



ELIMINATING DISPARITIES IN TREATMENT AND THE STRUGGLE TO END SEGREGATION

David Barton Smith

Fox School of Business and Management, Temple University

August 2005

ABSTRACT: Segregation was the central issue facing the civil rights challenges and achievements of the 1950s and 1960s—specifically, the *Brown vs. Board of Education* decision, the Civil Rights Act of 1964, and the implementation of the Medicare program. However, current efforts to eliminate racial and ethnic disparities in health care treatment fail to address the effect of segregation on disparities. By reviewing the history of the civil rights era efforts to integrate health care in the United States and assessing its accomplishments, this report offers lessons of this experience for current efforts to eliminate disparities in health care treatment. Progress can best be achieved by making the reduction of health care segregation a measurable goal, reinvigorating regional planning, taking a more critical view of the impact of “consumer-driven” choice in the organization of care and health plans, and transforming health care reform into a civil rights issue.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the author and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

Additional copies of this and other Commonwealth Fund publications are available online at www.cmwf.org. To learn about new Fund publications when they appear, visit the Fund’s Web site and [register to receive e-mail alerts](#).

Commonwealth Fund pub. no. 775.

CONTENTS

About the Author	iv
Executive Summary	v
Introduction	1
The Struggle to Integrate Health Care	1
Current Patterns of Segregation in Health Care and Strategies for Eliminating Treatment Disparities	7
Reinventing Health Care's Civil Rights Struggle	16
Notes.....	19

ABOUT THE AUTHOR

David Barton Smith, Ph.D., received his doctoral degree in medical care organization at the University of Michigan in and is currently a professor in the department of risk, insurance, and healthcare management at Temple University. He is the author of numerous articles and five books on the organization of health services including, *Health Care Divided: Race and Healing a Nation* (The University of Michigan Press, 1999) and *Reinventing Care: Assisted Living in New York City* (Vanderbilt University Press, 2003). He received a 1995 Robert Wood Johnson Health Policy Research Investigator Award for research on the history and legacy of the racial segregation of health care and continues to write and do research on this topic.

EXECUTIVE SUMMARY

Segregation was the central issue of the civil rights challenges and achievements of the 1950s and 1960s—specifically, the *Brown vs. Board of Education* decision and the Civil Rights Act of 1964, with the implementation of the Medicare program dealing a further blow to the institution. Current efforts to eliminate racial and ethnic disparities in health care treatment, however, fail to address the effect of segregation on disparities. Segregation is simply not part of the current vocabulary of clinicians, health care executives, policymakers, or advocacy groups in their discussions of racial disparities in treatment or health. To address this omission, this report aims to:

- review the history of the early efforts to integrate health care in the United States;
- assess the trends and effectiveness of the strategies used for reducing segregation; and
- outline the lessons of this experience to assist current efforts in the elimination of disparities in health care.

The Struggle to Integrate Health Care

Unlike the more visible, protracted battles that took place over the integration of public accommodations, housing, and schools during the civil rights era, the parallel struggle in health care was brief, quiet, private, and incomplete. At the time of the *Brown* decision in 1954, health care was sharply divided along racial lines. This separate care system represented a double-edged sword: while marginalizing black physicians and dentists, it provided insulation from white control and allowed some practitioners, particularly in the South, the freedom to act as advocates for their patients and their communities.

In 1954, at the time of the *Brown* decision, the vast majority of black and white health professionals saw little promise that there would ever be any significant change. In most communities, racial integration in hospitals and health care was too difficult an issue, and efforts instead focused on the integration of schools and public accommodations, which seemed easier to achieve. Yet, a small network of activist black physicians and civil rights lawyers coalesced after the *Brown* decision and began to map out a campaign to accomplish what most felt was impossible. This resulted in the inclusion of Title VI in the Civil Rights Act of 1964, which prohibited the provision of federal funds to organizations or programs that engaged in racial segregation or other forms of discrimination. The first significant test of Title VI enforcement came with the implementation of the Medicare program in 1966. More than 1,000 hospitals quietly and uneventfully integrated their medical staffs, waiting rooms, and hospital floors in less than four months.

However, outside the hospital, the rest of the health care system was never directly affected by the Medicare integration efforts. No effort to inspect nursing homes for compliance was ever mounted. Physicians were specifically exempted from compliance with Title VI. Until the recent resurgence of interest in health disparities, health care has been left to drift, unrestrained by concerns about segregation and responding only to changing market forces.

Current Patterns of Segregation in Health Care and Strategies for Eliminating Treatment Disparities

There are four main conclusions regarding the reduction of segregation in health care:

1. *In spite of progress in eliminating disparities, health care remains quite segregated and may be becoming more so.* The civil rights era in health care produced impressive and lasting accomplishments. However, substantial segregation remains. Data on Medicare discharges from hospitals by elderly beneficiaries suggest both wide variation and the persistence of segregation in hospital care in the United States. Racial segregation is also a factor for outpatient care and nursing home care.
2. *How health care is regulated and financed shapes the degree of segregation and disparities in treatment.* In the 1980s, a fundamental shift took place in the planning and financing of capital projects in health care. Federal support for regional health planning was abandoned and most states chose to terminate or greatly reduce the scope of their Certificate of Need programs. By eliminating the federal program, providers in most states were then freed of any external planning constraints on decisions concerning new services or capital projects. Capital projects and service expansions were viewed strictly as business, rather than social investments.
3. *Segregation produces a health system that increases the cost and reduces the quality of care for everyone.* Unburdened by the restrictions of the pre- and early post-Medicare periods, providers have expanded profitable services in areas with the most advantageous payer mix. This has tended to increase services in predominantly white, affluent suburban areas and reduce services in less affluent, predominantly minority, inner-city areas. By increasing racial and economic segregation, everyone loses in terms of cost and quality.
4. *Segregation exaggerates disparities.* One of the most socially destructive and stigmatizing effects of segregation in health care, as in other areas of American society, is the exaggeration of differences. For instance, minorities in most

metropolitan areas have relied more heavily on medical schools, teaching hospitals, and public clinics that tend to routinely screen for sexually transmitted diseases and for drug use and, consequently, tend to report a higher rate of positive findings for these conditions.

REINVENTING HEALTH CARE'S CIVIL RIGHTS STRUGGLE

Racial segregation in health care not only distorts and contributes to disparities; it increases the cost and reduces the quality of care for everyone. The lessons of the past half-century's efforts to desegregate health care suggest four possible strategies for reducing racial, ethnic, and economic disparities in treatment:

1. *Make the reduction of health care segregation a goal.* Include measures of segregation in the health care quality and disparity report cards of providers, plans, regions, and the nation as a whole. Reducing segregation will reduce disparities and total costs and will improve the overall quality of care.
2. *Reinvent regional planning.* Make obtaining a Certificate of Need contingent on providing convincing evidence of a reduction in the racial and economic segregation of care.
3. *Do not confuse market-driven reforms for real choice.* When health plans and providers are more driven by market conditions, care becomes more fragmented and segregated by race and income. Consumer-driven choice, when applied to retirement security or access to medical care, amounts to an abdication of public responsibility.
4. *Transform health care reform into a civil rights issue.* Medicare was passed as a civil rights bill. Health care became a right under this universal entitlement program, which was driven to creation by the most powerful grass roots social movement this country has ever experienced. The time has come to return to the basic premises of this movement.

