

HEALTH DISPARITIES, HEALTH CARE REFORM, MORALITY, AND THE LAW: “KEEP YOUR GOVERNMENT HANDS OFF MY MEDICARE”

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I. INTRODUCTION

In January of 1939, President Franklin D. Roosevelt addressed Congress on the need to develop a national health care program, asserting:

The average level of health or the average cost of sickness has little meaning for those who now must meet personal catastrophes. To know that a stream is four feet deep on the average is of little help to those who drown in the places where it is ten feet deep. The recommendations of the committee offer a program to bridge that stream by reducing the risks of needless suffering and death, and of costs and dependency, that now overwhelm millions of individual families and sap the resources of the Nation.¹

Seventy years later, the problem of health disparities continues to plague the United States. The passage of the Health Insurance for the Aged Act, which created Medicare² to provide health care insurance for senior citizens³ and Medicaid⁴ to cover the poor who are disabled or have young children,⁵ has increased access to health care for some segments of the population. However, millions of citizens and residents of the country continue to suffer from lack of access to health care,⁶ relying on hospital emergency rooms as a last—or in some instances the first—resort for health care.⁷

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1. Franklin Delano Roosevelt, *A Request for Consideration of the Recommendations of the Interdepartmental Committee to Coordinate Health Activities, with Respect to the National Health Program. January 23, 1939*, in *THE PUBLIC PAPERS AND ADDRESSES OF FRANKLIN D. ROOSEVELT* 97, 99 (1941), available at <http://www.ssa.gov/history/fdrstmts.html#12>.

2. Health Insurance for the Aged Act (Medicare Act), Pub. L. No. 89-97, 79 Stat. 290 (codified as amended at 42 U.S.C. §§ 426–426a, 1395–1396d (2006)).

3. *See, e.g., Hultzman v. Weinberger*, 495 F.2d 1276, 1281 (3d Cir. 1974) (explaining purpose of Medicare is to ensure “medical care is available to the aged throughout this country”).

4. Medicaid Act, Pub. L. No. 89-97, 79 Stat. 343 (codified as amended at 42 U.S.C. §§ 1396–1396g, 1396i–1396v (2006)).

5. *See, e.g., Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 686 (2003) (describing purpose of Medicaid as enabling states to provide medical assistance to children of low-income families and disabled persons without means for attaining adequate care).

6. CARMEN DE NAVAS-WALT ET AL., U.S. CENSUS BUREAU, *INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2008*, at 20 (2009); *see also* OMB Blog, <http://www.whitehouse.gov/omb/blog/09/09/10/CountingtheUninsured46MillionorMorethan30Million/> (Sept. 10, 2009, 14:52 EST) (discussing which populations are included in calculation of how many Americans are uninsured).

7. *See* Arthur L. Kellermann, *Crisis in the Emergency Department*, 353 *NEW ENG. J. MED.* 1300, 1301–02 (2006) (describing inadequacy of existing emergency care system, arguing that Congress needs to act

President Barack Obama declared at the outset of his administration in January 2009 that health care reform was at the top of his domestic agenda.⁸ He aimed to persuade Congress to enact a major reform statute before the end of the year.⁹ Enjoying the potential support of a clear majority of Democrats in both the House of Representatives and the Senate, he challenged members of Congress to roll up their sleeves and get the job done.¹⁰

The year ended with two different bills adopted by the Senate and the House of Representatives but no newly enacted statute.¹¹ The debate about the wisdom of wholesale reform of the health care system continued into 2010. In January of 2010, a potentially disastrous bombshell exploded in the form of the election of a Republican senator to fill the vacant senatorial seat in Massachusetts that had been filled for four decades by the late Senator Edward Kennedy.¹² The special election deprived the Democratic Party of the sixtieth vote and a filibuster-proof supermajority in the Senate, and caused both the President and Congress to go back to the drawing boards on health care reform.¹³

The Democratic Party's loss of the Massachusetts senate seat caused both emotional and political harm to proponents of health reform. Emotionally, reformers had to absorb the unthinkable loss of a seat that belonged to an icon who had advocated universal health care since 1970.¹⁴ Practically, the loss meant that the Democrats could not stop the Republicans from filibustering the proposed health care reform statute. In the face of this emotional and political defeat, the Democrats adopted a strategy of passing the statute through a process known as reconciliation, which enabled the passage of a bill previously approved by both the Senate and the House of Representatives with a majority vote in each body, instead of a filibuster-proof sixty vote supermajority in the Senate.¹⁵ To hold together the majority vote, President

to fund emergency care by supporting development of coordinated, regionalized system). See also *infra* notes 102–09 and accompanying text for a discussion of the use and misuse of the emergency room and the hardships imposed on both patients and health care providers.

8. Scott Harris, *Despite Economy, Health Care Reform Still a Priority for President, Congress*, AAMC REP. (Am. Ass'n of Med. Colls.) Jan. 2009, available at https://www.aamc.org/newsroom/reporter/jan09/80214/jan09_reform.html.

9. David M. Herszenhorn & Robert Pear, *Obama Pushing, but Early Vote on Health Fades*, N.Y. TIMES, July 21, 2009, at A1.

10. See generally Address Before a Joint Session of the Congress on Health Care Reform, DAILY COMP. PRES. DOC. NO. DCPD200900693 (Sept. 9, 2009), <http://www.gpo.gov/fdsys/pkg/DCPD-200900693/pdf/DCPD-200900693.pdf>.

11. See Robert Pear, *Senate Approves Health Care Bill in Party-Line Vote*, N.Y. TIMES, Dec. 25, 2009, at A1 (discussing passage of different bills and work still to be done to make health care reform law).

12. Michael Cooper, *G.O.P. Senate Victory Stuns Democrats*, NYTIMES.COM, Jan. 20, 2010, <http://www.nytimes.com/2010/01/21/us/politics/21elect.html>.

13. *Id.*

14. When the health care reform act was finally passed, Senator Kennedy's son, Representative Patrick J. Kennedy of Rhode Island, attended the signing ceremony and gave President Obama a copy of a bill his father introduced in 1970 to establish national health insurance. Sheryl Gay Stolberg & Robert Pear, *Obama Signs Health Care Overhaul Bill, with a Flourish*, NYTIMES.COM, Mar. 23, 2010, <http://www.nytimes.com/2010/03/24/health/policy/24health.html>.

15. For a helpful discussion of the budget reconciliation procedure, see David M. Herszenhorn, *Budget Reconciliation: Overview*, NYTIMES.COM, Apr. 6, 2010, <http://www.nytimes.com/info/budget-reconciliation->

Obama and the Democratic leadership in Congress swung into action, making adjustments in the bill to satisfy a wide variety of interest groups.¹⁶ In the end the Democrats succeeded in passing the Patient Protection and Affordable Care Act,¹⁷ the first major health care reform bill in the United States in fifty years,¹⁸ precipitating jubilant celebration from many supporters of reform¹⁹ and bitter protest from opponents of health care reform. The responses to the passage of the health reform statute revealed even deeper divisions among politicians and citizens than had surfaced during the year-long debate, as reflected in threatening words and rude conduct on the part of opponents of the bill.²⁰ An examination of a nation's health care system exposes its values and its soul. An honest assessment requires that the investigator shine a light in dark places in the United States; the light reveals humans suffering physically and economically, with medical bankruptcies constituting 46.2% of all bankruptcies.²¹ A threshold issue is whether the majority of members living in a democratic and capitalist country are willing to make the personal economic sacrifices necessary to guarantee a minimum level of health and health care to all members of the community. As Judge Calabresi has observed, the private market often hides individual tragedies or at least confines their appearance to spaces that allow private citizens to avoid feeling responsible for their existence, while the political process exposes the tragedies in a way that makes them difficult to ignore.²² When an individual tragedy catches media

us-congress/ and THE BUDGET RECONCILIATION PROCESS, U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON RULES MAJORITY OFFICE, http://www.rules.house.gov/archives/bud_rec_proc.htm (last visited May 17, 2010).

16. The fight over payments for abortion procedures and Medicare payment rates garnered a great deal of controversy. David M. Herszenhorn & Robert Pear, *Democrats Woo Abortion Foes in Push for Health Bill*, NYTIMES.COM, Mar. 19, 2010, <http://www.nytimes.com/2010/03/20/us/politics/20health.htm>.

17. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119; Stolberg & Pear, *supra* note 14; David M. Herszenhorn & Robert Pear, *Final Votes in Congress Cap Battle on Health*, N.Y. TIMES, Mar. 26, 2010, at A17.

18. The last major overhaul of the U.S. health care system occurred in 1965 with the amendment of the Social Security Act, extending insurance coverage to seniors over the age of sixty-five under the popular name of Medicare. Social Security Act of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified at 42 U.S.C. § 1395 (2006)).

