UNITED STATES
COMMISSION ON
CIVIL RIGHTS

624 Ninth Street, N.W.
Washington, D.C. 20425

October 9, 2009

President Barack Obama
The Honorable Nancy Pelosi, Speaker of the House
The Honorable John A. Boehner, Republican Leader
The Honorable Charles B. Rangel, Chairman, Committee on Ways and Means
The Honorable David Lee Camp, Ranking Member, Committee on Ways and Means
The Honorable George Miller, Chairman, Committee on Education & Labor
The Honorable John Kline, Ranking Member, Committee on Education & Labor
The Honorable Henry Waxman, Chairman, Committee on Energy & Commerce
The Honorable Joe Barton, Ranking Member, Committee on Energy & Commerce
The Honorable Edolphus Towns, Chairman, Committee on Oversight & Govt. Reform
The Honorable Darrell Issa, Ranking Member, Committee on Oversight & Govt. Reform
The Honorable John Spratt, Chairman, Committee on the Budget
The Honorable Paul Ryan, Ranking Member, Committee on the Budget

Dear President Obama and Distinguished Members of Congress:

We write to express our deep reservations about racially discriminatory provisions included in H.R. 3200 (the "Health Care Bill").[1] This bill contains provisions that appear to be designed to ensure that medical schools, dental schools and other institutions that train health professionals will give preferential treatment in admissions to members of underrepresented minorities. Failure to do so could cause these institutions to be ineligible for federal grants and contracts. Some advocates say this heavy-handed pressure for racial preferences is necessary in order to alleviate racial health care disparities. But we have two concerns. First, racial preference policies that assume racial health disparities are caused by a shortage of medical professionals of particular races misdiagnose the problem and may well exacerbate it. Second, Congressionally-mandated affirmative action of this type is likely to be held unconstitutional.

The bill would authorize the Secretary of Health and Human Services ("HHS") to enter into contracts with, and award grants to, eligible entities that operate a range of professional training programs for health care professionals,[2] including programs designed for primary care physicians,[3] dentists,[4] dental hygienists,[5] and public health professionals.[6] In awarding grants and contracts on

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[1] The decision to send this letter was arrived at in an opening meeting of the United States Commission on Civil Rights on August 7, 2009. The vote was 4-2 with two members abstaining.

The U.S. Commission on Civil Rights was established by the Civil Rights Act of 1957. Civil Rights Act of 1957, P.L. 85-315, § 101(a), 71 Stat. 634, 634 (1957). Among other things, it studies and collects information relating to discrimination or denial of equal protection because of color, race, religion, sex, age, disability or national origin; appraises the laws and policies of the federal government relating to discrimination or denials of equal protection; and serves as a national clearinghouse of information relating to discrimination or denials of equal protection on the basis of protected classifications.

[2] America's Affordable Health Care Choices Act of 2009, H.R. 3200, 111th Cong. § 2213(3)(b) (2009).

[3] *Id.* § 2214(e)(2).

[4] *Id.* § 2215(b).

behalf of these programs, HHS must give preference to entities that have a "demonstrated record" of training individuals who are from underrepresented minority groups or disadvantaged backgrounds.[7] But these provisions are constitutionally suspect and ill-defined. For instance, the bill does not define "demonstrated record," giving potential grantees and contractors every incentive to give preferential treatment to minority group members who apply for training.

Racial Health Care Disparities and Public Policy. The gaps in life expectancy and morbidity rates that exist among racial groups in America are cause for concern. Some of these differences are the result of diet, exercise or other differences in life style, and some may be the result of differing genetic inheritance. But there is evidence that some are the result of different medical treatment. A good example is the likelihood that a patient will undergo cardiac catheterization after acute myocardial infarction. Several studies conclude that white patients are more likely to receive this treatment than black patients (certain other medical indications being the same).[8]

Over the years, some observers have argued that racial disparities in health are the result of disparities—whether caused by conscious or unconscious discrimination—in the provision of health care, and that expanding the number of minority physicians (even if that means lowering academic standards in medical school) and ensuring that all health care professionals receive "cultural competency" training would help remedy the problem. But as Dr. Amitabh Chandra of Harvard University testified at a recent briefing before the Commission, this view is "grounded in hope more than science."[9]

A growing body of evidence shows that health care disparities are not the result of individual physicians treating their white patients differently from their black patients or of non-black physicians' lack of familiarity with African-American culture. Rather, the problem lies with the fact that, as a population, black patients use different doctors, clinics and hospitals than white patients. On the whole, the doctors who treat black patients with frequency are less likely to be highly credentialed and more likely to report obstacles in gaining access to high-quality service for their patients.[10] As one might expect, these circumstances can lead to poorer health outcomes.[11]

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[5] *Id.*

[6] *Id*. § 2232(b).

