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TRAGEDY AND REMEDY: REPARATIONS FOR DISPARITIES IN BLACK HEALTH

*Kevin Outterson**

INTRODUCTION

The Tragedy of American health care is the stubborn persistence of disparities in Black health,¹ 140 years after Emancipation, and more than four decades after the passage of Title VI. Formal legal equality has not translated into actual health equality. This Tragedy is deeper and older than mere legal forms; it has been supported by powerful social institutions, including some governments, charities, market participants, religions, ideologies, and cultures. Black health disparities interact with other vestiges of slavery such as disparities in wealth, education, employment and housing. They have permeated the American health experience. Efforts to eliminate Black health disparities will require something more transformative than Title VI. The history of oppression in America is laid bare by Black disparities in health.

The recent scientific literature on disparities in Black health tends to minimize the context in which these disparities arise. Medical research in particular is distracted by an etiological reductionism which overlooks the underlying history of slavery, racism and segregated health care. The dominant research model is ill-equipped to diagnose the social health effects of being Black. Standard practice controls for variables such as income and education, even though these variables themselves bear the legacies of American racism. These studies

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¹ While many racial and ethnic categories exhibit health disparities in the United States, this Article focuses on the Black experience.

underestimate actual Black health disparities and obscure the relevant social contexts.

One candidate for transforming the Black health experience is reparations for the historic crimes of slavery, segregation and discrimination.² When reparational analysis is applied to Black health disparities, history and social context are brought front and center and the weakness of mere legal equality is made clear. Black reparations would require transformative change in society rather than just another programmatic band-aid. Reparational analysis also avoids the errors of etiological reductionism and racialized research by focusing upon the underlying causes of disparities in Black health, and connecting it with centuries of American history and law.

Black reparations are considered a fringe political movement and a weak legal argument. One important objection to Black reparations is remoteness of the injury – the crimes were long ago, all of the defendants and plaintiffs are dead, and the statutes of limitation have run. Lawsuits raising broad claims for Black reparations are invariably dismissed without reaching the merits. In July 2005, the African-American Slave Descendants Litigation was dismissed without reaching the merits. The Tulsa Race Riot reparations litigation met a similar fate the previous September.

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

This project may also breathe some reality into the critical race theory and reparations literature and respond to Richard Delgado's call for reparations scholarship which moves beyond mere discourse to

² Professor Randall appears to be the only legal scholar to have examined the intersection to any significant degree. See Vernellia R. Randall, *Eliminating the Slave Health Deficit: Using Reparations to Repair Black Health*, 11 POVERTY & RACE 3 (2002) [hereinafter Randall, *Deficit*]. Professor Randall's article focuses on describing potential reparational remedies for Black health disparities, a quite different project from this Article. She is preparing a book on the subject, following the path of her article. VERNELLIA R. RANDALL, *DYING WHILE BLACK* (forthcoming 2005).

practical, structural changes in society. Health is not a peripheral social concept but is a key indicator of how society is structured and its resources allocated. If you want to know something about inequality in a society, look at its health outcomes. Eliminating American disparities in Black health is both a practical remedial goal and a revolutionary step in social justice.

I. DISPARITIES IN BLACK HEALTH

A. The Tragedy of American Health Care

In 1999 Congress instructed the Institute of Medicine to prepare a report on racial disparities in health.³ The study committee performed a literature review of articles in the PUBMED and MEDLINE databases published in peer-reviewed journals from 1992 to 2002. To be selected, the articles must have addressed racial differences in health care while controlling for access and a range of other potential confounding variables.⁴ Over 100 studies were selected and summarized in *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, and a larger group of 600 studies were identified in a companion article covering the last 30 years.⁵ Many of these studies have been cited in law review articles concerning racial discrimination in health care, Title VI enforcement, and related topics.⁶

³ INSTITUTE OF MEDICINE, *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* 30 (Brian D. Smedley et al. eds., 2003) [hereinafter *UNEQUAL TREATMENT*]. See Consolidated Appropriations Act, Pub. L. No. 106-113, 113 Stat. 1501 (1999).

⁴ *Id.* at 38. Variables include patient preferences, racial differences in disease severity or presentation, and geographic availability of specific services or procedures. Controlling for access generally reduces the extent of racial disparities since access is a confounding variable for many racial minorities. See *infra* Part II (providing a critique on the use of confounding variables in disparity research).

⁵ *Id.* at 39. See H. Jack Geiger, *Racial and Ethnic Disparities in Diagnosis and Treatment: A Review of the Evidence and a Consideration of Causes in UNEQUAL TREATMENT*, *supra* note 3, at 417, for a comprehensive literature review.

⁶ See, e.g., Heather K. Auschleman, *The White World of Nursing Homes: The Myriad Barriers to Access Facing Today's Elderly Minorities*, 8 *ELDER L.J.* 367 (2000); Ian Ayres, et al., *Unequal Racial Access to Kidney Transplantation*, 46 *VAND. L. REV.* 805 (1993); M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 *YALE J. HEALTH POL'Y L. & ETHICS* 95 (2001); Rene Bowser, *Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities*, 7 *MICH. J. RACE & L.* 79 (2001); Gwendolyn Roberts Majette, *Access to Health Care: What a Difference Shades of Color Make*, 12 *ANN. HEALTH L.* 121 (2003); Barbara A. Noah, *Racial Disparities in the Delivery of Health Care*, 35 *SAN DIEGO L. REV.* 135 (1998); Randall, *Deficit*, *supra* note 4, at 3; Vernellia R. Randall, *Slavery, Segregation and*

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

Racial and ethnic disparities in healthcare exist. These disparities are consistent and extensive across a range of medical conditions and healthcare services, are associated with worse health outcomes, and occur independently of insurance status, income, and education, among other factors that influence access to healthcare. These disparities are unacceptable.⁷

None of this should be surprising. For as long as records have been kept, studies have reported racial differences in health care access and health status in the United States.⁸ In 1985, the *Report of the*

Racism: Trusting the Health Care System Ain't Always Easy! An African American Perspective on Bioethics, 15 ST. LOUIS U. PUB. L. REV. 191 (1996) [hereinafter Randall, *Trusting*]; Sidney D. Watson, *Race, Ethnicity and Quality of Care: Inequalities and Incentives*, 27 AM. J.L. & MED. 203 (2001) [hereinafter, Watson, *Race, Ethnicity and Quality of Care*]; Sidney D. Watson, *Race, Ethnicity and Hospital Care: The Need for Racial and Ethnic Data*, 30 J. OF HEALTH & HOSP. L. 125 (1997) [hereinafter Watson, *Race, Ethnicity and Hospital Care*]; and Michael S. Shin, *Comment: Redressing Wounds: Finding a Legal Framework to Remedy Racial Disparities in Medical Care*, 90 CALIF. L. REV. 2047 (2002). Several journals have recently published symposiums on racial disparities in health, including the Saint Louis University Law Journal (48 ST. LOUIS U.L.J. 1 (2003)); the American Journal of Law and Medicine (29 AM. J. L. & MED. 151 (2003); Mark R. Bradford, *An Introduction to Race as Proxy*, 53 DEPAUL U.L. REV. 929 (2004); Symposium, 8 DEPAUL HEALTH L.J. (2005).

⁷ UNEQUAL TREATMENT, *supra* note 3, at 79. Other high-income societies experience health disparities, but those disparities are usually expressed in terms of class rather than race. In the European Union, poorer social classes experience life expectancies which are about five years shorter than average. Tackling Health Inequalities: Governing for Health Summit (hosted by the UK Presidency of the EU 2005 on October 17-18, 2005),

<http://www.regteam.com/healthinequalityessummit/en/welcome.php>.

⁸ See, e.g., PAUL FARMER, *INFECTIONS AND INEQUALITY: THE MODERN PLAGUES* (1999) (discussing social inequalities often determine the distribution and clinical outcomes of diseases such as AIDS and tuberculosis); MARIANNE ENGELMAN LADO, *INEQUALITY IN THE DISTRIBUTION OF HEALTH CARE: CLOSING THE GAP* (1992); ROBERT M. MAYBERRY ET AL., *RACIAL AND ETHNIC DIFFERENCES IN ACCESS TO MEDICAL CARE: A SYNTHESIS OF THE LITERATURE* (1999); Marianne Engelman Lado, *Breaking the Barriers of Access to Health Care: A Discussion of the Role of Civil Rights Litigation and the Relationship Between Burdens of Proof and the Experience of Denial*, 60 BROOKLYN LAW REVIEW 239 (1994) (describing studies of racial health disparities at pages 239-247 and examples of post-desegregation methods used by hospitals to adjust their "payor mix" to reduce the number of poor

Secretary's Task Force on Black and Minority Health clearly noted the problem twenty years ago:

[C]ontinuing disparity in the burden of death and illness [is] experienced by Blacks and other minority Americans as compared with our nation's population as a whole. That disparity has existed ever since accurate federal record keeping began – more than a generation ago. And although our health charts do itemize steady gains in the health of minority Americans, the stubborn disparity remained – an affront to both our ideals and to the ongoing genius of American medicine... [this report] can – it should – mark the beginning of the end of the health disparity that has, for so long, cast a shadow on the otherwise splendid American track record of improving health.⁹

The Kerner Commission in 1968,¹⁰ and the United States Commission on Civil Rights in 1963 found racial discrimination and segregation in health care:

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

patients, often racial minorities, at pages 248-252); B.A. Noah, *Racial Disparities in Health Care*, 35 *SAN DIEGO LAW REVIEW* 135 (1998); Watson, *Race, Ethnicity and Quality of Care*, *supra* note 6, at 203-24 (discussing racial disparities as serious medical error, requiring education and cultural shift in medicine).

⁹ DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, REPORT OF THE SECRETARY'S TASK FORCE ON BLACK AND MINORITY HEALTH (1985) (quoted in Hearings on the Health Care Fairness Act of 1999: Testimony Before the Subcomm. on Health and Environment, House Commerce Committee, 106th Cong. 26 (May 11, 2000) (statement of David Satcher, Surgeon General), *available at* <http://www.hhs.gov/asl/testify/t000511a.html>).

¹⁰ NATIONAL ADVISORY COMMISSION ON CIVIL DISORDERS (KERNER COMMISSION), REPORT OF THE NATIONAL ADVISORY COMMISSION ON CIVIL DISORDERS 269, 271-72 (1968) ("fewer doctors, dentists, and medical facilities are conveniently available to Negroes – especially to poor families – than to most whites. This is a result both of geographic concentration of doctors in higher income areas in large cities and of discrimination against Negroes by doctors and hospitals").

supports racial discrimination in the provision of health facilities.¹¹

The 1948 report to President Truman from the National Health Assembly detailed discriminatory barriers to Black health,¹² as did Gunnar Myrdal's *An American Dilemma* in 1944.¹³ The Assistant Surgeon General in 1915 identified the root causes of racial disparities in mortality as socio-economic and remediable.¹⁴ In 1903, W.E.B. Du Bois wrote *The Souls of Black Folk*, illustrating the many struggles of life within the Veil of American racism,¹⁵ followed in 1906 by *The Health and Physique of the Negro American*.¹⁶ In 1869, the Freedmen's Bureau pleaded the great health needs of the newly freed Black population.¹⁷

Disparities in Black health have been studied to death, while the patients continue to die. Still more studies and reports are in the pipeline.¹⁸ The Tragedy of American health care is that while disparities in Black health are not new, they remain newsworthy, persisting for centuries right up to the present day.

B. Black Health In America

Andrew Hacker and Cheryl Harris suggested that one way to test the persistence and magnitude of racism is to ask white students how much

¹¹ UNITED STATES COMMISSION ON CIVIL RIGHTS, 1963 REPORT OF THE UNITED STATES COMMISSION ON CIVIL RIGHTS.

¹² THE NATIONAL HEALTH ASSEMBLY, AMERICA'S HEALTH: A REPORT TO THE NATION (1949) [hereinafter AMERICA'S HEALTH].

¹³ See GUNNAR MYRDAL, AN AMERICAN DILEMMA: THE NEGRO PROBLEM AND MODERN DEMOCRACY (1944).

¹⁴ John W. Trask, *The Significance of the Mortality Rates of the Colored Population of the United States*, 6 AM. J. PUB. HEALTH 254, 259 (1916).

¹⁵ W.E.B. DUBOIS, THE SOULS OF BLACK FOLK 4 (Penguin Classics 1996) (1903).

¹⁶ THE HEALTH AND PHYSIQUE OF THE NEGRO AMERICAN 76-90 (W.E.B. DuBois ed., 1906).

¹⁷ *Report of the Commissioner Bureau Refugees, Freedmen &c in 1 U.S. WAR DEPARTMENT: ANNUAL REPORT, 1868-69*, at 502 (1869).

¹⁸ See, e.g., AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, GUIDANCE FOR THE NATIONAL HEALTHCARE DISPARITIES REPORT 1 (Elaine K. Swift ed., 2002), available at <http://www.ahrq.gov>; National Institutes of Health, STRATEGIC RESEARCH PLAN TO REDUCE AND ULTIMATELY ELIMINATE HEALTH DISPARITIES: FISCAL YEARS 2002-2006 (draft, Oct. 6, 2000). See also Centers for Disease Control and Prevention, PROGRAM ANNOUNCEMENT 01123: RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH 2010 (2001) (examining research in racial and ethnic approaches to community health), <http://www.cdc.gov/od/pgo/funding/01123.htm>.

money it would take for them to choose to become Black.¹⁹ I ask a similar question of my students in Health Law. When white students understand the health dimensions of that choice, they generally refuse at any price. Few students will name a price for their untimely death.

Black mortality rates are significantly higher than white rates in seven of the ten leading causes of death, resulting in more than 73,000 excess Black deaths per year.²⁰ If being Black was a separate cause of death, it would rank sixth in the United States, ahead of diabetes, influenza and pneumonia, Alzheimer's, nephritis, suicide, septicemia, chronic liver disease, homicide, and HIV.²¹ Black infant mortality in the United States is more than triple the European rate, and significantly higher than infant mortality in countries like Bulgaria, Costa Rica, Estonia, Greece, South Korea, Lithuania, and Oman, among many others.²² Black men's life expectancy at birth (LEAB) is currently 5.7 years less than white men's; the female disparity is 4.3

¹⁹ Cheryl I. Harris, *Whiteness as Property*, 106 HARV. L. REV. 1709, 1758-59 (1993) (citing ANDREW HACKER, TWO NATIONS: BLACK AND WHITE, SEPARATE, HOSTILE, UNEQUAL 31-32 (1992)).

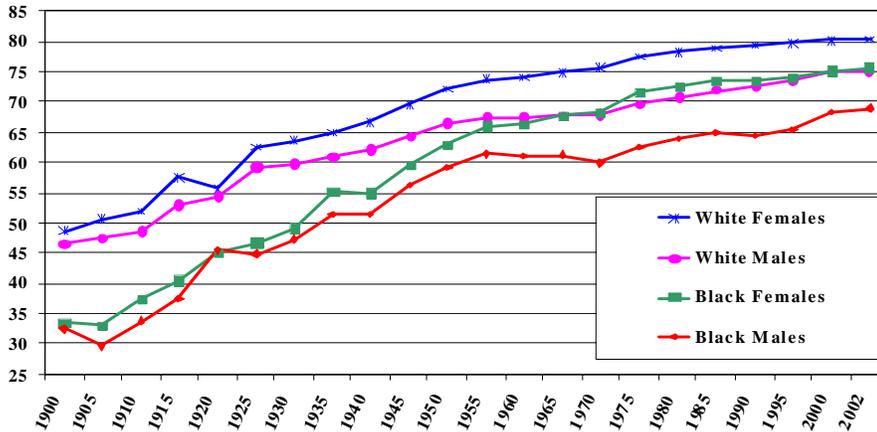
²⁰ Louis W. Sullivan, *The Role of Historically Black Colleges and Universities in Addressing Disparities in Health Status and Health Care in the United States*, Address at National NBCU Week, Session II, at 6 (Sept. 16, 2002), available at http://ncmhd.nih.gov/about_ncmhd/DrSullivansSpeech091602.pdf (excess Black deaths); Kenneth D. Kochanek et al., NATIONAL CENTER FOR HEALTH STATISTICS, *Report No. 5, Deaths: Final Data for 2002*, 53 NATIONAL VITAL STATISTICS REPORT 5Table C (2004) (Table C lists vital statistics related to the 15 leading causes of death), available at http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_05acc.pdf.

²¹ Robert N. Anderson & Betty L. Smith, NATIONAL CENTER FOR HEALTH STATISTICS, *Report No. 17, Deaths: Leading Causes for 2002*, 53 NATIONAL VITAL STATISTICS REPORTS 9 tbl.E (2005), available at http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_17.pdf. Significant regional variations are present across the US. See, e.g. MICHELE L. CASPER ET AL., WOMEN AND HEART DISEASE: AN ATLAS OF RACIAL AND ETHNIC DISPARITIES IN MORTALITY 78-79, 200-201 (2nd ed. 2000); ELIZABETH BARNETT ET AL., MEN AND HEART DISEASE: AN ATLAS OF RACIAL AND ETHNIC DISPARITIES IN MORTALITY 72-73, 194-95 (2001), available at <http://www.cdc.gov/nccdphp/cvd>.

²² NATIONAL CENTER FOR HEALTH STATISTICS, *Health, United States, 2004* 135 tbl.22 (Table 22 indicates that the U.S. Black infant mortality rate in 2002 is 14.4), available at [http://www.cdc.gov/nchs/data/04.pdf](http://www.cdc.gov/nchs/data/hus/04.pdf). The infant mortality rates for the following countries or group of countries is taken from the World Bank World Development Indicators database: Bulgaria (12); Costa Rica (8); Estonia (8); European Monetary Union (4); Greece (4); Hungary (8); Korea, Rep. (5); Lithuania (8); Oman (10); and Poland (6). World Bank, Basic Demographic Information, <http://devdata.worldbank.org> (last visited Oct. 20, 2005).

years.²³ If a white male student were to agree to become Black, almost six years of life would be forfeited. Table 1 demonstrates the historical record of this disparity from 1900 to the present:

Table 1. Life Expectancies at Birth²⁴



Even as general population health improves, most Black health disparities remain, especially for men. While gaps in health care access narrowed in the period 1968 – 1978, during the expansion of Medicare

²³ Elizabeth Arias, NATIONAL CENTER FOR HEALTH STATISTICS, *Report No. 6, United States Life Tables, 2002*, 53 NATIONAL VITAL STATISTICS REPORTS 3 tbl.A, 4, 33 tbl.12, 34 tbl.12 (2004), available at http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_06.pdf.

