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Article

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INACCESSIBLE HEALTH CARE

I. INTRODUCTION

Quality health care is valuable--but only to the extent it is accessible. From 2020 to 2022, I had the privilege of working on a team to launch a medical-legal partnership ("MLP") in a Chicago suburb with majority Black and Hispanic populations. The MLP provides free legal assistance and inter-professional support to patients of six local medical clinics who face social, structural and/or environmental conditions that prove harmful to their health. Partnering health care providers refer patients to the MLP to address various health-harming legal issues. For example, patients facing imminent threats of eviction, disability-related unemployment, or unsafe dwellings are eligible for referrals to the MLP.

In one sense, patients who are referred to the MLP have effective access to health care insomuch as their connections to primary care physicians created the opportunity for the referral. However, we found that significant access challenges persisted. Some patients could not afford their prescribed medications and revealed that they cut dosages or simply went without necessary treatment. We also met a pregnant client living with a disability who needed to travel to required doctor's appointments, but she faced significant transportation hurdles. The MLP also spoke to individuals whose residential water services had been shut off when they became unable to pay service fees (in many cases, due to COVID-related job loss). Many were forced to choose between paying for water, food, medications, or other necessities. These and other situations highlighted challenges patients faced in accessing health-related services that were critical to sustaining their lives. This Articles will discuss how these obstacles to health care access have thrived in communities of color.

This Article discusses how access to quality health care has remained elusive for large numbers of African descendants in the United States for generations. [1] Black, Hispanic, and Indigenous populations experienced disproportionate rates of illness and mortality as a result of the COVID-19 pandemic due, in part, to disparities in health care access. [2]

***394** Section II of this Article references the role that universal health care has had on global health care access in the countries that have implemented these policies. Access to care within these countries is contrasted with access in the United States. According to the results of an international survey, the United States placed last in many of the polled health care system categories.

The unimpressive state of United States health care, this Article argues, is fueled by governmental failure to address historical and systemic racial health inequities. This failure has made it substantially more difficult for some non-white populations to access health care services. So, in Section III, we narrow our focus on the United States and explain the history of health care segregation in this country and its impact on health care access. We explore how health care segregation yielded a two-tier health care system. In Section IV, this Article discusses Title VI and its limitations. Section V details how efforts towards desegregation have played a critical role in depriving many Black communities of health care access. In Section VI, the Article offers recommendations to address these issues and allow for more equitable access in the United States.

Racial health inequities have been one of the most indelible extensions of systemic racism. [3] To achieve health equity across racial groups and tackle systemic health care inequities, historical and current barriers to access must be addressed.

II. GLOBAL UNIVERSAL HEALTH CARE AND ACCESS

In 2023, 50% of the world's population lacks access to necessary health care. [4] To address access shortfalls, many countries have implemented universal health care policies. [5] In 2023, over seventy countries have implemented some form of universal care system. [6]

Countries with Universal Healthcare 2023 [7]

TABULAR OR GRAPHIC MATERIAL SET FORTH AT THIS POINT IS NOT DISPLAYABLE

***395** According to the World Health Organization, universal health care coverage means "that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship." [8] Countries that offer universal health coverage fund the health care needs of most of its citizens. They also assure high-quality, free and low-cost health care programs to those of all income levels. [9]

Such a concept is hard to imagine in the United States. In 2021, annual health care spending in the United States reached $4.3 trillion, or nearly $13,000 per person. That year, about 40% of American adults reported delaying or foregoing medical care due to the associated costs. One in four said that at least one person in "their household have not filled a prescription, cut pills in half, or skipped doses of medicine in [2021] because of the cost." [10] Forty-one percent of adults in the United States are in debt due to medical costs. [11]

Adults in the United States who are Black, Hispanic, uninsured and have lower incomes are disproportionately impacted by health care costs and have reported foregoing or delaying care because of costs. [12] Black and Hispanic people are more likely to be unable to afford health insurance. [13]

A 2021 survey compared the health care systems of eleven high wealth countries. [14] Access to care was a factor used in measuring countries' performance. [15] The survey suggested a correlation between greater access to health care and improved outcomes. Providing universal health care and removing barriers to access were common characteristics of the survey's best performers. [16] The top-performing countries in the survey employ health care systems that have reduced avoidable mortality rates and produced, overall, more equitable and superior health outcomes. [17]

The survey ranked the United States last. [18] The country is the only high-income nation that does not embrace universal health care. [19] Despite spending a greater share of its gross domestic product on health care than any other nation in the survey, the United States ranked poorly in the area of access to care and ranked last in most of the other survey categories. [20] The United States had, on average, a ***396** sicker population than all other surveyed high income countries. [21] Unremedied race-based policies and laws in the United States have contributed to this dismal outcome.