[7] *Id.* § 2213(d)(2).

[8] *See* Jersey Chen, Saif S. Rathmore, Martha J. Radford, Yun Wang & Harlan M. Krumholz, *Racial Difference in the Use of Cardiac Catheterization After Acute Myocardial Infarction*, 344 N. ENGL. J. MED. 1443, 1444 (May 10, 2001) (citing numerous empirical studies in footnotes 1-9 of their article for this point).

[9] A full transcript of the briefing can be found at http://www.usccr.gov/calendar/trnscrpt/061209ccr2.pdf.

[10] Peter B. Bach, Hoangmai H. Pham, Deborah Schrag, Ramsey C. Tait, J. Lee Hargraves, *Primary Care Physicians Who Treat Blacks and Whites*, 351 N. ENGL. J. MED. 6 (August 5, 2004). The contrast under study was not between white doctors and black doctors, but rather between doctors who treat white patients and doctors who treat black patients. Both groups of doctors were majority white, although the degree of racial diversity among treating physicians who treat black patients was greater than it was among those who treat white patients. Many doctors, of course, treat large numbers of both white and black patients. For visits by a white patient to a physician, the physician was white 85.3% of the time, black 0.7% of the time, and Asian 10.3% of the time. For visits by a black patient, the physician was

A significant portion of the problem is geographic; the poorest regions of the country tend to have the poorest health care. In *Geographic Variation in Health Care and the Problem of Measuring Racial Disparities*, the authors commented that "blacks tend to live in parts of the country that have a disproportionate share of low-quality providers." "Within those hospitals," they wrote, "both whites and blacks tend to receive low-quality care, but since blacks are over-represented in such areas, the quality of the hospital will cause an overstatement of the role that race plays …."[12]

These findings argue not for more black physicians or for more physicians who treat black patients in Connecticut or Colorado, but for more first-rate physicians, no matter what their race, willing to practice medicine in the poorest regions of the Deep South and other areas of low-quality health care, where their patients may also be of any race. President Obama's choice for Surgeon General, Dr. Regina Benjamin, who makes house calls along the impoverished Gulf Coast, is an excellent example. The findings also argue for ensuring that these doctors have adequate resources to deliver top-quality care.

Those who assert that greater "cultural competency" among doctors is the key to improving health care for minorities are not supported by the evidence.[13] If cultural competency were the problem, one would expect doctors who treat black patients most frequently to provide superior care to black patients, since their extensive experience with black patients would cause them to be, on average, more culturally competent.[14] Yet, if anything, precisely the opposite seems to be the case,[15] which again suggests that the doctor's ability and not his cultural sensitivity is the key to improving health care for minorities.

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white 59.7% of the time, black 22.4% of the time and Asian 15.7% of the time. For hospital visits, the figures for white patients were 81.5% (white physician), 2.5% (black) and 13.2% (Asian) for the patient's local area and 80.1% (white), 3.5% (black) and 13.2% (Asian) for the patient's regional area. For hospital visits by black patients, the figures were 69.7% (white physicians), 12.5% (black) and 13% (Asian) for local hospitals and 75.2% (white), 6.7% (black) and 14.8% (Asian) for regional hospitals.

[11] *See, e.g.*, Jonathan Skinner, Amitabh Chandra, Douglas Staiger, Julie Lee & Mark McClellan, *Mortality After Acute Myocardial Infarction in Hospitals That Disproportionately Treat Black Patients*, 112 CIRCULATION 2634, 2634 (2005) ("Risk-adjusted mortality after AMI is significantly higher in US hospitals that disproportionately serve blacks. A reduction in overall mortality at these hospitals could dramatically reduce black-white disparities in health care outcomes.").

[12] Katherine Baicker, Amitabh Chandra, & Jonathan S. Skinner, *Geographic Variation in Health Care and the Problem of Measuring Racial Disparities*, 48 PERSPECTIVES IN BIOLOGY & MED. S42, S43 (Winter 2005).

[13] Public opinion polls show that most patients—including members of minority groups—are similarly uninterested in whether their physician is of the same racial background. Rather, they are most concerned about service-related issues such as how much time the doctor spends with them, how well the doctor answers their questions, and whether the doctor or the doctor's staff responds to questions and follows up. In one poll asking patients about factors influencing their choice of doctors, the physician's race/ethnicity ranked 12th out of 13 possible options. Jonathan Klick & Sally Satel, THE HEALTH DISPARITIES MYTH: DIAGNOSING THE TREATMENT GAP (AEI Press 2006).

[14] Emphasizing cultural competency when lack of such competency does not appear to be the crux of the problem is not harmless. The medical school curriculum is not infinitely elastic. There are only so many hours in the day for instruction and study. Emphasizing one subject necessarily implies that another subject will not be emphasized. *See* Testimony of Peter B. Bach, M.D., Briefing on Healthcare Disparities, U.S. Commission on Civil Rights, at 85 (June 12, 2009).