ELIMINATING DISPARITIES IN TREATMENT AND THE STRUGGLE TO END SEGREGATION

INTRODUCTION

Segregation was the central issue of the civil rights challenges and achievements of the 1950s and 1960s—specifically, the *Brown vs. Board of Education* decision, the Civil Rights Act of 1964, and the implementation of the Medicare program. Current efforts to eliminate racial and ethnic disparities in health care treatment, however, fail to address the effect of segregation on disparities. As noted by Massey and Denton more than a decade ago, “during the 1970s and 1980s a word disappeared from the American vocabulary.”¹ That word was segregation. This is particularly true in the arena of health care. “Segregation” is absent from *Healthy People 2010*, a Department of Health and Human Services’ report that set national health goals for the decade.² It is also absent from the Institute on Medicine (IOM) report on quality, *Crossing the Quality Chasm: A New Health System for the 21st Century*, which set equity as one of six, high-quality health care goals.³ The word is not present in the IOM’s recent report on racial disparities in treatment, nor is it in the first *National Health Care Disparities Report* issued by the Agency for Healthcare Research and Quality.⁴

Segregation is simply not part of the current vocabulary of clinicians, health care executives, policymakers, or advocacy groups in their discussions of racial disparities in treatment or health. It is an eerie omission, reminiscent of the absence of the word “slavery” from the U.S. Constitution. “Slavery” then, similar to the use of “segregation” now, signified something too politically divisive and complicated to address and was buried in the hope that it would disappear on its own. Yet, separate and unequal care persists, and the effects of the actions of health plans, delivery systems, and public policy on segregation remain undocumented and not widely understood. This report will:

- review the history of the early efforts to integrate health care in the United States;
- assess the trends and effectiveness of the strategies used for reducing segregation; and
- outline the lessons of this experience to assist current efforts in the elimination of disparities in health care treatment.

THE STRUGGLE TO INTEGRATE HEALTH CARE

Unlike the more visible, protracted battles that took place over the integration of public accommodations, housing, and schools during the civil rights era, the parallel struggle in

health care was brief, quiet, private, and incomplete. At the time of the *Brown* decision in 1954, health care was sharply divided along racial lines.

In the South, Jim Crow laws imposed separate accommodations. In communities not large or affluent enough to afford separate, full-service hospitals, blacks were cared for in basement wards or separate wings or were excluded altogether.⁵ In many larger southern communities, separate hospitals were clustered near each other to accommodate white physicians with racially mixed practices.⁶ Many of the black hospitals were cast-off facilities vacated after the construction of new accommodations for whites. With rare exceptions, like the twin towers of Atlanta's Grady Memorial public hospital, hospital care for blacks and whites in the United States was far from equal. Grady's twin towers, which are even now part of Atlanta's skyline, had been planned as an airtight defense of the separate-but-equal doctrine. Construction of the towers began in the same year as the *Brown* decision.⁷ In addition to separate patient floors, the hospital had separate and physically identical emergency rooms, operating rooms, and morgues—arrangements that were persistently criticized for their inefficiency and cost to taxpayers of both races.⁸ Private practice care for blacks in the South was limited. Most white physicians who provided care for black patients either arranged to see them after normal office hours or provided separate accommodations.

In the North, at least in urban areas with a large concentration of blacks, care could be just as separate and unequal as in the South. This was achieved, however, in a more subtle way. In Chicago, for example, almost all black hospitalizations took place either at Cook County Hospital or at the historically black Provident Hospital, bypassing many voluntary hospitals that were in closer proximity to black neighborhoods. Seventy-one percent of all black deaths and 42 percent of all black births took place at Cook County Hospital; only 2 percent of white births took place at Cook County.⁹ These differences could not be explained by differences in health insurance coverage. This de facto segregation resulted from black physicians being denied admitting privileges to hospitals other than Cook County and Provident, and from the informal understanding by white physicians with admitting privileges about where it was acceptable to admit black patients.

A separate system of care, including separate hospitals, medical societies, accreditation bodies, and training programs, developed as black communities and physicians struggled to adapt to these restrictions. More than 200 historically black hospitals served black communities at some time during the first half of the 20th century.

Many provided nurse training programs and several dozen provided residency training programs for medical graduates.

The paradox of this separate care system, reflected in the deep ambivalence many members of black communities still feel about integration, was that it represented a double-edged sword. It marginalized black physicians and dentists, limiting their opportunities. Yet, for some practitioners, particularly in the South, it also provided insulation from white control and gave these practitioners the freedom to act as advocates for their patients and their communities. They did not need to worry about losing hospital privileges that they did not have, or membership in professional societies that they were not permitted to join. They also did not need to worry about being excluded from health insurance plans in which neither they nor their patients participated. Instead, these practitioners had a loyal following of patients who trusted them, looked to them for broader community leadership, and assured them—at least in the urban areas of the South with growing black, middle-class populations—a secure, fee-for-service livelihood. The white establishment could not threaten that livelihood, as opposed to local businessmen, who could have their loans and contracts terminated, or teachers, who could be fired if they pressed too hard to end discrimination.

In the 1940s and 1950s, the letterhead of local NAACP chapters listed many doctors and dentists as officers.¹⁰ Dentists were particularly prominent. Their practices were more self-contained and, unlike physicians, they were less likely to need the assistance of white specialists to care for their patients in hospitals. In many of the lawsuits that were brought to integrate schools and hospitals, dentists figured prominently as plaintiffs. From the 1930s through the 1960s, black physicians and dentists were the backbone of civil rights efforts in the South. The civil rights activists represented a small, tightly knit minority group among black physicians and dentists, but without them there might never have been a civil rights movement. Their success in breaking down the racial barriers in medicine and health care, however, has muted their voices as advocates.

While significant racial disparities presumably existed in 1954, these disparities were never measured—probably due to a lack of interest and a lack of commitment to resolving the problem. The Committee on the Costs of Medical Care’s 1932 study on health care financing and use—a groundbreaking study that is the foundation of current health services research—excluded blacks from its survey of 9,000 households. Since the study required recordkeeping, the researchers concluded that they “could not procure satisfactory information from Negro families.”¹¹ While racial health disparities were well documented, the measurement of access disparities—the “smoking gun” behind the way

health care was organized and financed—was lacking. Opponents of national health insurance insisted that no drastic measures were required and that anyone that really needed medical care received it. In spite of the stark racial separation documented in this paper, no spokesperson for any group in the United States, regardless of political ideology or racial attitudes, has ever advocated that essential care should be denied to those who cannot afford to pay for it nor has anyone ever acknowledged that they discriminated on the basis of race in the provision of care. The resistance to acknowledging such problems persists. National estimates of black use of health care did not begin to be collected until the introduction of the National Health Interview Survey in 1958. The information from this ongoing survey about income and racial disparities in access to care played an important role in increasing the pressure for passage of the Medicare and Medicaid legislation in 1965.

In 1954, at the time of the *Brown* decision, the vast majority of black and white health professionals saw little promise that there would ever be any significant change. In most communities, the racial integration in hospitals and health care was considered too difficult, and efforts instead focused on the integration of schools and public accommodations, which seemed easier to achieve. Voluntary hospitals and local medical societies were insulated. The public political process seemed equally impermeable. At the national legislative level, the seniority system allowed southern senators and congressmen to control the agenda. Indeed, the entire system by which medical care was organized and financed seemed designed to block racial integration.

Yet, a small network of activist black physicians and civil rights lawyers coalesced after the *Brown* decision and began to map out a campaign to accomplish what most felt was impossible. An improbable sequence of events followed that—briefly—broke the logjam. In a narrow legal victory, the federal courts concluded that by accepting federal Hill-Burton program funds, nonprofit hospitals were, in fact, an “arm of the state” and thus could not discriminate on the basis of race.¹² This legal victory drove the inclusion of Title VI in the Civil Rights Act of 1964, which prohibited the provision of federal funds to organizations or programs that engaged in racial segregation or other forms of discrimination. The first significant test of Title VI enforcement came with the implementation of the Medicare program in 1966. The rising tide of the civil rights movement provided an edge to these efforts that has since been lacking. The Medicare legislation, which offers universal entitlement to those over 65, was the culminating gift of this movement. With the help of local advocacy groups, more than 1,000 hospitals quietly and uneventfully integrated their medical staffs, waiting rooms, and hospital floors in less than four months.

