



How Has Racial Segregation Affected Health Care?

Assessing the legacy, impact and remedies racial segregation in American health care

SUMMARY

David Barton Smith, PhD, studied the historical link between racial segregation and discrimination in health care, described efforts through the courts and U.S. regulation to end discrimination in health care, and examined possible approaches to address, through regulatory and health care reform, certain continuing discrepancies and the persistence of segregation.

The project was part of the Robert Wood Johnson Foundation's (RWJF) *Investigator Awards in Health Policy Research* program (for more information see [Program Results](#)).

Key Results

Smith published his study in *Health Care Divided: Race and Healing a Nation*, published by the [University of Michigan Press](#) in 1999.

Six conclusions are presented in the book:

- The advocacy of independent health practitioners was one of the keys to the emergence of the civil rights movement; the largest threat embedded in the current transition of health care is the elimination of their ability to serve as advocates for their patients and communities.
- Voluntary health care organizations, insulated from public accountability, contributed both to the perpetuation of segregation and to its elimination.
- The purchasers of health care define the self-interests of providers and, in the process, either narrow or widen health care's racial divisions.
- The selective enforcement of Title VI of the Civil Rights Act of 1964 exerted a profound, unintended, and unacknowledged influence on the organization of health services in the United States.
- A divided health system persists, both exacerbating and distorting racial disparities.

- Health care settings can close racial divisions.

Principal Deputy Assistant Secretary for Health at the time the book was published, Nicole Lurie, MD, lauded *Health Care Divided* as recommended reading for U.S. Department of Health and Human Services staff, commending its potential contribution to the reduction of health disparities.

Key Recommendations

Smith recommends routine and ongoing examination of racial disparities in the use of health care services and in the choices of diagnostic and therapeutic alternatives. Such monitoring should be part of the quality assurance protocols of all health care organizations and could easily be added to existing quality-assurance-reporting formats.

As of February 2000, the book had sold more than 1,000 copies.

Funding

RWJF supported this project with a \$156,879 grant to [Fox School of Business, Temple University](#).

THE PROJECT

With this RWJF grant, David Barton Smith, PhD, professor of Health Care Management in the Fox School of Business at Temple University in Philadelphia, Pa., researched the link between the history of racial segregation and discrimination in health care, described the efforts through the courts and US regulation to end discrimination in health care, and examined the possible approaches through regulatory and health care reform to address continuing racial discrepancies in health care and the persistence of segregation in more subtle forms.

Smith analyzed US history from 1940 to the present through:

- A review of the archives of relevant organizations and agencies.
- Interviews with approximately 100 key informants—(patients, physicians, civil rights advocates, hospital administrators, and public officials—who participated in various periods of that history.
- A synthesis of morbidity, mortality, and utilization data compiled from government, academic, and industry sources.

Smith also assessed the current organizational, methodological, and data gaps associated with enforcing compliance with Title VI of the Civil Rights Act—which aims to prevent discrimination when federal funds are involved—through the courts and regulatory agencies.

By presenting a history of racial segregation in health care and insights into the impact of discrimination on discrepancies in access and outcomes, the study aimed to focus attention on the need for policy interventions that would monitor bias and ensure that changes in the delivery system do not institutionalize patterns of discrimination.

Smith's book, *Health Care Divided: Race and Healing a Nation*, was published by the University of Michigan Press in 1999. It tells the story of how race has cast what Smith perceives as a pervasive shadow over the development and organization of health care in the United States, reflected, according to Smith, in the nation's lack of a national health insurance program, for example.

The book first presents the history and evolution of the nation's divided health care system and describes the early battles to integrate hospitals at the national policy level. It focuses on battles in North Carolina in the 1950s and 1960s, when the key legal precedents for racial integration of health care were set.

It also describes the remarkable transformation that took place in the implementation of the Medicare program through the enforcement of the 1964 civil rights legislation, because compliance with Title VI of the Civil Rights Act served as a condition for health professionals and institutions to receive Medicare funds. Bringing this history to the present, the book describes what Smith sees as the decline and dissipation of attention to civil rights issues in health.

The book's second part describes the legacy of a historically divided health care system and assesses the accomplishments and uncompleted agenda of the civil rights movement as it pertains to health care. It notes that in spite of dramatic changes to the health care system and the elimination of most financial barriers to health care, racial differences in health outcomes persist.

Those differences are explored in chapter 7, which covers the impact of a segregated system on the provision of services for the elderly, and chapter 8, which outlines the patterns of use of maternity services in a metropolitan area.

FINDINGS AND CONCLUSIONS

David Barton Smith draws several conclusions from his research:

- For independent health practitioners who were involved in the civil rights movement, especially physicians and dentists, the largest threat embedded in the current transition to corporate health care is to their independence and their ability to serve as advocates for their patients and communities. Medical practice is now organized much differently from the days before the civil rights movement when black physicians were solo, fee-for-service practitioners, relying mostly on out-of-pocket payments by their patients for their income. Payments from health insurance plans

contributed little to their income. Today most physicians, at least in urban areas, have been absorbed into integrated delivery systems and rely increasingly on payments by large health plans for their livelihoods. The new systems may limit physicians' ability to serve as patient advocates—for example, because of gag rules that prohibit physicians from criticizing or even explaining to their patients the incentive systems imposed on physicians by those systems. State medical societies now fight for legislation to prohibit gag rules in physician contracts with HMOs.