²⁴ Elizabeth Arias, NATIONAL CENTER FOR HEALTH STATISTICS, *Report No. 3, United States Life Tables, 2000*, 51 NATIONAL VITAL STATISTICS REPORT 33 tbl.12 (2002) [hereinafter *United States Life Tables, 2000*], available at http://www.cdc.gov/nchs/data/nvsr/nvsr51/nvsr51_03.pdf. Data prior to 1929 is from death-registration states only. See *id.* Black data prior to 1970 is not available; data shown from 1900-1969 is from the non-white population. See *id.*; WERNER TROESKEN, WATER, RACE, AND DISEASE 10 (2004) (arguing that municipal water and sewer systems were provided on a non-discriminatory basis from 1900 to 1940, resulting in remarkable reductions in water-borne disease among Blacks). The US Census Bureau has performed projections for 2025, 2050 and 2100. FREDERICK W. HOLLMANN ET AL., METHODOLOGY AND ASSUMPTIONS FOR THE POPULATION PROJECTIONS OF THE UNITED STATES: 1999 TO 2100, at 10-12 (2000) (Table C also lists projected life expectancy at birth by race and hispanic origin for 1999 to 2100).

and Medicaid,²⁵ the gaps in life expectancy at birth (LEAB) have not narrowed appreciably over the last century. Table 2 demonstrates that for as long as reliable records have been kept, whites have achieved any given life expectancy approximately one generation before Blacks, a gap which remains relatively unchanged from the 1930s:

Table 2. Black Disparity in Life Expectancy at Birth (LEAB)²⁶

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

²⁵ See Lu Ann Aday, *Achieving Equity of Access to the American Health Care System: An Empirical Look at Target Groups*, in UNITED STATES COMMISSION ON CIVIL RIGHTS, CIVIL RIGHTS ISSUES IN HEALTH CARE DELIVERY: A CONSULTATION SPONSORED BY THE UNITED STATES COMMISSION ON CIVIL RIGHTS 266 (1980) [hereinafter CIVIL RIGHTS ISSUES IN HEALTH CARE DELIVERY] (“The gaps between whites and nonwhites with respect to both potential and realized access indicators have narrowed considerably over the past 25 years. The preceding analysis suggests that racial inequities do persist along certain access dimensions, however, even when income differences are controlled.”); KAREN DAVIS & CATHY SCHOEN, HEALTH AND THE WAR ON POVERTY: A TEN-YEAR APPRAISAL 26 (1978) (“Although the gap between the health of the poor and that of others narrowed in the decade 1965-75, it has not disappeared.”). See also Richard Cooper et al., *Improved Mortality Among U.S. Blacks, 1968-1978: The Role of Antiracist Struggle*, 11 INT’L J. OF HEALTH SERVICES 511 (1981) (impact of Medicare and Medicaid).

²⁶ See *United States Life Tables, 2000*, supra note 24, at 33 tbl. 12. See generally Rashi Fein, *An Economic and Social Profile of the Negro American*, 94 DAEDALUS 815 (1965) (similar time lag studies in LEAB, infant mortality rate, educational attainment, and other measures). Fein also notes that time lag studies understate the permanent disparity: “if the Negro in 1965 is where the white was in 1945, this does not mean that the Negro considers himself as well off as the white considered himself twenty years ago.” *Id.* at 818.

For Black men, the disparity in LEAB is even greater. As Table 1 illustrates, much of the gains in Black health have been among women. At current rates of change, these disparities may persist for many generations, even as absolute health improves for most groups.

Nor is the situation likely to improve in the near term. For American children born in 2100, the US Census Bureau projects female LEAB to exceed 91 years for women and 87 years for men. The US Census Bureau blatantly assumes that Black LEAB will improve by 2100, converging almost entirely with white LEAB. This assumption is made without any externally validating data.²⁷ But even under this wildly optimistic and ahistorical assumption, Black health disparities will outlast every law professor teaching today.

The analysis and conclusions in this first section are relatively uncontroversial, acknowledged by both the Left and the Right.²⁸ This Article now leaves the safe waters of consensus for controversies over causation, history and remedies. The next section describes the search for a biomedical “cause” of Black disparities in health. The dominant approach is critiqued as *etiological reductionism*.

²⁷ FREDERICK W. HOLLMANN ET AL., METHODOLOGY AND ASSUMPTIONS FOR THE POPULATION PROJECTIONS OF THE UNITED STATES: 1999 TO 2100, at 10-12 (2000) (“Our projections assume a narrowing of the observed mortality gaps among race and Hispanic origin groups over time ... our assumptions about future race and Hispanic origin differentials are generated internally.”), available at <http://www.census.gov/population/www/documentation/twps0038.html>. The Social Security Trustees generally assume smaller gains in life expectancy (an assumption which delays the projected date of insolvency), but do not publish the data by race. CENTERS FOR MEDICARE AND MEDICAID SERVICES, 2005 ANNUAL REPORT OF THE BOARD OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTAL MEDICAL INSURANCE TRUST FUNDS 6 tbl.II.C1 (2005) (note that the ‘middle series’ assumptions by the Census Bureau are much higher than the ‘High Cost’ assumptions by the Social Security Trustees), available at <http://www.cms.hhs.gov/publications/trusteesreport/tr2005.pdf>.

²⁸ See, e.g., William H. Frist, *Overcoming Disparities in U.S. Health Care*, 24 HEALTH AFFAIRS 445 (March/April 2005) (U.S. Senate Majority Leader); Edward M. Kennedy, *The Role of the Federal Government in Eliminating Health Disparities*, 24 HEALTH AFFAIRS 452 (2005) (ranking Minority Member on the Senate Health, Education, Labor, & Pensions Committee).

II. ETIOLOGICAL REDUCTIONISM: SEARCHING FOR MICRO CAUSES IN A MACRO WORLD

Scientific research attempts to identify causes rather than just associations. Biomedical scientists search for the precise causal or *etiological* pathways of disease and health status. This model has worked well in many infectious diseases categories such as influenza, malaria and AIDS, as well as chronic diseases such as cancer and diabetes.²⁹ But etiological reductionism can be misleading when applied to race and health.

Researchers generally consider socio-economic status (SES) factors, such as income and education, as *confounding variables*, to be adjusted for and controlled in any experiment to determine if any residual impact of race remains. But in the United States, Blacks suffer disparities in most SES variables such as income, wealth, education, insurance, occupation, and housing. If race (or racism) is *prior* or *antecedent*, then all of these SES variables are co-morbidities or simultaneous symptoms rather than confounding variable.³⁰ Black disparities of all types may point to a deeper social problem. The cause may be macro rather than micro, obscured by reductionist methodology.

For example, assume a study is undertaken to determine the cause of large health differences between Group X and the general population. Group X is a minority racial group, and suffers much higher morbidity and mortality rates. Members of Group X are overwhelmingly poor, lack health insurance, are disproportionately unemployed, live in unsanitary housing, are poorly educated and otherwise occupy the lowest quintile of any socioeconomic indicator, all resulting from persistent racial discrimination. Adjusting for all of these variables may well show that Group X suffers no racial health disparities, but the overall conclusion would be false. Aggressive adjustment for confounding variables may obscure the relationship between health and race, “treat[ing] race-associated differences as nuisance confounders rather than as important clues to be mined.”³¹

²⁹ See, e.g., RANDY SHILTS, *AND THE BAND PLAYED ON: POLITICS, PEOPLE, AND THE AIDS EPIDEMIC* (1987); JOHN M. BARRY, *THE GREAT INFLUENZA: THE EPIC STORY OF THE DEADLIEST PLAGUE IN HISTORY* (2004).

³⁰ See Ichiro Kawachi et al., *Health Disparities By Race And Class: Why Both Matter*, 24 *HEALTH AFFAIRS* 343, 346 (2005).

³¹ Camara Phyllis Jones, “Race,” *Racism, and the Practice of Epidemiology*, 154 *AM. J. OF EPIDEMIOLOGY* 299, 302 (2001). See Paula Braveman et al., *World Health Report 2000: How It Removes Equity from the Agenda for Public Health Monitoring*

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

To a great extent, attempts to separate the relative contribution of these factors risks presenting an incomplete picture of the complex interrelationship between racial and ethnic minority status, socioeconomic differences, and discrimination in the United States. For example ... racial and ethnic housing segregation is a by-product of both historic and contemporary racism and discrimination, as well as socioeconomic differences (itself the legacy of poorer opportunities for many minority groups). The committee therefore stresses that attempts to “parcel out” access-related factors from the quality of healthcare for minorities remains an artificial exercise, and that policy solutions must consider the historic and contemporary forces that contribute to access to and quality of healthcare.³²

Almost all of the rigorous studies examined in *Unequal Treatment* demonstrated reduced disparities after controlling for SES variables, although most still found remaining racial disparities.³³ The annual *National Healthcare Disparities Report* issued by the Agency for Healthcare Research and Quality generally reports racial disparities in health measures without adjustment for SES, although it does occasionally present multivariate analyses which adjust for age, gender,

and Policy, 323 BRIT. MED. J. 678 (2001) (supporting broader reporting of health disparities by social inequality). See generally Ichiro Kawachi et al., *Health Disparities By Race And Class: Why Both Matter*, 24 HEALTH AFFAIRS 343 (2005) (exploring the interrelationships between race and class in health disparities).

³² UNEQUAL TREATMENT, *supra* note 3, at 32 (mandate), 34-35 (quote).

³³ UNEQUAL TREATMENT, *supra* note 3, at 42. See, e.g., David R. Williams, *Race, Health, and Health Care*, 48 ST. LOUIS U. L.J. 13, 21-26 (2003) (citing many racial disparities in health studies which adjusted for various SES factors). A recent publication by the National Academies recommended more adjustments for SES in racial disparities research. Patricia O’Campo & Jessica Burke, *Recommendations on the Use of Socioeconomic Position Indicators to Better Understand Racial Inequalities in Health*, in COMMITTEE ON NATIONAL STATISTICS, ELIMINATING HEALTH DISPARITIES: MEASUREMENT AND DATA NEEDS 184 – 187 (Michele Ver Ploeg & Edward Perrin eds., 2004).

household income, education, insurance and residence location.³⁴ The *2004 National Healthcare Disparities Report* recognized that race, health and SES indicators are highly correlated in American society, but nevertheless adjusted for SES in a few categories.³⁵ Adjusting for SES may underreport the true scope of the Tragedy of Black health in America.

The alternative to etiological reductionism is to treat Black disparities in health and SES as co-morbidities rather than confounding variables. Black disparities of all types point to deeper problems in our society. This approach is similar to that taken by Dr. Paul Farmer. He does not shrink from the “biosocial realities” of health disparities, but includes all available data, “linking molecular epidemiology to history, ethnography, and political economy.”³⁶ To Farmer, “inequality itself [has] become a pathogenic force.”³⁷

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

III. TRAGEDY IN HISTORY: BLACK HEALTH IN AMERICA

The history of Black health in America is cruel and shocking. From the inception of the Atlantic slave system until quite recently, medicine treated Blacks in a grossly inferior manner. Rare were the medical

³⁴ AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, 2004 NATIONAL HEALTHCARE DISPARITIES REPORT 7, 10, 12-13 (2005), available at <http://www.qualitytools.ahrq.gov/qualityreport/documents/nhqr2004.pdf>.

³⁵ *Id.* at 12-13. In 2005, U.S. government researchers continue to refine methodological issues in health disparities research, but fail to discuss this problem of over adjustment. See Kenneth Keppel et al., *Methodological Issues In Measuring Health Disparities*, in VITAL HEALTH STATISTICS (National Center for Health Statistics, Series 2, No. 141, 2005).

³⁶ PAUL FARMER, *INFECTIONS AND INEQUALITIES: THE MODERN PLAGUES* 5 (1999).

³⁷ *Id.* at 16, 37-58.

voices asserting the innate equality of Blacks.³⁸ Disparities in Black health arose in the context of slavery and were reinforced by state action in segregation and discrimination.³⁹ Roma Stewart notes the connection:

Some disparities are the vestiges of historical patterns of racial segregation. In Louisiana, for example, separate hospitals were built for blacks. Race, not ability to pay, determined which hospital was accessible to which patient. Until 1964 the Federal Government made grants and loans to segregated hospitals under the Hill-Burton Act. Further, until the mid-1960s, black physicians were not given staff privileges at some nonpublic hospitals. The vestiges of this system when combined with subtle discriminatory practices of today perpetuate health care access problems for black Americans.⁴⁰

The following section focuses on the acts of the federal, state and local governments and nonprofit organizations (such as the American Medical Association) to create and perpetuate Black health disparities.

A. The Slave Health System

Good farmers take care of their livestock, providing care and enlisting the assistance of a veterinarian as the situation warrants. Human

³⁸ See Nancy Krieger, *Shades of Difference: Theoretical Underpinnings of the Medical Controversy on Black/White Differences, 1830-1870*, 17 INT'L J. HEALTH SERV. 259, 260 (1987) [hereinafter Krieger, *Shades of Difference*].

³⁹ See W. MICHAEL BYRD & LINDA A. CLAYTON, 1 AN AMERICAN HEALTH DILEMMA: RACE, MEDICINE, AND HEALTH CARE IN THE UNITED STATES (BEGINNINGS TO 1900) (2000) [hereinafter DILEMMA (BEGINNINGS TO 1900)]; W. MICHAEL BYRD & LINDA A. CLAYTON, 2 AN AMERICAN HEALTH DILEMMA: RACE, MEDICINE, AND HEALTH CARE IN THE UNITED STATES (1900 TO 2000) (2002) [hereinafter DILEMMA (1900 TO 2000)] (an exhaustive two-volume review of the history of Black health); Nancy Krieger, *The Ostrich, the Albatross, and Public Health: An Ecosocial Perspective – Or Why an Explicit Focus on Health Consequences of Discrimination and Deprivation Is Vital for Good Science and Public Health Practice*, 116 PUBLIC HEALTH REPORTS 419 (2001); Randall, *Trusting*, *supra* note 6; Randall, *Deficit*, *supra* note 2, and Watson, *Race, Ethnicity and Quality of Care*, *supra* note 6, at 203. See generally SMITH, HEALTH CARE DIVIDED (1999) (an excellent book-length treatment).

⁴⁰ Roma J. Stewart, *Health Care and Civil Rights*, in CIVIL RIGHTS ISSUES IN HEALTH CARE DELIVERY, *supra* note 25, at 322-23.

chattel property was no different.⁴¹ Managing slave health was a major economic issue for the slave owner.⁴²

Todd Savitt studied the slave health care system in antebellum Virginia, finding several layers of care. Sanitary and public health measures were somewhat effective,⁴³ often supported as necessary for white health due to physical proximity.⁴⁴ This concept was later known as “germs have no color line.”⁴⁵

In addition to public health and sanitation, the master or overseer provided care in routine cases. Domestic medicine could be effective in some cases.⁴⁶ For serious cases of illness or injury, the slave owner hired physicians, either on an annual contract or on a fee for service basis.⁴⁷ In the mid-nineteenth century, the services of a physician did not necessarily improve health. Prior to the discovery of

⁴¹ WILLIAM DOSITE POSTELL, *THE HEALTH OF SLAVES ON SOUTHERN PLANTATIONS* (1951) (finding slaves to be as healthy as the general antebellum population); SMITH, *HEALTH CARE DIVIDED*, *supra* note 39, at 11-12; TODD L. SAVITT, *MEDICINE AND SLAVERY: THE DISEASES AND HEALTH CARE OF BLACKS IN ANTEBELLUM VIRGINIA 150* (1978) [hereinafter SAVITT, *MEDICINE AND SLAVERY*] (“Virginians often displayed concern for the health of blacks in bondage. The reasons were threefold: slaves represented a financial investment which required protection; many masters felt a true humanitarian commitment toward their slaves; and whites realized that certain illnesses could easily spread to their own families if not properly treated and contained.”); Walter Fisher, *Physicians and Slavery in the Antebellum Southern Medical Journal*, *J. OF THE HIST. OF MED.* 36-49 (Jan. 1968); Felice Swados, *Negro Health on the Ante Bellum Plantations*, 10 *BULL. HIST. MED.* 460, 460-472 (1941) (detailing the deficiencies of plantation health care). Apologists of slavery tended to exaggerate the medical benefits of the slave health system. See, e.g., L.C. Allen, *The Negro Health Problem*, 5 *AM. J. PUB. HEALTH* 194-195 (1915) (“It is undoubtedly true that the negro race has deteriorated physically and morally since slavery times...There was no more healthy race of people to be found anywhere in the world than the slaves of the South before the Civil War”) [hereinafter Allen, *Problem*]. See Postell, *supra*, at 164, for a more balanced conclusion.

⁴² FREDERICK LAW OLMSTED, *THE COTTON KINGDOM: A TRAVELLER’S OBSERVATIONS ON COTTON AND SLAVERY IN THE AMERICAN SLAVE STATES* 439-440, 449 (Arthur M. Schlesinger ed., 1969) (1861) (quoting a Mississippi planter as encouraging better health care for slaves, in the economic interests of the planters); Postell, *supra* note 41, at 22, 50-52 (accord, and also suggesting that planters responded to morality in providing health care to slaves); *but see* Frederick Douglass, *NARRATIVE OF THE LIFE OF FREDERICK DOUGLASS, AN AMERICAN SLAVE* 153-59 (Houston A. Baker, Jr. ed., Penguin Books 1982) (1845).

⁴³ SAVITT, *MEDICINE AND SLAVERY*, *supra* note 41, at 57-73.

⁴⁴ SAVITT, *MEDICINE AND SLAVERY*, *supra* note 41, at 208, 221-22.

⁴⁵ See VANESSA NORTHINGTON GAMBLE, *GERMS HAVE NO COLOR LINE: BLACKS AND AMERICAN MEDICINE, 1900-1940* (1989) [hereinafter GAMBLE, *GERMS*].

⁴⁶ POSTELL, *supra* note 80, at 102 (comparing various treatment regimes).