19. Some who favored major health care reform expressed disappointment that the bill that passed did not go far enough in addressing the core problems of our health care system such as the excessive administrative costs associated with multiple insurers or the skyrocketing costs of health care delivery. *See, e.g.,* Matthew Rothschild, *Victory for a Mediocre Health Care Bill*, THE PROGRESSIVE, Mar. 22, 2010, <http://www.progressive.org/wx032210.html> (critiquing lack of public option, lack of federal limits on insurance industry pay hikes, and failure to remove health insurers' anti-trust exemption); Posting of Bob Samuels to THE HUFFINGTON POST, http://www.huffingtonpost.com/bob-samuels/the-progressive-case-again_b_508473.html (Mar. 22, 2010, 13:26 EST) (stating that failure to effectively reduce costs while mandating purchase of private insurance is "major problem" with bill).

20. The aftermath of the passage of the bill included racial epithets and threats as well as acts of vandalism aimed at Congressmen who voted in favor of the health reform statute. *See* Michael Cooper, *Accusations Fly Between Parties Over Threats and Vandalism*, N.Y. TIMES, Mar. 26, 2010, at A11 (reporting on acts of vandalism against relatives of New York congressman because of his vote for health care bill); Courtland Milloy, *Amid a Sea of Disrespect, Congressmen Exhibit Grace, Restraint*, WASH. POST, Mar. 24, 2010, at B1 (describing incident where protesters hurled hurtful invective at congressmen).

21. David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 741 (2009).

22. GUIDO CALABRESI & PHILIP BOBBITT, TRAGIC CHOICES 39 (1978). Calabresi and Bobbitt assert:

attention—for example, a person dies from cancer because the insurance company denies coverage—we respond with help or at least moral outrage, declaring that each life is priceless.²³ However, if someone proposes universal access to health care so that no one delays getting an examination that could detect the cancer at an early stage, many Americans vote against it.²⁴ They reject universal access that may provide preventive care²⁵ and choose instead to rely on a law that demands that hospitals provide universal access through their emergency rooms, shifting the cost to hospitals and keeping stories of people who die from lack of access to care out of public view.²⁶ Studies of the American health system in comparison to the health systems of other developed nations consistently find the American system near the bottom in terms of cost and effectiveness.²⁷ Yet, Americans—at least those who seek to make a rational

If the political process refuses to provide a group such as the aged with hemodialysis, the clear assertion has been made that some lives are not worth saving. To the extent that our lives and institutions depend on the notion that life is beyond price, such a refusal to save lives is horribly costly.

Id.

23. *See id.* at 39–40 (suggesting existence of market “defect” where valuation of individual life depends on immediacy and obviousness of risk).

24. *See* Petition2Congress.com, Vote No on Universal Health Care Legislation Now, <http://www.rallycongress.com/2/2159/please-vote-no-on-universal-health-care-legislation/> (last visited Mar. 2, 2011) (providing form for citizens to petition legislators to “vote no” on health care bill and claiming over 29,000 petitions sent).

25. While many Americans assert that they want everyone to have access to health care, the political process consistently drives those expressed preferences underground. *See* CALABRESI & BOBBITT, *supra* note 22, at 38–39 (arguing that social empathy to individual suffering caused by government policies is reduced because of lack of immediately obvious connection). The Clinton attempt at health care reform is an example of this conflict. *See* THEDA SKOCPOL, BOOMERANG: HEALTH CARE REFORM AND THE TURN AGAINST GOVERNMENT 9–18 (1996) (tracing reasons for failure of Clinton health care plan); Robert J. Landry, III & Amy K. Yarbrough, *Global Lessons from Consumer Bankruptcy and Healthcare Reforms in the United States: A Struggling Social Safety Net*, 16 MICH. ST. J. INT’L L. 343, 362–64 (2007) (discussing Clinton-era health care reform failure). *See generally* Manish C. Shah & Judith M. Rosenberg, *Health Care Reform in the 103D Congress—A Congressional Analysis*, 33 HARV. J. ON LEGIS. 585 (1996) (chronicling political history of Clinton attempt at health care reform).

26. A small percentage of the cases come to public view because the failure to give care is so indefensible that it shocks the conscience and attracts media attention. *See, e.g.,* Tom Avril, *Executive: Hospital Ignored Policy in Rivera Death*, PHILA. INQUIRER, Feb. 3, 2010, at B1 (recounting how patient walked into waiting room with chest pain, then died in waiting room after not having been seen more than eighteen minutes later). Three comprehensive studies supported by the Institute of Medicine underscore the fact that avoidable deaths in the emergency room occur all too often. *See* BD. ON HEALTH CARE SERVS., INST. OF MED., HOSPITAL BASED EMERGENCY CARE: AT THE BREAKING POINT 19 (2007), *available at* http://books.nap.edu/openbook.php?record_id=11621 (explaining widespread problem of hospital overcrowding); BD. ON HEALTH CARE SERVS., INST. OF MED., EMERGENCY MEDICAL SERVICES AT THE CROSSROADS (2007), *available at* http://books.nap.edu/openbook.php?record_id=11629 (outlining numerous problems EMS systems face including costs, personnel, and oversight); BD. ON HEALTH CARE SERVS., INST. OF MED., EMERGENCY CARE FOR CHILDREN: GROWING PAINS (2007), *available at* http://books.nap.edu/openbook.php?record_id=11655 (introducing issues faced in providing emergency pediatric care). For a thoughtful analysis of these reports, see Kellermann, *supra* note 7, at 1300.

27. A recent book by a noted scholar who has devoted his career to studying the American health care system notes:

[A]ny report card rating the United States to 28 other developed countries it competes with, both diplomatically and in the market place, would put us near the bottom of the class. In 1960, we ranked 14th in the world in life expectancy at birth and in 2005 our rank on this measure had fallen

decision—must be defending the present system on the basis of a political, social, or moral philosophy.²⁸ If that is the basis of the defense of the existing system, proponents of health care reform must engage in the debate on the basis of political, social, and moral values.²⁹ Focusing the debate primarily on costs, without a link to other values, leads inevitably to confusion or a sense of helplessness.

The present Essay highlights the basic issues of social justice³⁰ and morality³¹ at stake as we respond to health care reform proposals that are likely to either reduce or exacerbate existing health disparities among various groups in our communities. The critical value at stake is basic human dignity, and the question is whether we are prepared to protect and promote that value on a basis of equality and affordability. Human dignity is jeopardized by any system that produces a gross disparity in the distribution of a good essential to human survival.

II. HEALTH, POLITICS, AND RACE

The year-long national debate in 2009 on the need to reform the U.S. health care system largely ignored the disparities in health and health care among Americans in terms of race, ethnicity, and gender. By ignoring these disparities we lost an opportunity to advance our understanding of the causes of disparities and to energize a political will to do something about them. It is true that the health care reform debate revealed some heartbreaking stories of individuals who suffered or died because an insurance company determined their proposed treatment was not covered by their insurance policy.³² However, the debate about the disparate impact of the existing

to a dismal 24th. . . . [P]remature mortality . . . [in] the United States ranks 27th for women and 24th for men among these 28 nations. A combination of higher rates of infant mortality, homicide and death from accidents contribute to this poor showing. . . . [In most countries,] the amount of money expended per capita on healthcare correlates with better health and life expectancy. . . . [H]owever, the United States is the lonely outlier, spending more and getting much less in return.

DAVID BARTON SMITH, *THE FORENSIC CASE FILES* 4 (2010).

28. See, e.g., Andrea Seabrook, *At Capitol, Tea Party Groups Protest Health Care Bill*, NPR, Dec. 15, 2009, <http://www.npr.org/templates/story/story.php?storyId=121480824> (describing Tea Party protest on Capitol over “government control” of health care); Tea Party Patriots Mission Statement and Core Values, <http://teapartypatriots.org/Mission.aspx> (last visited Mar. 2, 2011) (describing mission of organization as protecting fiscal responsibility and constitutionally limited government).

29. See generally GEORGE LAKOFF, *MORAL POLITICS: HOW LIBERALS AND CONSERVATIVES THINK* (2002) (arguing that George W. Bush was elected President because Republican Party became much more adept than Democratic Party in framing their arguments in moral terms).

30. The difference principle articulated by John Rawls in *A Theory of Justice* provides an appropriate standard for judging our collective decision making about who gets access to health care. “Social and economic inequalities are to be arranged so that they are both: (a) to the greatest benefit of the least advantaged . . . and (b) attached to offices and positions open to all under conditions of fair equality of opportunity.” JOHN RAWLS, *A THEORY OF JUSTICE* 302 (1973); see also Samuel Freeman, *Original Position*, in *THE STANFORD ENCYCLOPEDIA OF PHILOSOPHY* (Edward N. Zalta et al. eds., rev. ed. 2010), <http://plato.stanford.edu/archives/spr2009/entries/original-position> (discussing Rawls’s theory of “justice as fairness”).