In contrast to the Title VI enforcement efforts in housing and schools, Title VI enforcement in hospitals for Medicare had distinct advantages. Medicare payments were large, essential, and generous. Hospitals were reimbursed on a cost-plus basis. Combined with Medicaid dollars, the federal dollars would account for the majority of hospitals' income. Ultimately, hospitals had to choose between affluence through compliance or bankruptcy. Furthermore, the same characteristics that frustrated earlier integration efforts worked to the advantage of integration efforts in hospitals. Voluntary hospitals, unlike school boards, are insulated from the public pressure of local communities. Hospital board members are not publicly elected and can generally be counted on to use their insulated positions to protect the financial viability of the enterprise they oversee.

As in the desegregation of schools, those who resisted integration argued that the new Medicare program should allow for "freedom of choice." Virginia, Mississippi, Alabama and other southern states supported "freedom of choice" plans for their hospitals for Title VI compliance. Under such a plan, black patients would have the right to "choose" whether they wanted to be admitted to an all-black facility or one that had previously been all white. Indeed, freedom of choice proved an effective strategy in undermining efforts to enforce Title VI in the dispersion of federal education funds to local school districts.¹³ School districts were not required to integrate, but simply had to demonstrate that they had "desegregated." In other words, token black attendance at previously all-white schools or evidence that blacks were offered a choice was sufficient to ensure the continued flow of federal dollars. Similarly, many argued that patients should be free to choose whether they wanted to be placed in a white wing or in a semi-private room with a white patient. As one black witness testified in one of the early hearings on this issue, he did not choose to have his daughter placed in a white wing, saying, "who knows what would be done to her in the hospital after making such a choice."¹⁴

The Office for Equal Health Opportunity (OEHO), which was responsible for Medicare Title VI certification, and President Johnson concluded that the only way to ensure integration was to take away choice. Everyone, regardless of race or income, had to be treated the same. This meant physically changing the structure and processes of providing care—not just eliminating the visible symbols of a segregated system or signing forms claiming they did not discriminate. For example, inspectors would not only insist that the "White" and "Colored" signs over doors be removed, but that those same doors be relabeled "Exit" and "Entrance" and equipped with hardware that would ensure they be used that way.¹⁵ Not only were similar signs in the waiting areas removed, but the areas were redesigned. Inspectors insisted that one waiting area be cordoned off with a sign that said "Overflow waiting area, to be used only when the main waiting area is filled."¹⁶

In Louisiana, even though the hospitals had begun to integrate, the state's blood supply remained segregated. Again, patients were not given the "choice" of what blood they would prefer. All the hospitals in the state were notified that unless the state's blood supply was integrated, all the hospitals would be out of compliance with Title VI. The blood supply was integrated overnight.

OEHO inspectors used race-blind room assignment as the acid test for integration. Admission officials were required to assign patients in a race-blind way, and not ask patients if they minded being assigned to a room with a patient of another race. In the fall of 1966, Senator John C. Stennis (D-Miss.) attempted to blunt the impact of such requirements by inserting an amendment in the Department of Health Education and Welfare (DHEW) appropriations bill prohibiting the use of funds appropriated by the act to require race-blind room assignment in situations where, as ascertained by the patient's physicians, it would be "contrary to the beneficiaries' physical and mental well being." While this potential loophole was deleted from the final bill, Stennis did succeed in extracting assurances in writing from DHEW Secretary John Gardner that permitted an individual patient to be placed in segregated accommodations if the attending physician, the medical staff, or hospital administrator's designee determined that it was medically necessary.¹⁷

However, in March 1967, a decision by the U.S. Court of Appeals for the Fourth Circuit rejected any variation from race-blind assignments.¹⁸ The opinion ignored Secretary Gardner's accommodation. Judge Sobeloff, who wrote the majority opinion, doubted the constitutionality, observing in a letter to a colleague: "the Secretary might just as well say as to public schools that, while the law forbids segregation by race, if the principals or school superintendents certify that in their opinion it is better for the welfare of any child to segregate him, he, the Secretary, will treat such a certificate as conclusive. This would be a fine kettle of fish."¹⁹ This conclusion was never directly challenged. Thus, the complicating medical condition of racism underwent a seemingly instantaneous and miraculous cure.

In retrospect, what was remarkable to those involved in making such changes was how little resistance there was. Patients did not insist on choice and just accepted the guidance of providers. Atlanta's Grady Hospital, whose twin towers remain a symbol of the separate-but-equal era, was integrated in the middle of the night. Fearing the worst, the plans were kept secret. Patients were simply told that the hospital was reassigning rooms. By morning, the hospital was fully integrated without a single protest. Throughout the nation, patients obediently complied.

Yet, outside the hospital, the rest of the health care system was never directly affected by the Medicare integration efforts. No effort to inspect nursing homes for compliance was ever mounted. Physicians were specifically exempted from compliance with Title VI. DHEW chose to avoid a more difficult battle with organized medicine and concluded that Part B of Medicare, which paid for physicians' services through a voluntary, federally subsidized plan, was a "contract of insurance" with its subscribers and not a direct grant of public funds. The federal office in charge of Medicare Title VI certification attempted to test the boundaries of this exemption in several cases of racially exclusionary admitting practices, arguing that hospitals had oversight over the admitting practices of their medical staffs and thus were accountable for them. These efforts failed and have contributed to the persistence of disparities in referral rates for specialized services that continue to be documented.

Since 1968, providers have been insulated from any effective, external Title VI accountability for their federal Medicare and Medicaid funds. The high-water mark of federal health care integration efforts came in 1966. The Office for Equal Health Opportunity was disbanded in 1968 and its Title VI certification responsibilities were shifted to the new, centralized Office for Civil Rights in DHEW. For the next critical decade, that office shifted resources to address the issue of school desegregation. Even after the reorganization of DHEW, which created a separate Department of Education and Office for Civil Rights in the new Department of Health and Human Services (DHHS) in 1980, the Office for Civil Rights never managed to regain the offensive. Until the recent resurgence of interest in health disparities, health care has been left to drift, unrestrained by concerns about segregation and responding only to changing market forces.

CURRENT PATTERNS OF SEGREGATION IN HEALTH CARE AND STRATEGIES FOR ELIMINATING TREATMENT DISPARITIES

All the persistent, complex, and interrelated forms of segregation influence current patterns of disparities in treatment and health. Some have argued that segregation is the fundamental cause of health disparities.²⁰ An individual's health risks are shaped by the environment in which he or she lives. This environment determines the quality of the public schools people can attend, which, in turn, influences their economic prospects and, consequently, their health as adults. It also determines the distinctive character of the health system they can access. Success in one area affects success in others. Effective strategies for ending housing discrimination, integrating schools, or eliminating health disparities overlap.