⁴⁷ SAVITT, *MEDICINE AND SLAVERY*, *supra* note 41, at 165-71, 191.

the germ theory and anesthetics, modern (allopathic) medicine could be dangerous and was not very effective.⁴⁸ Effective antebellum therapies included smallpox vaccination,⁴⁹ hernia repair,⁵⁰ and quinine.⁵¹ Many other therapies, such as heroic bleeding and purging, were useless or dangerous.⁵²

Black communities accepted traditional African medicine surreptitiously, parallel to the master's medicine.⁵³ Black suspicion of white medicine began in slavery, but was reinforced by the exclusion of Blacks from the medical establishment and the use of Blacks in medical training and experiments in the nineteenth and twentieth centuries.⁵⁴ Understanding this history might inform the current literature on patient compliance; it might explain some of the difficulties experienced today between white providers and Black patients.⁵⁵ Todd Savitt noted the pattern of reticence to submit to the master's medicine:

Beyond the master's and overseer's eyes, back in the slaves' cabins, some Virginia blacks took medical matters into their own hands. When under the surveillance of whites, slaves usually (but not always) accepted their treatments. Some even administered them in the

⁴⁸ Kevin Outterson, *Healthcare, Technology & Federalism*, 103 W. VA. L. REV. 503, 507-11 (2001); Savitt, *Medicine and Slavery*, *supra* note 41, at 167 ("The main virtue of most irregular health systems was their relative harmlessness, especially when compared with traditional approaches.").

⁴⁹ SAVITT, *MEDICINE AND SLAVERY*, *supra* note 41, at 220; Outterson, *supra* note 48, at 507-11.

⁵⁰ SAVITT, *MEDICINE AND SLAVERY*, *supra* note 41, at 135.

⁵¹ SAVITT, *MEDICINE AND SLAVERY*, *supra* note 41, at 155-56.

⁵² POSTELL, *supra* note 41, at 50-128.

⁵³ EDWARD H. BEARDSLEY, *A HISTORY OF NEGLECT: HEALTH CARE FOR BLACKS AND MILL WORKERS IN THE TWENTIETH-CENTURY SOUTH* 30-35 (1987) [hereinafter BEARDSLEY, *NEGLECT*]; Postell, *supra* note 41, at 59; SAVITT, *MEDICINE AND SLAVERY*, *supra* note 41, at 149, 171-84.

⁵⁴ See, e.g., SAVITT, *MEDICINE AND SLAVERY*, *supra* note 41, at 281-307; Walter Fisher, *Physicians and Slavery in the Antebellum Southern Medical Journal* J. HIST. MED. 36, 45-49 (1968) (Black bodies were used in southern medical schools for training and experimentation); SMITH, *HEALTH CARE DIVIDED*, *supra* note 39, at 24-27; W. Montague Cobb, *Surgery and the Negro Physician: Some Parallels in Background*, 43 J. NAT'L MED. ASS'N 145, 147-49 (1951).

⁵⁵ See, e.g., Michelle van Ryn, *Paved with Good Intentions: Do Public Health and Human Service Providers Contribute to Racial/Ethnic Disparities in Health?*, 93 AM. J. PUB. HEALTH 248 (2003); Laura M Bogart et al., *Factors Influencing Physicians' Judgments of Adherence and Treatment Decisions for Patients with HIV Disease*, 21 MED. DECISION MAKING 28 (2001). See LAURIE KAYE ABRAHAM, *MAMA MIGHT BE BETTER OFF DEAD: THE FAILURE OF HEALTH CARE IN URBAN AMERICA* (1993), for a chronicle of a multi-generational Black family's interaction with the health care system in Chicago.

name of the master. But others developed or retained from an ancient African heritage their own brand of care, complete with special remedies, medical practitioners, and rituals. The result was a dual system of health care, the two parts of which constantly conflicted with each other.⁵⁶

The slave health system was paternalistic and primarily served the interests of the master; however, it provided some limited health care and retirement benefits to slaves.⁵⁷ By comparison, free Blacks arranged and paid for their own health care. Free Blacks suffered appalling health with a mortality rate approximately double the white rate.⁵⁸ Freedom did not mean equal health, so long as the other social conditions of life were unequally distributed. At Emancipation, all would be swept away and free Blacks would be abandoned to the marketplace to purchase or contract for whatever health care they could afford from whoever would be allowed to serve them.⁵⁹

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

Crises in public health often accompany war; the Civil War was no exception. Despite the end of legal slavery, Blacks suffered terribly from malnutrition, poverty and lack of access to land, capital, employment, education and health care.⁶⁰ In terms of health care, southern Blacks may have been worse off after the Civil War: they lost the paternalistic slave health care system and very little was available to replace it.⁶¹ A slave owner suffered financially if a slave died or

⁵⁶ SAVITT, *MEDICINE AND SLAVERY*, *supra* note 41, at 171.

⁵⁷ The practice of keeping aged slaves on the plantation, coupled with laws forbidding manumission of the aged and infirm, operated as a form of retirement benefit after the slaves were no longer able to work. SAVITT, *MEDICINE AND SLAVERY*, *supra* note 41, at 201-07. Postell goes further and concludes that slave health was equal to the general antebellum population. POSTELL, *supra* note 41, at 164.

⁵⁸ Gouverneur Emerson, *Medical Statistics*, 17 *AM. J. OF THE MEDICAL SCIENCES* 3, 35 (1831); Benjamin H. Coates, *On the Effects of Imprisonment on the African Races*, 4 *N.Y.J. MED.* 91, 92 (1844) (citing Emerson, *supra*, at 35-38). Black mortality within prisons was higher still. Coates' figures are for Philadelphia, since national data on antebellum Black health were not available.

⁵⁹ SAVITT, *MEDICINE AND SLAVERY*, *supra* note 41, at 207-17 (discussing antebellum health care for free Blacks); SMITH, *HEALTH CARE DIVIDED*, *supra* note 39, at 12-13.

⁶⁰ LEON F. LITWACK, *BEEN IN THE STORM SO LONG: THE AFTERMATH OF SLAVERY* (1979) [hereinafter LITWACK, *STORM*].

⁶¹ Todd L. Savitt, *Politics in Medicine: The Georgia Freedmen's Bureau and the Organization of Health Care, 1865-1866*, 38 *CIVIL WAR HIST.* 45, 64 [hereinafter Savitt, *Politics in Medicine*]. See Martin Abbott, *THE FREEDMEN'S BUREAU IN SOUTH CAROLINA, 1865-1872* 48-51, 66-69, 138-43 (1967) (some labor contracts overseen by the Freedmen's Bureau provided for health care); Howard N. Rabinowitz, *RACE*

missed work due to illness or injury. Antebellum landlords with Black contract laborers did not have similar financial incentives.⁶² White physicians, formerly paid by slave owners, were not eager to serve Blacks who were unable to pay for health care after the war.⁶³ At the dawn of the era that modern medicine was becoming more effective, Blacks were shut out from many of its benefits, with disastrous effects.⁶⁴ By 1900, the average Black life expectancy at birth was 30 to 35 years, 15 years less than the white LEAB.⁶⁵

When freedmen signed labor contracts with plantation owners after the Civil War, the contracts generally excluded any medical care coverage or required the freedmen to pay for it.⁶⁶ Alternative sources of health care were meager. The federal government and Northern philanthropists provided some charity care and limited public health programs; Blacks paid for other health care with their own resources.

1. Charitable Care and Public Health

Private charities were significantly involved in health care in the decades surrounding the Civil War, particularly for children and

RELATIONS IN THE URBAN SOUTH, 1865-1890, at 128-31 (1978); Marshall S. Legan, *Disease and the Freedmen in Mississippi During Reconstruction*, 28 J. HIST. MED. AND ALLIED SCIENCES 257-67 (1973); and Alan Raphael, *Health and Social Welfare of Kentucky Black People, 1865-1870*, 2 SOCIETAS 143-47 (1972). Although Abbott (and others) note the presence of health care provisions in labor contracts, he does not describe whether the freedmen were required to pay for the care when the crop was harvested. *C.f.* LOUIS S. GERTEIS, FROM CONTRABAND TO FREEDMAN: FEDERAL POLICY TOWARD SOUTHERN BLACKS 1861-1865, at 73, 86, 104, 127, 163 (1973) (employers charged for medical care). In addition, the contracts charged freedmen for absence from work, even if due to sickness, at the customary rate of 50 cents per day. The plantation owner after slavery probably did not have clear economic incentives to maximize the health of his Black workers.

⁶² POSTELL, *supra* note 41, at 22, 50-52. *See infra* n.100.

⁶³ *See* POSTELL, *supra* note 41, at 66 (noting that before the war, the plantation owner always was responsible for paying the physician's bill).

⁶⁴ UNEQUAL TREATMENT, *supra* note 3, at 103-05; Ann Hallman Pettigrew & Thomas F. Pettigrew, *Race, Disease and Desegregation: A New Look*, 24 PHYLON 315, 333 (1963); Postell, *supra* note 80, at 80, 143, 151 (describing the apparent increase in Black morbidity and mortality after the Civil War); Savitt, *Politics in Medicine*, *supra* note 61, at 63. Cutler and Meara found that most gains in mortality in the early 20th century resulted from public health and economic measures, while medical care began to significantly reduce mortality by mid-century. DAVID M. CUTLER & ELLEN MEARA, CHANGED IN THE AGE DISTRIBUTION OF MORTALITY OVER THE 20TH CENTURY 1-4 (Nat'l Bureau of Econ. Research, Working Paper No. 8556, 2001).

⁶⁵ Pettigrew, *supra* note 64, at 333; *United States Life Tables, 2000*, *supra* note 24, at 33 tbl.12.

⁶⁶ *See* Savitt, *Politics in Medicine*, *supra* note 61, at 61-62. *But see infra* n.96.

sanitary public health programs.⁶⁷ As the Civil War progressed, slaves who reached Union lines required some protection. Rather than permit uncontrolled Black refugee migration to the North, and to avoid hindering military operations, the Army settled them into camps in Union-controlled southern states.⁶⁸ In these camps and other Union-controlled areas, charities such as the American Missionary Association and the various Sanitary Commissions provided education and assistance, including public health care programs.⁶⁹

In the midst of the Civil War, the War Department and the Treasury Department organized relief and contract labor programs for “contraband” Blacks escaping slavery.⁷⁰ The goal of these efforts was to put Blacks back to work for the Union.⁷¹ At the end of the war, federal assistance to former slaves was transferred to the Freedmen’s Bureau, established by Congress on March 3, 1865.⁷² The efforts of the Medical Department of the Freedmen’s Bureau, while heroic in aspiration, were chaotically organized and ineffective in meeting the crushing needs.⁷³ Hospitals and other institutions were established across the South.⁷⁴ Five Black hospitals were established in Georgia

⁶⁷ See generally Robert H. Brenner, *THE PUBLIC GOOD: PHILANTHROPY AND WELFARE IN THE CIVIL WAR ERA* 14-34 (1980).

⁶⁸ Brenner, *supra* note 70, at 88-89; Gerteis, *supra* note 61, at 24 (discussing a federal policy which encouraged contraband slaves to remain in the South); CHARLES J. STILLE, *HISTORY OF THE UNITED STATES SANITARY COMMISSION* (J.B. Lippincott & Co. 1866).

⁶⁹ See GERTEIS, *supra* note 61, at 20, 121. See generally Brenner, *supra* note 70, at 91-110.

⁷⁰ See GERTEIS, *supra* note 61, *passim*.

⁷¹ See *id.* at 60, 83, 151.

⁷² An Act to Establish a Bureau for the Relief of Freedmen and Refugees, 13 Stat. 507 (1865).

⁷³ See Savitt, *Politics in Medicine*, *supra* note 61, at 45; Abbott, *supra* note 61, at 135 (concluding that the Bureau’s work in South Carolina was “a qualified failure,” hamstrung by meagre resources, daunting needs and southern opposition). Louis Gerteis viewed the Freedmen’s Bureau as still-born from inception, given the record of the contract labor system for contraband during the Civil War. GERTEIS, *supra* note 61, at 185 (“Under the circumstances, the Freedmen’s Bureau, which paid lip service to the idea of creating a class of independent black farmers, could do little more than preside over the liquidation of wartime labor programs while facilitating the restoration of antebellum property rights and institution of a contract labor system throughout the South. Denying the Bureau any real power and discarding the agricultural programs begun during the war, Congress replaced programs of government protection and support with hollow promises of land for freedmen and poor whites.”).

⁷⁴ See Brenner, *supra* note 106, at 116-17, n.11; Abbott, *supra* note 61, at 48-51 (describing significant medical care provided in South Carolina by the Bureau).

by the Freedmen's Bureau, but the lack of supplies, personnel and adequate facilities crippled efforts.⁷⁵ When beds were available at all, they were occupied by two or three patients simultaneously.⁷⁶ The head of the Freedmen's Bureau wrote in 1869 that only 1 out of 200 freedmen received assistance, generally the very poorest.⁷⁷ The health work of the Freedmen's Bureau only lasted for three years; afterwards impoverished former slaves could look only to local governments or charities for access to health care.⁷⁸ The institutional legacy of the Freedmen's Bureau was the Freedmen's Hospital and Asylum in Washington, D.C., which today is the Howard University Hospital,⁷⁹ one of the few remaining historically Black hospitals.⁸⁰

After Reconstruction, charities and public health agencies demonstrated little interest in Black health, with a few exceptions.⁸¹ Many public health efforts for Blacks were stained with racism and social Darwinism: Blacks were described as a race in decline; Black extinction would solve the American race problem.⁸² Black health was important primarily to avoid the spread of communicable diseases to whites, as if Blacks were merely an epidemiological vector like rats or

⁷⁵ Savitt, *Politics in Medicine*, *supra* note 61, at 55 (letter of Dr. D'Alvigny, Jan. 8, 1866). A letter from one of the physicians is instructive: "Many of my patients ... died from the Want of comfort and clothes: Some of then entirely Naked. Last week the weather was very inclement ... at which time I was not able to be Supplied with wood and five of my patients died from sudden chills.... I have not been able to give my female patients a change, even of chemise, since they are under me. Some are now laying all the time in Bed from want of covering their Frames. Notwithstanding repeated requisitions [for supplies] made by me." *Id.*

⁷⁶ *Id.* at 55.

⁷⁷ Brenner, *supra* note 70, at 125 (citing U.S. WAR DEPARTMENT, REPORT OF THE COMMISSIONER BUREAU REFUGEES, FREEDMEN, in 1 U.S. WAR DEPARTMENT: ANNUAL REPORT, 1868-69, at 502 (1869)).

⁷⁸ Savitt, *Politics in Medicine*, *supra* note 61, at 60-61.

⁷⁹ Brenner, *supra* note 106, at 142-43, n.91

⁸⁰ *The Crisis of the Disappearing Black Hospitals*, EBONY, March 1, 1992, at 23 [hereinafter *Black Hospitals*].

⁸¹ See generally Paul B. Cornely, *Segregation and Discrimination in Medical Care in the United States*, 46 AM. J. PUB. HEALTH 1074, 1075 (1956). One of the most ardent charities in support of Black health was the Julius Rosenwald Fund, but even this leading light only allocated \$1.5mm to Black health in the period 1928-1942. See generally Edwin R. Embree, *Two Years of Progress in Advancement of Health of the Negro Reported by Julius Rosenwald Fund*, 10 NAT'L NEGRO HEALTH NEWS 31 (1942). Embree was the scion of a famous abolitionist family. See generally Edwin R. Embree, BROWN AMERICANS (1943).

⁸² See GAMBLE, GERMS, *supra* note 45, at Introduction. See generally BEARDSLEY, NEGLECT, *supra* note 53, at 129-30.

mosquitoes.⁸³ At the 1914 General Session of the American Public Health Association, the Health Officer from Savannah, Georgia warned:

There are 5,000 or more negroes in this city who are parasites and their removal would lower the death-rate and reduce crime; therefore, it is recommended that some remedy be applied by enacting building laws preventing the congestion of negroes and the elimination of the depredate class.⁸⁴

The dominant white ideology was disdainful of making important long term investments in Black health.⁸⁵ One example was the publication in 1896 of Frederick L. Hoffman's RACE TRAITS AND TENDENCIES OF THE AMERICAN NEGRO, which argued that Blacks were physically and mentally inferior and would not survive long in North America.⁸⁶ Hoffman was not a fringe author, but a statistician for Prudential Insurance Company; the volume was published by the American Economic Association. This hugely popular book reflected and encouraged an apathetic approach to meeting the health needs of

⁸³ GAMBLE, GERMS, *supra* note 45, at Introduction. See Allen, *Problem*, *supra* note 41, at 194 (quoting a remarkably racist speech delivered before the 1914 General Session of the American Public Health Association) ("Disease among the negroes is a danger to the entire population. Communicable diseases find their favorite propagating grounds in the dirty negro sections of our cities, and in unsanitary negro homes in the country."). A similar speech at the same session warned: "recognize the negro as a potent factor in the transmission of disease...you will suffer. The negro of the lower class is thrown into domestic contact with you and he furnishes 80 per cent. of your household help. You cannot keep pace with modern sanitation unless you care for him." William F. Brunner, *The Negro Health Problem In Southern Cities*, 5 AM. J. PUB. HEALTH 183, 189 (1915). Racist ideology may have assisted in promoting public health measures such as municipal water and sewer systems, which could not be easily denied to Blacks. Troesken estimates that at least 25% of the reduction in Black mortality from 1900 to 1940 was due to the introduction of water and sewer systems. Troesken, *supra* note 24, at 208.

⁸⁴ Brunner, *supra* note 83, at 185. See Trask, *supra* note 14, for a contrary contemporary view.

⁸⁵ Nancy Krieger, *Shades of Difference*, *supra* note 38, at 259.

⁸⁶ FREDERICK L. HOFFMAN, RACE TRAITS AND TENDENCIES OF THE AMERICAN NEGRO (William S. Hein & Company 2004) (1896). Hoffman's book was reprinted in March 2004, with an introduction by Paul Finkelman. 1896 also marked the publication of the first of many statistical studies on the American Negro by Atlanta University with more sanguine prospects for Black survival. See generally MORTALITY AMONG NEGROES IN CITIES 42 (Thomas N. Chase ed., 1896).

Blacks, a view that largely held sway for a century after Emancipation.⁸⁷ Tuberculosis is a prominent example of the neglect of Black public health, particularly in the South.⁸⁸ Estimates in the 1920s suggested that effective control of tuberculosis using available methods would have extended the average Black life span by five years.⁸⁹ Southern public health agencies failed to serve the pressing needs of Black citizens:

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

⁸⁷ See generally DILEMMA (1900 TO 2000), *supra* note 39, at 35-65; SMITH, HEALTH CARE DIVIDED, *supra* note 39, at 8-24 (discussing the scope and effect of scientific racism on Black health). Similar views were expressed in medical journals prior to the Civil War. See Samuel A. Cartwright, *Report on the Diseases and Physical Peculiarities of the Negro Race*, NEW ORLEANS MED. & SURGICAL J. 89 (May 1851) (articulating biological and theological differences requiring slavery); BEARDSLEY, NEGLECT, *supra* note 53, at 11-41, 128-55 (providing a thorough review of Black health in the South during the first thirty years of the twentieth century and the role of public health for Blacks).