31. RAWLS, *supra* note 30, at 265; see also Norman Daniels, *Rights to Health Care and Distributive Justice: Programmatic Worries*, 4 *J. MED. & PHIL.* 174, 181–90 (1979) (arguing health care should be treated as primary right in Rawls’s framework).

32. The law provides many disturbing examples of the results of denial of health care to individuals. See, e.g., *Wilson v. Blue Cross*, 271 Cal. Rptr. 876, 877–78 (Cal. Ct. App. 1990) (describing how man committed suicide after hospital discharged him from psychiatric treatment because insurer said his policy only covered

health care system on the middle class and poor usually went no further than an acknowledgement that more than forty-six million people do not have health insurance.³³ The public did not benefit from a serious debate about why particular groups face disproportionate barriers to obtaining health insurance coverage or why they bear disproportionate burdens of poor health. For example, the hearings before the Senate Finance Committee on health insurance reform proposals received widespread media attention,³⁴ while hearings conducted at the same time before several congressional committees on racial disparities and health disparities related to breast cancer went virtually unnoticed by the press.³⁵ While it is understandable that coverage of the risks and impact of a major medical problem facing all women received considerable coverage in the health care debate, that does not explain why racial disparities among women did not warrant special public concern. The failure of Congress and the media to highlight racial health disparities as critical social, economic, and moral problems is particularly disturbing in light of well-known studies documenting these health disparities.³⁶

As Dr. Calvin Johnson has observed in a poignant essay in this symposium issue of the *Temple Law Review*,³⁷ multiple self-interested stakeholders who seek to protect a variety of interests consistently erect barriers to meaningful health care reform.³⁸ In my view, two widely reported statements made in the first year of the Obama administration—one by an administrative official and the other by a private citizen—provide insights toward understanding why reforming the U.S. health care system remains a daunting challenge, even to a popular president who has a majority of his

ten days of treatment); *Wickline v. State*, 239 Cal. Rptr. 810, 813–17 (Cal. Ct. App. 1986) (describing how woman lost her leg from infection after hospital discharged her notwithstanding her physician's declaration that it was medically necessary for her to stay in hospital for eight more days; discharge was made because insurance company refused surgeon's request for longer stay for observation and treatment); see also Tom Gorman, *Jury Adds \$77 Million Against HMO That Denied Coverage*, L.A. TIMES, Dec. 29, 1993, at A1 (describing how insurance company denied breast cancer patient's bone marrow transplant, deeming it experimental, resulting in patient's death).

33. DENAVAS-WALT ET AL., *supra* note 6, at 20; see also OMB Blog, *supra* note 6 (discussing which populations are included in calculation of how many Americans are uninsured).

34. See Robert Pear & David M. Herszenhorn, *A Senate Health Bill Gains with One Republican Vote*, N.Y. TIMES, Oct. 14, 2009, at A1 (discussing Senate Finance Committee's approval of health care legislation in October 2009); Donna Smith & John Whitesides, *Senate Health Bill Costs Pegged at \$829 Billion*, REUTERS, Oct. 7, 2009, <http://www.reuters.com/article/idUSN0749607120091007> (discussing costs of health care bill); *Senate Panel Passes Democratic Health Bill*, NPR.ORG, Oct. 13, 2009, <http://www.npr.org/templates/story/story.php?storyId=113743803> (discussing health care bill).

35. See *Breast Cancer Legislation: Hearing on H.R. 995, H.R. 1691, H.R. 1740, and H.R. 2279 Before the H. Subcomm. on Health*, 111th Cong. 23–24 (2009) (comments of Rep. Kathy Castor, Member, H. Comm. on Energy and Commerce), http://energycommerce.house.gov/Press_111/20091016/transcript_20091007.he.pdf (preliminary transcript) (reporting on problem of disparate treatment and diagnosis of breast cancer, particularly in African American women).

36. See *infra* notes 66–82 and accompanying text for a discussion of studies demonstrating health disparities among different races.

37. Calvin Johnson, *Health Care Reform, the Law, and Eliminating Disparities*, 82 TEMP. L. REV. 1137 (2010).

38. *Id.* at 1138. For example, the antiabortion lobby exerted consistent pressure to block any health care reform that allowed abortion funding. See George J. Annas, *Abortion Politics and Health Insurance Reform*, 361 NEW ENG. J. MED. 2589, 2589–90 (2009) (discussing current state of law on funding for abortions and antiabortion amendments attached to health care reform legislation).

party in both houses of the legislature. First, in a speech to the staff of the U.S. Justice Department in February 2009 during Black History Month, Attorney General Eric Holder, the first African American United States Attorney General observed: “[t]hough this nation has proudly thought of itself as an ethnic melting pot, in things racial we have always been and continue to be, in too many ways, essentially a nation of cowards.”³⁹ Mr. Holder was simply saying Americans are afraid to talk about race.⁴⁰

Another statement came from a citizen at a town meeting of participants offering reactions to pending proposals for national health reform. He screamed at the Congressman, “[K]eep your government hands off my Medicare.”⁴¹ On the surface this statement expresses a traditional, limited-government philosophy disconnected from Mr. Holder’s observation about race. However, if we peel one layer and contextualize the statement, the relevance to race becomes evident. The exercise of power by the federal government provokes resentment for a variety of reasons, often having nothing to do with group status or prejudice. However, race-conscious efforts to redistribute resources produce special resistance and anger as reflected in reactions in the South and the North to judicial orders compelling desegregation of public schools.⁴² The Supreme Court’s declaration in *Brown v. Board of Education*⁴³ that racially segregated schools violate the equal protection of the laws guaranteed by the Fourteenth Amendment of the U.S. Constitution evoked emotional cries from opponents for the government to keep its hands off of their schools.⁴⁴ The same resistance erupted in response to government-backed affirmative action programs.⁴⁵ While not all of the outsiders trying to get into the health care system are people of color, a disproportionate number are,⁴⁶

39. Eric Holder, Att’y Gen., Remarks at the Department of Justice African American History Month Program (Feb. 18, 2009), <http://www.justice.gov/ag/speeches/2009/ag-speech-090218.html>.

40. Holder continues to explain what he means:

Though race related issues continue to occupy a significant portion of our political discussion, and though there remain many unresolved racial issues in this nation, we, average Americans, simply do not talk enough with each other about race. It is an issue we have never been at ease with and given our nation’s history this is in some ways understandable.

Id.

41. See Paul Krugman, Op-Ed., *Health Care Realities*, N.Y. TIMES, July 31, 2009, at A23 (quoting unidentified man at town-hall meeting); Philip Rucker, *S.C. Senator Is a Voice of Reform Opposition – DeMint a Champion of Conservatives*, WASH. POST, July 28, 2009, at A1 (reporting same quote) Posting of Matthew Continetti to WeeklyStandard.com Blog, *Hands Off My Medicare*, http://www.weeklystandard.com/weblogs/TWSFP/2009/08/hands_off_my_medicare_1.asp (Aug. 17, 2009, 14:39) (repeating same quote).

42. See generally FRANCES LISA BAER, *RESISTANCE TO PUBLIC SCHOOL DESEGREGATION: LITTLE ROCK, ARKANSAS, AND BEYOND* (2008); RICHARD KLUGER, *SIMPLE JUSTICE: THE HISTORY OF BROWN V. BOARD OF EDUCATION AND BLACK AMERICA’S STRUGGLE FOR EQUALITY* (1975).

43. 347 U.S. 483 (1954).

44. KLUGER, *supra* note 42.

45. See, e.g., *Grutter v. Bollinger*, 539 U.S. 306, 317 (2003) (challenging law school’s affirmative action policy as violating Fourteenth Amendment); *Regents of the Univ. of Cal. v. Bakke*, 438 U.S. 265, 269–70 (1978) (challenging medical school’s affirmative action policy as violating Equal Protection Clause of Fourteenth Amendment). See generally *REALIZING BAKKE’S LEGACY: AFFIRMATIVE ACTION, EQUAL OPPORTUNITY, AND ACCESS TO HIGHER EDUCATION* (Patricia Marin & Catherine L. Horn eds., 2008); FRED L. PINCUS, *REVERSE DISCRIMINATION: DISMANTLING THE MYTH* (2003).