While acknowledging there are complex relationships among segregation in different areas, this section will focus on reducing segregation in health care. There are four main conclusions:

1. In spite of progress in eliminating disparities, health care remains quite segregated and may be becoming more so.

The civil rights era in health care produced impressive and lasting accomplishments. All the visible symbols of the Jim Crow era were quickly removed. Medical staffs and facilities ceased to be racially exclusionary. The combined effects of the integration efforts and the Medicare and Medicaid program gradually eliminated gross disparities in use of services. In 1964, blacks averaged 23 percent fewer visits to doctors than whites and 25 percent fewer hospital admissions.²¹ By 1975, blacks averaged 4 percent fewer visits to doctors and 4 percent more hospital admissions than whites. Within the Medicare program, there has been a progressive narrowing of differences in expenditures for white and nonwhite beneficiaries. In 1967, the first full year of the program, hospital expenditures for nonwhites averaged 26 percent less than for whites, physician expenditures were 40 percent lower, and skilled nursing home expenditures were 76 percent lower.²² Those differences in expenditures per beneficiary have progressively shifted. In 1999, the Medicare program was spending 29 percent more for hospital care, 4 percent more for medical services, and 2 percent less for nursing care per nonwhite beneficiary than per white beneficiary.²³ Black use of health care has progressively increased, relative to white use of health care. The largest disparity in use was for nursing home care. In 1964, blacks older than 65 were 62 percent less likely to be residents in nursing homes than whites. In 1999, however, elderly blacks were 33 percent more likely than elderly whites to be residents in nursing homes.²⁴ These results mirror even more significant equalization in access to care for low-income Americans compared with higher-income Americans.

Although rarely documented, substantial segregation remains. The dissimilarity index is the most widely used objective indicator of segregation. It provides an easily comparable and interpretable measure. An index of 1.00 indicates complete separation of blacks and whites, while an index of 0.00 shows an even racial distribution across residential areas or health providers. The index describes the total proportion of the population in each facility that would have to move to achieve a perfectly even racial distribution. For example, a medical service area that included 200 hospitalized patients, with 100 blacks in one hospital and 100 whites in another hospital, would have an index of dissimilarity of 1.00, since the two populations are totally segregated. Fifty patients or

50 percent of the patients in each hospital must be relocated to the other hospital to achieve an even racial distribution and a dissimilarity index of 0.00.²⁵

Data on Medicare discharges in 1993 from hospitals by elderly beneficiaries suggest both wide variation and the persistence of segregation in hospital care in the United States.²⁶ The national hospital segregation or dissimilarity index was .529. In other words, hospitals are less than midway between total segregation (1.00) and full integration (.00). For the state of Pennsylvania, this measure of segregation was .607; for the Philadelphia metropolitan area, it was .471, and for the city of Philadelphia, it was .334.²⁷ The most segregated state, according to this measure, was Wisconsin (.716), and the least segregated was Delaware (.154). The metropolitan areas with the highest degree of segregation in hospitals in the United States were Gainesville, Florida (.639) and Detroit, Michigan (.620). The least hospital-segregated metropolitan areas were Huntsville, Alabama (.055) and Galveston, Texas (.108). The degree of hospital segregation in metropolitan areas in the United States is significantly related to the size of metropolitan area, the number of hospitals per unit of population (e.g., the number of choices), and the degree of residential segregation.²⁸ Hospital segregation is significantly lower in the South.

Outpatient care—which is more closely tied to residential patterns and insurance status and which has never been subjected to Medicare Title VI compliance reviews—is more segregated than hospital care. For example, compared with whites, blacks have 1.67 times the number of emergency department visits per year, 2.20 times the number of outpatient department visits, but only .87 times the number of physician office visits.²⁹ As documented by a recent assessment that linked the race of Medicare beneficiaries to information obtained from a telephone survey of physicians, primary care for blacks tends to be separate and unequal.³⁰ Eighty percent of the visits of black Medicare beneficiaries were accounted for by 22 percent of physicians. The physicians providing such care to blacks were less likely to be board-certified and more likely to report difficulty in obtaining access for their patients to high-quality specialist and diagnostic services.

The degree of segregation in nursing home care is high and is the subject of frequent comment.³¹ Using white and nonwhite breakdowns from an annual survey conducted by the Pennsylvania Department of Health, the nursing home dissimilarity index in Pennsylvania in 1988 was .680; in 2002, it increased slightly to .687. In the city of Philadelphia, the nursing home dissimilarity index changed from .630 in 1988 to .709 in 2002. Nursing home segregation is higher than hospital segregation and, at least in Philadelphia, it appears to be increasing.

Health care for whites and minorities remains, to a large extent, separate. In general, the segregation of health care reflects a combination of geographic dispersion, residential segregation, differences in insurance coverage, patient preferences, and provider bias.

2. How health care is regulated and financed shapes the degree of segregation and disparities in treatment.

Prior to the implementation of the Medicare and Medicaid program, nonprofit hospitals and nursing homes acquired most of the money they needed for capital projects from local philanthropy and matching funds from the Hill-Burton program. In order to obtain Hill-Burton funds, a provider had to show that its project was needed in terms of standard-service-area bed/population ratios and had to give assurances that it would provide a reasonable volume of care for patients who could not afford to pay.*

Regional planning agencies established after implementation of the Medicare program adopted a similar approach. In order to obtain a Certificate of Need (CON), a condition for receiving Medicare and Medicaid payments, the provider had to convince the planning body that the capital project was a needed and a socially equitable use of resources. Medicare and Medicaid then covered the interest and depreciation cost of the project. Civil rights groups in the 1970s attempted to use these regional planning requirements, as well as Title VI of the Civil Rights Act, to block hospitals from abandoning inner cities for growing, predominantly white suburban areas. While gaining some concessions, these efforts were generally unsuccessful.³²

However, in the 1980s, a fundamental shift began to take place in the planning and financing of capital projects in health care. Federal support for regional health planning was abandoned and most states chose to terminate or greatly reduce the scope of their CON programs. Pennsylvania, for example, maintained a limited CON program until 1997. This program controlled the expansion of specific services with possible cost and quality implications, like open-heart surgery, therapeutic and diagnostic cardiac catheterization, and skilled nursing care. By eliminating the federal planning program, providers in most states were freed of any external planning constraints on decisions

* The Hill-Burton legislation in 1946 required that state plans provide adequate facilities without discrimination on the basis of race, creed or color and provide for adequate accommodation for persons unable to pay for care. As noted in the previous section, however, a protracted legal struggle followed to reject state plans and arrangements in facilities receiving Hill-Burton funding that provided care on separate but equal basis that received funds. The requirements for adequate accommodations for those that could not afford to pay were not resolved until 1972. Health care providers' capital planning now is not typically constrained even by the vague and watered down requirements of the original Hill-Burton legislation, even though most receive the majority of their income from public sources.

concerning new services or capital projects. Because payment had changed to place providers at financial risk for these decisions, it was assumed that such external constraints on expansion were no longer necessary.

While these new financial risks constrained providers' investment decisions, they also distorted them. Providers focused on services and projects that were clearly profitable and promised a rapid return on investment. Capital projects and service expansions were viewed strictly as business, rather than social, investments. In 1998, the bankruptcy of Allegheny Health, Education and Research Trust (AHERF) helped underscore these risks. AHERF, valued at \$1.3 billion, represented the nation's largest nonprofit failure.³³ While the financing available to nonprofits through tax-exempt bonds has shrunk, the stock market has begun to have a renewed interest in health care investment. As a result, there has been a resurgence of nonprofit provider joint ventures and sales to publicly traded companies.³⁴ These shifts in capital financing have placed even greater importance on profitable services in growing, affluent, predominantly private-pay, white suburban areas. Providers chose to develop and expand services in these more profitable areas. While this was certain to increase the segregation and racial disparities in care, no regional planning concerns about the equitable allocation of resources constrained these developments in most states.

3. Segregation produces a health system that increases the cost and reduces the quality of care for everyone.

Unburdened by the restrictions of the pre- and early post-Medicare periods, providers have expanded profitable services in areas with the most advantageous payer mix. This has tended to increase services in predominantly white, affluent, suburban areas and reduce services in less affluent, predominantly minority, inner-city areas. As the evolution of cardiovascular and long-term care in the Philadelphia market illustrates, it also increased the cost and reduced the quality of care for everyone.

