HEALTHY, WEALTHY, & FAIR
Health Care and the Good Society
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How Market Ideology Guarantees Racial Inequality

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The Negroes of the South Are Free as Air to Vote for the Republicans if They So Choose. Thomas Nast, Harper's Weekly, October 24, 1874.
Race has always fractured American politics. The United States never had the kind of strong class-based politics common to Western European nations in large part because the American working class was divided by race. Elites could exploit whites' racial fears to foment hostilities and quell any nascent working-class mobilization. At the same time, class differences and the prospect of upward social mobility hindered black political movements. Black political equality has been stymied in no small measure by America's commitment to preserving economic differences—all in the name of liberty.

Just as American democracy aspires to a standard of full political equality ("one person, one vote"), the ideal standard of justice in health care should be "equal care for equal needs." But market ideology serves much the same role in health care as racism has served in the larger political economy. Market ideology turns the health care system into a competition between the rich and the poor instead of an orderly distribution of medical care according to medical need.

Of course, income and race are not the only sources of health care inequities. Disparities exist whenever some groups fail to receive the same clinically necessary and appropriate care that other groups receive, or when they suffer illness, disability, or death that could be prevented by appropriate medical care. The medical system is rife with disparities according to gender, state residence (some states are much more generous in social provision than others), regional and local residence, immigrant status, and type of illness (e.g., people with mental illness fare worse than those with physical illness). The "disadvantaged classes" in health care are thus divided by many fault lines other than race and income. At various times, different pieces of this identity puzzle mobilize themselves. As each group gains greater political salience, it draws attention away from the general problem of disparities in medical care. These cross-cutting divisions weaken any political support for reforms to make the system more just. Nevertheless, I argue, market ideology is the biggest obstacle to health care equity because in market theory, distribution is not supposed to follow need. It is supposed to follow economic demand.

The U.S. health care system is designed to produce disparities. Although physicians are trained to distribute medical care according to medical need, the larger health care system is organized to allocate medical care primarily by market criteria rather than by medical need. Market principles create, perpetuate, and intensify racial and ethnic disparities. Market ideology not only justifies racial and ethnic disparities in health care, it allows racism to continue under cover of economic justifications. Worse, market ideology organizes the financing and delivery of medical
care in ways that reward physicians and hospitals for discriminatory practices and ensure that racial inequality will persist.

A Standard for Judging Disparities

American political culture vacillates between two philosophic poles: egalitarianism and libertarianism. These poles provide our standards for distributive justice. Equality is homogenizing and centripetal. It holds people together by not letting anyone get too far away from the group norm. Under the egalitarian ideal, collective power is used to extract resources from those who get too far above to help those who fall too far below. Liberty is differentiating and centrifugal. It encourages people to innovate, take risks, and separate themselves from the masses. It rewards those who succeed but offers little comfort to those who fail. Liberty resists the very idea of collective governance. Medical care disparities are so intractable in part because the distribution of medical care is constantly pulled between these two poles, tugged by radically different standards of distributive justice.

As political philosopher Michael Walzer showed in *Spheres of Justice*, most societies, like the United States, operate with multiple standards of distributive justice. Various goods, services, opportunities, and punishments are meted out according to standards the culture deems appropriate for each sphere of life. Walzer envisioned multiple spheres, each with its own criterion, legitimate in that sphere but not in others. In the United States, votes are distributed according to a standard of absolute equality: one person, one vote. Jobs and places in higher education are distributed according to merit (or at least, that’s the ideal). Consumption goods are distributed according to ability to pay. To argue that any distributive outcome is inequitable and morally unacceptable, one has to make a convincing case that the distribution violates the standard that best applies to that sphere. Any political contest over distributive justice, therefore, begins by showing which standard, among several legitimate ones, ought to apply to the resource in question.

In contemporary American culture, the standard in the sphere of medical care is medical need. Everyone who needs cataract surgery to be able to see should have it; no one who does not need it should get it. Need-based distribution of medical care is something like custom tailoring—what each person gets should fit him or her to a T. Of course, this is the ideal standard, not the reality, but it is against philosophical ideals that we judge our practice.
Need occupies a small portion of the American distributive galaxy, and it partakes of elements of both the egalitarian and libertarian ideals. In one sense, distribution according to need is equality to the Nth—equality perfectly customized to the tiniest details of each person's situation. "To each according to his need" is a radically egalitarian standard. In another sense, though, distribution according to need is liberty to the Nth. Under a political system that maximizes liberty, each person should be able to follow his dreams, to do and give whatever he wants. Because, under a need standard, each person receives exactly what it takes to enable him to flourish as a free and independent person, distribution according to need is also radically libertarian. Libertarians object to government-organized redistribution primarily because it interferes with the individual's freedom to choose the recipients and amounts of his donations, but this objection doesn't resolve the curious paradox of the need standard: it is simultaneously egalitarian and libertarian.

There are three reasons (at least) why medical care ought to be distributed according to the standard of medical need. First, health is a prerequisite to everything else we value in life. Just as "equal starting resources" are necessary for the textbook ideal of free-market competition, basic health is necessary for a fair meritocracy. Health enables people to learn, work, contribute, and achieve; people cannot earn, merit, or deserve if they cannot function in the first place. If medical care were not distributed according to medical need, all merit-based distributions would be suspect—or should be.