46. See, e.g., Posting of Tom Hester Sr. to Newjerseynewsroom.com, <http://www.newjerseynewsroom.com/healthquest/study-minorities-would-benefit-from-health-care-reform> (July 15, 2009, 13:59 EST)

and the anger that surfaces particularly toward extending coverage to undocumented workers stops just short of express references to race.⁴⁷

Both the “keep your government hands off” and the “nation of cowards” statements evoked contentious reactions from the public. Attorney General Holder’s statement directly raised the issue of race, and the controversy that followed was perhaps to be expected. Much of it focused on the use of the word “cowards.”⁴⁸ The other statement made top ten lists for quotes of the year.⁴⁹ Because Medicare is a government program,⁵⁰ the response of the legislator who was conducting the town hall meeting was one of puzzlement.⁵¹ It is difficult to determine how the government could keep its hands off of its own program. The protester obviously had no appreciation that he was the beneficiary of a government program enacted to ensure that all senior citizens have access to health care, and that for that reason his assertion was ludicrous. Subject to more serious scrutiny, the town hall encounter reveals troublesome ideas, emotions, and values that serve as barriers to promoting health equity. At its core, the exchange shows that citizens are willing to oppose governmental action aimed at relieving the suffering of millions of fellow citizens and to do so based on almost no understanding of what the government is attempting to do, or is in fact currently doing for the benefit of the speaker.

As David Blight has shown in his illuminating book exploring the history of political reconciliation between the South and the North after the Civil War, at least since the resolution of the Civil War, Americans have struggled with the need to use governmental power to promote equal access to goods and services to all citizens regardless of race, and a desire to keep a racially diverse nation united.⁵² The default position of “benign neglect”⁵³ continues to drive many governmental officials and politicians, except when social or economic turmoil dictates otherwise.⁵⁴

(explaining how flaws in current health care system disproportionately hurt minorities and how proposed legislation would affirmatively seek to erase disparities).

47. See, e.g., William March, *Experts: Health Reform Anger Stems from Racism, Partisanship*, TAMPA TRIB., Aug. 17, 2009, <http://www2.tbo.com/content/2009/aug/17/experts-health-reform-anger-stems-racism-partisans/news-politics/> (discussing how submerged—as opposed to overt—racism affects level of trust in “Obama’s presidency in general and the health care proposal in particular”).

48. See, e.g., Ed Hornick, *Holder ‘Nation of Cowards’ Remarks Blasted, Praised*, CNN.COM, Feb. 19, 2009, <http://www.cnn.com/2009/POLITICS/02/19/holder.folo/> (presenting remarks from commentators regarding Holder’s description of Americans as “cowards”); Posting of Michelle Levi to CBS NEWS.COM, http://www.cbsnews.com/8301-503544_162-4813418-503544.html (Feb. 19, 2009, 14:43) (describing conservatives’ negative reaction to Holder’s comments).

49. John Christoffersen, *‘Keep Your Government Hands Off My Medicare’ Tops Yale List of Year’s Most Memorable Quotes*, WASH. EXAMINER, Dec. 16, 2009.

50. See 42 U.S.C. § 426 (2006) (establishing Medicare as government program). See generally Medicare.gov: The Official U.S. Government Site for Medicare, <http://www.medicare.gov/default.aspx> (last visited Mar. 2, 2011).

51. Krugman, *supra* note 41 (describing Representative Inglis’s response to statement “keep your government hands off my Medicare”).

52. See DAVID W. BLIGHT, *RACE AND REUNION: THE CIVIL WAR IN AMERICAN MEMORY* 30–38 (2002) (describing how America suppressed pursuit of racial equality and justice, allowing South to create myth of how it had been unjustly invaded by North, in order to reunite country after Civil War ended).

53. Daniel Moynihan’s use of this phrase in 1970 to describe a preferred strategy to deal with the civil rights debate during the post civil rights era provoked many concerned responses from many social commentators. See, e.g., “Benign Neglect” Proposed, 77 *CRISIS* 156, 156 (1970) (decrying Moynihan’s

History has proved that racism is too volatile and resilient to die from periodic doses of benign neglect. Yet, apparently succumbing to the realities of national politics, the Obama administration has opted for the benign racial neglect sedative in its effort to achieve health care reform. Idealism may drive a candidate for national office, but pragmatism takes over after election.

III. TEMPLE UNIVERSITY CONFERENCE ON HEALTH DISPARITIES

On November 13, 2009, a group of panelists and participants met in Philadelphia for a conference entitled “Health Disparities, Financing, and the Law: From Concept to Action,” hosted by Temple University’s Center for Health Law, Policy and Practice, and sponsored in part by the Temple Law Review. This issue of the *Temple Law Review* presents some of the ideas explored and concerns expressed at that conference. The panelists agreed that insurance reform represented an important first step in addressing health disparities. However, many argued that if Congress does no more than reform health insurance coverage, the impact on existing health disparities would be far less than needed. Multiple factors contribute to disparities among racial, ethnic, and economic groups, and the adoption of effective remedies requires an in-depth analysis of complex issues, followed by bold action to confront deeply rooted social and economic problems. The speakers at the conference described important programs and policies that demonstrate the importance of reexamining the impact of race and racism, and the role of government in promoting equality. This examination is necessary to develop and implement effective policies and practices narrowly tailored to reduce health disparities in a nation that remains racially segregated and economically stratified.⁵⁵

The articles presented in this symposium issue highlight some of the dangers of relying on a colorblind approach to health care reform if the ultimate goal is to reduce health disparities and support a system that promotes health equity among all citizens and residents. The essays and articles provide illuminating perspectives and solid evidence demonstrating the benefits that flow from facing directly the racial disparities in health that challenge the health of citizens and the nation in the 21st century.

Dr. Calvin Johnson observes how important it is to take the first step toward health care reform, even if the initial reform may be limited to insurance coverage, leaving substantial work to be done to address the other sources of disparities.⁵⁶

strategy as calculated effort “to wipe out all the civil rights gains made in the 1950s and 1960s”); Richard L. Marcus, *Benign Neglect Reconsidered*, 148 U. PA. L. REV. 2009, 2009–10 (2000) (discussing controversy surrounding Moynihan’s use of phrase “benign neglect”); see also Adam Clymer, *Daniel Patrick Moynihan, Scholar Who Turned Statesman, Is Dead at 76*, N.Y. TIMES, Mar. 27, 2003, at A1 (discussing Moynihan’s life and legacy).

54. President Barack Obama has tried to stay clear of the race issue both during his campaign and after taking office, but has on two notable occasions found it necessary to address the race issue directly. Barack Obama, President, Prime Time News Conference (July 22, 2009) (transcript available at <http://www.cbsnews.com/stories/2009/07/23/politics/main5182101.shtml?tag=contentMain;contentBody>); Barack Obama, U.S. Senator, A More Perfect Union, Remarks at the National Constitution Center, Philadelphia, PA (Mar. 18, 2008) (transcript available at <http://www.npr.org/templates/story/story.php?storyId=88478467>).

55. For more information about the symposium and panelists’ presentations, see generally TU Law: Health Disparities Conference, <http://www.temple.edu/lawschool/healthdisp/> (last visited Mar. 2, 2011).

56. See generally Johnson, *supra* note 37.

Michael Campbell points out the importance of consciously assessing the impact that specific reforms may have on racial disparities, lest we reap unintended consequences that aggravate, rather than reduce, disparities.⁵⁷ Ruqaiyah Yearby reviews evidence showing the unequal care in nursing homes based on race, a critical problem that promises to grow even worse as baby boomers become seniors in need of care.⁵⁸ Tine Hansen-Turton, Jamie Ware, and I document the shortage of health care providers and the need to enact laws and create an environment that encourages the growth of nurse practitioners who can fill the primary care gap.⁵⁹ Scott Burris, Evan D. Anderson, Ave Craigg, Corey S. Davis, and Patricia Case discuss the positive effects of syringe access and the current barriers to such access.⁶⁰ Finally, Ronda Goldfein challenges us to rethink the use of traditional remedies and creatively pursue new approaches that do not depend upon changing the hearts and minds of individuals bent on maintaining and acting upon negative stereotypes.⁶¹

The present Essay highlights some of the important findings that have emerged from studies of health disparities in the United States. Using these studies I explore the connections between race, health reform, political power, and morality. I then consider philosophical and political barriers to developing effective remedies and suggest some strategies for reducing or eliminating the barriers to promoting equitable access to health care and improvement of health status. I contend that the benefits of acknowledging that race and racism are important factors contributing to health disparities far outweigh the costs of ignoring those factors. By facing them we can develop and apply remedies tailored to promote health equity.⁶² By ignoring race and racism as factors contributing to inequities we allow forces damaging to health to fester and damage individuals and communities in a way that makes it more difficult to develop effective cures for the underlying diseases.⁶³

My analysis has led me to the conclusion that a declaration from the President and Congress that access to health care in the United States is a human right is an important first step in breaking down the barriers to critical health care reform.⁶⁴ I do not argue

57. See generally Michael Campbell, *Did I Do That?: An Argument for Requiring Pennsylvania to Evaluate the Racial Impact of Medicaid Policy Decisions Prior to Implementation*, 82 TEMP. L. REV. 1163 (2010).