- Voluntary health care organizations, insulated from public accountability, contributed both to the perpetuation of segregation and to its elimination. Voluntary institutions represent the dominant form of organization of health care in the United States. Race and ethnic divisions contributed to the emergence of this distinctive form of ownership, insulated from political control by government and from market control by privately operated, for-profit businesses. Smith concluded that voluntary health care institutions resulted on one hand in either rigidly segregated care or the total exclusion of blacks, or on the other hand, contributed to the elimination of segregation. In explaining the latter result, he notes that since voluntary health care organizations were considered public institutions, they were entitled to federal and state funds under the Fourteenth Amendment, which prohibited any state from denying to any person within its jurisdiction equal protection under the law.
- Purchasers of health care define the self-interests of providers and in the process, either narrow or widen health care's racial divisions. One of the key points presented in the book is the power of the purchasers of services to shape the behavior of providers. Purchasers, whether contracting for services for private employees or for public beneficiaries in the Medicare or Medicaid programs, now set the rules that define the self-interest of providers. Those rules can either widen or narrow the racial divisions in the provision of health care services, for example, through changes in conditions of participation and methods of payment, thereby making it more or less difficult for certain groups to participate. Smith concluded purchasers can therefore influence providers' civil rights compliance and how patients are protected from discrimination.
- The selective enforcement of Title VI of the Civil Rights Act of 1964 exerted a profound, unintended, and unacknowledged influence on the organization of health services in the United States. No purchaser exerted a more profound influence on the racial divisions in health care than Medicare, the federal program that provides uniform entitlement for those older than age 65. Compliance with Title VI of the Civil Rights Act was a condition of institutional and professional participation in the program. Yet, enforcement was selective, reflecting the administrative and political realities faced by President Lyndon B. Johnson's administration in launching this ambitious new program. Providers responded selectively—accommodating these requirements but moderating their impact on the communities they served. For example, nursing homes were subjected to only pro forma paper compliance reviews, and private-physician practices were specifically exempted. Providers adapted in

other ways, including massive expansion of private-room accommodations in acute-care hospitals.

- A divided health system persists, both exacerbating and distorting racial disparities. In spite of federal efforts to end segregation, health care remains at best, in Smith's opinion, more than half the distance between a fully separate and an integrated system. For example, the shift away from acute-hospital-care settings to non-acute-care settings has a disparate impact on blacks located in neighborhoods where institutions providing non-acute care are in shorter supply. Since health care remains substantially divided along racial lines, changes in health care financing and organization should be evaluated with an eye to that division and its continued impact.
- Health care settings can close racial divisions. The changes in Title VI regulations permitted attending physicians to certify in individual cases that the health and recovery of a patient were threatened by a racially mixed room assignment and permitted those physicians to let patients stay in an unmixed room. Such changes in the regulations—however—acknowledged that such a necessity was an exception, not a rule. According to Smith, they indicated that racism was not an embedded part of the structure of American society, but a condition that could be corrected or, at least, managed. Under Title VI, physicians and health care institutions had been delegated great latitude and trust in the integration of hospital settings, and such delegation proved effective. Compared with other sectors such as schools, there was little protest over integration within hospital settings. That lack of protest made integration of hospital settings the quietest and smoothest transition of the civil rights decade.

Recommendations

Health Care Divided: Race and Healing a Nation recommends the following step to address racial disparities in health care.

- Routine and ongoing examination of racial disparities in the use of services and in the choices of diagnostic and therapeutic alternatives should be part of the quality assurance protocols of all health care organizations. Major structural changes in the organization of health care have produced substantial changes in the way medical care is monitored. Those changes are reflected in the nature of the information collected by providers and purchasers of health care. Different "report cards" have been developed to ensure accountability, consumer choice, and goal-directed action. To monitor civil rights in the health care system would require only minor changes in the reporting formats, according to the book.

Communications

Health Care Divided: Race and Healing a Nation was published by the University of Michigan Press in 1999. Principal Deputy Assistant Secretary for Health Nicole Lurie, MD, lauded the book as recommended reading for US Department of Health and Human

Services staff, commending its potential contribution to the reduction of health disparities.

The national program office disseminated the findings from *Health Care Divided* to policymakers, the media, and the general public through the *Author Series* and media briefings. As of February 2000, the book had sold more than 1,000 copies. The author also published articles in such journals as the *American Journal of Public Health* and the *Journal of Health Policy, Politics and Law* and made numerous presentations on race and health care. (See the [Bibliography](#) for details.)

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Grant ID # 26426

Program area: Human Capital

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