Second, in our modern scientific culture, we do not believe health is primarily a matter of individual effort for which people deserve rewards. Sickness is not sin. Yes, smoking, drug and alcohol abuse, unsafe sex, overeating, and a "couch potato" lifestyle all cause health problems. The lifestyle theory of disease modified the earlier "germs and accidents" causal story and transformed at least some sickness into sin. But modern genetic research significantly diminishes the realms of illness where individual responsibility is a reasonable causal story. More important, the notion that people ought to receive medical care in accordance with their moral deservingness strikes most of us as wrong. Few of us would withhold medical care from sick people who smoked, lived on junk food, or got into an accident while driving and dialing.

Third, medicine is a science. We understand science to be a realm of expertise and objectivity where there are right and wrong answers and where remedies can be proven effective or not. This means that a standard of need can be arbitrated clearly and fairly. Each medical problem has a proper remedy; each person should get the remedy (or test,
HOW MARKET IDEOLOGY GUARANTEES RACIAL INEQUALITY

procedure, etc.) that is appropriate to his or her problem. Political and economic clout should have no bearing. To be sure, medicine is plagued by uncertainty, and the reigning cliché is that it is as much art as science. It is beset by internal disputes about the best treatments for a given disease. But if medicine lacks a correct answer for every individual situation, there are a great many diseases and problems for which there are proper standards of care. These are the standards we use to assess quality of care, and we use them this way precisely because they meet the test of scientific verifiability.

Disparity, as we now use the term in discussions of racial and ethnic patterns of care, has come to mean a deviation from a scientific standard of medically appropriate care. At first glance, the term seems to denote a comparison between groups, such as blacks and whites, without reference to an external scientific standard. However, public health advocates are really concerned about differences between racial and ethnic groups that cannot be explained by clinically relevant differences and that indicate that one group receives substandard care. For example, several studies demonstrated racial disparities in treatment of people who had heart attacks: whites received sophisticated diagnostic procedures and aggressive surgical treatments more frequently than blacks. Some researchers speculated that the disparities might be spurious. The differences, these critics said, might signify that whites (and their physicians) were overusing invasive cardiac procedures rather than that black patients were getting inadequate care. If that had been the case, the argument went, then black patients weren’t disadvantaged by the disparities, and although the pattern of care might be wasteful, it wasn’t particularly unjust. Further studies did not support this argument. But the spat shows that the disparities issue is not about just any differences between groups, but only differences that reflect under-provision of clinically necessary and appropriate care.

The medical need concept of disparities provides a powerful moral justification for addressing all disparities, not only racial ones. If medical need is the right criterion for distribution of medical care, then any deviation from it is wrong and unjust. Disparities across regions, states, gender, age, race, ethnicity, and immigration are all troubling when they mean deviation from a medical need standard.

There are also several strategic reasons for addressing all medical disparities together. First, as the controversy over affirmative action has shown, remedying racial disadvantage directly provokes a profound backlash. We need solutions that apply the same standards to everybody—qualification and potential to succeed in the case of education, need, and potential effectiveness in the case of medical care. Second, race,
income, education, gender, and region are overlapping categories, thoroughly interconnected and impossible to disentangle, so that disparities in one dimension will produce disparities in the others. We cannot hope to eliminate only racial disparities if other disparities are left intact. Third, multiple fault lines of privilege and disadvantage create a kind of identity politics in which reformist energies are divided and dissipated. Last, and perhaps most important, if the political culture permits some kinds of deviations from a need standard, this tolerance creates a climate of acceptability for deviations per se. When distributions according to some non-medical criteria are legitimate (say, income and state residence), the political system will not likely undertake to make medical need the sole criterion for distribution of medical care. It becomes much harder for those who are disadvantaged by the maldistribution to argue for change. The burden of proof falls on those who are disadvantaged to show why the particular form of deviation that harms them is morally and politically unacceptable.

And here the plot thickens.

How American Pluralism Sanctions Medical Disparities

The U.S. health care system is self-consciously, deliberately pluralistic. It is designed to produce heterogeneous patterns of care rather than one monolithic standard.

For one thing, the U.S. health care system, like the rest of the political economy, is based on principles of federalism. Responsibility for “public welfare” is one of the constitutional prerogatives of the states, and that has come to mean state responsibility for public health. “States’ rights,” in turn, have been invoked fiercely and doggedly to maintain local race relations. Even our most centralized health insurance programs—Medicare, Medicaid, and Supplemental Security Income—are significantly decentralized. Medicare is the most federal of the three. Even though it was arguably made federal so that it could enforce black civil rights, and even though it succeeded in reducing racial disparities in access to care, enforcement of the civil rights component was selective and splotchy, and by providing lots of new revenue for hospitals, Medicare inadvertently enabled them to finance construction of private rooms, which in turn enabled de facto segregation. Medicaid, though nominally a national program, is highly decentralized. States have authority to set and administer their own eligibility criteria; reimbursement rates; policies for participation of doctors, hospitals, and managed care plans; and to an ever larger
extent, thanks to a flurry of waivers from federal standards, their own benefit packages and coverage policies. Supplemental Security Income, a major source of health insurance for low-income people with disabilities, uses federal guidelines to define disability but state agencies to examine applicants and decide who is eligible. Federalism means that citizens of different states who are "clinically identical"—that is, they have the same medical needs—may be legally entitled to different preventive, diagnostic, and therapeutic services.

In addition, the U.S. health care system is based on market principles. Markets cherish the distribution of goods and services according to consumer tastes and ability to pay. Markets also cherish multiplicity of producers, and they idealize the freedom of producers to provide goods and services as they see fit, as they imagine they might make the greatest profits. Freedom in the quest for profits is the key to innovation and productivity. Because the U.S. health care system is predicated on market principles, it will distribute medical care with great sensitivity to consumer income. Because it treats doctors and hospitals as economic suppliers, it will supply medical care with great sensitivity to provider profitability. Medical care will not flow only along channels of medical need, but some—maybe most—will be diverted through channels of economic demand and supply.