58. See generally Ruqaiyah Yearby, *African Americans Can't Win, Break Even, or Get Out of the System: The Persistence of "Unequal Treatment" in Nursing Home Care in Post-Racial America*, 82 TEMP. L. REV. 1177 (2010).

59. See generally Tine Hansen-Turton et al., *Nurse Practitioners in Primary Care*, 82 TEMP. L. REV. 1235 (2010).

60. See generally Scott Burris et al., *Racial Disparities in Injection-Related HIV: A Case Study of Toxic Law*, 82 TEMP. L. REV. 1263 (2010).

61. See generally Ronda Goldfein, *From the Streets of Philadelphia: The AIDS Law Project of Pennsylvania's How-To Primer on Mitigating Health Disparities*, 82 TEMP. L. REV. 1205 (2010).

62. See for example the careful analyses of remedies called for in the articles by Campbell, *supra* note 57; Goldfein, *supra* note 61; and Yearby, *supra* note 58.

63. See generally HARLON L. DALTON, *RACIAL HEALING* (1995) (arguing that honest and open discussions of race are critical to solving racial problems).

64. South Africa guarantees a right to health care.

(1) Everyone has the right to have access to –

(a) health care services, including reproductive health care;

(b) sufficient food and water; and

that recognition of a right to health care as a human right will translate to realization of that right. Clearly many factors influence health, and access to care is just a first step. However, I contend that leadership is needed to prioritize health and health care as one of the highest values that must be pursued and protected by our government, so that the question becomes how we achieve the goal, and not whether the goal is a legitimate objective of our national government. In other words, a declaration of health as a human right would provide our country with the appropriate moral compass to guide our future decision making about health and health care, just as declarations that all men are created equal, or that each person is entitled to due process or freedom of speech provide standards and guidance. Such declarations provide a vision of a society and standards by which to judge governmental exercise of power.⁶⁵ The way to clarification of values requires first that we face the facts about disparities. The next section offers some of the basic facts about health disparities.

IV. EVIDENCE OF RACIAL DISPARITIES IN HEALTH IN THE UNITED STATES

Alarming evidence of health disparities based on race has been accumulated over the past three decades.⁶⁶ People of color in general, and African Americans in particular, do considerably worse than white Americans when one considers issues relating to insurance coverage,⁶⁷ health care access,⁶⁸ quality of care provided after gaining access,⁶⁹ and general quality of life. The same negative effect holds true for

(c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

S. AFR. CONST. 1996 ch. 2, § 27, *reprinted in* 17 CONSTITUTIONS OF THE COUNTRIES OF THE WORLD 17 (Gisbert H. Flanz ed., 2004), *available at* <http://www.info.gov.za/documents/constitution/1996/a108-96.pdf>; *see also* Universal Declaration of Human Rights, G.A. Res. 217A, ¶ 76, U.N. GAOR, 3d Sess., 183d plen. mtg., U.N. Doc. A/810 (Dec. 10, 1948) (recognizing right to medical care); AM. MED. ASS'N, CODE OF MEDICAL ETHICS § 2.03 (2008), *available at* <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.shtml> (stating ability to pay should not be factor considered in allocating medical resources); ELIZABETH WICKS, HUMAN RIGHTS AND HEALTHCARE 17–36 (2007) (discussing health care as human right and government's duty to provide treatment in United Kingdom).

65. In their book discussing the choices societies make in the allocation of resources, Calabresi and Bobbitt assert:

We cannot know why the world suffers. But we can know how the world decides that suffering shall come to some persons and not to others. . . . [I]t is by the values that are foregone no less than by those that are preserved at tremendous cost that we know a society's character.

CALABRESI & BOBBITT, *supra* note 22, at 17.

66. COMM. ON UNDERSTANDING & ELIMINATING RACIAL & ETHNIC DISPARITIES IN HEALTH CARE, INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 5 (Brian D. Smedley et al. eds., 2002), *available at* http://books.nap.edu/openbook.php?record_id=12875.

67. E. RICHARD BROWN ET AL., RACIAL AND ETHNIC DISPARITIES IN ACCESS TO HEALTH INSURANCE AND HEALTH CARE, at xi (2000), *available at* <http://www.escholarship.org/uc/item/4sf0p1st.pdf>.

68. *Id.* at xi–xii.

69. *See* COMM. ON UNDERSTANDING & ELIMINATING RACIAL & ETHNIC DISPARITIES IN HEALTH CARE, *supra* note 66, at 8–10 (suggesting racial and ethnic biases, stereotypes, and prejudices may affect doctors' decisions when providing care for certain patients).

statistics describing average life expectancy,⁷⁰ infant mortality,⁷¹ cancer care,⁷² AIDS/HIV infections,⁷³ arthritis,⁷⁴ and many other conditions. A recent article describing health disparities in hip and joint replacements adds to the mountain of accumulated evidence that the race of individuals has a significant effect on future health projections.⁷⁵ Yet, the evidence of health disparities based on race produces neither national alarm nor a national consensus that we as a country have a moral obligation do something about the disparities.

The seminal 2002 report of the Institute of Medicine on health disparities highlighted some disturbing findings:

Evidence of racial and ethnic disparities in healthcare is, with few exceptions, remarkably consistent across a range of illnesses and healthcare services. These disparities are associated with socioeconomic differences and tend to diminish significantly, and in a few cases, disappear altogether when socioeconomic factors are controlled. The majority of studies, however, find that racial and ethnic disparities remain even after adjustment for socioeconomic differences and other healthcare access-related factors.⁷⁶

As Justice Blackmun observed in *Regents of the University of California v. Bakke*,⁷⁷ a decision limiting state affirmative action efforts to correct racial disparities in education, colorblind jurisprudence will not always advance equality.⁷⁸ Justice Blackmun admonished the proponents of colorblind jurisprudence: "In order to get beyond racism, we must first take account of race. There is no other way."⁷⁹ Justice Sandra Day O'Connor echoed this sentiment in *Grutter v. Bollinger*,⁸⁰ as she reflected on the question of whether active pursuit of diversity in a university qualifies as a

70. David Satcher et al., *What If We Were Equal? A Comparison of the Black-White Mortality Gap in 1960 and 2000*, 24 HEALTH AFF. 459, 459–64 (2005). Satcher et al. state:

We examined trends in black-white standardized mortality ratios (SMRs) for each age-sex group from 1960 to 2000. The black-white gap measured by SMR changed very little between 1960 and 2000 and actually worsened for infants and for African American men age thirty-five and older. In contrast, SMR improved in African American women. Using 2002 data, an estimated 83,570 excess deaths each year could be prevented in the United States if this black-white mortality gap could be eliminated.

Id. at 459.

71. W. Parker Frisbie et al., *The Increasing Racial Disparity in Infant Mortality: Respiratory Distress Syndrome and Other Causes*, 41 DEMOGRAPHY 773, 773 (2004).

72. COMM. ON UNDERSTANDING & ELIMINATING RACIAL & ETHNIC DISPARITIES IN HEALTH CARE, *supra* note 66, at 42–46.

73. *Id.* at 48.

74. Jeffrey J. Sacks et al., *Deaths from Arthritis and Other Rheumatic Conditions, United States, 1979–1998*, 31 J. RHEUMATOLOGY 1823, 1824 (2004).

75. Said A. Ibrahim, *Racial and Ethnic Disparities in Hip and Knee Joint Replacement: A Review of Research in the Veterans Affairs Health Care System*, 15 J. AM. ACAD. ORTHOPEDIC SURGERY S87, S87 (Supp. 2007).

76. COMM. ON UNDERSTANDING & ELIMINATING RACIAL & ETHNIC DISPARITIES IN HEALTH CARE, *supra* note 66, at 5.

77. 438 U.S. 265 (1978).

78. *Bakke*, 438 U.S. at 407 (opinion of Blackmun, J.).

79. *Id.*

80. 539 U.S. 306 (2003).

compelling governmental interest and observed that in our society “race unfortunately still matters.”⁸¹

Studies demonstrate that people of color have worse health, even if they are not poor. The 2006 *National Healthcare Disparities Report* offers a foundation for understanding the causes of the disparities and proposes solutions.⁸² There is nothing about “benign neglect” that offers hope to those who regard reducing disparities as a critical priority of our society, other than a blind faith that remedial measures that benefit whites will also offer the same benefit to people of color. History does not support this faith. As the articles in this symposium indicate, with substantial support in the literature, we ignore the racial effects of health reform policies at the peril of the people who need health reform the most.