⁸⁸ See H.M. Green, *Hospitals and Public Health Facilities for Negroes*, 1928 PROC. OF THE NAT’L CONF. OF SOC. WORK 179-180 (1928). See GAMBLE, GERMS, *supra* note 45 (providing a collection of medical articles from the period 1900 to 1940 on Black health, particularly tuberculosis). Public health efforts amongst Blacks in Northern cities were more effective. See BEARDSLEY, NEGLECT, *supra* note 53, at 26-27.

⁸⁹ C.S. Johnson, *Negro Health In Light of Vital Statistics*, 1928 PROCEEDINGS OF THE NATIONAL CONFERENCE OF SOCIAL WORK 173-75 (1928). Johnson also notes that even with the significant racial disparities in health status in the United States, substantial progress had been made when compared to many European countries. For example, he notes that the Black infant mortality rate in the mid-1920s was less than the overall infant mortality rate in Austria, Belgium, Bulgaria, France, Germany, Italy, Rumania, Hungary and Spain. *Id.* at 175. See GAMBLE, GERMS, *supra* note 84; Troesken, *supra* note 24, at 10, 208 (substantial progress in municipal water and sewer systems for both whites and Blacks greatly improved public health).

their black patrons by a wider margin than any other group.⁹⁰

2. Market-Based Health Care

In the decades surrounding the Civil War, health care was a relatively free market, mostly unencumbered by regulation.⁹¹ Blacks with financial resources purchased health care services in the marketplace. Other Blacks aspired to provide those services as doctors or other health professionals. Both of these options were frustrated by racism. Racism forced Blacks to resort to a segregated medical system to serve their health needs.

After the Civil War, hospitals became increasingly important sites for medical care,⁹² but hospital discrimination relegated Black patients to segregated wards or excluded them altogether. Many hospitals were not available to Blacks in the first half of the twentieth century.⁹³ In addition to the hospitals practicing racial segregation, almost a quarter of hospitals in 1922 practiced complete exclusion of Blacks.⁹⁴ According to a 1928 survey, “each white citizen of the United States has fourteen times as good a chance at proper hospital care as has the Negro.”⁹⁵ In 1930, the number of hospital beds per person available to Blacks was one-fourteenth the white rate.⁹⁶ A 1956

⁹⁰ BEARDSLEY, *NEGLECT*, *supra* note 53, at 128. *See* Cornely, *supra* note 120, at 1080. *But see generally*, 10 NAT’L NEGRO HEALTH NEWS (1942) (emphasizing the advanced made in public health for Blacks).

⁹¹ *See generally* Outterson, *supra* note 48, at 510-15. In some respects, the current consumer-driven health care movement seeks a return to this milieu. DAVID BARTON SMITH, *ELIMINATING DISPARITIES IN TREATMENT AND THE STRUGGLE TO END SEGREGATION* vii, 8-17 (2005) [hereinafter SMITH, *ELIMINATING DISPARITIES*] (a well documented look at current segregation in U.S. healthcare, circa 2005, with a strong critique against reliance upon market-based solutions to racial disparities in health).

⁹² CHARLES E. ROSENBERG, *THE CARE OF STRANGERS: THE RISE OF AMERICA’S HOSPITAL SYSTEM* 5 (1987).

⁹³ Cornely, *supra* note 81, at 1074-75 (discussing racial discrimination in health care 1930-1949, both North and South); DuBois, *supra* note 16, at 93-95 (hospital segregation as of 1906).

⁹⁴ ROSEMARY STEVENS, *IN SICKNESS AND IN WEALTH: AMERICAN HOSPITALS IN THE TWENTIETH CENTURY* 137 (1989) [hereinafter STEVENS, *IN SICKNESS AND IN WEALTH*].

⁹⁵ Green, *supra* note 88, at 179. Dr. Green compared the 6,807 U.S. hospitals with 853,318 beds to the 210 hospitals “available to [Negroes]” with 6,780 beds. *Id.* It is unclear how he accounts for segregated wards in white hospitals.

⁹⁶ Peter Marshall Murray, *Hospital Provision for the Negro Race*, 4 BULL. AM. HOSP. ASS’N 37 (1930), *reprinted in* GAMBLE, *GERMS*, *supra* note 45, at 109.

survey found only 5.8% of southern hospitals to be integrated.⁹⁷ When segregated hospitals were available to Blacks, they were often used for training white physicians, residents and interns.⁹⁸ The Veteran's Administration built a Black hospital in Tuskegee rather than accept integration of World War I veterans.⁹⁹ Post-acute and sub-acute institutions also excluded Blacks.¹⁰⁰

These forms of segregation were supported by Supreme Court opinions eviscerating the Fourteenth Amendment's Equal Protection Clause. Beginning in the 1870's, the Supreme Court embraced a color-blind jurisprudence in numerous cases gutting civil rights, including *Virginia v. Rives*,¹⁰¹ *Gibson v. Mississippi*,¹⁰² *The Civil Rights Cases*,¹⁰³ *Plessy v. Ferguson*,¹⁰⁴ *Hodges v. United States*,¹⁰⁵ and *Corrigan v.*

⁹⁷ Cornely, *supra* note 81, at 1079. Northern hospitals claimed to be 82.5% integrated, but this figure was likely to be highly inflated, given the Department of Health, Education and Welfare's experience in Title VI compliance certification a decade later. *Id.* See Michael Meltsner, *Equality and Health*, 115 UNIV. OF PENN. L. REV. 22, 31-38 (1966).

⁹⁸ See Green, *supra* note 88 ("Many cities, especially in the South, provide wards, usually in the basement of their city hospitals, for Negro patients. A few northern cities admit Negro patients to their free wards along with their white paupers. These institutions invariably exclude Negro physicians. Here the Negro patients (North and South) are used largely as clinical material for training interns of another race, a practice employed by no other civilized country in the world."). See also Myrdal, *supra* note 15, at 635 (describing segregation and racial exclusion practices in hospitals in the United States in the early 1940's); STEVENS, IN SICKNESS AND IN WEALTH, *supra* note 129, at 137.

⁹⁹ STEVENS, IN SICKNESS AND IN WEALTH, *supra* note 94, at 127. Thirty years later, a proposal to build a second Black VA hospital was defeated, an early limited victory for hospital integration. VANESSA NORTHINGTON GAMBLE, MAKING A PLACE FOR OURSELVES: THE BLACK HOSPITAL MOVEMENT, 1920-1945, at 186 (1995) [hereinafter GAMBLE, MAKING A PLACE].

¹⁰⁰ Brenner, *supra* note 67, at 182-83; SMITH, HEALTH CARE DIVIDED, *supra* note 39, at 236-75 (discussing long term care).

¹⁰¹ See generally *Virginia v. Rives*, 100 U.S. 313 (1879) (upholding a facially color blind Virginia juror selection system which had the effect of excluding all Blacks).

¹⁰² See generally *Gibson v. Mississippi*, 162 U.S. 565 (1896) (upholding the juror qualification provision of the infamously racist Mississippi Constitution of 1890).

¹⁰³ See generally *The Civil Rights Cases*, 109 U.S. 3 (1883) (finding the Civil Rights Act of 1875 unsupported by the Civil War Amendments).

¹⁰⁴ See generally *Plessy v. Ferguson*, 163 U.S. 537 (1896) (upholding "equal, but separate" public accommodation on Louisiana railroads).

¹⁰⁵ See generally *Hodges v. United States*, 203 U.S. 1 (1906) (private conspiracy to forcibly prevent African Americans from working, solely on the basis of race and color).

Buckley.¹⁰⁶ As I concluded in an *amicus* brief for the University of Michigan affirmative action cases:

These cases are the oration of Brutus, praising the one he has slain; they were the federal pillars of white supremacy for nearly a century, shamelessly professing ‘color blind’ equality while turning a blind eye to the harsh reality of life as an African American during Jim Crow.¹⁰⁷

The Black response to health care segregation was to construct a parallel Black system, which at its peak in the 1920s and 1930s numbered perhaps 200 Black hospitals.¹⁰⁸ These hospitals did not embrace segregation, but were a defensive response to American racism. Black medical institutions and professionals were largely insulated from white interference, permitting advocacy for Black issues without fear of economic reprisal.¹⁰⁹ In theory, a separate but equal system of health care would not be dangerous for Blacks. Truly equal systems would not suffer disparities. But white supremacy, particularly after Reconstruction, denied equality and corralled Blacks into an inferior health care system for generations.¹¹⁰

¹⁰⁶ See generally *Corrigan v. Buckley*, 271 U.S. 323 (1926) (racially restrictive covenants).

¹⁰⁷ See Kevin Outterson et al., Brief for the National Coalition of Blacks For Reparations in America (N’COBRA) and the National Conference of Black Lawyers (NCBL) as Amici Curiae Supporting Respondents, *Grutter v. Bollinger*, 539 U.S. 306 (2003) and *Gratz v. Bollinger*, 539 U.S. 244 (2003), available at <http://ssrn.com/abstract=392060>. See generally Glenn C. Loury, *THE ANATOMY OF RACIAL INEQUALITY* (2002) (providing an economic and philosophical critique of color blind jurisprudence). See generally Andre Douglas Pond Cummings, *Grutter v. Bollinger, Clarence Thomas, Affirmative Action and the Treachery of Originalism: The Sun Don't Shine Here in this Part of Town*, 21 HARV. BLACKLETTER L.J. 1 (2005) (providing a narrative and critical treatment).

¹⁰⁸ GAMBLE, *MAKING A PLACE*, *supra* note 99, at 183 (listing 169 Black hospitals in 1929). See generally SMITH, *HEALTH CARE DIVIDED*, *supra* note 39, at 16-21; Edward T. Morman, *Book Review*, 70 BULL. OF HIST. OF MED. 335 (1996) (reviewing GAMBLE, *MAKING A PLACE*, *supra* note 99); Cornely, *supra* note 81, at 1078-80; *Black Hospitals*, *supra* note 80, at 23.

¹⁰⁹ SMITH, *HEALTH CARE DIVIDED*, *supra* note 39, at 38 (“Black physicians and dentists made up the backbone of local chapters of the NAACP.”).

¹¹⁰ See, e.g., Josiah C. Nott, *Caucasian and Negro Races*, 30 BOSTON MED. SURG. J. 244 (1844) (arguing that Blacks are a different species, not suited to non-tropical regions, and linking this argument to higher morbidity and mortality rates); See STEVENS, *IN SICKNESS AND IN WEALTH*, *supra* note 94, at 9, 50 (social stratification is a primary characteristic of American hospitals).

Racism also led to the creation of segregated Black medical professions.¹¹¹ Paul Starr chronicled the rise of medicine as a profession from the 1850s, and the growing power of the American Medical Association,¹¹² but Black physicians were largely excluded from the AMA and its constituent societies. Black physicians were generally denied admitting privileges to hospitals, even to segregated wards. Denial of admitting privileges hurt Black physicians financially; some Black physicians (such as surgeons) needed a hospital in order to practice at all. The mechanism of exclusion was a requirement that the physician hold membership in the all-white local AMA medical society. This permitted both the AMA and hospitals to maintain the facade of equal opportunity for decades while the local medical society enforced discrimination.¹¹³

Overt discrimination against Black physicians in the South persisted well into the 1960's, with the AMA issuing non-binding proclamations of non-discrimination, but refusing to challenge discriminatory practices by its local and state constituent medical societies.¹¹⁴ In June, 1963, the Medical Committee for Civil Rights

¹¹¹ SMITH, HEALTH CARE DIVIDED, *supra* note 39, at 42-43. The segregated medical professional organizations included physicians (American Medical Association and National Medical Association), dentists (American Dental Association and National Dental Association) and hospitals (American Hospital Association and National Hospital Association (1923)); the parallel nursing organizations (American Nurses' Association and the National Association of Colored Graduate Nurses) effectively merged after a long history of working together to combat segregation. *Id.* In 1971, Black nurses re-founded a separate association, the National Black Nurses Association. GAMBLE, MAKING A PLACE, *supra* note 99, at 195. See DIETRICH C. REITZES, NEGROES AND MEDICINE 3-12 (1958) (describing data showing increased access for Black physicians, particularly in the North); Cornely, *supra* note 81, at 1078 ("at the present time [1956] not one state or county dental society is opened to Negro dentists ... who... [are] barred from even joining his national organization, the American Dental Association").

¹¹² See generally Paul Starr, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982).

¹¹³ Cornely, *supra* note 81, at 1077-78 (discussing role of AMA and its constituent societies in denying hospital admission privileges to Black physicians). See generally BEARDSLEY, NEGLECT, *supra* note 92, at 79-80; DILEMMA (1900 TO 2000), *supra* note 39, at 35-65; SMITH, HEALTH CARE DIVIDED, *supra* note 57, at 13-21, 32-39, 68-74 (1999); REITZES, *supra* note 111, at 331-32 (providing tables which summarize the extent of health care discrimination in the 1950s in fourteen cities across the nation); Cobb, *supra* note 54, at 150.

¹¹⁴ HERBERT M. MORAIS, THE HISTORY OF THE NEGRO IN MEDICINE 152, 153, 175, 224 (1970). The AMA passed weak resolutions in 1950 and 1952, but did nothing to prevent its local and state medical societies from excluding Blacks from membership,

issued “An Appeal to the AMA” which challenged the AMA to: (1) speak out against segregation and discrimination; (2) terminate any state or local medical societies which continued to practice racial exclusion; (3) oppose Hill-Burton “separate but equal” funding; and (4) oppose the re-credentialing of any non-integrated hospital.¹¹⁵ The AMA failed to act decisively until the passage of the Civil Rights Act of 1964 and Medicare in 1965. For example, the first Black member of the Chattanooga and Hamilton County Medical Society was Dr. Hiram B. Moore in 1964.¹¹⁶ Admission to the Society was required before gaining hospital admission privileges at Chattanooga’s two hospitals, publicly-owned Erlanger and the private Memorial Hospital.¹¹⁷ Similar conditions prevailed in Chicago in 1963.¹¹⁸ The residual effects of this legacy still remain: a recent study found that Black doctors still report greater difficulty obtaining hospital admissions than white physicians, even after controlling for a wide range of practice and environmental characteristics.¹¹⁹

Blacks also developed a separate medical education system. Under AMA pressure, access to the medical profession increasingly required a college degree followed by medical school; both avenues were less available to Blacks.¹²⁰ The nursing profession faced similar barriers. Of the 1800 accredited nursing schools in the mid-1920’s, only 58 admitted Black students.¹²¹ Black colleges were the natural response,¹²² including the two leading Black medical schools, Howard in Washington and Meharry in Nashville. Prior to the 1960’s, the vast

with full knowledge that such membership was necessary to be appointed to the medical staffs of most hospitals. *Id.*

¹¹⁵ MORAIS, *supra* note 114, at 162. Beardsley highlights some token moves by the AMA and its societies in the 1950’s, but fails to explain why the Medical Committee for Civil Rights was still demanding desegregation from the AMA in 1963. BEARDSLEY, NEGLECT, *supra* note 53, at 251-52.

¹¹⁶ MORAIS, *supra* note 114, at 178.

¹¹⁷ *Id.* at 179.

¹¹⁸ See *Morris v. Chicago Hospital Council*, 9 RACE REL. REP. 1838 (1964).

¹¹⁹ J. Lee Hargraves et al., *Minority Physicians’ Experiences Obtaining Referrals to Specialists and Hospital Admissions*, 3 MEDSCAPE GEN. MED., August 9, 2001, at ¶18, available at <http://www.medscape.com/viewarticle> (also reporting that Hispanic physicians were more likely to report problems in obtaining a specialist referral; 58% of Hispanic physicians were educated outside the U.S., compared with 11% of white physicians).

¹²⁰ Cobb, *supra* note 54, at 149; DuBois, *supra* note 16, at 95-109.

¹²¹ Abbie Roberts, *Nursing Education and Opportunities for the Colored Nurse*, 1928 PROCEEDINGS OF THE NATIONAL CONFERENCE OF SOCIAL WORK 183, 183 (1928).

¹²² Brenner, *supra* note 67, at 212.

majority of Black physicians were trained in Black medical schools, but Blacks were barely 1% of all medical students in training.¹²³ The first southern medical school to admit Blacks was the University of Arkansas in 1948.¹²⁴ It was not until 1966-67 that the last southern medical schools admitted a Black medical student.¹²⁵ In 1950, Blacks were 10 percent of the population, but only 2.2 percent of all physicians,¹²⁶ and only 133 Blacks graduated from medical school, mostly from Meharry and Howard.¹²⁷ Over the last decade, the number of Black graduates from medical school has declined despite the fact that Blacks are underrepresented as physicians¹²⁸ and medical school faculty members.¹²⁹ Since the end of legal segregation, the Black physician deficit has been reduced somewhat (in 2004, only 6.4% of graduating medical students were Black);¹³⁰ however, at these rates it may take a long time to reach equality.

By the dawn of the twentieth century the pattern was firmly set: official neglect of Black health needs, unmitigated by the former property interest; discrimination against Black health institutions and providers in a separate and unequal system; government deferral to racist professional organizations; and 'color-blind' interpretations of the Equal Protection Clause to deny a Constitutional remedy.

C. The New Deal Generation, 1933-1964

The Depression visited economic havoc on Black communities. Employment discrimination meant that Blacks were the last to be hired and the first to be fired, and trade unions generally excluded Blacks to protect white privilege.¹³¹ To some extent, the New Deal responded to

¹²³ Cornely, *supra* note 81, at 1074, 1076-77. See REITZES, *supra* note 111, at 3-43 (including a statistical review of Black physicians, medical students and applicants, published in 1958).

¹²⁴ Cornely, *supra* note 81, at 1075.

¹²⁵ BEARDSLEY, NEGLECT, *supra* note 53, at 255; Sullivan, *supra* note 20, at 14.

¹²⁶ REITZES, *supra* note 111, at xxvii.

¹²⁷ *A JBHE Check-Up on Blacks in U.S. Medical Schools*, Journal of Blacks in Higher Education, July 18, 2005, at ¶4, available at http://www.jbhe.com/features/47_medicalschoools.html.

¹²⁸ Hargraves, *supra* note 124, at tbl.1.