Much of the recent attention on racial disparities in treatment has been focused on cardiovascular care. There is a greater prevalence of heart disease and higher cardiovascular death rates among blacks.³⁵ However, blacks are also less likely to receive diagnostic workups and treatment.³⁶ Overuse of services by whites accounts for some, but not all, of the differences.³⁷ Profitability tends to increase supply and oversupply tends to produce overuse. Regional health planning was originally established to curb these tendencies.

In the Philadelphia metropolitan area, cardiovascular CONs served two useful social functions. First, these highly profitable franchises made sure that all providers would

operate with a volume believed necessary to provide high-quality, cost-effective services. Second, since they were held by the region's inner-city teaching hospitals, they provided a cross-subsidy for care of the low-income minority patients concentrated in their primary service areas. This time-honored, medical "Robin Hood" strategy required that those in even the most affluent and white suburban areas needing angioplasty or bypass surgery had to travel to Philadelphia to one of these inner-city teaching facilities. In most cases, this involved traveling less than 30 minutes by car, but much farther in "social distance."[†]

In the mid-1980s, the Philadelphia regional planning agency had rejected cardiac catheterization and coronary bypass surgery CON applications from about six affluent and politically well-connected suburban hospitals. The planning agency argued that, in order to operate cost-effectively and provide the necessary practice to ensure good outcomes, a certain minimum volume of procedures was required. Expansion would reduce the volume of most programs below acceptable levels. However, in 1996, the Pennsylvania legislature declined to renew the CON law and suburban hospitals began to set up cardiac catheterization and open-heart surgery programs. The number of hospitals that did open-heart surgery in the region doubled. In 2002, only seven of the 21 hospitals in the Philadelphia region were doing more than 350 open-heart surgeries per year, and only one was doing more than 450 such surgeries per year—the commonly used minimum volume guidelines for ensuring safety and efficiency of such programs.[‡] This expansion and growing segregation increased the overall cost and reduced the quality of cardiac care for everyone in the region.

Large racial disparities in access and quality have also been reported for more "high touch" services, such as long-term care. Until recently, the largest racial disparities in care were in access to nursing homes, which had not been subjected to the Title VI reviews that hospitals were subjected to when the Medicare program began.³⁸ In 1967, Medicare's first full year of operation, expenditures for nursing homes for white beneficiaries were 2.8

[†] Just as in most metropolitan areas in the Northeast and Midwest, there are stark differences in poverty rates and racial composition between the inner city (Philadelphia) and the surrounding suburban counties. Racial, political, and social animosities are sufficiently high, that any organization that tries to recruit members or support across the region avoids even using the name "Philadelphia" in their title. Trial lawyers in medical malpractice cases, on the other hand, have tried to take advantage of these divisions by finding a pretext for changing the venue of cases to Philadelphia, thus assuring a more diverse jury and one less sympathetic to the defendant, doubling their chances of a guilty verdict and substantially increasing their chances of a multi-million dollar award. One of the malpractice reforms legislated in 2002 restricts malpractice proceedings to the county where the injury took place. Partly as a result, malpractice filings in Philadelphia in 2003 dropped by one-half.

[‡] It was well documented and continues to be documented that there is a strong relationship between volume and outcomes. New Jersey, one of the few states that have maintained a CON planning process, raised the limits from 250 to 350 open heart surgeries per year in 1998. The Leapfrog Group, a coalition of private purchasers of health benefits organized by the Business Roundtable, set a recommended safety standard of referrals to hospitals that do at least 450 coronary by pass procedures per year.

times higher than those for nonwhite beneficiaries.³⁹ From 1973 to 1974, whites over the age of 65 were, on an age-adjusted basis, 2.2 times more likely than blacks to be a resident of a nursing home.⁴⁰

In the last quarter-century, however, long-term care in the United States underwent a major transformation.⁴¹ Many states changed Medicaid payments to nursing homes and developed other alternatives to discourage use of nursing homes. During the last 25 years, overall age-adjusted, elderly use of nursing homes has declined 26 percent. But while whites' use of nursing homes declined 46 percent during this period, blacks' use increased 50 percent.⁴² As a result, blacks now use nursing homes at an age-adjusted rate that is 33 percent higher than the rate for whites. In the five-county, Philadelphia metropolitan area, nursing home use rates among nonwhites are now 38 percent higher than among whites.

The changes in nursing home payment and use coincided with rapid expansion of for-profit assisted living arrangements. Assisted-living developers catering to the profitable high-end private market found it easy to get financing. Publicly traded national chains that had sprouted up overnight were flush with money for expansion. In the past 10 years in the Philadelphia area, at least 46 for-profit assisted living facilities (each with 75 or more units) were constructed, for a total capacity of more than 5,582 residents. This new segment of the long-term care market suddenly had a total capacity that was equivalent to 22 percent of all the nursing home beds in the region. For those with sufficient personal funds to purchase additional services, these facilities often provide a substitute for nursing home care in more attractive physical surroundings. In the pre-civil rights era South—in a process disparagingly referred to as “Old Clothes to Sam”—aging and out-of-date hospitals were “donated” to the black community while new facilities were constructed for the white community.⁴³ The transformation of the long-term care system, at least in the Philadelphia region, would appear to be a modernized version of this pattern.

This “cream skimming” has adversely affected nursing homes and disproportionately affected black nursing home residents. Similar to hospitals, nursing homes have relied on private-pay patients to help cover shortfalls in payments for Medicaid residents. As the Medicaid payer mix of a nursing home increases, the quality of care declines. Homes with a higher concentration of Medicaid residents have a significantly lower rate of full-time-equivalent resident nurses per resident, and are twice as likely to have their participation in the Medicaid program terminated.⁴⁴ Blacks are four times as likely as whites to be residents in such facilities.⁴⁵

It is not clear, however, that even more affluent, white elderly adults and their families—those who are part of the white flight from nursing homes to private assisted living—have benefited from the segregation. The total costs for care in assisted living and nursing homes are roughly equivalent. As is typical of the real estate market, private assisted living has gone through a boom-and-bust cycle. The Philadelphia market now appears to be overbuilt: the average occupancy rate of these assisted-living facilities in the Philadelphia area is now only 71 percent. Private assisted-living facilities in a price-sensitive, competitive market usually need to achieve about 85 percent occupancy to break even.

Financial concerns about maintaining financially viable occupancy levels place the managers of these facilities at odds with direct-care providers. Such concerns may result in facilities admitting or keeping residents despite inadequate staffing levels. Meanwhile, assisted-living facilities located in the affluent outer suburbs—where affordable housing and public transportation is inadequate—often face serious staffing and turnover problems. According to both operators and residents, the relationships between residents and personal care staff is the most critical factor affecting residents’ quality of life.

By increasing racial and economic segregation, everyone loses in terms of cost and quality. This is not a new argument. Similar claims were made by managers and policymakers in the 1950s, when they argued for an end to racially separate hospitals. Unfortunately, history seems to be repeating itself.

4. Segregation exaggerates disparities.

One of the most socially destructive and stigmatizing effects of segregation in health care, as in other areas of American society, is the exaggeration of differences. Differences in rates of illicit drug use, sexually transmitted disease, and perhaps even infant mortality tend to be exaggerated because minorities tend to use providers with different patterns of testing and reporting.