V. HEALTH CARE, RACE, AND CLASS: THE FUNDAMENTAL QUESTIONS OF MORALITY, ETHICS, AND SOCIAL JUSTICE

Medical studies are now starting to document the health impact of continuous small adversities on the people who endure them. A recent documentary titled *Unnatural Causes* highlighted a study in the city of Houston that enabled scientists to predict health based on a person’s zip code.⁸³ In light of the racially segregated living patterns, researchers are able to correlate the health disparities not only with economic class, but also race.⁸⁴ Theories now under exploration to explain the glaring disparities have honed in on the negative effects of stress. Noting that people of color suffer additional stress due to higher unemployment, violence in their neighborhoods, and environmental hazards, as well as the day-to-day affronts based on race,⁸⁵ researchers are testing the hypothesis that even when African Americans enjoy high income and professional jobs, racial discrimination, real or perceived, adds sufficient stress to their lives to take a toll on their physical health.⁸⁶

81. *Grutter*, 539 U.S. at 333. Justice O’Connor explained:

Just as growing up in a particular region or having particular professional experiences is likely to affect an individual’s views, so too is one’s own, unique experience of being a racial minority in a society, like our own, in which race unfortunately still matters. The Law School has determined, based on its experience and expertise, that a “critical mass” of underrepresented minorities is necessary to further its compelling interest in securing the educational benefits of a diverse student body.

Id.

82. See AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP’T OF HEALTH & HUMAN SERVS., NATIONAL HEALTHCARE DISPARITIES REPORT 2–16 (2006), available at <http://www.ahrq.gov/qual/nhdr06/nhdr06report.pdf> (finding disparities related to race, ethnicity, and socioeconomic status persist across quality, access, and type of care received, and suggesting “neighborhood solutions” are key to reducing these problems).

83. *Unnatural Causes* (California Newsreel 2008), available at <http://www.unnaturalcauses.org/>.

84. See Myron Orfield, *Land Use and Housing Policies to Reduce Concentrated Poverty and Racial Segregation*, 33 *FORDHAM URB. L.J.* 877, 883 (2006) (linking “huge health disparities” with racial segregation).

85. See *id.* at 880–83 (noting how racial discrimination in housing and lending leads to impoverished, racially segregated neighborhoods with host of problems for residents, including social isolation).

86. See Carolyn M. Sampselle, *Nickel-and-Dimed in America: Underserved, Understudied, and Underestimated*, *FAM. & COMMUNITY HEALTH*, Supp. 1 Jan.–Mar. 2007, at S4, S4 (noting negative health effects of discrimination, controlling for economic resources and access to health care).

Atul Gawande, a surgeon and bestselling author, candidly admits in his book titled *Complications* that medical care provided in hospitals in many instances reflects two standards, allowing the least experienced to learn and practice on the poor, while the well educated and wealthy insist on and receive care from the more experienced and accomplished practitioners.⁸⁷ After suggesting that people with education and resources insist on the most experienced doctors providing their care, Gawande states:

Conversely, the ward services and clinics where residents have the most responsibility are populated by the poor, the uninsured, the drunk, and the demented. Residents have few opportunities nowadays to operate independently, without the attending docs scrubbed in, but when we do—as we must before graduating and going out to operate on our own—it is generally on these, the humblest of patients.⁸⁸

The question raised by these common practices that reflect disparate treatment is whether a different quality of care is justified on moral, ethical, or social grounds. Morally, the existing practices challenge the notion that each human being is entitled to respect and dignity that is not dependent on his wealth.⁸⁹ Ethically, the medical profession claims to provide care based on medical need, and not based on judgments about the economic or social value of a patient.⁹⁰ Social justice theory of equality similarly would not seem to tolerate a deliberate practice that provides the best quality of care to the businessman, and the least quality of care available to the janitor or the unemployed laborer.⁹¹ However, that is what occurs every day and remains unchallenged until a dramatic story attracts widespread media attention that requires the public and governmental officials to take note of the impact of disparate treatment.⁹² Unequal care undoubtedly contributes to existing health disparities, even when it is provided pursuant to a sound purpose such as medical education.

Occasionally, the practice of placing different values on individuals' lives surfaces and compels a declaration of public policy that either supports or condemns the practice. The one area of health care that has evoked widespread public debate about whether it is ethical and moral to consider the social value of individuals in making decisions about the allocation of scarce resources is the selection of organ transplant recipients. The scarcity of essential life saving organs has made the community aware we are deliberately saving the lives of some while consciously allowing others to die.⁹³ As Judge Guido Calabresi has observed, when we are

87. ATUL GAWANDE, *COMPLICATIONS: A SURGEON'S NOTES ON AN IMPERFECT SCIENCE* 24 (2002) (noting that ward services and clinics where physicians in training have most responsibility are populated by indigent).

88. *Id.*

89. See Myres S. McDougal et al., *The Protection of Respect and Human Rights: Freedom of Choice and World Public Order*, 24 AM. U. L. REV. 919, 921 (1975) (defining respect to entail, inter alia, equal opportunity for all without discrimination based on factors indeterminate of capability).

90. See AM. MED. ASS'N, *supra* note 64, § 2.03 (stating ability to pay should not be factor considered in allocating medical resources).

91. See RAWLS, *supra* note 30, at 302 (asserting that unequal distributions may be justified only if those at bottom would be worse off without them).

92. See *infra* notes 96–101 and accompanying text for a discussion of the problematic relationship between race and emergency room care that led Congress to pass EMTALA.

93. For a provocative article on the use of social value criteria for selecting organ recipients, see Alvin H. Moss and Mark Siegler's, *Should Alcoholics Compete Equally for Liver Transplantation?*, 265 JAMA

confronted with a concrete case of an individual whose life can be saved—such as the coal miner trapped in the mine or child in need of a kidney—we profess that life is invaluable so we should spend millions to preserve it.⁹⁴ However, if the question is posed in terms of adoption of an overall policy that would save the same person for \$100 as part of a group where faceless individuals need access to medical care, we turn our backs and say we can't save everyone.⁹⁵

Stories of disparate emergency health care treatment arose so frequently that Congress passed the Emergency Medical Treatment and Active Labor Act (“EMTALA”),⁹⁶ compelling hospitals with emergency rooms that receive federal funding to provide the same care to emergency patients, regardless of insurance coverage, wealth, or social status.⁹⁷ EMTALA represented Congress's response to medical reports of hospitals refusing to admit individuals, usually poor and black, into the emergency room for urgently needed medical care that could have saved the person's life.⁹⁸ EMTALA places a legal duty on the hospital who receives federal funds to treat and stabilize everyone who presents in need of emergency care.⁹⁹ Notwithstanding EMTALA, equal care does not occur today in emergency rooms, if the equality is assessed from a community-to-community perspective, as illustrated in the next section. In other words, the geographical location of the hospital has tremendous influence on the operation of its emergency room and members of the community who rely on the hospital for emergency services.¹⁰⁰ Unfortunately, Congress mandated universal access to emergency care, but has yet to follow up with funding to support equal access.¹⁰¹

1295, 1296 (1991) (arguing that patients who develop end-stage liver disease through no fault of their own should receive priority to alcoholics whose liver disease results from a failure to obtain treatment for alcoholism); the opposite view was articulated by the Council on Ethical and Judicial Affairs of the American Medical Association in *Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients*, 155 ARCHIVES INTERNAL MED. 29, 32 (1995) (arguing that “a social worth criterion ignores diversity and the value of each individual”).

94. CALABRESI & BOBBITT, *supra* note 22, at 39.

95. *Id.*

96. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9121, 100 Stat. 82, 164–67 (1986) (codified as amended at 42 U.S.C. § 1395dd (2006)) (creating EMTALA in response to concerns about lack of available care for uninsured); *see also* Dana E. Schaffner, Note, *EMTALA: All Bark and No Bite*, 2005 U. ILL. L. REV. 1021, 1022 (discussing legislative intent behind EMTALA).

97. *See* Roberts v. Galen of Va., Inc., 525 U.S. 249, 250 (1999) (holding that proof of violation of EMTALA does not require showing of improper motive in failing to provide care).

98. *See* Vickers v. Nash Gen. Hosp., Inc., 78 F.3d 139, 142 (4th Cir. 1996) (noting Congress's concern with patient dumping as motivation for EMTALA); *see also* Mazurkiewicz v. Doylestown Hosp., 305 F. Supp. 2d 437, 447 (E.D. Pa. 2004) (finding admission for inpatient care to be defense to EMTALA claims so long as it was not subterfuge to avoid liability).