¹²⁹ Journal of Blacks in Higher Education, *supra* note 127.

¹³⁰ Association of American Medical Colleges, *Minorities in Medical Education; Facts and Figures, 2005*, <http://www.aamc.org/factsandfigures>.

¹³¹ MICHAEL K. HONEY, SOUTHERN LABOR AND BLACK CIVIL RIGHTS: ORGANIZING MEMPHIS WORKERS 221 (1993).

these needs, a remarkable achievement given the tenuous position held by Blacks in American society at the time.¹³²

1. A New Deal For Blacks¹³³

FDR and several of his close advisors cautiously advanced some programs for Blacks. Actions included appointments of Blacks to federal offices,¹³⁴ and employment in the Works Progress Administration and other federal programs.¹³⁵ In an early model for Title VI, President Franklin Delano Roosevelt signed Executive Order 8802 mandating non-discrimination in some government contracts.¹³⁶ The impetus was Philip A. Randolph's threatened march on Washington in 1941.¹³⁷ In health care, Public Health Service grants to states improved Black health¹³⁸ and the Public Works Administration embarked on a program of hospital construction which made an additional 8,000 beds available to Blacks.¹³⁹ Social Security was passed without explicit racial tests for participation or benefits, although the exclusion of agricultural and household workers disproportionately affected Blacks.¹⁴⁰ In contrast to unbridled white supremacy, the New Deal provided some benefits to Blacks on a basis of near equality, providing the first significant federal assistance since the Freedmen's Bureau.¹⁴¹ Black advances were modest overall. Most of the relief programs accommodated the southern planting and harvesting schedule, suspending operations in order to encourage adequate field labor.¹⁴² Robust civil rights laws were not passed and

¹³² John Brueggemann, *Racial Considerations and Social Policy in the 1930s: Economic Change and Political Opportunities*, 26 SOC. SCI. HIST. 139, 139 (2002)

¹³³ See generally HARVARD SITKOFF, *A NEW DEAL FOR BLACKS: THE EMERGENCE OF CIVIL RIGHTS AS A NATIONAL ISSUE: THE DEPRESSION DECADE* (1978).

¹³⁴ Arthur M. Schlesinger, Jr., *THE AGE OF ROOSEVELT: THE POLITICS OF UPHEAVAL* 435 (1960).

¹³⁵ See Brueggemann, *supra* note 133, at 144; C.S. Johnson, *The Negro*, 47 AMERICAN JOURNAL OF SOCIOLOGY 855, 857 (1942).

¹³⁶ See SITKOFF, *supra* note 134, at 321; Johnson, *supra* note 136, at 860.

¹³⁷ See SITKOFF, *supra* note 134, at 316.

¹³⁸ BEARDSLEY, *NEGLECT*, *supra* note 53, at 157-185.

¹³⁹ See Johnson, *supra* note 136, at 857. See also Myrdal, *supra* note 13, at 345 n.35.

¹⁴⁰ Bruggemann, *supra* note 133, at 150, 164.

¹⁴¹ Johnson, *supra* note 136, at 855; Sitkoff, *supra* note 134; see, e.g., *Over Million Negro Youths Receive School Lunches*, 11 NAT'L NEGRO HEALTH NEWS 15 (Jan.-Mar. 1943) (assistance provided on conditions of equality).

¹⁴² Bruggemann, *supra* note 133, at 144-45.

many examples of segregation remained in long-term federal projects and organized labor.¹⁴³

In Gunnar Myrdal's landmark 1944 study, segregation and discrimination still characterized American health care.¹⁴⁴ Facilities for Blacks, North and South, remained "qualitatively inferior;" and rural hospital facilities were "totally inadequate almost everywhere in the South, especially for Negroes."¹⁴⁵ Civilian health needs were largely on the sideline during the Second World War,¹⁴⁶ but in the immediate post war years various health care proposals were floated in Congress.¹⁴⁷ In January 1948, President Truman requested a report on the nation's health status. The result was the National Health Assembly, which produced an official report entitled AMERICA'S HEALTH: A REPORT TO THE NATION.¹⁴⁸ The report identified disparities in Black health and called for dramatic government action.¹⁴⁹ This view did not carry the day; the National Health Assembly did not recommend an end to health care segregation or embrace a national health system.¹⁵⁰ The American Medical Association and the American Hospital Association had previously endorsed a more limited, decentralized proposal fashioned by Senators Lister Hill (D-AL) and Harold Burton (R-OH). The Hill-Burton program provided federal money for state-supervised hospital and medical facility construction, including racially segregated facilities.¹⁵¹

¹⁴³ See Bruggemann, *supra* note 133, at 145-149, 159.

¹⁴⁴ See Myrdal, *supra* note 13, at 323 ("There are only a few hospitals in the United States, such as Harlem Hospital in New York City, where Negro and white doctors work together in a system of absolute equality.").

¹⁴⁵ See Myrdal, *supra* note 13, at 344-45.

¹⁴⁶ See generally STEVENS, IN SICKNESS AND IN WEALTH, *supra* note 94, at 208-13.

¹⁴⁷ See MORAIS, *supra* note 114, at 158; STEVENS, IN SICKNESS AND IN WEALTH, *supra* note 94, at 215-16.

¹⁴⁸ AMERICA'S HEALTH, *supra* note 12. The Chairman of the National Health Assembly, Oscar R. Ewing, also published his personal report to President Truman. OSCAR R. EWING, THE NATION'S HEALTH: A TEN-YEAR PROGRAM (1948). The primary difference between the two reports is that The Nation's Health called for national health insurance whereas the official report did not.

¹⁴⁹ AMERICA'S HEALTH, *supra* note 12, at 200-01.

¹⁵⁰ AMERICA'S HEALTH, *supra* note 12, at 150 ("The committee brought in a recommendation that discrimination and segregation is out of line with democratic principles and should be abolished not only in the institutions of higher learning but also throughout the general educational system. No agreement, however, could be reached on this subject either in general or with reference to medical education.").

¹⁵¹ SMITH, HEALTH CARE DIVIDED, *supra* note 39, at 46; STEVENS, IN SICKNESS AND IN WEALTH, *supra* note 94, at 216; David Barton Smith, *Addressing Racial Inequities*

By providing the funds without guarantees of nondiscrimination, the Hill-Burton program entrenched segregation in a new generation of facilities.

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

The federal government supported a segregated health care system through hospital construction grants under the 1946 Hill-Burton Act,¹⁵² eventually providing more than \$13 billion in federal funds.¹⁵³ Between 1949 and 1962, about 30% of all hospital construction projects were assisted under Hill-Burton.¹⁵⁴ Two provisions of the Hill-Burton program are of interest here: (a) the “community service” and “uncompensated care” requirements; and (b) the Hill-Burton provision embracing segregation in health care.

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

The Hill-Burton program required recipients such as hospitals to provide community services and uncompensated care in exchange for federal funds.¹⁵⁵ From the beginning of the Hill-Burton program until 1980, the Department of Health, Education and Welfare did little to actively enforce these requirements.¹⁵⁶ Private attempts began in the 1970s as legal service lawyers set up specialized programs in health law advocacy.¹⁵⁷ In *Cook v. Ochsner Foundation Hospital*, a private

in Health Care: Civil Rights Monitoring and Report Cards, 23 J. HEALTH POL., POL'Y & L. 75, 81 (1998) [hereinafter Smith, *Addressing Racial Inequalities*].

¹⁵² See Hospital Survey and Construction Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946). See also CONGRESSIONAL QUARTERLY, INC., *Hill-Burton Hospital Survey and Construction Act, 1946* in CONGRESS AND THE NATION 1945-1964, at 1122-23 (1965) (providing a legislative history of Hill-Burton).

¹⁵³ Judith R. Lave & Lester B. Lave, THE HOSPITAL CONSTRUCTION ACT: AN EVALUATION OF THE HILL-BURTON PROGRAM, 1948-1973, at 16 (1974).

¹⁵⁴ *Id.* at 16.

¹⁵⁵ P.A. Paul-Shaheen & H. Perlstadt, *Class Action Suits and Social Change: The Organization and Impact of the Hill-Burton Cases*, 57 IND. L.J. 385, 385 (1982) (containing a good summary of the community service and uncompensated care cases as of 1982); Kenneth R. Wing, *The Community Service Obligation of Hill-Burton Health Facilities*, 23 BOSTON COLL. L. REV. 577, 577 (1982) [hereinafter Wing, *Community Service*].

¹⁵⁶ See Institute of Medicine, HEALTH CARE IN A CONTEXT OF CIVIL RIGHTS 14-15 (1981) [hereinafter IOM, *CONTEXT OF CIVIL RIGHTS*].

¹⁵⁷ Sylvia A. Law, *A Right to Health Care That Cannot be Taken Away: The Lessons of Twenty-Five Years of Health Care Advocacy*, 61 TENN. L. REV. 771, 778 (1994).

right of action was inferred for intended beneficiaries of the uncompensated care and community service regulations.¹⁵⁸ The Hill-Burton program was discontinued shortly thereafter. Had the federal government enforced Hill-Burton as written, Black access to health care would have improved. The first government survey of the social and racial composition of recipients of uncompensated care at Hill-Burton hospitals occurred in 1995, by which time they were unable to identify racial disparities in a program that had been discontinued for more than twenty years.¹⁵⁹

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

The Internal Revenue Service proceeded under Section 501(c)(3) of the Internal Revenue Code, as interpreted by Revenue Ruling 56-185.¹⁶⁰ The language of the Revenue Ruling is expansive and could have significantly helped the state of Black health: the hospital “must not ... refuse to accept patients in need of hospital care who cannot pay for such service” and “must not restrict the use of its facilities to a particular group of physicians and surgeons.” The 1956 Revenue Ruling also permitted some discretionary authority to “impose limitations on the extent to which [the hospital facilities] may be made available to all reputable and competent physicians in the area.”¹⁶¹ In 1958, the Tax Court denied tax exemption to a physician clinic which provided charity care equal to only 2% to 5% of its revenues.¹⁶² In 1969, a further Revenue Ruling removed the charitable care requirement and restated the community benefit standard to include operating an emergency room open to all without regard to ability to pay.

Language in both the 1956 and 1969 Revenue Rulings could support denying exemption to a hospital which racially discriminated against qualified doctors or against patients. The IRS did not make

¹⁵⁸ *Cook v. Ochsner Foundation Hospital*, 319 F. Supp. 603, 606 (E.D. La. 1970) (one of a series of published opinions involving Ochsner).

¹⁵⁹ U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *HRSA Studies Hill-Burton Patient Demographics*, 110 PUB. HEALTH REP. 111-12 (1995). The full 31-page monograph is: U.S. Department of Health and Human Services, *The Demographic and Treatment Characteristics of the Hill-Burton Population* (1995).

¹⁶⁰ See Rev. Rul. 56-185, 1956-1 C.B. 202-04.

¹⁶¹ See Rev. Rul. 56-185, 1956-1 C.B. 202-04.

¹⁶² *Lorain Ave. Clinic v. Commissioner*, 31 T.C. 141, 141 (1958).

serious attempts to enforce these provisions prior to the early 1980's, when tax-exempt status was finally denied to the racially discriminatory Bob Jones University.¹⁶³ The IRS had the sole power to enforce these provisions; the Supreme Court dismissed a private suit to enforce Revenue Ruling 56-185 for lack of standing.¹⁶⁴

The IRS could have vigorously enforced the charitable care and community benefit standard in the decades prior to the *Bob Jones* case. Their success in attacking racial discrimination in *Bob Jones* demonstrates what was possible, operating under a statute which was practically unchanged from 1939.¹⁶⁵ What was lacking was the will to enforce, not the text of a statute.

b. Black Exclusion and Segregation under Hill-Burton

The federal government fully embraced segregated health care in Hill-Burton.¹⁶⁶ Under the program, federal and state governments assisted in the planning and construction of thousands of hospitals and other health facilities across the United States, most of which continued their existing patterns of discrimination and segregation untroubled by the receipt of federal funds.¹⁶⁷ The Hill-Burton Act delegated to the states

¹⁶³ See, e.g., *Bob Jones University v. United States*, 461 U.S. 574 (1983) (denying tax exemption to racially discriminatory university).

¹⁶⁴ *Simon v. Eastern Kentucky Welfare Rights Organization*, 426 U.S. 26, 26 (1976). See SMITH, *HEALTH CARE DIVIDED*, *supra* note 39, at 171, for a discussion of this case.

¹⁶⁵ See 26 U.S.C. §501(c)(3) (1954); 26 U.S.C. §101(6) (1939).

¹⁶⁶ See SMITH, *HEALTH CARE DIVIDED*, *supra* note 39, at 47; David Barton Smith, *Healthcare's Hidden Civil Rights Legacy*, 48 ST. LOUIS U. L.J. 37, 39-50 (2003); STEVENS, *IN SICKNESS AND IN WEALTH*, *supra* note 94, at 254 ("Sanctions for social stratification, built into the private voluntary hospital system, were endorsed (and furthered) by federal legislation. Through its policy of decentralization, Hill-Burton allowed for the segregation of patients by race and for the continuation of the multiclass system...hospitals in the South were able to continue white-only policies where they wished.").

¹⁶⁷ MORAIS, *supra* note 114, at 152. It is important to distinguish various forms of segregation at this point. Many hospitals, perhaps a quarter, practiced racial exclusion altogether. Others admitted a limited number of Blacks, but relegated them to Black wards in the basement or in a separate building. Some cities operated two public hospitals, one white and one Black. Other hospitals were effectively all Black. Most Hill-Burton funds went to hospitals which were not racially exclusive, but rather practiced segregation. Some Hill-Burton funds went to build "separate but equal" facilities, 84 for whites only and 20 for Blacks. See *generally id.* at 180-81 ("For more than a decade and a half, the 'separate-but-equal' clause of the [Hill-Burton] law

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

Segregation and the Hill-Burton program were fellow travelers from the beginning. Senator Lister Hill (D-AL) was a segregationist, and he carefully designed the statute to permit “separate but equal” facilities.¹⁶⁸ A provision requiring “non-discrimination” was interpreted to permit segregation.¹⁶⁹ Senator Burton (R-OH) lent his support and name to the program,¹⁷⁰ but left the Senate for the U.S. Supreme Court before Hill-Burton was enacted.¹⁷¹ At the Supreme Court he joined in the unanimous 1954 opinion in *Brown v. Board of Education* striking down segregation in education,¹⁷² although Burton considered allowing segregated schools to continue so long as they were “equal to those provided white pupils.”¹⁷³ Senator Hill later signed the Southern Manifesto pledging to “use all lawful means” to oppose and reverse *Brown*.¹⁷⁴ As a former Chairman, his portrait still hangs in the anteroom adjacent to the Hearing Room of the Senate Health, Education, Labor and Pensions Committee.

Debates occurred within the Black community¹⁷⁵ and in white liberal groups¹⁷⁶ on whether to apply for Hill-Burton assistance for segregated facilities. In some cities, civil rights leaders opposed it as

was discretely kept in the background while nearly two billion dollars of federal funds were poured into the rebuilding of the American hospital system.”).

¹⁶⁸ See SMITH, HEALTH CARE DIVIDED, *supra* note 39, at 47.

¹⁶⁹ See Hospital Survey and Construction Act of 1946, Pub. L. No. 79-725, 60 Stat. 1040 (1946) (formerly codified at 42 U.S.C. § 291e(f)); 42 C.F.R. § 53.112; 21 Fed. Reg. 9841 (Dec. 12, 1956). See also SMITH, HEALTH CARE DIVIDED, *supra* note 39, at 47; Kenneth Wing, *Title VI and Health Facilities: Forms Without Substance*, 30 HAST. L.J. 137, 144 (1978) (reviewing history of the Hill-Burton non-discrimination regulations prior to Title VI).

¹⁷⁰ MARY FRANCES BERRY, STABILITY, SECURITY AND CONTINUITY: MR. JUSTICE BURTON AND DECISION-MAKING IN THE SUPREME COURT 1945-1958, at 13 (1978).

¹⁷¹ See Berry, *supra* note 170, at 125; 60 Stat. 1040.

¹⁷² See *Brown v. Board of Education*, 347 U.S. 483 (1954); Berry, *supra* note 170, at 123-25, 154-58 (discussing Burton’s bench memo for oral argument in *Brown* and the Court’s discussions in *Brown*).

¹⁷³ Berry, *supra* note 170, at 157 (quoting from one of Burton’s draft decrees for *Brown*).

¹⁷⁴ The Decision of the Supreme Court in the School Cases – Declaration of Constitutional Principles, 102 Cong. Rec. 4459-4460 (1956).

¹⁷⁵ See GAMBLE, MAKING A PLACE, *supra* note 99, at 188.

¹⁷⁶ See MORAIS, *supra* note 114, at 152, 158 (discussing the largely white Physicians’ Forum).

accommodation of segregation,¹⁷⁷ joined by older Black doctors with a vested interest in the existing system.¹⁷⁸ In others, the facilities were welcomed as vitally needed improvements.¹⁷⁹ The National Medical Association opposed Hill-Burton “separate but equal” hospital construction,¹⁸⁰ but in 1940, W.E.B. DuBois was not willing to sacrifice Black health while fighting for equality:

[W]hat Negroes need is hospital treatment now; and what Negro physicians need is hospital practice; and to meet their present need, poor hospitals are better than none; segregated hospitals are better than those where the Negro patients are neglected or relegated to the cellar....I am certain that for many generations American Negroes in the United States have got to accept separate medical institutions. They may dislike it; they may and ought to protest against it; nevertheless it will remain for a long time their only path to health, to education, to economic survival.¹⁸¹

DuBois may have been correct to concede that segregated health facilities were better than nothing, no matter how inferior the facilities

¹⁷⁷ See Beardsley, *Good-Bye To Jim Crow: The Desegregation of Southern Hospitals, 1945-70*, 60 BULL. HIST. MED. 367, 372 (1986) [hereinafter Beardsley, *Good-bye to Jim Crow*] (citing W. Montague Cobb, *Editorial*, 44 J. OF THE NAT'L MED. ASS'N 387 (1952)) (describing the reversal by the Memphis chapter of the NAACP, ultimately opposing the construction of an all-Black Hill-Burton hospital). The presence of a Black hospital may have actually permitted segregationist practices to persist in the 1940s and 1950s. REITZES, *supra* note 111, at 333-35 (providing a case study of health care discrimination in fourteen major cities).

¹⁷⁸ BEARDSLEY, *NEGLECT*, *supra* note 53, at 258.

