor for cancer care as compared to a resident—could be “thrown out” by a court and not survive a legal motion to dismiss.²⁹ At the same time, however, hospital lobbyists in New York City poured millions of dollars into the coffers of Andrew Cuomo and his election campaigns for attorney general and governor until his resignation in 2021.³⁰ The complaint is still active, albeit dormant, and the new attorney general, Letitia James, could choose to revive it.

At the federal level, we have seen positive steps toward equity with the 2010 Affordable Care Act (ACA) functioning “as a stealthy civil-rights achievement of the Obama presidency, promising to make health care less of a financial burden, end disparities in health-care coverage, ease barriers to access for people of color, and subsidize preventative health-care services that proved especially lacking in black neighborhoods.”³¹ The equity promise of the law was severely damaged by the Supreme Court decision in 2012 that allowed states to opt out of the **Medicaid expansion**.³² But President Biden now has another chance to eliminate health disparities if he chooses—for example, by expanding “Medicaid-funding services such as food and housing that the government insurance plan hasn’t traditionally offered.”³³ There are also possibilities on the state and federal legislative front.^{34,35,36}

The story of health care in the United States is still being drafted. Will it be equal and just to communities of color, or will it remain unequal and separated? Before he produced his searing report on health care across the country, Du Bois had a personal story to tell on health care and race. His 2-year-old son, Burghardt, contracted diphtheria.³⁷ Du Bois searched for the two or three black doctors in Atlanta with no success, and the White doctors refused to treat his son. While diphtheria is serious, it was curable, even in the mid-1890s.³⁸ Nevertheless, Du Bois’ son died 10 days later simply because he and his father were Black people. Can we change that outcome in 2022 and beyond? Through continued discussions regarding institutional racism, events such as those recollected by Vanessa and Du Bois can be prevented.

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