99. 42 U.S.C. §§ 1395dd(b)–(c).

100. *See* Erik J. Olson, Comment, *No Room at the Inn: A Snapshot of an American Emergency Room*, 46 STAN. L. REV. 449, 475–77 (1994) (discussing problems faced by hospitals serving geographic areas populated by predominantly nonpaying patients and excessive use of emergency rooms in such areas).

101. *See* Kellermann, *supra* note 7, at 1301–02 (criticizing EMTALA because it is federally unfunded mandate).

VI. EMERGENCY ROOMS: WHERE MORALS AND MONEY COLLIDE

The clash between the value that a community places on wealth distribution preferences and the worth of human life occurs every time an uninsured person needs urgent medical care to treat a condition threatening to take a person's life or posing a risk of permanent, serious injury. *Guerrero v. Copper Queen Hospital*¹⁰² reflects the clash between the moral value of rendering aid essential to the health of a stranger and the private market value of economic survival. The suit against the hospital alleged that the emergency room personnel refused to provide medical care to two children who were brought to the emergency room by their parents after they suffered burns from a stove in their home in Mexico.¹⁰³ The trial court accepted the hospital's argument that it had no duty to provide care to the children because it was a private hospital and the common law imposed no duty on the hospital to provide emergency care to all who request it.¹⁰⁴ The Arizona Supreme Court reversed, finding that while the common law imposed no duty to provide emergency care, a state licensing statute required all general hospitals to maintain emergency rooms and that statutory duty obligated all licensed hospitals in the state to provide emergency care to all patients who come to the emergency room.¹⁰⁵ The Arizona court made this finding in the face of a threat of increasing demand for care from residents of Mexico.¹⁰⁶ The statute, as interpreted by the court, expressed a legislatively declared policy that hospital emergency rooms provide emergency care to all patients who need such care and made no exceptions based on the residency of the person needing care.¹⁰⁷ The court explained:

The proximity of the appellee hospital to the international border presents special problems to it and other hospitals similarly situated. The lack of modern medical facilities in the Mexican border cities is the primary factor. Despite this obvious condition, we decline to find an exception in the statutes; this condition was equally obvious to the legislators, and they chose not to make an exception in the law.¹⁰⁸

In emergency situations, as well as everyday life, health disparities impact everyone. The uninsured and poor experience the impact each time they feel sick and do not have access to a primary care provider. People who enjoy the benefits of insurance or wealth do not experience the effects of disparities as acutely as the poor and insured, but they do not escape the impact of disparities completely. People suffering from acute or chronic illnesses miss going to work or school more often than others. Delayed diagnosis and treatment allow small health issues to become big ones. Whether through taxes to pay for the higher costs for delayed health care or through decreased productivity in the workplace or decreased academic performance in schools, health disparities affect communities as a whole and the entire country.

Health care access disparities produce tragic consequences to individuals and families, whether insured or uninsured. Consider the following hypothetical situation:

102. 537 P.2d 1329 (Ariz. 1975).

103. *Guerrero*, 537 P.2d at 1330.

104. *Id.*

105. *Id.* at 1331.

106. *Id.* at 1332.

107. *Id.*

108. *Id.*

A forty-five-year-old African American was taken by ambulance to the emergency room in an urban hospital. The emergency room technicians (EMTs) who transported him to the hospital explained to the attending doctor and nurse that they responded to a 911 call of a child stating that his father was unconscious. Two of the patient's sisters met the arriving ambulance in the emergency room and told the emergency room doctor that their brother had a history of heart disease and had called them that morning complaining of dizziness and difficulty breathing. After receiving a phone call from one of his children, they had rushed to his house and found him unconscious. The EMTs performed CPR and put an oxygen mask on him. The patient arrived at the hospital at 7 a.m. conscious and stabilized.

Unfortunately, the emergency room was packed. His sisters remained with him all day. By 2 p.m. he had not been seen by a cardiologist and had not been transferred to intensive care. He pulled a breathing tube out that the emergency room doctors had inserted to assist his breathing, sat up, gasped for breath and died.

The emergency room doctor in charge of his care was a senior resident. He testified later, when the sisters brought a lawsuit, that he knew it would be a bad day when he walked into the emergency room at 8 a.m. and saw that there was not even enough room for all of the patients and their families to sit. They had ten beds, forty patients needing care, and no available beds in the cardiac ward. The emergency room doctor responsible for supervising the emergency room that day had placed a call at 7:30 a.m. that morning to ask that his hospital be bypassed by ambulances for a while, but was told that there were no other emergency rooms in the area that could receive the patients. At 8:15 a.m. he requested that a cardiologist see this patient and two others who had arrived earlier with complaints of heart problems, but no cardiologists were available. He argued that he simply did the best that he could under difficult circumstances.

The sisters of the deceased patient demanded compensation for their brother's death to be used to support his children. They also wanted an apology from the hospital and the emergency room doctor who cared for their brother. They noted that almost everyone in the emergency room seeking care was black, and they were sure that America would have done something about this situation if the same thing was happening to white people. The case awaits trial as a medical malpractice action.

The patient in the story presented above did not receive the care that a reasonable doctor or hospital would provide in light of his known medical condition. If that is the standard of care, negligence exists as a matter of law. On the other hand, the hospital will certainly contend that it did the best it could under difficult circumstances. The hospital will rely not only upon the demands for its services that particular day, but also upon the overall demand the community makes on scarce hospital resources, to justify the failure to provide the patient with the evaluation and treatment of a cardiologist. If required to defend its services before a state legislative committee or to the media, the hospital will emphasize the low reimbursement it receives from the state government for treating uninsured patients in its emergency room and in the hospital as a whole, and the financial losses it sustains because of the economic mix of patients it serves. The hospital will point out the large number of patients who use the emergency room for primary care needs because they lack a primary care provider. In addition, the hospital faces a daily challenge to provide good medical care in the emergency room because of the high number of patients who present with little understanding of their

health condition and are either illiterate or function at such a low level of literacy that the time required to service them places extraordinary demands on the hospital staff. Moreover, because the majority of patients who rely on the hospital are poor, uninsured, and people of color, other potential patients who have private insurance choose other hospitals for their care, thus depriving the urban hospital of a potentially lucrative source of funds that could offset some of the cost of caring for the poor. In short, the hospital will argue that it is unfair for it to be required to bear a disproportionate cost of providing universal access to care when the federal, state, and local governments are unwilling to provide the financial support required to care for members of the community who lack insurance and money.

The impact on the future conduct of the hospital of the resolution of an individual tort claim of negligence that raises issues of structure and funding is uncertain. Whether the hospital changes the manner in which it operates the emergency room or closes, it is likely to be affected by who wins the case, the size of the verdict if the plaintiff wins, and the political clout and financial condition of the hospital.¹⁰⁹ In all likelihood, however, the outcome will not have a positive impact on health disparities or access to health care for members of the community that the hospital serves.

VII. SEARCHING FOR SOLUTIONS: HEALTH CARE AS A HUMAN RIGHT AND THE AFFIRMATIVE DUTY OF GOVERNMENT TO PROTECT HEALTH

*“Any law that uplifts human personality is just. Any law that degrades human personality is unjust.”*¹¹⁰

Generations of lawyers were educated with a theme that law is not governed by moral principles. The classic tort doctrine that membership in the community does not by itself create a duty to aid another reinforces the notion that one may engage in immoral conduct without violating American law. The common law endorsed the view that each person bears responsibility for his own safety and well-being and cannot hold others responsible unless he can offer proof that a special relationship existed or that the other person was responsible for the risk of harm that caused or threatens to harm the other person.¹¹¹ For the most part, the common law reinforced this philosophy in the area of health care by holding that a hospital had no duty to provide aid to a person facing a risk of imminent harm or death, in the absence of having contracted with that person to do so.¹¹² A few states passed such laws or construed the common law to mandate emergency hospital care in specific circumstances,¹¹³ but most continued to

109. For a discussion of the numerous forces, including medical malpractice claims, that have made the operations of hospitals extremely volatile in the past decade, see generally SMITH, *supra* note 27.

110. MARTIN LUTHER KING, JR., *Letter from Birmingham Jail* (Apr. 16, 1963), in WHY WE CAN'T WAIT 77, 85 (1963), available at http://www.africa.upenn.edu/Articles_Gen/Letter_Birmingham.html.

111. RESTATEMENT (SECOND) OF TORTS § 314 cmt. c (1965).

112. For a historical discussion of the common law duty or lack of duty to treat, see generally Jonathan M. Purver, Annotation, *Liability of Hospital for Refusal to Admit or Treat Patient*, 35 A.L.R.3d 841 (1971).

