United States of America

Submission to the United Nations
Universal Periodic Review

Ninth Session of the Working Group on the UPR
Human Rights Council
1-12 November 2010

From Civil Rights to Human Rights: Implementing US Obligations Under the International Convention on the Elimination of All forms of Racial Discrimination (ICERD)

Submitted by:

CERD Task Force[1]

Cidadao Global

Women's HIV Collaborative*

Women of Color United*

Atlanta Public Sector Alliance*

Professor Thandabantu Iverson*

Malcolm X Grassroots

Endorsed by the following 57 Organizations and 37 Individuals:

Organizational Endorsements: Advocates for Environmental Human Rights; Afrolatina Forum; American Civil Liberties Union of Mississippi (ACLU-MS); Amigos Multicultural Services Center; Anti-Racism Committee of the National Lawyer's Guild; Arab-American Association of New York; Atlanta Public Sector Alliance; Black People Against Police Torture; Black Workers for Justice; CADRE*; Casa Esperanza; Center

1 This report was written by Ramona Ortega for the CERD Task Force. The CERD Task Force is made up of human rights and civil rights advocates, lawyers, and organizations dedicated to the full implementation of the Convention on the Elimination of All Forms of Racial Discrimination within the United States. The Task Force is a sub-group of the U.S. Human Rights Network.
* Denotes membership of the CERD Taskforce of the U.S. Human Rights Network.

for Community Alternatives; Center for Constitutional Rights; Center for Law & Social Justice of Medgar Evers College, CUNY; Center for the Human Rights of Users and Survivors of Psychiatry; Center for Women's Global Leadership at Rutgers University; Center of Housing Rights and Evictions (COHRE); Champaign-Urbana (Illinois) Citizens for Peace and Justice; Chicago Anti-Eviction Coalition To Protect Public Housing; Data Center; Dominican Development Center; Emory University Institute of Human Rights; Families United for Economic Justice; First Peoples Human Rights Coalition; Gideon's Army Grassroots Army for Children; Green Worker Cooperatives; Harlem Tenants Council; Human Rights Caucus at Northeastern University School of Law; Human Rights Project of the Urban Justice Center*; INDIGENOUS; Indigenous Peoples and Nations Coalition; International Indian Treaty Council; Jewish Council on Urban Affairs; Justice Now; Latina & Latino Critical Legal Theory, Inc. (LatCrit, Inc.); Latin American and Caribbean Community Center; Lawyers Committee for Civil Rights*; Leonard Peltier Defense Offense Committee; Malcolm X Center for Self Determination; Mayday New Orleans; Meiklejohn Civil Liberties Institute; Metro Atlanta Task Force for the Homeless; Midwest Coalition for Human Rights Ministries in Economic Justice; Picture the Homeless; Poverty and Race Research Action Council*; Public Interest Projects; Rainbow PUSH Coalition; Restaurant Opportunities Center of New York (ROC-NY); Society of American Law Teachers (SALT); South Asian Americans Leading Together (SAALT); South Asian Forum; South Bay Communities Alliance; The Kirwan Institute for the Study of Race and Ethnicity at Ohio State University; The Praxis Project; The Rita Fund; Three Treaties Task Force of the Social Justice Center of Marin; World Organization for Human Rights USA