In at least two ways, then—federalism and free markets—American political culture tolerates and sustains a distribution of medical care that deviates from the scientific standard of medical need. Because American political culture endorses, indeed seeks, distribution according to standards other than medical need, deviations from medical need are designed into American medical care. The health care system is designed to allow deviations from the medical need standard because it is designed to foster other distributive criteria. This is a fundamental cultural and structural problem that goes far deeper than race.

The distinctive cultural and political pluralism of the United States creates the disparities that trouble us so much. This pluralism generates not only racial and ethnic disparities, but all the others as well—income, gender, geography, citizenship status, and medical status. The nation will not be able to ameliorate racial and ethnic disparities until political leaders are willing to face up to the consequences of their devotion to these pluralistic ideals in medicine.

Racial disparities in health care are also caused by the nation's profoundly racist heritage. David Barton Smith has shown that many features of the current health care system grew partly as "adaptations" by doctors and hospitals to political pressures to desegregate, especially the
pressure of the 1964 Civil Rights Act. The virtually complete transformation of hospital accommodations from wards to private and semi-private rooms; the migration of hospitals out of center cities into suburbs; the migration of health care itself out of hospitals and into nursing homes, ambulatory clinics, and homes, where compliance with civil rights law was much, much harder to monitor, if it applied at all—each of these shifts in industrial organization was in part stimulated by a desire to evade the watchful eye of the Department of Health, Education, and Welfare’s Office for Civil Rights. Physicians’ practices were exempted from the Civil Rights Act from the start. Thus, physicians could go right on referring patients to specialists, hospitals, nursing homes, and other providers on the basis of race, and civil rights enforcement officers couldn’t reach them. No wonder researchers still find racially patterned streams of physician referrals.5

Race has had a lasting influence on American health politics and policy, just as it has in every other sphere of American politics. My purpose here, however, is to show how one seemingly race-neutral ideal—free markets—helps to justify and enable racial divisions in health care. No doubt this ideal is so attractive and tenacious in part because it indirectly justifies racial division. But I do not address motives here. Rather, I simply show how certain principles of political organization and culture in the United States perpetuate racial disparities, no matter anybody’s intent.

Over the last two decades, policy makers have pushed the health care system to conform more and more to market principles. Cost savings, the flip side of profit maximization, became the overriding goal for public payers as well as commercial insurers. Economic thinking became the dominant mode of analysis of health care systems. Legislators urged citizens to think of health insurance and medical care as consumption goods over which they should exercise their spending preferences. Insurers and health care providers were urged to think of themselves as producers—marketing goods, competing for customers, and producing the highest volume and quality at the lowest price. It is the consequences of this market thinking I want to explore.

How the Ideal of Consumer Sovereignty Perpetuates Racial Disparities

In market theory, the only morally relevant standards of distributive justice are consumer preference and ability to pay. Deviations from a medical need standard are perfectly acceptable so long as the distribution
of medical care (now treated as a consumption good) corresponds to the distribution of consumer preferences. Whatever distribution results from the free expression of consumer preferences is the morally right one. To the extent that medical care is organized according to market principles—in the United States, the trend is large and growing—there is little philosophical leverage for reforming distribution so that it accords more closely with any other standard.

Perhaps more disturbing, though, is the long-standing use of supposed consumer preferences to justify continued discrimination in health care (as well as other sectors). In 1966, as the Office of Economic Health Opportunity was trying to force southern hospitals into compliance with civil rights law, hospitals “adamantly refused to stop assigning patients on a segregated basis, insisting that Negroes and whites preferred to remain segregated.” Similarly, “freedom of choice” was a slogan commonly used by southern hospitals to justify segregation; the separation of white and black patients into different facilities, administrators claimed, was the natural result of patients freely choosing, and anyway, free choice of “assignment” was a right of hospital administrators.

Justifying racial and ethnic disparities on grounds that they reflect consumer preferences is not merely a relic of the segregated past. In a 1990 civil rights case, Tennessee invoked patient preferences to defend its policy of allowing nursing homes to limit the number of beds certified for (that is, available to) Medicaid patients. Plaintiffs argued, and the court agreed, that the policy had a disparate impact on blacks, because black families are disproportionately reliant on Medicaid to pay for nursing homes. Indeed, according to the court, blacks comprised almost 40% of the Medicaid population but only 15.4% of those Medicaid patients who have been able to gain access to Medicaid-covered nursing homes. Tennessee claimed that “the ‘self-selection preferences’ of the minorities, based upon the minorities’ reliance upon the extended family, lack of transportation, and fear of institutional care, adequately explain the disparate impact.” The court didn’t swallow this one.

In a similar vein, a few researchers have recently suggested that at least some of the racial disparities in medical treatment are due to black patients’ preferences. According to this theory, black patients choose to utilize certain procedures less often than white patients. They are more prone to refuse invasive and high-tech procedures, even when a physician recommends them. Thus, for example, researchers looked for, and found, differences in the proportions of black and white patients who refused physician recommendations for invasive cardiac procedures or kidney transplants.
In a culture of market distribution and consumer freedom of choice, any disparities due to patient preferences and choices are morally acceptable. They are not inequalities, not disadvantages, just different choices. In its recent report on racial and ethnic disparities, the Institute of Medicine showed little patience with the preference argument. There are still disparities in whether physicians recommend treatment to black and white patients in the first place, the report noted. Moreover, black and white patients’ preferences are shaped by their very different experiences in the health care system. Black and white preferences are simply not equally informed or similarly influenced. Nevertheless, the preference argument is still taken seriously in policy circles, seriously enough that there is a body of research on it and seriously enough that the prestigious Institute of Medicine felt compelled to consider it.