113. See, e.g., *Guerrero v. Copper Queen Hosp.*, 537 P.2d 1329, 1331 (Ariz. 1975) (holding private hospital with emergency care facility may not deny emergency care to any patient without cause); *Wilmington Gen. Hosp. v. Manlove*, 174 A.2d 135, 140 (Del. 1961) (holding that hospital may be found liable if it refuses care to patient “in case of an unmistakable emergency, if the patient has relied upon a well-established custom

passively witness the dumping of patients by private hospitals to public hospitals, at tremendous cost to the health of poor people in the community.

The United States Congress provided a limited remedy for such callous treatment of poor, sick people after the news media exposed morally intolerable cases of dumping.¹¹⁴ The Emergency Medical Treatment and Active Labor Act¹¹⁵ (“EMTALA”) mandates that hospitals receiving federal funds treat and stabilize everyone who presents in need of emergency care.¹¹⁶ Many problems remain in effectively and fairly using the federal mandate to protect ill patients.¹¹⁷ Nevertheless, the enactment of EMTALA harmonized the law with moral principles and shifted the debate from whether care should be provided to how it can be provided and financed.

A similar important step toward reducing health disparities would be taken if Congress were to issue a declaration that in the United States, access to health care is a human right. Such a declaration will not guarantee equality of health, nor will it solve the problem of access to health care.¹¹⁸ However, the declaration would change the moral tone of the health care reform debate. It would also create new long-range goals for our country. The immediate goal that we can achieve, however, is the establishment of a minimum level of access to goods and services that we recognize as critical to health. By recognizing health care as a human right we can begin the arduous task of determining what minimum level of health care we can provide in light of other competing social needs. The important change, however, is that once health care is characterized as a right, governmental officials, lobbyists, and citizens may engage in

of the hospital to render aid in such a case”); *Richard v. Adair Hosp. Found. Corp.*, 566 S.W.2d 791, 793 (Ky. Ct. App. 1978) (holding that liability could be predicated upon hospital’s refusal to admit patient in “unmistakable emergency situation”); *Stanturf v. Sipes*, 447 S.W.2d 558, 561–62 (Mo. 1969) (allowing patient-plaintiff to proceed on tort theory of reliance, analogous to negligent termination of gratuitous services); *Valdez v. Lyman-Roberts Hosp., Inc.*, 638 S.W.2d 111, 114 n.1 (Tex. App. 1982) (same); *Mercy Med. Ctr. of Oshkosh, Inc. v. Winnebago County*, 206 N.W.2d 198, 200 (Wis. 1973) (noting in dicta that some courts have carved out exceptions to general rule that no liability would attach to hospital’s failure to intervene in emergency).

114. See *supra* notes 96–98 and accompanying text for a discussion of Congress’s response to patient dumping. See, e.g., Office of Inspector Gen., U.S. Dep’t of Health & Human Servs., Patient Dumping, http://oig.hhs.gov/fraud/enforcement/cmp/patient_dumping.asp (last visited Mar. 2, 2011) (reporting recent cases of patient dumping that have resulted in fines imposed on health care providers); Jeffrey Kahntroff & Rochelle Watson, *Refusal of Emergency Care and Patient Dumping*, 11 VIRTUAL MENTOR 49, 49–53 (2009), <http://virtualmentor.ama-assn.org/2009/01/pdf/hlaw1-0901.pdf> (describing recent cases of patient dumping).

115. See Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9121, 100 Stat. 82, 164–67 (1986) (codified as amended at 42 U.S.C. § 1395dd (2006)) (enacting EMTALA).

116. § 9121, 100 Stat. at 164–65 (42 U.S.C. § 1395dd(b)–(c)).

117. See Michael J. Frank, *Tailoring EMTALA to Better Protect the Indigent: The Supreme Court Precludes One Method of Salvaging a Statute Gone Awry*, 3 DEPAUL J. HEALTH CARE L. 195, 195–96 (2000) (arguing that EMTALA’s broad language has led to creation of remedy that unwisely and unnecessarily duplicates state medical malpractice law).

118. As David Smith cautions, realistic solutions to America’s health care system require that we address the existing structural problems faced by the health care system, including:

- (1) ownership and governance, (2) the limitation of existing mechanisms of quality control, (3) the cyclical shortages of nursing staff and other providers of care, (4) the failure of government controls to regulate healthcare or to eliminate racial and ethnic disparities in treatment, (5) the failure of market forces to address the escalating cost and fragmentation of care, and (6) the political barriers to effective collaboration toward improving the health of communities.

SMITH, *supra* note 27, at 6.

budgetary debate undertaken with a different tone and undergirded by different values.¹¹⁹ Witness the change in the public discourse that occurred in Oregon when it adopted a plan to provide medical care to a broader portion of the population.¹²⁰ A similar change in the debate occurred and continues in Massachusetts after it adopted a state policy aimed at guaranteeing universal access to health care.¹²¹ Medicare presents another example of how the nature of the debate changes after the value judgment has been endorsed that people have a right to health care. Opponents of Medicare do not argue that the government should not guarantee access of seniors to health care. Instead they argue that the method by which the current system operates is not sustainable, and that those who want to assure the continuation of Medicare should accept the need for different methods of financing it, or reducing the coverage.¹²² While Medicare is not perfect, it has proven itself far superior to what the private market offers as an alternative way of providing seniors access to health care.¹²³ That is why the irate citizen at the health care reform town meeting yelled out “keep your government hands off my Medicare.”¹²⁴ He had conceptualized it as a right, and not a privilege.

Large numbers of community members suffer the consequences of inadequate health care access and poor health status. People of color represent a disproportionate number of those at the bottom of the health pool. We can regard this as one of the inherent costs of modern capitalism and ignore it until a social or economic explosion

119. For more in-depth discussions of theoretical foundations for viewing health care as a right, see Kevin P. Quinn, *Viewing Health Care as a Common Good: Looking Beyond Political Liberalism*, 73 S. CAL. L. REV. 277, 359–60 (2000) (arguing that conceptualizing health care as political common good will provide theoretical foundation for redesigning health care system); Jennifer Prah Ruger, *Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements*, 18 YALE J. L. & HUMAN. 273, 277–78 (2006) (arguing that “sustaining the effort to realize a right to health requires individual and societal commitments to [treat right to health as a] public moral norm[.]”).

120. See generally RATIONING AMERICA’S MEDICAL CARE: THE OREGON PLAN AND BEYOND (Strosberg et al. eds., 1992) (presenting various authors’ discussions of Oregon plan and process used to make health care decisions for poor); Howard Leichter, *Obstacles to Dependent Health Care Access in Oregon: Health Insurance or Health Care?*, 29 J. HEALTH POL., POL’Y & L. 237 (2004).

121. See generally Elizabeth A. Weeks, *Failure to Connect: The Massachusetts Plan for Individual Health Insurance*, 55 U. KAN. L. REV. 1283 (2007); Jonathan M. Kucskar, Comment, *Laboratories of Democracy: Why State Health Care Experimentation Offers the Best Chance to Enact Effective Federal Health Care Reform*, 11 J. HEALTH CARE L. & POL’Y 377 (2008).

122. See, e.g., Gail R. Wilensky, *Medicare Reform—Now Is the Time*, 345 NEW ENG. J. MED. 458, 459 (2001) (arguing that changed demographic reality over next thirty years “calls into question the fiscal future of the program within its current structure”).

123. Critics and supporters of Medicare agree: “Medicare solved the primary problem it was designed to address—ensuring that the elderly have access to high-quality, affordable health care.” *Id.* In addition, Medicare ensured access and high-quality care at an administrative cost that is substantially lower than the administrative costs of private insurers. See ROBERT H. LEBOW, *HEALTH CARE MELTDOWN: CONFRONTING THE MYTHS AND FIXING OUR FAILING SYSTEM* (2003) (arguing that private enterprise is not always better than government in producing goods and services as evidenced by the two to three percent administrative cost of Medicare as compared to the administrative cost of private insurers that ranges between 9 and 30%, with 15% being an average); see also Jonathan Gruber, *Getting the Facts Straight on Health Care Reform*, 361 NEW ENG. J. MED. 2497, 2498 (2009) (noting irony that critics of 2009 proposed health care reform bill argue that proposed statute makes an unfair attack on Medicare by reducing Medicare funds that represent overpayments to hospitals and to private insurers that sell Medicare Advantage plans).

124. For a discussion of the “keep your government hands off my Medicare” statement, see *supra* notes 41–51 and accompanying text.

demands that we pay attention. Alternatively, we can join the rest of the economically developed nations in the world who view the promotion and protection of the health of community members as a critical responsibility of the government. If we declare that access to health care is a human right in America, we will undertake the challenge of reforming our health care system to harmonize with our values.