Individual Endorsements: **Abdulai Bah**; **Ana A Tobar**; **Anita L. Beaty**, Board member of Habitat International Coalition; **Betsy Foss-Campbell**, Affordable Housing Task Force in Waukesha County; **Britt Wegner**; **Chandra Bhatnagar**, ACLU*; **Christine Garza**; **Deanna Richarson**; **Deborah LaBelle**, Attorney;**Diana Salas**; **Dr. Kwame-Osagyefo Kalimara**, NAPO/MXGM; **Genora Reed**; **George E. Edwards**, Indiana University School of Law; **JB Davis**; **Jevon Nicholson**; **Joanna Samuelson**; **Joel M. Ritsema**, Loyola University Chicago; **Johnnie L. Bobb**; **Joyce Carruth**; **Julia Kleppin**; **Kristofer Rios**; **Laura Pemberton**; **Meetali Jain**, American University; **Melenie M. Eleneke**; **Michael Calderon-Zakas**; **Michelle Matos**; **Molly Talcott**, PhD.; **Otto Santa Ana**, UCLA; **Paul McLennan**, Atlanta Public Sector Alliance;**Perfecto Caparas**; **Rev. Eric Wilson**, North Congregational United Church of Christ in Columbus, OH; **Stephen Menendian**, Kirwan Institute for the Student of Race and Ethnicity; **Sylvanna Falcon**, UCalifornia; **Ute Ritz-Deutch, Ph.D**, Tompkins County Immigrant Rights Coalition; **Vernellia Randal***, UDayton School of Law; **Victoria Sawicki**, CLUW; **Wade Rosenthal**, National Lawyer's Guild

A) Executive Summary

1. Equality and Non-Discrimination are among the most fundamental entitlements in the human rights framework. Non-Discrimination is non-negotiable and an immediate right given to all by virtue of their humanity. The right to non-discrimination is found in the Universal Declaration of Human Rights and numerous treaties, including the International Convention on the Elimination of All Forms of Racial Discrimination [hereinafter ICERD]. The United States adopted ICERD on November 20, 1994.
2. The CERD Task Force, a subgroup of the US Human Rights Network, was formed in 2007 to coordinate a national civil society shadow report that was submitted to the U.N. Committee on the Elimination of Racial Discrimination in 2008. The Task Force is made up of organizations that represent the leading voices in human rights and racial justice. Our core mission is to ensure the effective implementation of the ICERD and its key obligations at the national and local level.
3. The CERD Task Force is calling on the United States to introduce a federal plan of action on racial discrimination, similar to other nation states and in compliance with the Durban Plan of Action, to eliminate persistent racial disparities found in American society. Despite weak constitutional protections for disparate impact under US law, there are several policy measures, which must and should be taken under ICERD.
4. Reduction of racial disparities in poverty, education, health, and incarceration are essential to a healthy and vibrant democracy and will put the US on the path to eliminating racial discrimination. A Plan of Action, similar to the Millennium Development Goals, creates concrete and measurable progress in reducing disparities and promotes a more proactive and systemic approach to policy. Trillions of dollars have been spent to activate the national economy and those dollars must be used to create a more equitable society. In line with developed nations around the globe, a National Plan of Action on Racial Discrimination is not only an obligation under ICERD but also recognizes the continuing impact of past injustices.
5. The United States´ record on racial discrimination and racial disparities is discouraging. In his 2009 visit to the US, the Special Rapporteur on Racism noted that "Socio-economic indicators show that poverty and race and ethnicity continue to overlap in the United States. This reality is a direct legacy of the past, in particular slavery, segregation, the forcible resettlement of Native Americans, which was confronted by the United States during the civil rights movement. However, whereas the country managed to establish equal treatment and non-discrimination in its laws, it has yet to redress the socio-economic consequences of the historical legacy of racism."[2]
6. In every indicator of human development as measured by three core areas of well-being: living a long and healthy life, having access to knowledge, and enjoying a decent standard of living, racial minorities fall below the mark in comparison to their white counterparts.[3]
7. Full implementation and compliance with ICERD would go a long way in remedying stark racial disparities. The United States' failure to recognize article 1(1) and General Recommendation XIV "to undertake to prohibit and to eliminate racial discrimination in all its forms, including practices and legislation that may not be discriminatory in purpose, but in effect" is a major impediment to full

2 A/HRC/11/36/Add.3. 28 April 2009. para. 88-89.

3 Measure of America. Available at: http://measureofamerica.org/wp-content/uploads/2008/07/ahdr-execsumm.pdf

compliance with ICERD.

Civil Society Participation in the Universal Periodic Report

8. Robust civil society participation in the Universal Periodic Review process has produced a number of thematic reports which highlight racial dimensions of key human rights issues. This report focuses on racial discrimination and disparate impact under ICERD, with a particular emphasis on Article 5 and provides recommendations for full compliance.