Because the market model legitimizes disparities that are due to consumer preferences, it offers a powerful cultural excuse for allowing disparities to persist: “They prefer things that way.” As in the civil rights era, reformers are forced to demonstrate that black people’s apparent free choices are really coerced choices, or uninformed choices, or choices made in the context of distrust and fear and shaped by a legacy of mistreatment. Through the preference argument, market ideology dissipates the energies of those struggling to rectify racial inequalities, as they fight to prove the obvious—that blacks do not really prefer substandard care.

Faith in consumer sovereignty perpetuates racial disparities in another way. Most analyses of quality in health care point to having a “usual source of care” as a key ingredient. A stable relationship with a physician is essential for gaining access to medically appropriate tests and treatments, especially in an environment where insurers are seeking to cut costs by denying payment for care. In that kind of environment, having a physician who will advocate for your interests can make the difference between getting and not getting care. Minorities and people with low income are less likely than whites and people of higher income to have a regular physician and more likely to get their health care from a hospital or emergency room. This is true of minorities, even when insurance status is controlled.

There are many reasons why some people have regular doctors and others don’t, but market principles only exacerbate the problem. The market model of health care actually relies on instability for quality control. “Exit” is the main way consumers tell suppliers that they are unhappy with the quality of merchandise. They find a new supplier, buy a different brand, shop at a different market. In markets, mobility is the engine of progress and quality control. In a health care system organized around
market principles, patients are supposed to behave as active consumers. They are supposed to "shop around" for plans, diligently monitor quality, and vote with their feet. They are supposed to leave plans that aren't meeting their expectations or satisfying their preferences, whatever those preferences may be.

The theory of managed competition thus depends on the patient's willingness to sever his relationship with a provider in search of a better one. The market model fosters constant churning. Market ideology teaches patients that it's their responsibility to monitor the quality of their medical care and to rectify any problems by changing suppliers. It teaches them that they are suckers if they let loyalty override tough-minded critical scrutiny. If they receive poor quality care and don't change doctors, it's their own fault. When public policy relies on consumer sovereignty to police health care quality, it undermines one the key elements of quality—stable doctor-patient relationships. And it does nothing to correct racial (or any other) disparities in access to primary care physicians for their usual source of care.

**How the Ideal of Competitive Supply Creates Racial Disparities**

Health insurance, a prerequisite to medical care, can be supplied as a public good or as a private, market good. As a market good, suppliers will supply it only if they can make a profit doing so. The United States has chosen to supply health insurance primarily through the market, using public programs only to cover those groups for whom the market fails.

Commercial health insurance operates on a different standard of distributive justice than the medical need standard. It is designed to be most expensive and least accessible to the people with the greatest medical needs. Insurers aim to price insurance so that people pay as closely as possible for the care they will eventually need and receive. This is called "experience rating." According to the principle of actuarial fairness at the heart of commercial insurance, premiums should be proportionate to risk. Those who are sicker or have a higher risk of becoming sicker (and therefore needing more care) should pay more for their insurance than those who are healthier and at lower risk of illness. The ubiquitous preexisting condition clauses mean that people who are already sick when they purchase insurance will not have their care for those conditions covered. In the actuary's ideal world, insurance would be priced as if there
were no insurance and policy holders were paying directly for their own care on the open market.

In the private market, insurers’ pricing practices actually promote deviations from the standard of medical need. In fact, actuarial principles reverse the medical need standard; they make insurance, and therefore care, most accessible to those who least need it. The political choice to insure as many citizens as possible through private commercial insurance instead of public social insurance is a choice to promote a distribution of medical care that deviates substantially from medical need.

Advocates of organizing health insurance around market principles naturally do not argue for distribution of care according to financial status rather than need. But they do tend to justify competitive markets by portraying insurance as a “financial product” distinct from medical care itself. As a financial product, they say, it is not essential. Consumers should be allowed to exercise their “tastes” for different levels of risk, their “preferences” for different levels of quality, and their freedom to make their own budgetary trade-offs. According to market principles, health care comes in a wide range of acceptable styles and quality. There is “Cadillac Care” and “Volkswagen Care” and lots in between. So long as everyone gets a car, variations in quality are not a problem. Within the range of clinically acceptable quality, care ought to be distributed according to consumer tastes and ability to pay.

In pursuit of this ideal of maximum consumer freedom, the market model encourages insurers to offer multiple plans with a variety of different covered services (some might cover reproductive and mental health, while others may not), different coverage limits (for example, unlimited mental health visits versus a lifetime limit of thirty visits), different limits on which doctors and hospitals members may use (ranging from small health maintenance organization panels to any qualified provider), and different provider reimbursement levels. Such variations in quality, according to the market model, are eminently desirable. They enhance consumer choice.