The notion that simply increasing the numbers of black doctors is the solution to the problem of inferior treatment for minorities fares no better. Contrary to what one would expect to be the case, evidence presented to the Commission revealed that black doctors are not more likely than white doctors to provide black patients with the highest level of care. For example, in *Racial Differences in the Use of Cardiac Catheterization After Acute Myocardial Infarction*, the authors found no significant interaction between the patient's race and the physician's race, indicating that black patients treated by black physicians did not undergo cardiac catheterization at a different rate from black patients treated by white physicians.[16] They wrote:

> We found that black patients were significantly less likely than white patients to undergo cardiac catheterization within 60 days after admission, regardless of whether the attending physicians were white or black …. The rate of cardiac catheterization among white patients did not differ significantly according to whether their physicians were white or black (45.7 percent and 49.6 percent, respectively …). Similarly, the rate of cardiac catheterization among black patients did not differ significantly according to whether their physicians were white or black (38.4 percent and 38.2 percent, respectively …).[17]

If all this is so, pressuring medical schools to admit more minority medical students does not address the issue. Increasing access to high-quality physicians—whatever their race or ethnicity—and removing the obstacles they face in obtaining high-quality services for their patients is the way to mitigate health disparities.

Constitutionality. However well-intentioned it might be, the Health Care Bill's insistence that federal monies go only to medical schools with a "demonstrated record" of training individuals from underrepresented minority groups will undoubtedly be read by some as a demand that these schools apply less demanding academic standards to their minority applicants.[18]

Some might argue that the Health Care Bill does not specifically require medical schools to lower standards on the basis of race; it simply offers subsidies to those schools that can demonstrate that they have recruited a "sufficient" number of minority members. But this approach ignores reality and the relevant jurisprudence in this area.

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[15] *See* Bach et al., *supra* note 10.

[16] *See* Chen et al., *supra* note 8. *See also* Thomas R. Konrad, Daniel L. Howard, Lloyd J. Edwards, Anastasia Ivanova, Timothy S. Carey, *Physician-Patient Racial Concordance, Continuity of Care, and Patterns of Care for Hypertension*, 95 AM. J. PUB. HEALTH 2186 (December 2005) (finding that "African American individuals' elevated hypertension diagnosis risk was unaffected by physicians' race").

[17] Chen et al., *supra* note 8, at 1445.

[18] In *Grutter v. Bollinger*, 539 U .S. 306 (2003), the Court acknowledged that, given the widespread use of racially preferential admissions policies, the University of Michigan Law School had no choice but to engage in such policies if it wished to attract a racially diverse law school class. *Id.* at 340. Similarly, we believe that the Court would acknowledge that, given the widespread use of heavy preferences for minority students in medical schools, a medical school that wished to maintain a "demonstrated record" of training minority students would have to engage in racially preferential admissions policies.

The Health Care Bill's racial provisions are thus constitutionally suspect. *Adarand v. Pena* clarified the constitutional standard for evaluating all racial classifications—state and federal, including race-conscious programs in federal contracting.[19] All governmentally imposed racial classifications trigger strict scrutiny—a highly demanding standard of review.[20] To pass it, a restriction must be necessary to serve a compelling state interest and must be narrowly drawn to serve that end.[21]

The strong weight of the evidence is against the proposition that racially preferential admissions policies can help solve the health care disparity problem. Consequently, that purpose cannot fulfill the requirements of strict scrutiny. Unless Congress has concrete evidence that these provisions are likely to accomplish some other compelling purpose, they will likely be held unconstitutional.[22]

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[19] 515 U.S. 200 (1995).

[20] *Id.* at 227. That Section 2213(3)(d) does not call for the federal government to administer a racial preference program directly, but that it instead offers tremendous financial incentives to reward those public and private entities that do, is of no legal moment. It is well-settled that Congress is precluded from accomplishing indirectly that which the Constitution and the courts forbid it from doing directly. *Bailey v. State of Alabama,* 219 U.S. 219, 239 (1911) ("It is apparent that a constitutional prohibition cannot be transgressed indirectly by the creation of a statutory presumption any more than it can be violated by direct enactment. The power to create presumptions is not a means of escape from constitutional restrictions."). Thus, Congress is not permitted to circumvent the equal protection principle of the Fourteenth and Fifth Amendments by enticing entities—whether public or private—to engage in race discrimination. *See, e.g. South Dakota v. Dole*, 483 U.S. 203, 210-211 (1987) ("[T]he language in our earlier opinions stands for the unexceptionable proposition that the [spending] power may not be used to induce the States to engage in activities that would themselves be unconstitutional. Thus . . . a grant of federal funds conditioned on invidiously discriminatory state action . . . would be an illegitimate exercise of the . . . spending power."); *Adarand*, 515 U.S. at 226 (strict scrutiny applies to congressionally mandated race-based classifications). Nor is this a circumstance in which Congress has made factual findings regarding race discrimination in medical school admissions or in minority members' access to medical care that are deserving of judicial deference. *See Walters v. National Ass'n of Radiation Survivors*, 473 U.S. 305, 330 n.12 (1985) ("When Congress makes findings on essentially factual issues . . ., those findings are of course entitled to a great deal of deference . . . ."). In fact, Section 2213(3)(d) is noticeably lacking legislative findings to support its underlying assumption—specifically, that increasing minority members' access to doctors of their own race will improve or eliminate racial disparities in their health outcomes.