B) Background and Normative Framework

Human Rights Framework

9. The United States has undergone two reviews by the Committee on the Convention on the Elimination of All Forms of Racial Discrimination; in 2001 and 2008 respectively. [4] In both instances US civil society contributed shadow reports that provided substantial factual information about the reality of racial discrimination in the United States. In 2001 and 2008 the committee included several important recommendations in its final reports [A/56/18 and A/63/18] many of which remain unfulfilled.

10. The two reports of the Committee overlap in their attention to several topics. These include the need for additional affirmative action measures aimed at increasing opportunity for minority group members; pervasive obstacles to access for minority group members in the areas of education, housing, and health care; the impact of disparate treatment of minorities at all stages of criminal legal proceedings, including police brutality and violence towards members of minority groups, higher rates of incarceration and death penalty sentences for members of minority groups, and political disenfranchisement due to felon voting prohibitions; US treatment of indigenous peoples; and the need for stronger US efforts to publicize the work of the Committee and US obligations under the Convention.

11. The U.S.'s narrow interpretation of the definition of racial discrimination as proposed under the Convention continues to be a major impediment towards its full implementation. Under the Convention and other customary human rights law, racial discrimination is understood to mean both intentional and *de-facto* discrimination. With few exceptions cognizable racial discrimination in the US requires evidence of *intent* to discriminate. This requirement is contrary to the Convention's framework and does not reflect the real-world operation of discriminatory behavior in contemporary American society.[5]

12. As recognized by both the Convention and the Committee, discrimination includes policies and practices that produce outcomes that have a disparate impact, including those impacts in the areas of education, health, housing, and other economic, social, and cultural rights as elaborated in Article 5 of ICERD.

13. The Committee expressed concern in both 2001 and 2008 that the US law, policy, and court practice

---

4 The use of the term "minority" throughout this document indicates reference to racial, ethnic, and national minority groups, which are the same groups addressed in the CERD Committee's concluding observations. The use of the term "Convention or ICERD" throughout this document refers to the International Convention on the Elimination of All Forms of Racial Discrimination. The use of the term "Committee" throughout this document refers to the Committee on the Elimination of Racial Discrimination.

5 A Summary of U.S. NGO responses to the U.S. 2007 Combined Periodic Reports to the International Committee on the Elimination of All Forms of Racial Discrimination, February 2008, 6. Available at http://www.U.S.hrnetwork.org/files/U.S.hrn/images/linkfiles/CERD/0_Executive%20Summary.pdf

relies on a definition of racial discrimination at odds with their obligations under article 1, paragraph 1 of the Convention to ensure prohibition of conduct not only discriminatory not only in purpose but also in effect.[6] It recommended in both years that the US review its legislation and practices to ensure protection against all forms of racial and ethnic discrimination and any unjustifiably disparate impact upon persons from different racial and ethnic backgrounds.

14. Numerous U.N. human rights monitors, including the Special Rapporteur on Education, Racism, and Housing have highlighted the challenge of racial disparities in combating racial discrimination in the United States.[7]

15. Each of the Special Rapporteur's noted the presence of racial disparities and highlighted the importance of policies to reduce these disparities.

National Framework

16. The US has an extensive constitutional and legislative framework to address intentional discrimination by public and private actors but lacks adequate protections and remedies related to the racially disparate impact of "neutral" policies and practices.

17. The fourteenth amendment of the Constitution contains an Equal Protection Clause that formally recognizes the principle of equality before the law. The fifteenth amendment further extends the right to vote to all races.

18. The advent of the "intent" doctrine, established through a 1976 court ruling, essentially narrowed the fourteenth amendment by requiring that victims of discrimination to prove "intent" to discriminate as a condition to getting a remedy; this is in direct conflict with the Convention.

19. The United States has robust legal protections for racial discrimination as defined and understood under the Civil Rights Act of 1964.[8] The challenge in remedying contemporary manifestations of racial discrimination under the Civil Rights Act is the limited scope of protections and narrow definition of racial discrimination.