In theory, and certainly in fine print, all plans cover “medically necessary” care. When it comes to paying the bills, however, plans differ in how much money they can spend on their members in the name of medical necessity. They also have wide latitude in how they interpret medical necessity. Higher-end plans provide greater access to specialists, because they are more liberal about deeming referrals necessary and more generous in paying specialists. They are more liberal about allowing their members to be hospitalized, and about permitting longer stays. They pay
for more expensive and (sometimes) more effective medications. They pay doctors and hospitals higher rates for treating their members than lower-end plans can pay for their members. Variations among insurance plans are often not matters of style, like tail fins and sunroofs. They are matters of essential mechanics and safety.

A highly diversified insurance market will stratify itself according to income. Racial and ethnic minorities, because they are more likely to have lower incomes, are more likely than whites to enroll in plans with more restricted benefits and more restricted access to providers. Minorities are disproportionately covered by Medicaid. Once again, the market model knowingly accepts different levels of quality and predictably assigns racial and ethnic minorities to the lower tiers.

Many people argue that the high-end/low-end distinction is misleading. Medicaid, they say, may be a plan for poor people but it is not a poor plan. It offers a rich benefit package, more generous, in fact, than some commercial insurers and employer plans. For Medicaid beneficiaries, however, Medicaid’s richness is paper wealth because Medicaid pays notoriously low rates to doctors and hospitals. If you were a bounty hunter and the going rate for wolves was higher than the going rate for squirrels, which would you hunt? Some states deliberately delay paying their Medicaid bills for weeks or months so they can capture interest on the money while it sits in their bank account instead of somebody else’s. If you knew you were going to wait much longer to get paid for bringing in squirrels than wolves, would you waste much ammunition on squirrels? A rich benefit package on paper is an empty promise to patients if they can’t find anyone to make good on it.

How Market-Inspired Cost Control Creates Racial Disparities

Starting in the 1970s, policy makers became obsessed with controlling health care costs and turned to economics to help them get a grip on expenditures. Market theory recommended two strategies, one aimed at consumers (patients) and one aimed at suppliers (doctors, hospitals, nursing homes, and anyone who provides medical care).

According to market theory, health costs were out of hand because people were consuming it with abandon. Health insurance was the culprit; it takes the brakes off medical consumption. People with insurance don’t have to pay the full costs of their care. They pay only for insurance.
Insurance pays for whatever care they need and get. They have no incentive to hold back on enjoying medical care. Got an ache? Kids fussing? What the heck! See a doctor.

The market fix for this problem was obvious: cost sharing. Make patients pay at least a part of the cost of every doctor and hospital visit and they will think twice about consuming care. They will ask themselves, "Is it worth it to me? Do I really need a doctor visit or would I rather have a new coat?"

Cost sharing burdens some racial and ethnic groups more than others and increases the disparities in access to care. First, because blacks and Hispanics have lower incomes than whites (on average), any cost sharing places a higher average burden on their budgets. Second, blacks and Hispanics are less healthy and at greater risk for illness than whites (again on average). They need more medical care, so cost sharing hits them extra hard. Third, to the extent that cost sharing deters people from getting early and preventive care, it exacerbates racial and ethnic gaps in health status. As economist Tom Rice puts it, "Cost sharing results in de facto discrimination."19

The cost explosion wasn't all the fault of consumers, though. Providers bore part of the blame, and again, insurance was the culprit. Typical insurance plans paid doctors, hospitals, and nursing homes on a fee-for-service basis. Providers determined what services a patient needed, rendered the services, and submitted the bills. Insurers paid up. Doctors and nurses had absolutely no incentive to be frugal with their care. They could prescribe any care they thought might help, and it would be paid for.

To deal with this problem, market thinking prescribed prospective reimbursement. Under prospective payment, payers set fees for different diagnoses. Providers are no longer paid for whatever care they think their patients need. Instead, their fees are capped before any patients walk (or are wheeled) through the door. Prospective reimbursement is meant to dissociate reimbursement from the provider's judgment about the patient's need for care.

Prospective payment supposedly applies market principles to generate medical efficiencies. In theory, it entices providers to be efficient, because they may pocket the savings if they can treat a patient for less than the pre-arranged fee. In practice, providers can pocket more savings if they choose patients who are relatively healthy and don't need much—or much expensive—care to begin with. Thus, prospective payment gives providers incentives to direct their time and resources to the
patients who need the least care. It is a system knowingly designed to
direct medical resources according to provider profitability instead of
patient medical need.

Race dovetails with this system in a particularly pernicious way. Racial
and ethnic minority patients are disproportionately less healthy. They are
disproportionately uninsured or underinsured, so they have erratic access
to care. In turn, when they do finally seek care, their illnesses are more
likely to be advanced and more severe. At that point, they are very unat-
tractive (economically speaking) to providers in a prospective payment
system. Patients who are less healthy than average can’t be treated for the
full value of the fixed fee, let alone for less.

Because prospective pay encourages providers to avoid sicker patients,
it stimulates and exacerbates racial discrimination. Physicians and hospi-
tal administrators learn from epidemiology, if not from firsthand experi-
ence, that minority patients are likely to be less healthy than whites, to
be less well insured, and to have had inadequate primary and preventive
care. Race becomes a proxy for factors that make a patient detrimental to
the bottom line: chronic illness, prior inadequate care, and no insurance
or underinsurance. Prospective payment’s financial incentives give pro-
viders a cruel choice: use race as a proxy or lose money. No wonder, then,
as competitive pressures on hospitals increased in the 1980s, so did “finan-
cially motivated transfers of patients from private to public hospitals—up
to 90 percent involving minority patients in some cities.”