Historically, minorities in most metropolitan areas have relied more heavily on medical schools, teaching hospitals, and public clinics. These settings try to balance research and teaching with patient care missions. Patients receiving care in such settings are less likely to establish long-term, trusting relationships with their physicians. Until the passage of Medicare, a dual system of care existed. Those who could not afford to receive care from private practitioners received care from medical schools, teaching hospitals, and public clinics. The care was usually “free” but was provided in exchange for the patient’s role as “clinical material” that could assist in the training of physicians.⁴⁶ The passage of

Medicare presented a dilemma to teaching hospitals and medical schools that has yet to be fully resolved.⁴⁷ While there was talk of creating a single standard of care, house staff and medical students have more restricted and far less intrusive relationships with the patients of private attending physicians than with the medical center's own patients. Advocacy on behalf of higher Medicaid physician payments has been partly muted by concerns about the impact of the loss of this "teaching material."

After Medicare's passage, the teaching hospital and medical school share of the inner-city health care market grew. Medical schools and teaching hospitals expanded their services, increasingly using the new revenues from Medicare and Medicaid to help support their teaching and research and competing directly with other providers for patients. At the same time, private physicians exited the inner cities for the amenities and more attractive payer mix of the suburbs. In North Philadelphia, a predominantly African American and Hispanic low-income community, no private practice physicians remain. Instead, residents must rely on care from the clinics of medical schools and teaching hospitals. Five community hospitals that provided care in this area have either closed or been converted to other purposes by the medical school health systems that acquired them. The best predictor of a hospital's closure in the 1970s was the percentage of blacks in its service area.⁴⁸ The resulting hollowing-out left the urban medical schools and teaching hospitals as the remaining providers. The share of teaching hospital beds in urban areas increased from 41 percent in 1960 to 73 percent in 1997.⁴⁹

In contrast with private, suburban practices, public and teaching hospital clinics routinely screen for sexually transmitted diseases (STDs) and drug use. Since they test more, such clinics tend to report more positive findings of these conditions. State and local STD-control programs seek out larger, more organized providers in settings with higher rates in order to assist in the routine monitoring of disease prevalence. Reported rates for STDs, such as syphilis and gonorrhea, are as much as 30 times higher for blacks than for whites.⁵⁰ Yet, in private practice in the United States, fewer than one-third of women are routinely screened for STDs; routine screening for male patients is nonexistent; and less than one-half of the cases identified in private practices are reported.⁵¹ Due to this segregation, blacks are far more likely to be tested and far more likely to have positive results reported. Part of the differences in STD rates reflects this institutionalized "racial profiling" effect.

There may be a similar effect in the reporting of illicit drug and alcohol use during pregnancy. For example, one study of public clinics and private obstetrical practices in a Florida county found relatively similar rates of positive results among blacks and whites for

toxicological screening; however, but black women were 10 times more likely than white women to be reported to public health authorities, following delivery, for substance abuse during pregnancy.⁵²

Even differences in neonatal and infant mortality rates—the most commonly reported racial disparity in health—may be exaggerated in some metropolitan areas because of similar reporting aberrations. For example, in the Philadelphia metropolitan area, some of the differences in neonatal mortality rates appear to reflect differences in the locations in which blacks and whites are hospitalized for obstetrical care and not “true” differences. Generally, infants born at 22 weeks’ gestation or earlier are considered nonviable. Among such infants officially counted as live births, nearly all die within 12 hours. The rest of these nonviable, preterm infants are considered stillbirths and are not included in the calculation of neonatal and infant mortality rates. An audit of delivery records in Philadelphia found wide variations among hospitals in the proportion of such deliveries defined as live births as opposed to stillborn.⁵³

For example, at three of the major Philadelphia teaching hospitals, where most of the black births take place, the proportion of nonviable, preterm deliveries counted as live births was over 50 percent. In several of the hospitals that have a higher rate of white births, the proportion was less than 10 percent. Overall, the percentage of live births to 22-week-or-less-gestation deliveries in Philadelphia was .456 percent. In the United States as a whole it was .016 percent. If 22-week-or-earlier-gestation births were excluded from calculation of neonatal mortality rates, the white rate in Philadelphia would drop from 6.4 to 3.9 and the black rate would drop from 13.8 to 5.3. As a result, the black/white disparity in neonatal mortality rates would drop from 2.16 to 1.35, or by more than 60 percent.⁵⁴ This correction may even be understated, since urban teaching hospitals are more likely to define nonviable, preterm deliveries as live births than are suburban community hospitals staffed by private practice obstetricians and pediatricians. Similar differences in reporting practices have been used to explain some of the disparity in infant mortality rates between the United States and other developed countries.⁵⁵

REINVENTING HEALTH CARE’S CIVIL RIGHTS STRUGGLE

In accommodating the contradictions of its racial history, the United States has created the most ineffective, costly, and complex health system in the world. To address disparities in treatment and outcomes seriously, the health care community must reach beyond the “low hanging fruit” of programs designed merely to increase the cultural competency of individual health care providers. Fundamental cultural competency requires a clear understanding of our common history. The lessons of the past half-century’s efforts to

desegregate health care suggest four possible strategies for reducing racial, ethnic, and economic disparities in treatment:

1. ***Make reduction of health care segregation a goal.*** Include measures of segregation in the health care quality and disparity report cards of providers, plans, regions, and the nation as a whole. Reducing segregation will reduce disparities and total costs and will improve the overall quality of care. In general, larger volumes reduce costs and improve quality. This argument was used to encourage elimination of racially separate facilities in the 1960s, and it still holds true.
2. ***Reinvent regional planning.*** Make obtaining a Certificate of Need contingent upon providing convincing evidence of a reduction in the racial and economic segregation of care. Currently, specialized services such as open-heart surgery are moving from the inner suburbs of most urban areas to the outer ones, following white flight and urban sprawl. Market and convenience justifications mask a resegregation of care that increases the cost of health care and reduces its quality.
3. ***Do not confuse market-driven reforms with real choice.*** Market-driven reforms are, in many respects, a wolf in sheep's clothing. That is, they are the "freedom of choice" plans of the 1960s and thus result in separate and unequal choices. The same can be said for health care: when health plans and providers are more driven by market conditions, care becomes more fragmented and segregated by race and income. Consumer-driven choice sounds reassuring when spoken by a politician or health plan marketing representative, but the real choices are typically separate and unequal. This has a devastating, overall system effect of reducing quality and increasing cost, segregation, and disparities.
4. ***Transform health care reform into a civil rights issue.*** Medicare was passed as a civil rights bill. Health care became a right under this universal entitlement program, which was driven to creation by one of the most powerful grass-roots social movement this country has ever experienced. The time has come to return to the basic premises of this movement.

Is this a naïve and unrealistic agenda in the current environment? Perhaps. A recent report the Federal Trade Commission and Department of Justice advocates for a further rollback of Certificate of Need constraints and a greater dose of competition, ignoring the kinds of side-effects described in this paper.⁵⁶ Yet, this agenda is no more

naïve and unrealistic than the one of a small network of medical professionals, lawyers, and community activists in the 1950s following the *Brown* decision.