[21] *Adarand*, 515 U.S. at 236. Moreover, the drafters must consider race-neutral means of achieving their goals, such as race-neutral technical assistance programs or expanded outreach programs to potential health care professionals of all racial and ethnic backgrounds. This bill includes no such alternative strategies, which raises troubling questions about the constitutionality of the provisions granting racial preferences. *See* United States Commission on Civil Rights, Federal Procurement After *Adarand* (September 2005) (describing alternative strategies in greater detail). Similarly, *Adarand* requires that a program last no longer than necessary to eradicate the discriminatory effects that it was designed to eliminate. 515 U.S. at 238. This legislation includes no sunset period for these racial preferences, raising further constitutional questions.

[22] If the point is to ensure the "right proportion" of minority health care professionals for its own sake, then it is surely unconstitutional. As Justice Lewis Powell put it, that would be "discrimination for its own sake. This the Constitution forbids." *Regents of the Univ. of Cal. v. Bakke,* 438 U.S. 265, 307 (1978) (Powell, J.). Instead, the use of preferences can be justified only if there is an interest beyond the desire for a particular racial mix.

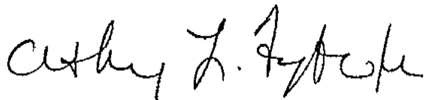
The educational benefits of diversity will likely not justify racial preferences by Congress. *Grutter v. Bollinger*, 539 U.S. 306 (2003), which upheld the authority of the University of Michigan Law School to adopt certain, limited kinds of racially-preferential admissions policies, cannot be relied upon to justify the Health Care Bill's racially discriminatory provisions. Although the University of Michigan was able to overcome the overwhelming presumption against state-sponsored race discrimination without concrete evidence of the benefits of diversity, it did so in the narrow context of academic freedom. Justice Sandra Day O'Connor, writing for the five-member majority, stated that "universities occupy a special niche in our constitutional tradition." *Id.* at 329. In the majority's view, universities are

Conclusion. Ensuring that all Americans, regardless of race, have access to quality health care requires both creativity and compassion, and hard-nosed attention to data. It also requires staying within the requirements of the Constitution. The current race-based provisions of the Health Care bill display none of those qualities. We urge Congress to re-examine those provisions and return the focus to the proven methods of improving health care outcomes for minority patients.

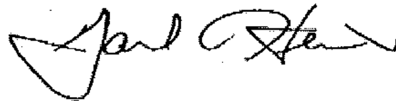
Respectfully submitted,

Gerald A. Reynolds
Chairman

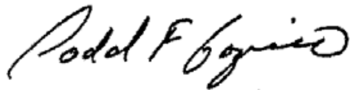
Peter N. Kirsanow
Commissioner



Ashley L. Taylor, Jr.
Commissioner



Gail Heriot
Commissioner



Todd F. Gaziano
Commissioner

cc: The Honorable Harry Reid, Majority Leader
The Honorable Mitch McConnell, Republican Leader
The Honorable Max Baucus, Chairman, Committee on Finance
The Honorable Charles Grassley, Ranking Member, Committee on Finance
The Honorable Thomas Harkin, Chairman, HELP Committee
The Honorable Michael Enzi, Ranking Member, HELP Committee
Abigail Thernstrom, Vice Chairman
Arlan Melendez, Commissioner
Michael Yaki, Commissioner

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entitled to special deference in their academic judgments. As Justice O'Connor put it, "'the freedom of a university to make its own judgments ... includes the selection of its student body.'" *Id.* at 329 (quoting *Bakke*, 438 U.S. at 312 (Powell, J.)).

Whatever the merits of this reasoning, it does not apply to Congress. Congress is a political institution, not an academic one; it is not entitled to deference to its academic judgments. It cannot avoid the full burden of the strict scrutiny standard. A legislature is precisely the kind of institution academic freedom is supposed to protect colleges and universities *from*. If anything, *Grutter* imposes even greater burdens on non-academic entities, like Congress, who attempt to impose racial classifications on academic entities, than the strict scrutiny standard alone would have imposed.