Once again, market logic hides discrimination. Market thinking and
market incentives allow doctors and hospitals to understand their own
behavior as economically motivated and economically necessary—and it
is—even as it is also racially discriminatory. Market thinking allows the
larger polity to pretend racial discrimination isn’t happening. Disparate
patterns of care can easily be understood as efficiency playing itself out.
Analysts can talk about “financially motivated transfers” when almost all
the transferred patients are black.

Market pressures, besides pushing providers to avoid racial and ethnic
minorities, also induce them to provide fewer services to those minority
patients they do treat. Under pressures to be cost effective, providers need
ways to judge when medical treatments are likely to be ineffective and
therefore not worth offering. In addition to biomedical factors, doctors
look for personal characteristics that might render treatment less effec-
tive. They look for things like not following medical advice (ominously
dubbed “non-compliance” in the medical literature, as if we were talking
about parolees), not filling prescriptions or not taking them as prescribed,
missing appointments, inability to afford ancillary therapies, inability to take time to recuperate, and lack of caregiver support.

People who cannot easily afford medical care are less likely to "comply" with medical recommendations, since such compliance usually means spending money they don't have. They may not fill prescriptions, or fill only some of them, or take medicines less often than prescribed to make them last longer. They may lack reliable transportation to get to a medical visit, or they may have difficulty getting time off from work during office hours. Simply knowing (or believing) that minority patients are less likely to be financially secure and well insured, physicians may assume they are also less likely to benefit from medical advice and treatment. At least one study found striking evidence of this: physicians believed that compared to whites, African-American patients were less intelligent and less educated, less likely to follow medical advice, more likely to abuse alcohol and drugs, and less likely to have caregiver support. Physicians often held these beliefs contrary to the written evidence in the patient's chart.

Competitive pressures induce physicians to use lingering race and class stereotypes under cover of evaluating cost effectiveness. The stereotypes, in turn, make minority and low-income patients "less worthy" of treatment. Competitive pressures and the austerity of prospective payment thus induce physicians to offer fewer costly medical regimens to minority patients than to white patients. Under the old forthrightly racist health care system, minority patients were unworthy of the same care as whites. Now they are just less cost-effective—but don't call it discrimination.

Prospective payment and its underlying cost-control impetus may fuel still another mechanism of racial inequalities. Under prospective payment, hospitals and managed care organizations succeed by keeping down their per capita costs. Black and Hispanic patients are (on average) sicker than white patients. Black physicians are likely to have a higher proportion of black patients in their practices than white physicians and are more likely to practice in minority, low-income, and medically underserved areas. Latino physicians are more likely to have a higher proportion of Hispanic patients. Presto: Hospitals and managed care organizations have strong economic incentives to avoid minority physicians as well as minority patients. So-called economic credentialing of physicians by managed care organizations thus fosters racial and ethnic profiling. Patterns of recruiting and retaining physicians that appear to be motivated by economics may disguise racial discrimination, or at least permit it to continue under cover of economic rationality.
How Market Ideology Subverts Civil Rights Enforcement

As we have seen, because racial and ethnic minorities are disproportionately low income, they are disproportionately harmed by market principles in health care. But as long as political culture countenances distribution of care at least partly by income, deviations from the medical need standard are not likely to generate much sympathy or impetus for reform. Market ideology forces people who come out behind to overcome a high political burden of proof. Why, they must answer, is the distributive outcome not morally acceptable? After all, we can't all live in mansions and drive Jaguars.

In American politics, racial discrimination is a trump (hence the expression “playing the race card”). Distributive outcomes that result from racial discrimination are not acceptable (at least not formally and openly.) If racial and ethnic minorities are disadvantaged by the distribution of medical resources and they can show that their disadvantage results from racial discrimination, they can invoke the power of government to alter the distributive rules. The chief legal weapon for such claims is Title VI of the Civil Rights Act of 1964; it bans discrimination on the basis of race, color, or national origin by entities that receive federal public assistance. Almost all hospitals receive substantial revenues from Medicare and Medicaid.

As in other areas of civil rights law, Title VI recognizes not only intentional discrimination, but also discrimination that results from the disparate impact of race-neutral rules and policies. But here's the rub: As Sara Rosenbaum puts it, “Title VI bars racial, not economic, discrimination.” Any disadvantages that result from economic factors—say, not being able to afford a hospital bed or not being a cost-effective patient—are not violations of civil rights law and will not be remedied by a court. Plaintiffs and their advocates face the difficult task of separating the effects of economic discrimination from those of race discrimination. Minorities are disproportionately poor and uninsured so they are doubly disadvantaged; but it is extremely difficult to prove that only racial discrimination, not economic discrimination, is behind their poorer care.

Essentially, civil rights law says, “Economic discrimination is not our department.” From the perspective of civil rights enforcement, economic discrimination is not on the table. Economic discrimination is not on the table because like the larger political culture, civil rights policy accepts market principles for distributing medical care. Thus does market ideology hobble civil rights enforcement and protect racial discrimination in health care.
Market ideology hobbles civil rights and the fight for a racially just health care system in other ways. One might think the Title VI ban on racial discrimination would apply to physicians as well as hospitals, as they, too, receive federal reimbursement for treating Medicare and Medicaid patients. It does not. Physicians are exempt from Title VI because when Medicare was passed, they pressed for an interpretation of the law that deemed them not recipients of federal financial assistance, even though they would be receiving reimbursement from the federal government for treating patients insured through Medicare. Physicians resisted the entire Medicare program out of a sense that government would interfere with their freedom as small businessmen. They jealously guarded their prerogatives to treat whomever they wanted and to select and exclude patients unimpeded by government rules.