NOTES

- ¹ D. S. Massey and N. A. Denton, *American Apartheid: Segregation and the Making of the Underclass* (Cambridge: Harvard University Press, 1993), p. 1.
- ² U.S. Department of Health and Human Services, *Healthy People 2010*, 2nd ed., 2 vols. (Washington, D.C.: U.S. Government Printing Office, 2000).
- ³ Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington, D.C.: IOM, 2001).
- ⁴ Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, D.C.: IOM, 2002); and Agency for Healthcare Research and Quality (AHRQ), *National Healthcare Disparities Report* (Rockville, Md.: U.S. Department of Health and Human Services, 2003).
- ⁵ H. A. Eaton, *Every Man Should Try* (Wilmington, N.C.: Bonaparte Press, 1984).
- ⁶ D. B. Smith, *Health Care Divided: Race and Healing a Nation* (Ann Arbor, Mich.: The University of Michigan Press, 1999).
- ⁷ *Ibid.*, p. 50.
- ⁸ W. M. Cobb, “Executive Procedure Without Effect in Hospital Area,” *Journal of the National Medical Association* 54 (1962): 256–59.
- ⁹ B. O’Hara, “Discrimination in Hospitals: Extension of Remarks of Hon. Barratt O’Hara of Illinois,” *Congressional Record*, 84th Cong., 1955.
- ¹⁰ Smith, *Health Care Divided*, 1999, pp. 38–39.
- ¹¹ I. S. Faulk, M. Klem, and N. Sinai, “The Incidence of Illness and the Receipt and Costs of Medical Care Among Representative Families,” Committee on the Cost of Medical Care, Report No. 27 (Chicago: University of Chicago Press, 1933), p. 5.
- ¹² *Simkins v. Moses H. Cone Memorial Hospital*, in F, 2d 959 (4th Cir.1963, cert. denied, 376 US 938, 1964).
- ¹³ G. Orfield, *The Reconstruction of Southern Education: The Schools and the 1964 Civil Rights Act* (New York: Wiley-Interscience, 1969).
- ¹⁴ Smith, *Health Care Divided*, 1999, p. 148.
- ¹⁵ Smith, *Health Care Divided*, 1999.
- ¹⁶ *Ibid.*
- ¹⁷ P. P. Reynolds, “Professional and Hospital Discrimination and the U.S. Court of Appeals Fourth Circuit 1956–1967,” *American Journal of Public Health* 94 (May 2004): 710–20.
- ¹⁸ *Cypress v. Newport News*, in Lexis: United States Court of Appeals for the Fourth Circuit, 1967: 9048.
- ¹⁹ S. E. Sobeloff, Letter to Judge John Minor Wisdom, March 14, 1967, in Simon E Sobeloff Papers, Box 84, *Cypress v Newport News Gen Hospital Association Folder 1*, Washington, D.C., 1967.
- ²⁰ D. R. Williams and C. Collins, “Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health,” *Public Health Reports* 116 (September/October 2001): 404–16; D. Acevedo-Garcia et al., “Future Directions in Residential Segregation and Health Research: A Multilevel Approach,” *American Journal of Public Health* 93 (February 2003): 215–21; and

A. P. Polednak, "Trends in U.S. Urban Black Infant Mortality, by Degree of Residential Segregation," *American Journal of Public Health* 86 (May 1996): 723–26.

²¹ Smith, *Health Care Divided*, 1999, pp. 202–03.

²² Smith, *Health Care Divided*, 1999, p. 206.

²³ Ibid.

²⁴ National Center for Health Statistics, *Health, United States, 2003* (Hyattsville, Md.: NCHS, 2003).

²⁵ For a more detailed description and the computational formula for this index, see J. Iceland and D. H. Weinberg, *Racial and Ethnic Residential Segregation in the United States: 1980–2000* (Washington, D.C.: U.S. Census Bureau, 2002), pp. 119–23.

²⁶ D. B. Smith, "The Racial Segregation of Hospital Care Revisited: Medicare Discharge Patterns and Their Implications," *American Journal of Public Health* 88 (March 1998): 461–63.

²⁷ Smith, *Health Care Divided*, 1999; and Bureau of Data Management and Strategy, *Data from the MEDPAR Files for Fiscal Year 1993* (Baltimore, Md.: Center for Medicare and Medicaid Services, 1993).

²⁸ Smith, "Racial Segregation Revisited," *American Journal of Public Health*, 1998.

²⁹ NCHS, *Health, United States, 2003*.

³⁰ P. B. Bach et al., "Primary Care Physicians Who Treat Blacks and Whites," *New England Journal of Medicine* 351 (August 5, 2004): 575–84.

³¹ United States Commission on Civil Rights, *Health Care in the Context of Civil Rights* (Washington, D.C.: U.S. Government Printing Office, 1971).

³² M. G. Rose, "Can Hospital Relocations and Closures Be Stopped Through the Legal System?" *Health Services Research* 18 (Winter 1983): 551–74.

³³ L. R. Burns et al., "The Fall of the House of AHERF: The Allegheny Bankruptcy," *Health Affairs* 19 (January/February 2000): 7–41.

³⁴ J. C. Robinson, "Bond-Market Skepticism and Stock-Market Exuberance in the Hospital Industry," *Health Affairs* 21 (January/February 2002): 104–17.

³⁵ AHRQ, *National Healthcare Disparities Report*, 2003.

³⁶ IOM, *Unequal Treatment*, 2002, pp. 40–42; and AHRQ, *National Healthcare Disparities Report*, 2003.

³⁷ E. C. Schnieder et al., "Racial Differences in Cardiac Revascularization Rates: Does "Overuse" Explain Higher Rates Among White Patients?" *Annals of Internal Medicine* 135 (September 4, 2001): 328–37.

³⁸ Smith, *Health Care Divided*, 1999, pp. 236–37.

³⁹ K. Davis, "Equal Treatment and Unequal Benefits: The Medicare Program," *Milbank Quarterly* 53 (Fall 1975): 449–88.

⁴⁰ NCHS, *Health, United States, 2003*.

⁴¹ C. E. Bishop, "Where Are the Missing Elders? The Decline in Nursing Home Use, 1985 and 1995," *Health Affairs* 18 (July/August 1999): 146–55.

⁴² NCHS, *Health, United States, 2003*.

⁴³ W. M. Cobb, “The Crushing Irony of De Luxe Jim Crow,” *Journal of the National Medical Association* 44 (1952): 386–87.

⁴⁴ V. Mor et al., “Driven to Tiers: Socioeconomic and Racial Disparities in Quality of Nursing Home Care,” *Milbank Quarterly* 82 (June 2004): 227–56.

⁴⁵ Ibid.

⁴⁶ K. M. Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care* (New York: Oxford University Press, 1999).

⁴⁷ Ibid.

⁴⁸ A. Sager, “Why Urban Voluntary Hospitals Close,” *Health Services Research* 18 (Fall 1983): 451–75.

⁴⁹ A. Sager and D. Socolar, *Graduate Medical Education Financing in the U.S.A.: Past, Present, and Future* (Boston: Boston University School of Public Health, 2002).

⁵⁰ Centers for Disease Control and Prevention, *Tracking the Hidden Epidemics: Trends in STDs in the United States 2000* (Atlanta: CDC, 2000).

⁵¹ J. S. St. Lawrence et al., “STD Screening, Testing, Case Reporting, and Clinical and Partner Notification Practices: A National Survey of U.S. Physicians,” *American Journal of Public Health* 92 (November 2002): 1784–88.

⁵² I. J. Chasnoff, H. J. Landress, and M. E. Barrett, “The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida,” *New England Journal of Medicine* 322 (April 26, 1990): 1202–06.

⁵³ E. Gibson et al., “Effect of Nonviable Infants on the Infant Mortality Rate in Philadelphia, 1992,” *American Journal of Public Health* 90 (August 2000): 1303–06.

⁵⁴ Ibid.

⁵⁵ S. Sepkowitz, “International Rankings of Infant Mortality and the United States’ Vital Statistics Natality Data Collecting System—Failure and Success,” *International Journal of Epidemiology* 24 (June 1995): 583–88.

⁵⁶ Federal Trade Commission and U.S. Department of Justice, *Improving Health Care: A Dose of Competition* (Washington, D.C.: FTC and DOJ, 2004).

RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's Web site at www.cmwf.org.