20. Various governmental agencies including the Justice Department Civil Rights Division, The Equal Employment Opportunity Commission, Department of Housing and Urban Development's Office of Fair Housing and Equal Opportunity among others are charged with authority to investigate and challenge patterns or practices of employment discrimination. The Voting Rights Act, as well as Titles VI and VII of the Civil Rights Act of 1964 are vehicles through which disparate impact claims may be litigated yet recent Supreme Court cases have limited the extent to which these statutes provide viable remedies for individuals injured by the racially disparate impact of racially neutral laws.[9]

---

6 As defined in Article 1 and General Recommendation XIV, racial discrimination includes distinctions and exclusions that have an "unjustifiable disparate impact" upon the rights of freedoms of particular racial or ethnic groups.

7 Special Rapporteur on the Right to Education Katarina Tomasevski visited the United States from 24 September to 10 October 2001. Her report (E/CN.4/2002/60/Add.1) was submitted on 17 January 2002. Special Rapporteur on Contemporary Forms of Racism, Racial Discrimination, Xenophobia and Related Intolerance, Doudou Diène, visited the U.S. from 19 May to 6 June 2008. His report (A/HRC/11/36/Add.3) was submitted on 28 April 2009. Special Rapporteur on Adequate HoU.S.ing as a Component of the Right to an Adequate Standard of Living, and on the Right to Non-Discrimination in this Context, Raquel Rolnik, visited the U.S. from 22 October to 8 November 2009. Her report was submitted on 12 February 2010.

8 The Civil Rights Act of 1964 prohibits discrimination in the areas of employment, housing and housing finance, access to public accommodations, and education.

9 Title VII prohibits tests that have a disparate impact on the basis of race or national origin that cannot be shown to be related to the job in question.

21. The United States is under an obligation to prohibit and eliminate laws, policies, and programs "which [have] the purpose or effect" of impairing rights or freedoms based on race." The United States did not reserve this definition of discrimination. However, plaintiffs alleging racial discrimination in United States courts must prove that the defendant was motivated by racial animus, and that this discriminatory intent caused the plaintiff's harm.[10]

22. One of the more substantive yet often overlooked obligations under ICERD is the requirement of states to collect and disaggregate data related to government policies and practices. CERD Committee's General Recommendations IV and XXIV elaborate on extent of this obligation. While the US collects substantial data at the federal level by race, it is often difficult to access at the state level or within particular agencies. For example there is no national disaggregated data on Native Americans on death row even though where data is kept on Native Americans they suffer the grossest disproportion of executions than those of all other races. In data kept in most states of the Union they are listed as "other."[11]

23. The electoral college, the process by which presidents become elected in the US, continues to be a highly contested policy. The historical roots of the electoral college, creating rules that used slave bodies to be counted as three-fifths of a person with no voting rights, gave slaveholders and southern states increased representation in the house of representatives and consequently in the electoral college. As a result, 32 of the Constitution's first 36 years, a white slaveholding Virginian occupied the Presidency.[12] The legacy of this slave era policy continues to have disparate impacts of privilege and discrimination. Under the Electoral College, each state gets a fixed number of electoral votes based on population and congressional representation, so a state has no incentive to expand voting rights-as in states where formerly incarcerated individuals have no right to vote.[13] As Harvard law professor Lani Guinier reports, in Wyoming, one Electoral College vote corresponds to 71,000 voters, while in large-population states (where the votes of people of color are more numerous) the ratio is one electoral vote to over 200,000 voters.[14]

24. In its report to the Committee the United States claimed to satisfy obligations to review policies and practices "through its ongoing legislative and administrative processes at all levels of government, as well as through court challenges brought by governmental and private litigants. Laws and regulations in the United States are under continuous legislative and administrative revision and judicial review."[15]

25. The piecemeal and fragmented approach taken by the US to comply with Article 2 (1) (c) of the convention impedes the protection of victims of racial discrimination and often excludes them from seeking justice under the law.