This respect for doctors as independent entrepreneurs not only allowed frank racial discrimination to continue in medical offices, but it also prevented the Office for Civil Rights from fully desegregating hospitals. Long after 1966, admissions to southern hospitals continued to follow clear racial lines largely because physicians directed the traffic. They simply referred black and white patients to different hospitals. The Office for Civil Rights could not stop this practice because Title VI didn't apply to physicians. At one point, the Office for Civil Rights tried to get a ruling that hospitals, as employers of physicians, could be held responsible for physicians' referral patterns, but the argument went nowhere. Entrepreneurial freedom trumped racial discrimination.

American health law has been very solicitous of doctors' entrepreneurial freedom. Malpractice law imposes a duty on physicians to render professionally competent and appropriate treatment to any and all patients they choose to treat, but no law requires them to accept patients in the first place. They have no legal obligations to provide care to anyone, no "affirmative duties" in legal parlance. This deference to doctors' freedom is not unique to the health arena; it is one of the core principles of capitalism. Sellers have a right to sell to whomever they wish—and to not sell to anyone they don't wish to do business with. People in general have a right to choose whether or not to enter into contracts. If someone doesn't want to contract with you because they don't like the color of your fingernail polish, that's their prerogative.

The implications for civil rights enforcement are obvious. Physicians can be "too busy" to accept minority patients. They can refuse to accept Medicaid or any other insurance. They can locate their offices in
places highly inaccessible to neighborhoods with high concentrations of minorities. They can do all these things even if their real motivations are racial rather than economic. They can fail to initiate a doctor-patient relationship with anybody for any reason and the law can say or do nothing about it. Even Title VI of the Civil Rights Act has no power, because physicians are exempt.

The market ideal protects hospitals’ ability to discriminate on the basis of race almost as much as it protects physicians’ discriminatory practices. Unlike physicians, hospitals are subject to Title VI, but as civil rights jurisprudence has evolved, courts have offered hospitals a very generous defense based on their role as market actors. Once plaintiffs have proven that a policy or practice has a disparate impact on racial or ethnic minorities, the defendant hospital will be permitted to continue the practice if it can show that the policy serves a legitimate business purpose. This is called the “business necessity defense.” Courthave interpreted this standard so leniently that hospitals may engage in behavior patently harmful to minorities under the protective coloration of entrepreneurship. A multihospital system may shut down its hospital that serves a minority community; it may stop offering emergency or acute-care services in its hospital that serves primarily minorities; it may relocate to a white suburb. To satisfy a court, it need only show that its decision serves its business objectives.

When New York City decided to close Sydenham Hospital in Harlem, minority patients filed a class action suit. The City argued that by closing the hospital, it could reduce its total health care expenditures and increase efficiency in the municipal hospital system as a whole. Never mind that the closure would eliminate care for many residents of Harlem, who were mostly black and Hispanic; as long as the hospital’s global efficiency would increase, the court was satisfied. In a variety of similar hospital closure and relocation cases, courts have accepted the most superficial statements of “business objectives” as legitimate justifications. If hospitals argued the moves could accomplish financial savings, enable them to better compete in their markets, or improve the quality of their services (without saying “to whom”), courts tipped their hats and allowed the moves. Here is how Sara Rosenbaum and colleagues summarize this aspect of civil rights enforcement: “Taken together, the cases suggest that where the issue at hand is a decision to move services away from a less generous market [read: poor or minority neighborhood] to one that is more amenable to the entity’s financial situation, neither courts nor the enforcement agency will interfere.”
What Is to Be Done?

The standard policy recommendations to address racial disparities fall into two broad categories: changing discriminatory attitudes and stereotypes, and changing structural features of the health care system that intensify or contribute to racial inequalities. My analysis suggests that neither of these approaches will work well in the absence of addressing the fundamental market principles at the heart of the health care system. Here I will sketch some examples of the most common policy recommendations.

Like a choral refrain, analysts of racial disparities typically conclude with a call for training in “cultural competence.” Somehow, such training is supposed to weed out stereotypes and re-educate health care providers, mainly physicians, to treat patients with objective clinical neutrality. Typically, “cultural competence” means speaking another language besides English or offering interpreters, providing information in languages other than English, becoming aware of one’s own stereotypes, and being aware of alternative and spiritual healing traditions. Sensitivity training and education in “cultural competence” may marginally influence providers’ thinking about racial and ethnic stereotypes, but that will make very little difference in an economic system that rewards them for spending less money on patient care and a social system that makes racial and ethnic minorities more expensive to care for. Capitation payment presses physicians to minimize the time they spend with each patient. Managed care productivity quotas, meant to make physicians more efficient, do likewise. These market-inspired mechanisms fairly beg the physician to use group patterns of patient behavior to create shortcuts for themselves. Moreover, the reality is that minority patients are sicker and more costly to treat (on average) than white patients. Market incentives to treat a patient population for a fixed price (usually a very low price) push hospitals and physicians to avoid minority and low-income patients and to take race, ethnicity, and income into account as they make their clinical decisions.

Another standard recommendation is to rely more on scientific evidence for clinical decisions and cost-control policy. “Evidence-based medicine” is the buzz word. Distribution of care on the basis of medical need and appropriateness should indeed be the ideal and the standard of distributive justice for health care. However, evidence-based decision-making can improve care only for patients who are already in the system receiving care. When providers have to survive in a competitive market and do so by living within a prospective budget, they have powerful
incentives to use all available evidence to avoid the sickest patients. The market model pushes insurers and providers to do evidence-based exclusion before they start doing evidence-based treatment. It pushes them to screen out patients according to need; it operates to keep those people who most need insurance from getting insurance and those people who most need care from getting care. Moreover, perfect, evidence-based medicine inside a hospital or an office cannot affect the distribution of care within the larger universe of people who don't get into hospitals and offices in the first place.