III. THE IMPACT OF SEGREGATED HOSPITALS ON ACCESS

"There has never been a time in the United States without racial health disparities." [22]

Racial segregation has impacted the ability of non-white communities in the United States to access quality health care. Just as governmental policies bolstered Jim Crow laws and oppressive segregation,[23] federal laws and judicial decisions have facilitated segregated and inequitable hospital policies.[24] 24

The Hill-Burton Act of 1946[25] sparked the most extensive construction of hospitals and public health facilities in the United States.[26] Nearly four billion in federal funds and over nine billion dollars from states and local governments financed the construction of hospitals and health facilities from 1947-1971.[27]

Racial discrimination, flowing from the highest level of the United States government, tainted the expansive Hill-Burton program from the start. Between 1946-1963, the Hill-Burton Act funded the construction of more than 100 health facilities that excluded patients based on race.[28] The Act also allocated dollars to over 7000 facilities that racially segregated patients.[29] Until it was overruled in 1954, the United States Supreme Court's ignominious *Plessy v. Ferguson*[30] decision made these "separate-but-equal" policies permissible.[31]

Black leaders at the time had advocated for the Act to include a provision mandating that the funding and construction of health facilities reflect "racial parity" in communities where racial segregation was legal.[32] Dr. Louis T. Wright, a doctor and graduate of Harvard Medical School, was the chair of the board of the ***397** National Association for the Advancement of Colored People.[33] In the 1940s, Wright and the NAACP advocated for equitable funding and racial parity within the segregated hospital system (instead of demanding a racially integrated system) as a means to achieve racial equity in health care.[34] Wright proposed that federal health policies "provide for a just and equitable apportionment of [funds] for hospitals and health centers for minority races."[35] Similar language eventually found its way into the Act.[36] The Act was the only federal legislation that included such text.[37]

Despite the buttressing of health care segregation, for a period of time, the Hill-Burton Act did increase the Black community's access to hospital services.[38] The number of modern, well-resourced hospitals that admitted both Black and white patients, albeit on a segregated basis, increased.[39] This was particularly true in the south.[40] Rural Black families gained access to hospitals to such a degree that the significant occurrence of non-hospital births among them declined.[41] When predominantly white hospitals admitted Black patients, they were placed in separate wards and, generally, received lower quality services.[42] Segregated wards often served as training grounds for white health care providers.[43]

During legal segregation, Black hospitals were established in the face of federally enabled racially segregated health care facilities.[44] Hospitals treating non-white patients began emerging in 1832.[45] These hospitals, however, were often severely under-resourced, housed second-rate equipment,[46] and the quality of health care delivered was seen as inferior to care delivered in conventional institutions.[47] Black patients who could afford to pay for health care were steered largely toward these hospitals and treated by health care providers who were disallowed from mainstream participation in the profession.[48]

The Hill-Burton Act's successful implementation of the racial parity in health care provisions that Black leaders demanded would depend on the federal government's commitment to enforcing the Act's nondiscrimination provisions.[49] The United States Public Health Service was charged with administering the Hill-Burton Act.[50] Members of the American Medical Association voiced strong resistance to racial equity initiatives by analogizing them to "socialized ***398** medicine."[51] Others argued that the Act would allow the federal government to interfere with the racial dynamics of local communities and with medical care.[52] Capitulating to the opponents of the racial parity objectives of the Act, the United States Surgeon General assured the dominant voices in the medical community that states and various localities would hold the ultimate responsibility for administering the Hill-Burton program.[53]

Federal and state officials then haggled over interpretations of nondiscrimination [54] and states were able to implement Hill-Burton plans in a manner that favored the interests of white communities over majority Black neighborhoods for hospital investment. [55] In the end, racial parity in the funding and construction of health facilities was never realized. [56]

Despite the failure to finance health facilities equitably across demographic groups, the actions of the Public Health Service did cause more Black patients to access medical care in segregated southern hospitals. [57]

The enhanced access afforded by the Act, however, was not sufficient to close disparity gaps in outcomes. Black communities' health outcomes struggled amid persistent disparities in access and segregation. [58] When the "separate-but equal" policies under the Hill-Burton Act ended in 1963, Black life expectancy rates dismally sat between seven to eight years lower than that of whites. [59]