C) Key Impacts of Racial Discrimination in the United States

26. Despite a clear understanding of Article 5 of the Convention, the United States continues to negate

---

10 See "Structural Racism in the United States." A Shadow Report to the U.N. Committee on the Elimination of Racial Discrimination. February 2008. Prepared by: Stephen Menendian, Marguerite Spencer, Lidija Knuth, John Powell, Sara Jackson, Fran Fajana, Andrew Grant-Thomas, Jason Reece, Eva Paterson, and Kimberly Rapp.

11 See, e.g., Death Penalty Information Center, http://www.deathpenaltyinfo.org/race-death-row-inmates-executed-1976. visited April 15, 2010

12 Presidency: Why We Should Junk the Electoral College. By Akhil Reed Amar and Vikram David Amar. Full article: http://hnn.us/articles/436.html

13 Nationwide, approximately 7% of African Americans, and 13% of Black men, are unable to vote. More than 30% of African American men in Alabama are prevented from voting by felon disenfranchisement laws. Statistic found at: http://www.eji.org/eji/node/360

14 Making Every Vote Count By Lani Guinier. December 4, 2000 edition of The Nation.

15 CERD/C/U.S.A/6, para. 82

obligations related to economic, social and cultural rights. "As noted in the Initial U.S. Report, some of these enumerated rights [in Article 5] which may be characterized as economic, social, and cultural rights, are not explicitly recognized as legally enforceable "rights" under U.S. law. However, article 5 does not affirmatively require States parties to provide or to ensure observance of each of the listed rights themselves, but rather to prohibit discrimination in the enjoyment of those rights to the extent they are provided in domestic law. In this respect, U.S. law fully complies with the requirements of the Convention."[16]

27. The data provided in this section clearly illustrates that the US has not lived up to its obligations to protect the right to non-discrimination in the enjoyment of rights enumerated under Article 5 and in fact discrimination in the enjoyment of these rights is increasing.

Poverty and Employment

27. In 2008, 24.7 % of blacks and 23.2 % of Hispanics were poor, compared to 8.6 % of non-Hispanic whites. The poverty rate for black and Hispanic children was 33.9 and 30.6 % respectively compared with 10 % of white children[17]. The wealth gap between whites and people of color, particularly women, creates and extreme burden on those most vulnerable in US society. A recent study found that for every dollar of wealth owned by the average white family the average family of color owns a mere 16 cents. Single black and Hispanic women are even more disproportionately affected by this wealth gap. Black and Latina women have just one penny of wealth for every dollar of wealth owned by their male counterparts and a tiny fraction of a penny for every dollar of wealth owned by white women.[18]

28. Nationally, the unemployment rate among blacks climbed in January 2010 to 16.5 %, while it declined for other groups. Unemployment is 12.6 % for Latinos and 8.7 % for whites.

29. Poverty is influenced by a number of factors, including housing segregation, transportation, and regional infrastructure. For many suburban dwellers, lack of adequate public services, like public transportation affects their ability to find and keep employment.

30. In Atlanta, Georgia, home to the civil rights movement, structural racism and a legacy of Jim Crow is responsible for the historic under-funding of city services and public institutions. For example, the Metropolitan Atlanta Rapid Transit Authority (MARTA) is the ninth largest transit system in the country and is the largest system in the U.S. that receives no operating help from the state.[19] According to MARTA's own research, 76% of its 500,000 daily transit riders are African American and low-income.

31. Lack of state support for transit has also led to the elimination of service in suburban Clayton County on March 31, 2010 to riders who were majority people of color yet the state is paying $28 million toward a $121-million expansion of the Xpress bus system for more affluent white suburban commuters.[20]

32. The economic vulnerability of people of color in the US is the cumulative effect of slavery, apartheid, and discriminatory policies and practices of the United States government. The persistent impacts of racial discrimination between institutions and among private and public actors aggravate structural