[*Equity Measures and Systems Reform as Tools for Reducing Racial and Ethnic Disparities in Health Care*](#) (August 2005). Sidney D. Watson, Center for Health Law Studies, Saint Louis University School of Law. Although Quality Assessment and Performance Improvement (QAPI) initiatives are becoming more widespread in federal programs, QAPI requirements do not stipulate that plans or providers must measure racial and ethnic disparities in their care. But performance measurements that do not track data by race and ethnicity, the author says, miss inequities and likely overlook promising techniques for reaching particular groups of patients.

[*Limited English Proficiency, Primary Language at Home, and Disparities in Children's Health Care: How Language Barriers Are Measured Matters*](#) (July/August 2005). Glenn Flores, Milagros Abreu, and Sandra C. Tomany-Korman. *Public Health Reports*, vol. 120, no. 4. In this article, the authors' analysis shows that, even when factoring in multiple variables, parents with limited English proficiency are three times more likely than parents who report speaking English very well to have a child in fair or poor health.

[*Caring for Patients with Diabetes in Safety Net Hospitals and Health Systems*](#) (June 2005). Marsha Regenstein, Jennifer Huang, Linda Cummings, Daniel Lessler, Brendan Reilly, and Dean Schillinger. According to this report's authors, "safety net hospitals," those public institutions that care for a large volume of underserved Americans, provide care to patients with diabetes that is generally as good as the national average.

[*Impact of the Medicare Prescription Drug Benefit on Home- and Community-Based Services Waiver Programs*](#) (April 2005). Charles J. Milligan, Jr., University of Maryland, Baltimore County. With home- and community-based services waiver programs, many low-income, elderly, and disabled adults enrolled in both Medicare and Medicaid can avoid institutionalization and remain in the community. The author of this issue brief says the impending transfer of prescription drug coverage from Medicaid to Medicare may place many "dual eligibles" in jeopardy.

[*Providing Language Services in Small Health Care Provider Settings: Examples from the Field*](#) (April 2005). Mara Youdelman and Jane Perkins, National Health Law Program. Community health centers and small physician practices can have a particularly difficult time effectively serving patients with limited English proficiency. The authors show how a number of solo practitioners, small group practices, and clinics around the country have found creative methods for meeting the needs of these patients.

[*Cultural Competence and Health Care Disparities: Key Perspectives and Trends*](#) (March/April 2005). Joseph R. Betancourt, Alexander R. Green, J. Emilio Carrillo, and Elyse R. Park. *Health Affairs*, vol. 24, no. 2 (*In the Literature* summary). The authors report that culturally competent health care—broadly defined as services that are respectful of and responsive to the cultural and linguistic needs of patients—is gaining attention not only as a strategy to reduce racial and ethnic disparities, but as a means of improving health care quality. Cultural competence initiatives may even help control costs by making care more efficient and effective.

[Creating a State Minority Health Policy Report Card](#) (March/April 2005). Amal Trivedi et al. *Health Affairs*, vol. 24, no. 2 (*In the Literature* summary). In the first “report card” to evaluate all 50 states on their progress in addressing disparities in minority health care, the authors found region of the country to be a significant predictor of performance, with high- and low-performing states tending to cluster geographically.

[Quality Report Cards, Selection of Cardiac Surgeons, and Racial Disparities: A Study of the Publication of the New York State Cardiac Surgery Reports](#) (Winter 2004–05). Dana Mukamel et al. *Inquiry*, vol. 41, no. 4 (*In the Literature* summary). According to the authors, quality report cards can work to level the playing field for minorities by improving their ability to see high-quality health providers, in addition to helping consumers make informed health care choices.

[Addressing Unequal Treatment: Disparities in Health Care](#) (November 2004). Gillian K. SteelFisher. Prepared for the 2004 Commonwealth Fund/John F. Kennedy School of Government Bipartisan Congressional Health Policy Conference, this issue brief reports that health care services in the U.S. have been improving for decades, but in many instances, racial and ethnic minorities receive fewer health care services, lower quality services, and services later in the progression of illness.

[Policies to Reduce Racial and Ethnic Disparities in Child Health and Health Care](#) (September/October 2004). Anne C. Beal. *Health Affairs*, vol. 23, no. 5 (*In the Literature* summary). The author argues that while a variety of public and private sector programs are taking on the issue of disparities in health care, better coordination and monitoring at the federal level is needed to maximize their effectiveness.

[R-E-S-P-E-C-T: Patient Reports of Disrespect in the Health Care Setting and Its Impact on Care](#) (September 2004). Janice Blanchard and Nicole Lurie. *Journal of Family Practice*, vol. 53, no. 9 (*In the Literature* summary). The authors find that minorities are significantly more likely than whites to report being treated with disrespect or being looked down upon in patient-provider relationships.

[A Review of the Quality of Health Care for American Indians and Alaska Natives](#) (September 2004). Yvette Roubideaux. The author documents health care disparities for American Indians and Alaska Natives (AIANs) and reports on progress made in the last five years to reduce or eliminate gaps in care. In examining the demographics of this group, she notes in particular a substantial urban AIAN population that is both understudied and which may be underserved by the traditional AIAN health care infrastructure.

[Child Health Disparities: Framing a Research Agenda](#) (July/August 2004). Ivor B. Horn and Anne C. Beal. *Ambulatory Pediatrics*, vol. 4, no. 4 (*In the Literature* summary). In this article, the authors set forth a research framework for identifying racial disparities in children’s health, determining their root causes, and developing effective interventions. They emphasize preventive care, culture, and language, and the social determinants of health, including housing, nutrition, and stress factors prevalent in low-income communities.

[Disparities in Patient Experiences, Health Care Processes, and Outcomes: The Role of Patient-Provider Racial, Ethnic, and Language Concordance](#) (July 2004). Lisa A. Cooper and Neil R. Powe. According to the authors, patients treated by doctors of the same racial or ethnic background generally experience greater satisfaction with their care and, in many cases, better outcomes, a new report concludes. The findings highlight the need for greater minority representation within the health care workforce.

[Explaining Disparities in Access to High Quality Cardiac Surgeons](#) (July 2004). Barbara M. Rothenberg, Thomas Pearson, Jack Zwanziger, and Dana Mukamel. *Annals of Thoracic Surgery*, vol. 78 (*In the Literature* summary). This study of cardiac patients in New York State finds that African Americans and Asian/Pacific Islanders who underwent coronary artery bypass graft surgery were treated by lower-quality surgeons than whites. According to the authors, physician referral patterns may be important determinants of where minorities received treatment.

[A State Policy Agenda to Eliminate Racial and Ethnic Health Disparities](#) (June 2004). John E. McDonough, Brian K. Gibbs, Janet L. Scott-Harris, Karl Kronebusch, Amanda M. Navarro, and Kimá Taylor. The authors of this report detail a wide range of state initiatives to reduce racial and ethnic disparities in health and health care, along with practical strategies for improving insurance coverage, access to care, and medical outcomes for minority Americans.

[Who, When, and How: The Current State of Race, Ethnicity, and Primary Language Data Collection in Hospitals](#) (May 2004). Romana Hasnain-Wynia, Debra Pierce, and Mary A. Pittman. The authors of this study find that, although the majority of hospitals are now collecting information on patients' race, ethnicity, and primary language, many say there are drawbacks, including problems with accuracy and confidentiality. The authors recommend standardizing the data collection process—relying on patients to provide information and giving them a uniform rationale for doing so.

[Urban Parents' Knowledge and Practices Regarding Managed Care](#) (April 2004). Glenn Flores, Milagros Abreu, Donglin Sun, and Sandra C. Tomany. *Medical Care*, vol. 42, no. 4 (*In the Literature* summary). Millions of children are enrolled in managed care programs under Medicaid. Yet the authors of this article find that many parents have limited knowledge of managed care and its rules and practices.