¹⁷⁹ NAACP, PAPERS OF THE NAT'L ASSN. FOR THE ADVANCEMENT OF COLORED PEOPLE, SERIES A: LEGAL DEPARTMENT FILES, PART 15: SEGREGATION AND DISCRIMINATION, Reel 5/19, frames 722-24 [hereinafter NAACP LEGAL FILES] (March 28, 1941 letter to Walter White describing the proposed expansion of a hospital in Columbia Missouri which will increase the number and quality of segregated Black rooms); Hila Richardson & Samuel Wolfe, *Public General Hospitals: A Redefinition of Their Crisis*, in FIGHTING FOR THE PUBLIC HOSPITAL CONFERENCE app. a, d (1980) (describing the history of the Homer Phillips Hospital in St. Louis and the relocation of white Memphis hospitals to suburbs).

¹⁸⁰ MORAIS, *supra* note 114, at 152.

¹⁸¹ W.E.B. DUBOIS, *DUSK OF DAWN* 309 (1940). DuBois' practical approach here does not minimize the crime of segregation, much as the work of the Red Cross in World War II did not legitimize Nazi atrocities.

compared to white hospitals.¹⁸² He did not agree, however, that these arrangements were just.¹⁸³ The integrationist view increasingly prevailed in the Black community, particularly after World War II as the deficiencies of the “Black medical ghetto” were increasingly evident.¹⁸⁴

The Hill-Burton program actually permitted two types of segregation. The “separate but equal” category could practice complete racial exclusion so long as each race had access to some facility. Hill-Burton funds were used to build 104 facilities which practiced complete racial exclusion. The second category was more than 7000 “non-discriminatory” facilities which – despite the name were permitted to segregate by ward, room or floor.¹⁸⁵ Hospitals in America both reflected and legitimized segregation.¹⁸⁶ The General Counsel of the Department of Health, Education and Welfare issued guidelines for these “non-discriminatory” hospitals, which permitted segregation of patients by race, creed or color and denial of staff privileges to physicians on the basis of race, creed or color so long as everyone had

¹⁸² See BEARDSLEY, NEGLECT, *supra* note 53, at 247, 256.

¹⁸³ See, e.g., W.E.B. DUBOIS, *The Tuskegee Hospital*, THE CRISIS, July, 1923, (reprinted in W.E.B. DUBOIS: WRITINGS 1201-04 (Nathan Huggins ed., 1986) (voicing his strongly worded opposition to the imposition of an all-white professional staff at the Tuskegee Hospital in 1923)). DuBois noted prophetically that “[a]ny Negro in such a hospital...would be a subject of torture and murder rather than restoration of health.” *Id.* at 1204.

¹⁸⁴ GAMBLE, MAKING A PLACE, *supra* note 99, at 184-85.

¹⁸⁵ MORAIS, *supra* note 114, at 243. For example, the Dixie Hospital in Hampton, Virginia received over \$1,700,000 in Hill-Burton funds in 1956. The Dixie Hospital was not a “separate but equal” facility; indeed, it had certified that “the facility will be operated without discrimination because of race, creed or color.” *Smith v. Hampton Training School for Nurses*, 360 F.2d 577, 579 (4th Cir. 1966). In 1963, the Hospital fired several Black employees for eating in the white cafeteria. *Id.* The Fourth Circuit ruled the firings illegal and ordered reinstatement with back pay. *Smith*, 360 F.2d at 580-82 (citing *Simkins v. Moses H. Cone Memorial Hospital*, 323 F.2d 959 (4th Cir. 1963)). A second example is the Wake Memorial Hospital in Raleigh, North Carolina, built with Hill-Burton funds in 1961. Beardsley, *Good-bye to Jim Crow*, *supra* note 177, at 369. It also was not a “separate but equal” hospital, but placed Black patients in a segregated ward. *Id.* White hostility was so great to even a segregated hospital that Wake Memorial experienced a white boycott and grave financial difficulties in its early years. *Id.* at 369-70. Beardsley paints a generally sympathetic picture of the integration of southern hospitals by white administrators and Black physicians.

¹⁸⁶ STEVENS, IN SICKNESS AND IN WEALTH, *supra* note 94, at 50 (“Hospitals, as social institutions, carried (and enhanced) prevailing assumptions about social class and racial divisions in the United States, not only legitimising written rules but also making informal practices visible – and thus sanctioning them in turn.”).

access to the particular facilities built with Hill-Burton funds.¹⁸⁷ These rules remained in force until November 1, 1963 when they were suspended following the *Simkins v. Moses H. Cone Memorial Hospital* case discussed below.

Segregation and lack of access impacted Black health status. Even after controlling for poverty (an example of etiological reductionism), Blacks' health disparities were significant.¹⁸⁸ In 1963, Black life expectancy was still seven to eight years shorter than whites.¹⁸⁹ Forty years later, the gap is distressingly similar.¹⁹⁰

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

In the early 1960's Representative Adam Clayton Powell (D-NY) and Senator Jacob Javits (D-NY) attempted to block federal funds to projects which discriminated on the basis of race.¹⁹¹ The next year the United States Civil Rights Commission recommended to President Kennedy that Hill-Burton funds no longer be available to segregated facilities.¹⁹²

When the legal denouncement finally came, it was swift.¹⁹³ It began with the 1963 Fourth Circuit decision, *Simkins v. Moses H. Cone Memorial Hospital*,¹⁹⁴ reversing the District Court and finding that the Fifth and Fourteenth Amendment prohibited a private hospital from refusing to admit Black patients or to grant staff privileges to Black physicians and dentists. The key finding was that receipt of federal Hill-Burton funds provided the necessary state action to impose the Constitutional requirement. On November 1, 1963, the United States Public Health Service suspended the approval of new separate but equal Hill-Burton funding applications.¹⁹⁵ The United States Supreme Court denied review of *Simkins* on March 2, 1964. On May 18, 1964, the Public Health Service issued new regulations which prohibited

¹⁸⁷ MORAIS, *supra* note 114, at 243-44.

¹⁸⁸ See generally Leona Baumgartner, *Health and Ethnic Minorities in the Sixties*, 55 AM. J. PUB. HEALTH 495 (1965).

¹⁸⁹ See Pettigrew, *supra* note 65, at 333.

¹⁹⁰ See *supra* Part II.B.

¹⁹¹ See Beardsley, *Good-bye to Jim Crow*, *supra* note 178, at 374-75; Smith, *Addressing Racial Inequities*, *supra* note 152, at 82.

¹⁹² MORAIS, *supra* note 114, at 152.

¹⁹³ See generally BEARDSLEY, NEGLECT, *supra* note 53, at 245-71, 312 (claiming that white physicians provided key leadership in the process).

¹⁹⁴ *Simkins*, 323 F.2d at 969 (en banc, 3-2), *cert. denied*, 376 U.S. 938 (1964). See generally SMITH, HEALTH CARE DIVIDED, *supra* note 39, at 91-95 (providing an excellent section on the history and context of *Simkins*).

¹⁹⁵ MORAIS, *supra* note 114, at 244.

discrimination throughout any facility which had received Hill-Burton funds and required an open medical staff.¹⁹⁶ Under the political cover of this case, Congress extended the Hill-Burton program for five more years in August 1964, but with the “separate but equal” clause removed and the community services requirement strengthened.¹⁹⁷

The exorcism of racism from the Hill-Burton program quickly passed from the public forum. An otherwise comprehensive review of the Hill-Burton program in 1974 failed to even discuss this history of racial discrimination.¹⁹⁸

Simkins is rightly celebrated for these achievements, but in the context of health care reparations it established another key legal principle: state action. Under the Hill-Burton program, state and federal governments actively supported racial discrimination, sufficient for a Fourteenth Amendment nexus.¹⁹⁹ This state action provides a clear defendant for a Black reparations claim.

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

In segregated communities with multiple health care providers, voluntary desegregation disadvantaged the first mover: in a two-hospital town, the hospital which desegregated first would suffer white flight and economic loss. For example, Wake Memorial Hospital in Raleigh, North Carolina was built with Hill-Burton funds in 1961. It was not a “separate but equal” hospital, and yet it featured segregated wards for Black patients. White hostility was so great to even a segregated hospital that Wake Memorial experienced grave financial difficulties as white patients fled to Raleigh’s all-white hospitals. The white boycott of Wake Memorial demonstrated a preference for all-white hospitals over hospitals such as Wake with segregated wards.²⁰⁰

If one accepts that only the fear of being a first mover was hindering desegregation of southern hospitals,²⁰¹ then simultaneous

¹⁹⁶ *Id.* at 243.

¹⁹⁷ *See id.* at 182; Smith, *Addressing Racial Inequities*, *supra* note 152, at 82.

¹⁹⁸ *See generally* Lave, *supra* note 154.

¹⁹⁹ *Simkins*, 323 F.2d at 965-68. *But see* BEARDSLEY, NEGLECT, *supra* note 53, at 256-57 (highlighting the benefits of Hill-Burton to Blacks).

²⁰⁰ *See* Beardsley, *Good-bye to Jim Crow*, *supra* note 178, at 369-70. *See also* SMITH, HEALTH CARE DIVIDED, *supra* note 39, at 230 (providing an example of hospital integration from Mobile, Alabama). Beardsley paints a generally sympathetic picture of the integration of southern hospitals by white administrators and physicians.

²⁰¹ *See* BEARDSLEY, NEGLECT, *supra* note 53, at 264-68, 271; Beardsley, *Good-bye to Jim Crow*, *supra* note 178, at 386. This view does not fully appreciate the value of

regulatory action might be effective. President Johnson employed this approach.²⁰² From 1964 to 1966, virtually all forms of legal segregation ended in U.S. hospitals: the Jim Crow signs came down and patients were randomly assigned to hospital rooms. The carrot was the offer of federal money in Medicare and Medicaid, passed in 1965 and effective in 1966. The stick was Title VI of the Civil Rights Act of 1964, prohibiting discrimination in federal health programs.²⁰³ One consequence was the economic destruction of Black hospitals.²⁰⁴

Unlike Title VII, which operates under the Commerce Clause and the Fourteenth Amendment, Title VI is authorized under the Spending Power.²⁰⁵ Title VI is a condition accepted by vendors participating in federal programs such as Medicare and Medicaid. The Supreme Court has not articulated many Constitutional limitations upon the exercise of the Spending Power,²⁰⁶ making Title VI potentially a more powerful and unconstrained force for non-discrimination than Title VII.²⁰⁷

the incentives: federal money through Medicare and Medicaid. Perhaps white hospital administrators wanted Black patients now that they brought federal money. The first-mover hypothesis also does not explain why physicians' offices and nursing homes did not join the desegregation parade in 1966, nor does it explain segregation or racial exclusion in one hospital towns. See SMITH, HEALTH CARE DIVIDED, *supra* note 39, at 236-75. See generally Loury, *supra* note 107 (providing an economic analysis of racial disparities).

²⁰² See generally James M. Quigley, *Hospitals and the Civil Rights Act of 1964*, 57 J. OF THE NAT'L MED. ASS'N 455 (1965) (emphasizing the efficacy of instant desegregation of hospitals and the threat of enforcement).

²⁰³ See Civil Rights Act of 1964 § 601, 42 U.S.C. § 2000d (2003). See generally Mitchell A. Horwich, Note, *Title VI of the 1964 Civil Rights Act and the Closing of a Public Hospital*, 1981 DUKE L.J. 1033 (1981) (providing a thorough review of the legislative history of Title VI with regard to health care); SMITH, HEALTH CARE DIVIDED, *supra* note 39, at 98-106 (providing an interesting account of the passage of Title VI).

²⁰⁴ See GAMBLE, MAKING A PLACE, *supra* note 99, at 191; SMITH, HEALTH CARE DIVIDED, *supra* note 39, at 195; *Black Hospitals*, *supra* note 80, at 23.

²⁰⁵ See UNITED STATES COMMISSION ON CIVIL RIGHTS, FEDERAL TITLE VI ENFORCEMENT TO ENSURE NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS 25-27 (June 1996) (providing a short discussion of the Constitutional basis for Title VI).

²⁰⁶ See Symposium, *Spending Clause Symposium*, 4 CHAPMAN L.R. 1 (2001) (covering a recent symposium devoted to the Spending Clause).

²⁰⁷ See SMITH, HEALTH CARE DIVIDED, *supra* note 39, at 182. See generally Sidney D. Watson, *Reinvigorating Title VI: Defending Health Care Discrimination – It Shouldn't Be So Easy*, 58 FORDHAM L. REV. 939-78 (1990) (encouraging a more robust interpretation of Title VI vis-à-vis Title VII) [hereinafter Watson, *Reinvigorating Title VI*].

In connecting Title VI with Medicare, President Johnson risked a boycott of the fledgling health care program.²⁰⁸ The National Medical Association supported the linkage of Medicare and Title VI and rallied some Black support behind Medicare.²⁰⁹ President Johnson addressed the Black health problem at a speech at Howard University on June 5, 1965.²¹⁰ The lure of federal funds, together with Johnson's political skills, ultimately convinced physicians and hospitals to participate in Medicare and Medicaid,²¹¹ although physicians were exempted from the proscriptions of Title VI.²¹²

Enforcement of Title VI got off to a good start when the Department of Health, Education and Welfare asked hospitals to certify under Medicare that they did not practice segregation or discrimination.²¹³ The Title VI regulations at first blush appear well suited to end discrimination in federal health care benefits or services. Prohibited practices include outright denials, segregation, and discrimination, including providing a benefit "which is different, or is provided in a different manner, from that provided to others..."²¹⁴ The regulations cover both intentional discrimination as well as disparate impact.²¹⁵ Over 3,000 hospitals agreed to change their practices to

²⁰⁸ See Watson, *Race, Ethnicity and Quality*, *supra* note 6, at 214; Lado, *supra* note 8, at 245.

²⁰⁹ Hearings on H.R. 6675 before the S. Fin. Comm., 89th Cong. 323-28 (1965) (statement of Dr. W. Montague Cobb, President of the National Medical Association).

²¹⁰ Lyndon B. Johnson, *To Fulfill These Rights*, Address at Howard University, 1 PUB. PAPERS (June 4, 1965). See Lyndon B. Johnson, *Forward to the Issue*, 94 DAEDALUS 743 (1965).

²¹¹ See Smith, *Addressing Racial Inequities*, *supra* note 152, at 83 ("Title VI was a sleeper section in the chaotic passage of the Civil Right Act... Although *Simkins* was used as an example to justify Title VI, the impact of the passage of the Medicare and Medicaid legislation the following year was unanticipated"); Watson, *Race, Ethnicity and Quality of Care*, *supra* note 39, at 212-13; Joanne Silberner, Weekend Edition (National Public Radio broadcast July 31, 1999) (transcript on file with author).

²¹² See IOM, CONTEXT OF CIVIL RIGHTS, *supra* note 157, at 24; Smith, *Addressing Racial Inequities*, *supra* note 151, at 85; Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 AM. J. L. & MED. 191, 191 (1995) (describing difficulties in recruiting physicians to participate in Tennessee's Medicaid Waiver program, Tenn-Care).

²¹³ See IOM, CONTEXT OF CIVIL RIGHTS, *supra* note 157, at 24. See generally SMITH, HEALTH CARE DIVIDED, *supra* note 39, at 128-42.

²¹⁴ 45 C.F.R. § 80.3(b)(1).

²¹⁵ 45 C.F.R. §§ 80.3(b)(1),(b)(2).

comply with the law.²¹⁶ Formal racial exclusion in medical schools also ended with Title VI.²¹⁷

In heavily segregated communities, desegregation of the hospitals translated into immediate health gains for Blacks. A recent study documented a large reduction in Black infant mortality in Mississippi from 1965 to 1971.²¹⁸ The reduction in Black infant mortality was especially strong in rural Mississippi, and this six-year period accounted for the largest relative gains for Black infant mortality since 1945.²¹⁹ The authors conclude that desegregation of hospitals in Mississippi played a causal role in this significant reduction in Black infant mortality.²²⁰ Desegregation of the hospitals saved lives.

These great victories deserve to be celebrated; they also demonstrate the power that could have been utilized decades earlier to tie receipt of federal WPA and Hill-Burton funds to desegregation, along the lines of President Roosevelt's Executive Order. Rather than absolving the government from responsibility for health care segregation, the events of 1964-1966 demonstrate the opportunity cost of decades of willful neglect. Premature celebration also ignores the aspects of Medicare and Medicaid which continue to disadvantage Blacks, such as differential access based upon reimbursement methodologies.²²¹

A stranger to the jurisprudence of Title VI might be forgiven in assuming it to be a formidable weapon against disparities in Black health; the actual state of affairs stands as a grim reminder of the limits of legal formalism in the absence of underlying social change. Federal enforcement of Title VI has been roundly criticized as ineffective.²²² In 1980, the United States Commission on Civil Rights reported that:

²¹⁶ IOM, *CONTEXT OF CIVIL RIGHTS*, *supra* note 157, at 24 (1981); BEARDSLEY, *NEGLECT*, *supra* note 53, at 264 (widespread voluntary compliance by hospitals).

²¹⁷ MORAIS, *supra* note 114, at 173.

²¹⁸ Douglas V. Almond et al., *Civil Rights, the War on Poverty, and Black-White Convergence in Infant Mortality in Mississippi*, (Nat'l Bureau of Econ. Research, Working Paper, 2003), available at <http://www.nber.org/~almond/mississippi.pdf>.

²¹⁹ *Id.* at 1-6.

²²⁰ *Id.* at 29-30.

²²¹ See SMITH, *HEALTH CARE DIVIDED*, *supra* note 39, at 172-73, 176-83, 199-200, 217-35, tbl.6.15. Medicare and Medicaid cost-based reimbursement permitted hospital relocations from poor neighborhoods to the suburbs; the index of dissimilarity in Medicare continues to be high, particularly in the North.