16 CERD/C/U.S.A/6, para. 148.
17 National Poverty Center. Available at: http://www.npc.umich.edu/poverty/#4
18 Lifting as we Climb: Women of Color, Wealth, and America's Future. Spring 2010. Insight: Center for Economic and Community Development.
19 Robert D. Bullard, "Highway Robbery" (2004), South End Press
20 CTRAN Reaches End of the Line," Atlanta Journal-Constitution, March 29, 2010http://www.ajc.com/news/clayton/c-tran-reaches-end-416424.html

racism.[21]

Housing

33. The average white American residing in a metropolitan area lives in a neighborhood that is 80 % white and just 7 % African American.[22] The majority of whites also enjoy housing conditions that diverge drastically from those found in many communities of color. Minority groups live disproportionately in areas of concentrated poverty characterized by substandard housing, high rates of crime and violence, and inadequate access to education, health care, and employment opportunities.

34. In 2008, three of four non-Hispanic Whites owned homes, while fewer than half of all Blacks and Latinos did.[23]

35. Residential racial segregation in the U.S. was systematically promoted by federal programs such as the Home Owners Loan Corporation and the Federal Housing Authority. "The development of the segregated housing market provides an example of the influence of public actions on private decision-making."[24] From 1938 through the end of the 1950s, the FHA insured mortgages on nearly one-third of all new housing produced annually in the United States. But the FHA's Underwriting Manuals considered blacks' adverse influences' on property values and instructed personnel not to insure mortgages on homes unless they were in 'racially homogenous' white neighborhoods.

36. The US Secretary for Housing and Urban Development stated in 2009 that concentrations of poverty across the American landscape have "resulted not in spite of government policy - but in many cases because of it."[25]

28. The recent sub-prime mortgage crisis, while further decreasing the availability of affordable housing, has harmed persons of color in disproportionate numbers. Subprime loans were made in African American communities at a rate five times greater than in white communities. In addition, approximately 47 % of Latinos received subprime loans, compared with just 17 % of whites.

29. The CERD Committee observed in General Recommendation 19 that racial segregation may be a product of government policies as well as the actions of private persons. In fact, in 2008 the Committee noted with great concern the disparate impact that Hurricane Katrina had on low-income African American residents in affected areas, particularly the fact that many of these persons continued to be displaced more than two years after the hurricane.

---

21 "As a signatory to the Convention on the Elimination of Racial Discrimination (CERD), 1 the United States is under an obligation to condemn and pursue a policy of eliminating racial discrimination, in all its forms (art. 2, ¶1). The U.S. has not taken seriously the duty under Article 2 of CERD to affirmatively address racial discrimination. Instead, the U.S. has rationalized racial discriminatory effects as not covered by U.S. law. Sometimes these effects are caused by explicit government polices. At other times they are caused by private actors. Frequently, it is a combination of both." See Structural Racism in the United States: A Report to the U.N. Committee on the Elimination of Racial Discrimination, 2008. Available at: http://www.U.S.hrnetwork.org/files/U.S.hrn/images/linkfiles/CERD/1Structural_Racism.pdf.

22 John Logan, Lewis Mumford Ctr. For Comparative Urban & Reg'l Research, Ethnic Diversity Grows, Neighborhood Integration Lags Behind 1 (2001), available at http://www.s4.brown.edu/cen2000/WholePop/WPreport/MumfordReport.pdf.

23 Census Bureau Reports on Residential Vacancies and Homeownership," February 3, 2009 at 8. http://www.census.gov/hhes/www/housing/hvs/qtr408/files/q408press.pdf).

24 Ibid " Structural Racism in the United States" pg. 8

25 Prepared Remarks for Secretary of Housing and Urban Development Shaun Donovan at the Brookings Institution Metropolitan Policy Program's Discussion – "From Despair to Hope: Two HUD Secretaries on Urban Revitalization and Opportunity." National Press Club, Washington, D.C., Tuesday, July 14th, 2009.

Education

30. In the 2006/2007 academic year 76.8 % of whites held a Bachelors degree compared with 8 % and 5.3 % of black and Hispanics respectively.[26] The rate is substantially lower for more advanced degrees. Students living in low-income families were approximately 10 times more likely to drop out of high school between 2006 and 2007 than were students living in high-income families.[27] The high correlation between poverty and race creates a disproportionate impact on the right to education for racial minorities.