IV. HEALTH CARE ACCESS AFTER THE CIVIL RIGHTS ACT OF 1964

Explicit policies to deny Black patients access to quality health care appeared to be coming to an end in 1964. That year, Title VI of the Civil Rights Act of 1964 [60] was enacted and, a year later, President Lyndon B. Johnson signed the Social Security Act Amendments into law, establishing Medicare and Medicaid. [61] The federal government was able to directly address public and private hospitals' discriminatory practices through federal funding, tax subsidies, and the application of Medicare and Medicaid programs. [62] Title VI required health care institutions to prohibit racially discriminatory practices before receiving Medicare or Medicaid funds. [63]

***399** Title VI and the Social Security Amendments incentivized health care facilities to desegregate. [64] Title VI played a key role in stopping overt discrimination in health care delivery [65] by conditioning the flow of federal dollars on a recipient's perceived abstinence from implementing racially discriminatory policies. [66] The passage of the Social Security Amendments caused most hospitals to desegregate rapidly to avoid missing out on substantial revenue from Medicare and Medicaid funding. [67] In one community in North Carolina, Black and white hospitals quietly merged in less than six weeks. [68] Most integrated within one day. [69] Within one year, one thousand hospitals had adopted racially integrated admissions policies. [70]

Health outcomes within Black communities initially improved after hospital desegregation. [71] The significant drop in the infant mortality rate among Mississippi's Black population between 1965 to 1971, as an example, was attributed to desegregation laws. [72] Still, some were skeptical that anti-discrimination laws would have only limited effect. [73] The skepticism was justified. Title VI's limitations played out in numerous ways. One Title VI limitation arose from a 2001 United States Supreme Court decision. In *Alexander v. Sandoval*, [74] the Court held that private plaintiffs could not bring suit under Title VI for discrimination based on disparate impact. [75] Private plaintiffs may only bring a Title VI claim by showing that a Title VI fund recipient had the intention to discriminate, the Court held. [76] After *Sandoval*, the responsibility for enforcing impermissible disparate impact under Title VI fell squarely on the shoulders of federal funding agencies. [77]

Another limitation was the federal government's ineffective Title VI enforcement measures. [78] When the federal government delegated to the states the responsibility of precluding discriminatory policies that denied Black people access to health care, it was then incumbent on federal agencies to monitor states' efforts and ensure that this intention is carried through. [79] Decades have shown that the federal government's monitoring and enforcement of Title VI compliance has been ineffective. [80] This allowed violations of Title VI by federally funded health ***400** facilities to go unchecked. [81] Title VI's limitations make it insufficient to disconnect federal funding from policies that have significant disparate impacts to health care access. [82]

V. PROXIMITY TENDS TO YIELD GREATER ACCESS

"Who would choose to go to an institution where they know the ... death rate is higher than that in some developing countries?" [83]

In the 1980s, private hospitals started leaving communities of color in favor of richer, whiter neighborhoods. [84] In addition, large numbers of public hospitals that were heavily relied upon by low-income, diverse communities, were closed by local governments due to strained resources. [85] These changes, in light of the ubiquity of residential racial segregation in the United States, made **health care** more **inaccessible**, farther in physical distance and inconvenient for many residents in Black communities. [86] Fewer hospitals in the area decreased the opportunities to access health care. [87]

Nearly sixty years after the passage of Title VI, segregated hospitals still remain. [88] A 2022 Lown Institute study found that Detroit, Michigan, area hospitals are the most racially segregated. [89] The study found that metropolitan Detroit hospitals are segregated at a rate of 90%. [90] St. Louis, Missouri, followed with a 77% segregation score. [91]

Systemic racism and generations of redlining have steered Black people to hospitals where all patients have experienced worse outcomes than patients at other hospitals. [92] People, generally, obtain health care services near their homes. [93] ***401** Hospitals in lower income communities have less resources available to provide consistent quality care. [94] In June 2021, the Washington Post reported that the mortality rate for Black patients with COVID-19 would have been 10% lower if they went to hospitals treating their white counterparts. [95]

A. Hospital Relocations from Black Communities

Most of the hospitals that freely welcomed Black patients during the "separate but equal" era closed due to financial strain or were folded into all-white hospitals. [96] White hospitals began relocating out of predominantly Black communities, leaving health care deserts in their place. [97]

Residents living in affected communities would not likely be able to bring a Title VI claim based on a hospital relocation. Hospital policies that are racially neutral on their face and where there was inadequate evidence of discriminatory intent sufficient may not trigger Title VI's prohibition against discrimination. [98] For example, when a hospital moves its operations from one community to another, it is likely a racially neutral policy, on its face, because all residents in the former area are deprived of health care services--regardless of race or ethnicity. [99] Closer inspection reveals that Black and Hispanic patients historically have faced the greatest likelihood of adverse impact when a hospital closes in an urban area. [100] Rural hospital closures occurring between 1990 and 2020 were more likely to impact non-white populations. [101] Further, when these hospitals relocated, there was a good chance that it would have a new address in a mostly white suburb. [102]