The Institute of Medicine report on racial and ethnic disparities recommends "de-fragmentation of health-care financing and delivery" in order to address the "disproportionate presence of racial and ethnic minorities in lower-end health plans." It is an eminently sensible recommendation, but it runs counter to federal policy direction over the past 30 years. Federal policy makers have resisted consolidating insurance into large national pools. Instead, they have actively stimulated the proliferation of insurance options so there could be vigorous competition among them. Just as market theory considers that deviations from a need standard are good, it thinks that uniformity of insurance coverage is bad.

Similarly, well-meaning reformers call for policies to create stable doctor-patient relationships for minorities. The Institute of Medicine, for example, urges federal and state governments to set performance standards for managed care plans that include "guidelines for the stability of patients' assignments to primary-care providers." This recommendation, too, ignores the entire rationale for competitive managed care. Why would any government require "stability of patient assignments" to doctors if it is trying to promote market competition in health care? In a health care market, patients are supposed to "shop around" for plans and diligently monitor quality. They are supposed to vote with their feet and leave plans that aren't meeting their expectations or satisfying their preferences, whatever those preferences may be. Consumer mobility is the engine of progress and quality control in markets. The theory of managed competition depends on the patient's willingness to sever his relationship with a provider in search of a better one. The good consumer (oops, patient) is one who does not place a high priority on stability. The good policy maker who is overseeing a system predicated on the market model shouldn't overvalue stability of patient-provider relationships, either. He should foster high turnover in the name of aggressive consumer shopping and quality control. And the good evaluator, when he sees high turnover in patient-physician relationships, should judge the system to be working well: competition is doing its job. Without taking
on the market model, recommendations such as these are whistling in the dark. Addressing racial and ethnic disparities in health care is difficult if not impossible when economic disparities are encouraged, when distributive standards other than medical need are considered legitimate, and when market mechanisms actually exacerbate racial disparities and give providers incentives to stereotype and discriminate. Cultural legitimacy of market distribution undercuts the moral legitimacy of the medical need standard and renders legal tools against discrimination impotent. There is only one cure for racial and ethnic disparities: health care rules and institutions that purposefully direct resources in accordance with medical need.

Notes

1. The basic insight that one political fault line (such as race) disrupts and mutes conflict along another (such as class) was stated most forcefully by E. E. Schattschneider in *The Semi-Sovereign People* (Hinsdale, IL: Dryden Press, 1970), chapter 4. The application to race and class in American politics has been studied and sustained by many political scientists and historians. See David R. Roediger, *The Wages of Whiteness: Race and the Making of the American Working Class* (London: Verso, 1991).


9. See, for example, Jeff Whittle, Joseph Conigliaro, C. B. Good, and Monica Joswiak, “Do Patient Preferences Contribute to Racial Differences in Cardio-
vascular Procedure Use?" Journal of General Internal Medicine 12 (1997): 267–273, finding that "racial differences in revascularization rates may be due in part to differences in patient preferences." See Institute of Medicine, Unequal Treatment, 136–148, for a review of this line of research.


19. Rice, Institute of Medicine, Unequal Treatment, 708.

20. The federal government now uses prospective payment to pay for hospital, nursing home, and home health care, and insofar as Medicare and Medicaid encourage or require beneficiaries to use managed care, prospective payment applies to their ambulatory care as well. Managed care, which is now the dominant form of private insurance, uses prospective reimbursement as well.

21. Institute of Medicine, Unequal Treatment, 38–64, 83–87.


24. Lucette Lagnado, “Uninsured and Ill, a Woman Is Forced to Ration Her Care,” Wall Street Journal (12 November 2002): A1, describes how a young woman with glaucoma and no health insurance rations her own medical care, visiting doctors only when she is in severe pain and husbanding her eye drops.


26. See also Bloche, “Race and Discretion in American Medicine,” especially 103–104.


30. Ibid.
31. Ibid., 238–239; the history of this fight is nicely rendered in Barton Smith, *Health Care Divided*, 161–164.


33. The lack of affirmative duties to treat or help someone is not unique to medicine. American law does not impose a duty on any citizen to “rescue” people who need help. There are few legal obligations to help another person, whether you are a layperson, a doctor, or someone with any kind of specialized rescue skills. For an explanation of the general principle of “no duty to care” in medicine, see Rosenblatt, *Law*, and Rosenbaum, *Law and the American Health Care System*, 42–63. For the lack of obligations to render assistance more generally in American law, see Mary Ann Glendon, *Rights Talk: The Imposition of Political Discourse* (New York: Free Press, 1991), chapter 4.

34. In theory, hospitals must overcome another hurdle. Plaintiffs may argue that the hospital could accomplish its business objectives with “less discriminatory means,” and hospitals then must persuade the court that less discriminatory practices would not accomplish this objective. But as Sidney Watson has shown, courts rarely require this third step: “Reinvigorating Title VI: Defending Health Care Discrimination—It Shouldn’t Be So Easy,” *Fordham Law Review* 58 (1990): 939–978.

35. Watson, “Reinvigorating Title VI.”


38. Ibid., 248, words in brackets added.


41. Institute of Medicine, *Unequal Treatment*, 13–14.

42. Ibid., chapter 5, 184–185.