²²² See, e.g., IOM, *CONTEXT OF CIVIL RIGHTS*, *supra* note 157, at 153; SMITH, *HEALTH CARE DIVIDED*, *supra* note 39, at 164-68, 173-76, 317-19; UNITED STATES COMMISSION ON CIVIL RIGHTS, *FEDERAL TITLE VI ENFORCEMENT TO ENSURE NONDISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS* 1-10 (1996) ("the

[The Federal government] brought enforcement proceedings only rarely under Title VI, especially since 1970 The record of achievement in elimination of discrimination is bleak ... no recipient of Federal health funds has had its funds terminated since 1973.²²³

An optimist might find the lack of enforcement actions encouraging, assuming that segregation and discrimination had been eliminated in 1966 and no violations were left to enforce. Alternatively, the difficulties faced by the Office of Civil Rights in enforcing Title VI are to be expected: with the elimination of *de jure* segregation, the low-hanging fruit had been picked. Remaining discriminatory practices are much more difficult to root out, either structurally (as in the case of Medicaid's low reimbursement) or floundering upon the difficulty of proving discriminatory intent and the identification of the causative "facially neutral policy."²²⁴ One lesson from Title VI is that new legal norms do not quickly translate into social change: "[T]he more visible symbols of Jim Crow disappeared quickly, but the underlying structural patterns were more resistant to change."²²⁵ The persistence of disparities in Black health in 2005, nearly four decades after the abolition of formal health care segregation, is a testament to deeply engrained patterns and speaks of the need for a remedy other than mere legal neutrality.²²⁶

Commission found that the Federal agencies were not enforcing Title VI effectively...the deficiencies identified in 1974 have persisted for 20 years...the Department of Justice has neglected its responsibility..." *Id.* at 4); Marianne Engelman Lado, *Unfinished Agenda: The Need for Civil Rights Litigation to Address Race Discrimination and Inequalities in Health Care Delivery*, 6 TEX. FORUM CIV. LIB. & CIV. R. 1 (2001); Smith, *Addressing Racial Inequities*, *supra* note 152, at 75; Sidney Dean Watson, *Minority Access and Health Reform: A Civil Right to Health Care*, 22 J. L. MED. & ETHICS 127 (1994); Wing, *supra* note 169, at 137.

²²³ CIVIL RIGHTS ISSUES IN HEALTH CARE DELIVERY, *supra* note 25, at ix.

²²⁴ See generally Lado, *supra* note 8; Smith, *Addressing Racial Inequities*, *supra* note 39, at 87-92; Watson, *Reinvigorating Title VI*, *supra* note 208, at 939-77.

²²⁵ Smith, *Addressing Racial Inequities*, *supra* note 152, at 79.

²²⁶ See Meltsner, *supra* note 97, at 22 (providing a thoughtful, recent critique of mere racial neutrality). In 1966, Michael Meltsner warned that mere legal neutrality would not eradicate racism in health care: "The treatment accorded to Negroes by southern medical facilities ... reflects a striking contradiction between law and practice, a variance which exemplifies the historic method of accommodating Negro claims to equality: incorporation of egalitarian principles into legal norms, and administrative tolerance of actual inequality." *Id.* See generally Loury, *supra* note 107.

Gregg Bloche suggests that Americans are no longer tolerant of direct discrimination, but are less concerned once racism is mediated through the marketplace or provider discretion.²²⁷ The same polarity may be found in Title VI and Title VII litigation (direct discrimination versus disparate impact) and affirmative action (particularized showing of discrimination versus statistical under-representation of minorities). Attacking the intentional, *de jure* forms of racial discrimination permits the country to profess color-blind formalism, without descending into the marketplace to eradicate discrimination root and branch.

This section has outlined the main avenues of responsibility for segregation in health care. In a few situations, governments and medical institutions acted responsibly, demonstrating what could be done to improve Black health. For the most part, governments and medical institutions either passively permitted segregation or actively supported and financed segregated health care. Before plunging into Black reparations, a brief review of what has been established thus far:

1. Overwhelming evidence exists of disparities in Black health which have not changed appreciably in generations. (Section I – Disparities in Black Health)
2. Current studies may actually underreport the magnitude of Black health disparities due to over-adjustment for confounding variables. (Section II – Etiological Reductionism)
3. Disparities in Black health were not created in a vacuum. The history of health care in the United States demonstrates that Blacks have been relegated to a vastly inferior health care system for almost all of their time in America. State and federal governments and institutions, such as hospitals and the medical profession, actively supported this two-tiered health system from the founding of the Republic until at least 1966. Since the end of *de jure* discrimination, actual disparities in Black health have remained relatively unchanged. (Section III – Tragedy in History)

²²⁷ See Bloche, *supra* note 6, at 95, 98. See also Ana I. Balsa et al., *Clinical Uncertainty and Healthcare Disparities*, 29 AM. J.L. & MED. 203, 203 (2003).

IV. BLACK REPARATIONS

The Black reparations movement proclaims that a debt is owed for the crimes of slavery and Jim Crow segregation.²²⁸ Some reparations advocates have focused upon the strategy of litigation, working within the system,²²⁹ whilst others, including the adherents of Critical Race

²²⁸ See, e.g., Randall Robinson, *THE DEBT: WHAT AMERICANS OWE TO BLACKS* (2000) (providing an influential popular account). See *SHOULD AMERICA PAY?: SLAVERY AND THE RAGING DEBATE OVER REPARATIONS*, 209, 210 (Raymond A. Winbush ed., 2003) [hereinafter *SHOULD AMERICA PAY?*]; *WHEN SORRY ISN'T ENOUGH: THE CONTROVERSY OVER APOLOGIES AND REPARATIONS FOR HUMAN INJUSTICE* (Roy L. Brooks, ed., 1999) [hereinafter *WHEN SORRY ISN'T ENOUGH*]; Elazar Barkan, *THE GUILT OF NATIONS: RESTITUTION AND NEGOTIATING HISTORICAL INJUSTICES* (2000) (providing a particularly interesting book on broader themes of repairing historical injustice). See generally Boris I. Bittker, *THE CASE FOR BLACK REPARATIONS* (1973) (applying civil rights law to Jim Crow); Derrick A. Bell, Jr., *Dissection of a Dream*, 9 HARV. C.R.-C.L. L. REV. 156 (1974) (a critique of Bittker's law-based approach to reparations); Mari J. Matsuda, *Looking to the Bottom: Critical Legal Studies and Reparations*, 22 HARV. C.R.-C.L. L. REV. 323 (1987); Vincene Verdun, *If The Shoe Fits, Wear It: An Analysis of Reparations to African Americans*, 67 TULANE L. REV. 597 (1993); Rhonda V. Magee, *The Master's Tools, From the Bottom Up: Responses to African-American Reparations Theory in Mainstream and Outsider Remedies Discourse*, 79 VA. L. REV. 863 (1993); Robert Westley, *Many Billions Gone: Is It Time to Reconsider the Case for Black Reparations?*, 40 B.C.L. REV. 429 (1998); and Eric K. Yamamoto, *Racial Reparations: Japanese American Redress and African American Claims*, 40 B.C.L. REV. 477 (1998).

²²⁹ See, e.g., *Cato v. United States*, 70 F.3d 1103 (9th Cir. 1995); *In re African-American Slave Descendants Litig.*, No. 02-C-7764, 2005 WL 1561509 (N.D. Ill. July 6, 2005). See Commissions, National Coalition of Blacks for Reparations in America, <http://www.ncobra.org/comm.htm#mission> (describing the formation of the N'COBRA Litigation Committee in 1997 and the Reparations Coordinating Committee in 2000). See also Adjoa A. Aiyetoro, *The National Coalition of Blacks for Reparations in America: Its Creation and Contribution to the Reparations Movement*, in *SHOULD AMERICA PAY?*, *supra* note 229, at 209, 210. See generally Adjoa A. Aiyetoro, *Formulating Reparations Litigation Through the Eyes of the Movement*, 58 N.Y.U. ANN. SURV. AM. L. 457 (2003) [hereinafter Aiyetoro, *Reparations Litigation*]; Alfred L. Brophy, *Reparations Talk: Reparations for Slavery and the Tort Law Analogy*, 24 BOSTON COLLEGE THIRD WORLD LAW JOURNAL 81 (2004) (indeed this entire symposium issue is well done); Charles J. Ogletree, Jr., *Repairing the Past: New Efforts in the Reparations Debate in America*, 38 HARV. C.R.-C.L. L. REV. 279 (2003) (one of Ogletree's best articles on reparations); Alfreda Robinson, *Corporate Social Responsibility and African American Reparations: Jubilee*, 55 RUTGERS L. REV. 309 (2003); Yamamoto, *supra* note 229; Bittker, *supra* note 229; Verdun, *supra* note 229.

Theory (CRT), have looked more to the transformative power of reparations to remake society.²³⁰

This Article bridges this divide, proposing a strategy which includes litigation while responding to Richard Delgado's call for critical scholarship which leads to real structural reforms.²³¹ Any attempt to remedy health disparities cannot be limited to mere legal fictions of equality; Title VI has been ineffective in reducing disparities in Black health.²³² Token efforts will always be confronted with the troublesome facts of 73,000 excess Black deaths per year and the continuing gap in Black life expectancies.²³³ One example of a token effort which does not affect the underlying social structures is Virginia's recently-announced plan to offer reparations for racial exclusion in education in the years following *Brown v. Board of Education* by offering college scholarships to the individuals (now in their 50s and 60s) who were denied access to education more than four decades ago.²³⁴ While apologies and scholarships are certainly appropriate, the scholarships are not nearly as useful near the end of life as they would have been at age 20. Perhaps the scholarships should be offered to the grandchildren. Better yet, everyone should receive an excellent education. Rough justice is preferable to injustice.²³⁵

²³⁰ Many of the early articles on reparations emphasize this approach, including some scholars who are not identified with CRT. See, e.g., Bell, *supra* note 229; Matsuda, *supra* note 229; Magee, *supra* note 229; Westley, *supra* note 229. However, later articles have taken a different approach to reparations. See, e.g., Roy L. Brooks, *Toward a Perpetrator-Focused Model of Slave Redress*, 6 AFRICAN-AMERICAN LAW AND POLICY REPORT 49 (2004) (critiquing the tort model); Jeffery M. Brown, *Deconstructing Babel: Toward a Theory of Structural Reparations*, 56 RUTGERS L. REV. 463 (2004) (discussing recent reparations proposals which are not litigation oriented); Richard Delgado, *Crossroads and Blind Alleys: A Critical Examination of Recent Writing About Race*, 82 TEXAS L. REV. 121 (2003) (calling for CRT to return to concerns for practical structural change rather than mere discourse); Kim Forde-Mazrui, *Taking Conservatives Seriously: A Moral Justification for Affirmative Action and Reparations*, 92 CAL. L. REV. 683 (2004).

²³¹ See Delgado, *supra* note 230, at 150.

²³² See *supra* Part III.D, for a discussion on the weaknesses of Title VI enforcement. During the period of Title VI, disparities in Black health have not narrowed appreciably. See *supra* Section I.B.

²³³ See *supra* Part I.B, n.20.

²³⁴ See Michael Janofsky, *A New Hope for Dreams Suspended by Segregation*, N.Y. TIMES, July 31, 2005.

²³⁵ Adrian Vermeule, *Reparations as Rough Justice* (University of Chicago Law & Economics, Olin Working Paper No. 260, 2005) available at <http://ssrn.com/abstract=813086>.

Correcting disparities in Black health is a worthy goal because success will require massive structural changes in society. As a litigation strategy, focusing on disparities in Black health seems a much more likely strategy than the current crop of unsuccessful reparations lawsuits.

A. Legal Barriers to Litigating Black Reparations

The practical barriers to a successful Black reparations lawsuit are well known to any first year law student taking Civil Procedure.²³⁶ All of the broadly-focused suits have foundered on Rule 12 motions to dismiss, citing lack of standing, expiration of the statute of limitations, failure to state a claim upon which relief can be granted, sovereign immunity, and proximate causation.²³⁷ The Farmer-Paellman “corporate reparations” suits, consolidated in the Federal District Court in the Northern District of Illinois, were dismissed on July 6, 2005 on that basis.²³⁸ The Tulsa Race Riot reparations lawsuit was dismissed due to the statute of limitations. The 10th Circuit Court of Appeals conceded that the statute of limitations might have been equitably tolled for some period after the 1921 riot, but the tolling ceased no later than the publication of a 1982 book describing some of the aspects of the riot,²³⁹ not to mention the publication of Professor Brophy’s excellent book *RECONSTRUCTING THE DREAMLAND: THE TULSA RIOT OF 1921, RACE, REPARATIONS, AND RECONCILIATION* (2002). In this case, the writing of history tends to block litigation remedies.

²³⁶ See Bob Carlson, *Why Slavery Reparations Are Good For Civil Procedure Class*, 47 ST. LOUIS UNIV. L.J. 139, 139 (2003).

²³⁷ See, e.g., *Cato v. United States*, 70 F.3d 1103 (9th Cir. 1995); *African-American Slave Descendants Litig.*, 2005 WL 1561509. These issues have been well-identified, particularly since the *Cato* opinion in 1995. See, e.g., Eric K. Yamamoto, *Racial Reparations: Japanese American Redress and African American Claims*, 40 B.C.L. REV. 477 (1998); Aiyetoro, *Reparations Litigation*, *supra* note 229, at 464-472; Brophy, *supra* note 229, at 86-93; Keith N. Hylton, *A Framework For Reparations Claims*, 24 B.C. THIRD WORLD L.J. 31, 36-44 (2004). Similar barriers are discussed in a more theoretical approach by Eric A. Posner & Adrian Vermeule, *Reparations For Slavery And Other Historical Injustices*, 103 COLUM. L. REV. 689 (2003). The Black health disparities approach would also go a long way to addressing the theoretical concerns raised by Posner and Vermeule.

²³⁸ *African-American Slave Descendants Litig.*, 2005 WL 1561509.

²³⁹ *Alexander v. Oklahoma*, 382 F.3d 1206, 1219-20 (10th Cir., 2004); see also *Alexander v. Oklahoma*, 391 F.3d. 1155 (10th Cir., 2004) (petition for rehearing *en banc* denied, with a written dissent).

Richard Delgado suggests the possibility that litigation may be a dead end strategy for Black reparations.²⁴⁰ Continued losses on Rule 12 motions is an unlikely path to success. Disparities in Black health may provide a better foundation for successful litigation, resolving major issues in standing, statutes of limitations, and sovereign immunity.

1. Standing

Legal slavery in the United States ended with the ratification of the 13th Amendment to the Constitution on December 6, 1865, 140 years ago.²⁴¹ “Surely all applicable statutes of limitation have run,” opponents of reparations say, and federal judges tend to agree.²⁴² Related objections include appeals to “not get mired down in old history” or statements that all slaves and slave owners are long dead. The *remoteness* of the injury gives rise to challenges based on both standing and the statute of limitations.

Reparations plaintiffs have not succeeded with claims of “derivative” standing by descendants of slaves.²⁴³ A more promising line of approach is to focus on more recent acts of racial oppression, the “Jim Crow” strategy.²⁴⁴ Challenging disparities in Black health is one example, with millions of living citizens who suffer well-documented health disparities, beginning in slavery and extending to the present day. Standing should not be a barrier when the class is Black Americans currently suffering from health disparities, or alternatively,

²⁴⁰ Delgado, *supra* note 230, at 502.

²⁴¹ U.S. CONST. amend. XIII. Ratification was completed on December 6, 1865, when the legislature of the twenty-seventh State (Georgia) approved the amendment, there being then 36 States in the Union. On December 18, 1865, Secretary of State Seward certified that the Thirteenth Amendment had become a part of the Constitution. 13 Stat. 774 (1865).

²⁴² See, e.g., *African-American Slave Descendants Litig.*, 2005 WL 1561509; *Cato*, 70 F.3d at 1103; Alexander, 382 F.3d at 1219-20. See DAVID HOROWITZ, *UNCIVIL WARS: THE CONTROVERSY OVER REPARATIONS FOR SLAVERY* (2002), for a widely read book questioning the wisdom of reparations for slavery.

²⁴³ See *African-American Slave Descendants Litig.*, 2005 WL 1561509; *Cato*, 70 F.3d.

²⁴⁴ The best known example is the successful suit by Black farmers for government discrimination in lending. See *Pigford v. Glickman*, 206 F.3d 1212 (C.A.D.C. 2000). See also Brophy, *supra* note 229, at 90-103; David Lyons, *Reparations and Equal Opportunity*, 24 B.C. THIRD WORLD L.J. 177 (2004); Ogletree, *supra* note 229, at 281, 298-307. The Tulsa Race Riot of 1921 litigation is a second example. Alexander, 382 F.3d at 1219-20; Alfred L. Brophy, *RECONSTRUCTING THE DREAMLAND: THE TULSA RIOT OF 1921, RACE, REPARATIONS, AND RECONCILIATION* (2002).

living Americans who received care during the period of legal segregation in health care.²⁴⁵ Indeed, the August 2005 study by David Barton Smith finds that *de facto* racial segregation in health care is still quite common in nursing homes, hospitals and outpatient care.²⁴⁶ Black children who are born in 2005 are expected to suffer a life expectancy many years shorter than their white counterparts. Millions of Black American citizens are living members of the potential plaintiff class.

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

If Blacks had seamlessly merged into America's immigrant "melting pot," then Black reparations might not have relevance today. The issue might have been primarily class, not race.²⁴⁷ But slaves were not immigrants; they arrived in chains. For the vast majority, the Statue of Liberty did not greet them upon arrival; their fate was the auction blocks of Charleston, New Orleans, or even the Nation's capitol. For disparities in Black health, the proposed plaintiff class is not selected by race or descent from slaves. The plaintiff class was selected by the governments, institutions, health care organizations, and society at large which marginalized the health needs of Blacks. The plaintiff class would include a recent immigrant from Angola who was relegated to a second-class Black health care system, as well as the descendants of Virginia slaves.

Jim Crow strategies also improve the process of identifying defendants. Opponents of reparations may say "I never owned a

²⁴⁵ Issues may be raised under Federal Rule of Civil Procedure 23 as to the appropriate class, but having that discussion would be a great improvement over dismissal under Rule 12. In fact, the Black farmers' suit was successful precisely because a large class was approved. See Pigford, 206 F.3d.

²⁴⁶ SMITH, ELIMINATING DISPARITIES, *supra* note 91, at 8-10.

²⁴⁷ Other high-income societies experience health disparities, but those disparities are usually expressed in terms of class rather than race. In the European Union, poorer social classes experience life expectancies which are about five years shorter than average. Tackling Health Inequalities: Governing for Health Summit (hosted by the UK Presidency of the EU 2005 on October 17-18, 2005), available at <http://www.regteam.com/healthinequalitysummit/en/welcome.php>.

slave,” “My family never owned slaves,”²⁴⁸ or “All slave owners are now dead.”²⁴⁹ The issue is most acute if Black reparations are to be assessed against individuals, based on descent. If the injury occurred much more recently, living defendants will be easier to find. Moreover, if a defendant is a legal entity (such as a government or corporation) with continuity to the injury period, then this objection loses force. Many of the potential defendants for a health disparities reparations case are governments and corporations (charitable or for profit) which can be shown to have participated in the creation and continuation of the Black health disparities as described in Section III above.