These hospital moves compounded the impact of redlining policies plaguing urban Black and immigrant communities at the time. Since the 1930s, federal, state, and private redlining practices concentrated Blacks and immigrant groups within certain neighborhoods, while fostering blight, disinvestment, generational cycles of poverty and negative social determinants of health in these same areas. [103]

***402** Redlining policies spurred generations of residential segregation, while maintaining and exacerbating stark racial health disparities in the United States. [104] Health care providers appeared to prefer locations in communities with greater concentrations of affluent white residents. [105] Predominantly Black neighborhoods found it very difficult to attract providers, which led to an inadequate number of total providers. [106] The available providers were deemed "lower quality." [107] Residents

of those areas, therefore, endured decreased access to health care and were subjected to a lower quality of care. [108] The effects of redlining still impact communities today. [109]

Hospital moves and government-architected residential segregation fueled generations of racial inequities in health care. [110] White people received markedly broader access to quality health care, and Black patients suffered from limited options, worse health outcomes and shorter lifespans. [111] Yet, hope for enhanced access was on the horizon with the passage of the Affordable Care Act.

B. Access Through Expanded Health Insurance Coverage

After the Affordable Care Act was enacted in 2010, the Act expanded health insurance coverage across racial and ethnic groups across the country. [112] The Act sought to expand the scope of Medicaid to extend coverage to more people who would have been, at the time, deemed ineligible. [113] The Medicaid expansion provisions under the Act "saved the lives of at least 19,200 adults aged 55 to 64 from 2014 to 2017." [114]

After the Supreme Court's *NFIB v. Sebelius* [115] *2012 ruling,* states could elect whether to expand Medicaid within its borders. [116] In 2017, the Act's coverage gains began contracting and the uninsured rates, for three years thereafter, increased--eroding the previous gains. [117]

***403** As of July 2022, twelve states had refused to expand Medicaid under the Affordable Care Act. [118] These include states with the largest Black populations. [119] The Center on Budget and Policy Priorities reported that states' decision to not expand Medicaid led to the loss of 15,600 adult lives. [120]

The states that have chosen not to expand Medicaid have higher rates of uninsured people. [121] Over two million people in these twelve states fall in the gap of having incomes too high for Medicaid eligibility, but too low for subsidies. [122] Almost six in ten people across the United States within this coverage gap are people of color with "uninsured Black adults ... more likely than their white counterparts to fall into the gap (15% vs. 8%)." [123]

The impact of limits on Medicaid expansion on racial health disparities is noteworthy. More than half of those who remain uninsured due to their states' refusal to expand are people of color. Studies show that expanding Medicaid universally will reduce racial health inequities with respect to access. [124]

C. Hospital Closures in Black Communities

"... [I]nstitutional racial bias in health care is best demonstrated by hospital closures in African American communities, which leaves minority neighborhoods without access to medical services." [125]

At one time, during legal segregation, there was as many as 500 Black hospitals operating in the United States. [126] During the 1950s and 1960s, Black physicians and dentists were on the front lines of civil rights advocacy. [127] Largely excluded from working in white hospitals, these health care providers controlled health care institutions in Black communities and exercised leadership in promoting the Black community's interests. [128] Fees primarily flowed from ***404** patients, not insurance companies. [129] So, physicians and dentists could more freely advocate for the best interests of their patients and communities. [130]

Let us fast forward to 2022. In that year, there was only one Black hospital in the United States! [131] Further, independent Black provider advocacy is rare in modern times with only one Black hospital in the United States and with many Black professionals being compensated from insurers and private managed care entities. [132]

During the segregation-era in Detroit, Michigan, there were at least eighteen Black-owned and operated hospitals. [133] None of those institutions exist in the city at present. [134] Black hospital closures were the indelible consequences of the passage of desegregation laws. [135] According to Professor Christopher Ogolla, seventy Black hospitals either closed permanently or they merged with white facilities between 1961 and 1988. [136]

A study of hospital restructuring in various Northeastern and Midwestern cities between 1937-1980 revealed a correlation between the increased presence of people of color around a hospital to the rate at which that hospital closed. [137] An analysis of urban public hospital closures from 1987-2007 [138] found that high residential segregation, together with a high concentration of low-income residents, increased the likelihood of hospital closures. [139] Hospital closures have continued to significantly impair health care access and outcomes for Black patients with COVID-19. [140]

Closures of health facilities in Black communities deteriorate opportunities to access health care for residents who depend on these institutions for care. This is particularly cruel considering the federally-sanctioned segregation laws that denied them access to other hospitals for generations.