31. One out of every six African American public school students and one out of every nine Latino public school students attends a school with nearly 100 % minority students.[28] Moreover, minority public school students are more likely to attend schools with high numbers of poor students. In 2002-2003, 71 % of all African American public school students and 73 % of all Latino public school students attended high-poverty schools. For the same period, only 28% of all white public school students attended a high-poverty school.[29] Schools with high numbers of poor students face a host of attendant challenges for creating a productive learning environment.

32. The disparities in racial makeup and quality of public schools are inextricably linked to the similar imbalances in the housing context. Local property taxes typically make up a substantial portion of public school funding. For example, schools in inner-city neighborhoods of New York receive an average of $4,000 annually, while suburban New York schools on average receive $40,000 per year.[30]

33. Schools with smaller budgets face heightened barriers to providing variety and quality of educational opportunities, in turn decreasing students' chances of attaining higher education and narrowing their range of eventual employment opportunities. This correlation between race, neighborhood, and prospects for upward mobility is directly at odds with the principles of equal opportunity and meritocracy purported to characterize US political and social systems. Despite this dissonance, however, the US Supreme Court in 2007 ruled unconstitutional school district efforts to implement race-conscious affirmative action policies aimed at reducing de-facto segregation along racial and socio-economic lines.[31]

Criminal Justice and Juvenile Detention

34. As explored in numerous studies and reports submitted to United Nations bodies, the disproportionate number of black and Latino men, and increasing numbers of women, in the criminal justice system puts the United States out of compliance and in clear violation of ICERD and ICCPR. The urgent nature of this problem is found in both state and national data.

35. The United States has the largest incarceration rate in the world.[32] As of December 21, 2008, there were

---

26 U.S. Department of Education, National Center for Education Statistics. (2009). Condition of Education 2009, Indicator 24 (NCES 2009-081)

27 High School Dropout and Completion Rates in the United States: 2007, National Center for Educational Statistics 2009064. Cataldi, E.F., Laird, J., and KewalRamani, A

28 Gary Orfield & Chungmei Lee, Civil Rights Project, Why Segregation Matters: Poverty and Educational Inequality, (2005), note 93, at 12-13.

29 Id., at 19, tbl.7 (2005). Note that these figures exclude millions of private school students, who are disproportionately white. Data from the U.S. Department of Education shows that, of 5,122,772 private school students nationwide, 76.2% are non-Hispanic whites, even though non-Hispanic whites comprise only 59% of children in the United States. See U.S. Dep't Of Educ., Characteristics of Private Schools in the United States: Results from the 2003-2004 Private School Universe Study 13 Tbl.7, 19 Tbl.13 (2006); Child Trends Databank, Racial and Ethnic Composition of the Child Population 5 (2006).

30 Department of Education, Digest of Education Statistics, 2000 edition (www.doe.gov).

31 Parents Involved in Community Schools v. Seattle School District No. 1 Et Al., 551 U.S. 701 (2007).

32 Walmsley, Roy (2009). "World Prison Population List. 8th edition" International Centre for Prison Studies. School of Law, King's College

754 inmates per 100,000 U.S. residents.[33] According to the U.S. Bureau of Justice Statistics, "in 2008, over 7.3 million people or 1 in every 31 adults, were on probation, in jail or prison, or on parole. [34] While one in 30 men between the ages of 20 and 34 is behind bars, for black males in that age group the figure is one in nine.[35] The devastating impact of incarceration on families and communities is profound; affecting future income, opportunities for employment, civic engagement and well-being into the future.

36. According to The Sentencing Project, the incarceration rates of women of color, in particular mothers, is staggering. "The number of incarcerated mothers has more than doubled (122%) from 29,500 in 1991 to 65,600 in 2007" with evident racial disparities impacting their children: "One in 15 black children and 1 in 42 Latino children has a parent in prison, compared to 1 in 111 white children." Estimates indicate, "Black women represent 30 percent of all females incarcerated under state or federal jurisdiction and Hispanic women 16 percent" with black women being "three times as likely as white women to be incarcerated" and "Hispanic women 69 percent more likely." [36]

37. In its last report to the Committee, the United States noted that reasons for such [racial] disparities in the criminal justice system are complex and "do not necessarily indicate differential treatment of persons in the criminal justice system."