While it may seem unfair to expect current shareholders or taxpayers to pay for the “sins of their fathers”, the legal principle is well established that corporate liability follows the entity, without regard to the changing composition of the pool of shareholders. Likewise, government entities in continuous existence retain liability without regard to changes in the makeup of its citizens and taxpayers.

Other Jim Crow strategies are possible. Alfreda Robinson has examined the convict labor system, particularly in Alabama.²⁵⁰ While legal slavery ended in 1865, oppressive labor systems such as peonage and convict leasing sprung up to replace slavery with little improvement in the basic living conditions of southern Blacks.²⁵¹ Other examples include the (unsuccessful) recent suit against the 1921 Tulsa Race Riot²⁵² and the successful suit against the federal government for discriminatory lending practices against Black farmers.²⁵³

In the rush to pursue Jim Crow strategies, let us remember Richard Delgado’s call for structural change.²⁵⁴ One has to ask whether the Black farmers’ suit has achieved much lasting change in social structures. Even if it had been successful, the Tulsa suit was not

²⁴⁸ *But see* EDWARD BALL, *SLAVES IN THE FAMILY* (1998).

²⁴⁹ See DAVID HOROWITZ, *UNCIVIL WARS: THE CONTROVERSY OVER REPARATIONS FOR SLAVERY* (2002), for a widely read book questioning the wisdom of reparations for slavery.

²⁵⁰ Alfreda Robinson, *Corporate Social Responsibility and African American Reparations: Jubilee*, 55 *RUTGERS L. REV.* 309 (2003).

²⁵¹ See, e.g., LEON F. LITWACK, *TROUBLE IN MIND* (1999) [hereinafter LITWACK, *TROUBLE*]; LITWACK, *STORM*, *supra* note 60.

²⁵² *Alexander*, 382 F.3d at 1219-20. See *Alexander*, 391 F.3d. (petition for rehearing *en banc* denied, with a written dissent).

²⁵³ *Pigford*, 206 F.3d at 1212.

²⁵⁴ See *supra* Part IV.

a model for widespread replication. The remedy for disparities in Black health is not a sum of money; the remedy is equality of health outcomes. Achieving that equality will require remarkable changes in American society.

2. Statutes of Limitation

Slavery's remoteness in time also prompts the defense of the statute of limitations. Several legal scholars had suggested theories of equitable tolling of the statutes of limitation, but none were persuasive for Judge Norgle in his July 2005 ruling against Black reparations.²⁵⁵ The Jim Crow strategy partially responds to this issue by bringing the injury into the present (or at least into the recent past). But Jim Crow suits which rely on events from decades ago, such as the 1921 Tulsa Race Riot, are still quite remote, and are being dismissed on statute of limitations grounds.²⁵⁶

Professor Brophy has noted that justifications for statutes of limitation are 'under-theorized' in the reparations context.²⁵⁷ The strength of the policy justifications upholding the statute of limitations depends to some degree on the type of defendant. Compelling cases for the statute of limitations can be made when the defendant is a human individual, or when the passage of time has rendered a defense impossible. It is less clear that governments which supported the system through state action should be so protected, or that justice requires the statute of limitation to apply when the defense is not able to demonstrate prejudice. For these reasons, this present study - and my prior examination of slave taxes²⁵⁸ - focuses upon *government* responsibility. When the defendant is a government, the defense of the statute of limitations converges with sovereign immunity, a concept which is discussed briefly below. When the defendant is a corporate entity, the seeds of the statute of limitations may find more fertile soil. Yet these ideas did not prove persuasive to the 10th Circuit Court of Appeals when it dismissed the Tulsa Race Riot reparations suit on

²⁵⁵ *African-American Slave Descendants Litigation*, 2005 WL 1561509.

²⁵⁶ *Alexander*, 382 F.3d at 1219-20. See also *Alexander*, 391 F.3d (petition for rehearing *en banc* denied, with a written dissent).

²⁵⁷ Brophy, *supra* note 229, at 93.

²⁵⁸ Kevin Outterson, *Slave Taxes*, in SHOULD AMERICA PAY?, *supra* note 229, at 135, reprinted in THE PROCEEDINGS OF THE CAMBRIDGE TAX HISTORY CONFERENCE (John Tiley ed., 2004).

statute of limitations grounds.²⁵⁹ All of this again highlights the value of a claim with clear injury in 2005.

3. Sovereign Immunity

In every successful reparations program of the last generation, the issue of sovereign immunity was effectively waived by an enabling statute. When governments pay reparations it is essentially a political act. For example, in the Civil Liberties Act of 1988, President Reagan authorized an apology to Japanese-Americans for internment in World War II, while President George H. W. Bush signed the bill which appropriated the \$1.1 billion dollars necessary to make the \$20,000 reparation payment to internees and some descendants.²⁶⁰ In each of the Holocaust-era reparation commissions, governments participated without resort to the doctrine of sovereign immunity. Black reparations may ultimately be forced to rely on the same process when the defendant is a government. But sovereign immunity does not shield many of the private parties complicit with racial discrimination in health care, including the entities described in Section III, *supra*.

B. The Reparations Heuristic

Section II of this Article critiqued etiological reductionism which seeks to adjust health disparities studies for all SES variables. In exchange, this Article offers reparational analysis as a heuristic device for health disparities research. Reparational analysis modifies some of the methodologies and assumptions in the epidemiological literature on disparities in Black health. In research design, reparational analysis questions all adjustments for confounding variables which are themselves associated with a history of racial injustice. For Blacks, income, wealth, education, housing, and employment have all suffered under parallel histories of oppression. No matter how the strands are

²⁵⁹ *Alexander*, 382 F.3d at 1219-20. *See also Alexander*, 391 F.3d. (petition for rehearing *en banc* denied, with a written dissent).

²⁶⁰ *See* Commission on Wartime Relocation and Internment of Civilians Act, Pub. L. No. 96-317 (1980) (established study commission for persons of Japanese ancestry who were interned by the U.S. government during World War II) (for background, *Korematsu v. United States*, 323 U.S. 214 (1944); *Hirabayashi v. United States*, 320 U.S. 81 (1943); and *Yasui v. United States*, 320 U.S. 115 (1943)). The Report of the Commission on Wartime Relocation and Internment of Civilians led to the passage of the Civil Liberties Act of 1988, Pub. L. No. 100-383 (1988) (Congress accepted the findings of the Commission) and subsequent appropriations. Mitchell T. Maki et al., *ACHIEVING THE IMPOSSIBLE DREAM: HOW JAPANESE AMERICANS OBTAINED REDRESS* (1999).

twisted and knotted, racism was a major cause of disparities in each of these variables. Reparational analysis reverses the decision to adjust for many SES variables, and will result in finding larger Black health disparities than are now reported.

As a policy making tool, reparational analysis is also more holistic, reminding us that many factors influence health other than health care. The causes of ill health include major structural and societal components, including residential segregation, wealth and income disparities, inadequate investment in public health, and employment disparities. If these factors are just intermediate causes of disparities in Black health, then the remedies must run broadly and deeply. Some of the most interesting work on health disparities takes this approach,²⁶¹ connecting the health care system to other social factors such as racial segregation, education, employment and public health.²⁶² This research is also helpful in identifying the appropriate remedies. Opponents of reparations deride the notion of giving large sums of cash to Blacks, including people of mixed race or recent immigrants.²⁶³ Remedial programs in health will address Black disparities without cutting checks on the basis of skin color. One

²⁶¹ Farmer, *supra* note 36 (taking the broader view). David Williams has written extensively on the larger social and economic issues connected to Black health. *See, e.g.* David R. Williams & Chiquita Collins, *Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health*, 116 PUBLIC HEALTH REPORTS 404, 405 (2001) (citing D.S. Massey & N.A. Denton, *American Apartheid: Segregation and the Making of the Underclass* (1993)). David Smith reaches broadly similar conclusions. *See* SMITH, HEALTH CARE DIVIDED, *supra* note 39, at 325; SMITH, ELIMINATING DISPARITIES, *supra* note 91, at 8-17. *See also* Barnett, *supra* note 21, at 16-17 (“A holistic alternative to the lifestyle approach to heart disease prevention focuses on broad improvements in local social environments, recognizing that the social environment provides the context within which individuals are exposed to structural risk factors...”). Sidney Watson calls for systemic reform to address racial disparities in health, treating racial disparities as a serious quality problem. SIDNEY D. WATSON, EQUITY MEASURES AND SYSTEMS REFORM AS TOOLS FOR REDUCING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (2005) [hereinafter WATSON, EQUITY MEASURES], available at http://www.cmwf.org/usr_doc/776_Watson_equity_measures_systems_reform.pdf.

²⁶² David R. Williams & Toni D. Rucker, *Understanding and Addressing Racial Disparities in Health Care*, 21 HEALTH CARE FINANCING REV. 75, 78 (2000) [hereinafter Williams, *Understanding*]. *See* F.J. van Lenthe et al., *Neighborhood Unemployment and All Cause Mortality: A Comparison of Six Countries*, 59 J. EPIDEMIOLOGY & COMMUNITY HEALTH 231 (2005) (lowest quartile neighborhood all cause mortality was 14% to 46% higher, even with adjustments for age, education and occupation).

²⁶³ *See* DAVID HOROWITZ, UNCIVIL WARS: THE CONTROVERSY OVER REPARATIONS FOR SLAVERY (2002).

possible remedy would be specific performance, making the changes necessary to equalize Black health. Even if the damages were limited to the cost of first-class health care for the balance of their lives, the monetary value of this award would run to hundreds of billions of dollars, similar in magnitude to much broader Black reparation claims.²⁶⁴ Eliminating Black health disparities is a much more significant claim (in dollars) than other Jim Crow strategies, particularly single-event suits like the 1921 Tulsa Race Riot. To truly address Black health disparities would require changes to many of the confounding variables described in Section III, *supra*, such as unequal distributions of income, residential segregation, education and employment. Repairing Black health fully would require fundamental changes in American society.

Even if one limits the remedy to the health care system, much would have to be done. Professor Sidney Watson identified four prongs to any program to remedy racial disparities in health: health care financing (financial access); attracting sufficient providers to the inner cities (geographic access); combating discrimination (enforce Title VI); and developing a health care system which is responsive to the needs of the population (cultural competency).²⁶⁵ More recently,

²⁶⁴ Some “back of the envelope” estimates evidence the magnitude of a Black reparations claim: (1) unpaid labor: 20 million person/years at \$30,000 (2005 dollars) yields \$600 billion; (2) the value of slaves as property in 1860: \$2 billion (1860 dollars) yields over \$40 billion 2005 dollars; (3) free first-class health care for living Blacks who lived under segregation: at least 6 million Blacks for an average of 20 years of remaining life, at an average of \$3,000 per year incremental cost yields \$360 billion; (4) the Japanese-American model: \$10,000 per person for a few years of confinement in modest conditions, compared to the Black experience with slavery and segregation: perhaps \$10,000 (1865 dollars) should have been given to each of 4 million freedmen, yielding approximately \$800 billion in 2005 dollars; and (5) lost life expectancy: A recent study estimated that the cumulative gains in life expectancy during the 20th century was worth over \$1.2 million per person. KEVIN M. MURPHY & ROBERT H. TOPEL, *THE VALUE OF HEALTH AND LONGEVITY 1* (Nat’l Bureau of Econ. Research, 2005). Blacks have been denied a substantial share of this longevity gain, corresponding to a substantial share of the \$1.2 million per person calculated by Murphy and Topel. Allocating just 20% of this figure to 36 million Blacks suffering lower life expectancies would yields over \$5 trillion dollars. The data on inflation conversion factors from 1860 is by ROBERT SAHR, *INFLATION CONVERSION FACTORS FOR DOLLARS 1665 TO ESTIMATED 2015*, available at http://oregonstate.edu/Dept/pol_sci/fac/sahr/infcf16652005.pdf.

²⁶⁵ Sidney D. Watson, *Health Care in the Inner City: Asking the Right Question*, 71 N.C.L. REV. 1647, 1654 (1993). See Will Pittz et al., *CLOSING THE GAP: SOLUTIONS TO RACE-BASED HEALTH DISPARITIES* (Applied Research Center & Northwest Federation of Community Organizations) (2005) (providing recent case studies of

she has called for using quality improvement tools to reduce racial and ethnic disparities in health.²⁶⁶ Major structural changes will be required. Eliminating the second-class nature of Medicaid will require reimbursement of providers on the same basis as Medicare, and tying Medicare and Medicaid participation together. Massive changes in the system of educating providers would be required. Public health investments would be strongly supported, and not merely as a defense against terrorism. These and other remedies will not only improve Black health, but will have positive spillover effects to other minority groups and society as a whole.

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

Reparational analysis also avoids the tyranny of presentism.²⁶⁷ The Black reparations movement connects modern disparities in Black health with the historical record. As Williams and Rucker stated:

[W]e can only regard these [racial health disparity] findings as surprising if we take an ahistorical and decontextualized view of the data...Throughout the history of the United States, non-dominant racial groups have, either by law or custom, received inferior treatment in major societal institutions. Medical care is no exception.²⁶⁸

programs to reduce racial disparities in health), *available at* <http://www.arc.org/Pages/pubs/closinggap.html>.

²⁶⁶ WATSON, EQUITY MEASURES, *supra* note 261.

²⁶⁷ Ken Booth, *Three Tyrannies*, in HUMAN RIGHTS IN GLOBAL POLITICS 31 (Tim Dunne & Nicholas J. Wheeler eds., 1999).

²⁶⁸ Williams, *Understanding*, *supra* note 262, at 76 (“Many observers are surprised and perplexed by these findings [of persistent racial disparities in health]. However, we can only regard these findings as surprising if we take an ahistorical and decontextualized view of the data.”).

This historical approach has many practical implications. For example given the history of political under-representation and agency indifference, relying on government agencies in a *Chevron*²⁶⁹ mode is ill advised. As *Alexander v. Sandoval*²⁷⁰ and its expected progeny further restrict private rights of action under Title VI, the situation becomes dire. Reparational analysis suggests the need for a private right of action, placing the case in front of a life-tenured federal judge, rather than relying on majoritarian democratic politics as mediated through interest group politics. The historical approach also avoids the tendency to blame the victim, as some observers lay the blame for some health disparities upon cultural preferences. These cultural preferences – such as a distrust of the formal medical system – must be understood in the context of the history of medical abuse and neglect described in Section III above. Finally, the historical record also suggests that the remedy will not be cheap and easy. The injury spans many generations, and inflicted a remarkable crime against humanity. The remedy is likely to be equally powerful.

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

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

²⁶⁹ *Chevron v. Natural Res. Def. Council*, 467 U.S. 837 (1984).

²⁷⁰ *Alexander v. Sandoval*, 532 U.S. 275 (2001). See generally Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare System: Reinvigorating the Role of the Federal Government in the Aftermath of Alexander v. Sandoval*, 3 YALE J. HEALTH POL'Y, L. & ETHICS 215 (2003), for an analysis of the impact of *Sandoval* on Title VI.

blacks in favor of other possibly less pressing equitable claims...²⁷¹

Other examples include affirmative action in education, which could be supported on reparational grounds independent of Justice O'Connor's diversity rationale.²⁷²

Two potential problems with the heuristic must be mentioned. The first is very practical. Programs to eliminate health care disparities have some recent momentum in Congress, with support from both sides of the aisle.²⁷³ The Senate Majority Leader, Bill Frist (R-TN), is the sponsor and leading proponent of some of these programs to reduce racial disparities in health, but is probably not an ardent supporter of Black reparations. Why undermine Republican support for the program by linking it with Black reparations?

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

To the first question I would say that many reform programs move forward with multiple philosophical foundations, even contradictory foundations. The anti-slavery movement in the 19th Century united religious abolitionists and hard-nosed businessmen, cynical politicians and idealists. It ultimately did not matter that they supported anti-slavery for different reasons.²⁷⁴ As for the second question, the Black reparations movement does not oppose the

²⁷¹ Ian Ayres et al., *Unequal Racial Access to Kidney Transplantation*, 46 VAND. L. REV. 805, 842 (1993).

²⁷² See, e.g., Kevin Outterson et al., Brief for the National Coalition of Blacks For Reparations in America (N'COBRA) and the National Conference of Black Lawyers (NCBL) as Amici Curiae Supporting Respondents, *Grutter v. Bollinger*, 539 U.S. 306 (2003) and *Gratz v. Bollinger*, 539 U.S. 244 (2003), available at <http://ssrn.com/abstract=392060> (arguing that Black reparations is an independent ground for affirmative action in education).

²⁷³ See, e.g., Minority Health and Health Disparities Research and Education Act of 2000, 42 U.S.C. §§ 485E, 903; Press Release, United States Department of Health and Human Services, HHS Reshaping the Health of Minority Communities and Underserved Populations (Jan. 18, 2001), available at <http://www.hhs.gov/news/press/2001pres/01fsmihlth.html>. In October 2005, Senators Lieberman and Hatch introduced a new bipartisan bill to address health disparities. FairCare Act of 2005, S.1929, 109th Cong. (2005).

²⁷⁴ See Kevin Outterson, *Human Rights Before the Postmodern Critique* (2002) (unpublished LL.M. dissertation, Univ. of Cambridge) (on file with author).

elimination of all racial disparities in health. It merely stakes uniquely powerful claims for Black equality. Successfully equalizing Black health in America would require such major social changes that the spillover effect for all other groups would be significant. This rising tide would lift all boats.

CONCLUSION

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

One of our most serious questions of social policy is, then, this: Shall we merely try hard to act as if race had never existed? Or shall we undertake to remove by special action the handicaps left over from our long history of racial discrimination?²⁷⁵

Disparities in Black health are an American Tragedy, taking far more lives annually than AIDS and automobile accidents combined. These Black health disparities were created in a history of slavery, segregation and white supremacy. Halting steps have been made towards amelioration, but current programs will require generations to close the gap; meanwhile, millions of Blacks suffer and 73,000 die prematurely each year. Treating Black health disparities as a reparations claim may force the law to confront the substantive claims, rather than an easy dismissal on procedural grounds. Applying the reparations heuristic to health disparities may challenge American society to move beyond token responses. The goal must be to eliminate disparities in Black health. These efforts would partially redress one of the great crimes against humanity, moving from tragedy to remedy.

²⁷⁵ Everett C. Hughes, *Introduction* to REITZES, *supra* note 111, at xxxi.