A hospital closure in the predominately Black city of Detroit, Michigan at the turn of the 21st century exemplified some of these issues. Detroit is Michigan's largest city and, in 2005, over 52% of the city's residents were either uninsured or Medicaid-eligible. [141] Shortly before Christmas in 1999, Mercy Health Services Inc., then Michigan's largest health care provider, announced that it would close ***405** Mercy Hospital in Detroit. [142] Mercy Hospital was a 268-bed facility that had a daily bed occupancy rate of about 70% and saw 40,000 emergency room visits in 1998. [143] Mercy Hospital was located on the east side of Detroit in one of the most financially strapped areas in Michigan. [144] Two-thirds of those within Mercy Hospital's servicing area were living below the federal poverty level. [145] When Mercy Hospital closed in March of 2000, approximately 1,300 people became unemployed. [146] Eighty percent of Mercy Hospital's patients were covered by Medicaid and/or Medicare. [147] With revenues of $2.6 billion in 1999, Mercy Health Services cited “government reimbursement cuts” as a reason for the closing and that it “no longer could carry the burden for Mercy Hospital.” [148] In an unfortunate happenstance, on the day Mercy Health Services reported the final closing of Mercy Hospital, a national study published that the City of Detroit had the “largest percentage of underweight babies of all large cities in the United States.” [149]

When a hospital closes, people of color disproportionately suffer reduced access to necessary health care. [150] This is exacerbated by a lack of health care alternatives available to the abandoned communities. [151] Further, public hospitals have served as a safety net for low-income communities of color, partly due to discriminatory practices among hospitals and health care providers. [152]

After the Social Security Act Amendments established Medicare and Medicaid, hospitals that had previously denied access to Black patients and employment to Black doctors were forced to open their doors if they wanted federal dollars. [153] These bills promulgated hospital desegregation, but without providing assurances that all patients would have equitable access to quality health care that is affordable and proximate to those living in historically marginalized communities.

Title VI has not counteracted the extensive hospital closures and removal of hospital services from Black and underserved communities. [154] While Title VI of the Civil Rights Act of 1964 improved health outcomes in some ways, it also led to the destruction of a vibrant network of Black-owned and operated hospitals and failed to allow full recourse to address remaining inequities. It also did not substantially improve the ways that residential segregation effectively segregated ***406** hospital health services.

Likewise, the Affordable Care Act showed early improvements in access and expanded health care coverage, but *NFIB v. Sibelius* represented a missed opportunity to relieve some of the stress on the segregated system, since the Court left states free to decline a Medicaid expansion that would have provided more equity and access.

The failure to ensure access to quality health care for historically marginalized Black communities exemplified the gross negligence of the United States federal government, given its role in instituting and exacerbating the mental, physical, and emotional harm done to Africans and African descendants since the period of enslavement. This leaves an opportunity to explore other options to bring about more accessible health care for all.

VI. RECOMMENDATIONS

The Civil Rights Act of 1964 and the Affordable Care Act were passed with hopes of advancing health equity and access. Both, regrettably, failed to guarantee underrepresented groups long-term access to quality health care and neither adequately redressed generations of racial health inequity.

The United States should follow the lead of its international peers and embrace universal health care. The top performing countries in the 2021 survey with the most successful health care structures have all implemented universal health coverage and successfully reduced barriers and cost for individual patients. While this will not ameliorate all racial health inequities experienced in the United States, it will be a substantial step toward allowing for greater access to health for all population groups.

Relying on the individual fifty states to provide United States' citizens with quality health care has proven to be an inadequate approach. Instead of allowing for equitable healthcare access, this decentralized plan will continue to perpetuate future iterations of past racially discriminatory policies.

It is long overdue for the United States to adopt a universal system. There are various ways that countries have adopted universal health care and the United States can choose from a spectrum of alternatives. [155] The federal government's default method of delegating the administration of health care policy to the states becomes tainted and inextricably linked to the oppressive, racially subjugated systems that have denied Black people access to quality health care for generations.

The federal government is also encouraged to do what Title VI did not do and retroactively address past inequities in access. The federal government must commit--through funding, monitoring and enforcement--to ensuring that communities, like Detroit, that are most affected by the residual impact of redlining, hospital closures and segregation, are infused with quality health facilities with independent, culturally competent providers who advocate for the communities they serve.

Footnotes

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41 *Id*. at 847.

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