38. Although only 1 % of the U.S. youth population in 2003, Native youth made up a full 2 % of the cases referred to juvenile courts. This is the single greatest increase among any racial group in the U.S. Similarly, in 2003, Native American youth had a higher percentage of petitioned cases waived to adult criminal court, at 1.2 % of all Native American cases formally processed, than any other racial group in the US. Twenty-six out of every 100,000 African American youth are serving time in adult prison while for white youth the rate is only 2.2 per 100,000.

39. While the juvenile death penalty has been struck down in the U.S., the Juvenile Life Without Parole (JLWOP) condemns children to die in prison. Stark racial disparities in the imposition of the JLWOP sentence are evident nationwide: under age 17, African American youth are 19% of the population but 65% of youth serving JLWOP sentences.

40. The school-to-prison pipeline is a well documented phenomenon that criminalizes youth of color within the educational system by using punitive discipline policies that lead to exclusion and increased juvenile arrests. The school-to-prison pipeline not only denies students the right to a quality education, it directly increases the rate of juveniles in the criminal justice system. In 2003, African American youth made up 16% of the nation's overall juvenile population, but accounted for 45% of juvenile arrests[37]

Health Disparities

42. Research has shown that African Americans' continuing experiences with racism and discrimination may lie at the root of the many well-documented race-based physical health disparities that affect this population.

London. Available at: http://www.kcl.ac.uk/depsta/law/research/icps/downloads/wppl-8th_41.pdf

33 Sabol, William. J et al, "Prisoners in 2008". http://bjs.ojp.us.doj.gov/content/pub/pdf/p08.pdf

34 Total correctional population". United States Bureau of Justice Statistics. Available at: http://bjs.ojp.U.S.doj.gov/index.cfm?ty=tp&tid=11.

35 "One in 100:Behind Bars 2008". Pew Center on States. Available at http://www.pewcenteronthestates.org/uploadedFiles/One%20in%20100.pdf

36 The Sentencing Project. "Women in the Criminal Justice System" (May 2007). Available at: http://www.sentencingproject.org/template/page.cfm?id=136. See also Paige M. Harrison and Allen J. Beck, Prisoners in 2005, Bureau of Justice Statistics, November 2006.

37 School-to-Prison Pipeline Taking Points: ACLU. Available at: http://www.aclu.org/racial-jU.S.tice/school-prison-pipeline-talking-points

43. Access to healthcare and disparate rates of chronic illness, including diabetes, hypertension, high blood pressure, and obesity are just a few ways health intersect with race and class.

44. In a recent report by the Office of Women's Health and the Office of Health Assessment & Epidemiology, it was found that African American women were far more likely to suffer from sexually transmitted diseases, including AIDS, and to die from chronic illnesses. Additionally, although white women had a higher incidence of breast cancer, African American women were more likely to die from the disease.

45. According to the National Indian Health Board, "Native Americans are nearly three times more likely to be diagnosed with diabetes;" health problems, which are exacerbated by disproportionately high rates of poverty, compared to the national average. On the Yakama Indian reservation in Washington state, estimates indicate at least "one in five Yakama tribal members older than age 50 are affected by diabetes."[38]

46. Latina's reported the poorest health status of women in all ethnic groups, with disproportionately higher death rates from diabetes. Their obesity rate increased from 27% in 2005 to 31% in 2007 and they reported less access to healthcare, with more than a third lacking health insurance and about 41% reporting difficulty accessing care.[39]

47. African Americans and other communities of color bear a severely disproportionate burden of the AIDS/HIV epidemic. Though blacks represent 12 % of the U.S. population between 2001 and 2004 they accounted for 51 % of newly diagnosed HIV infections in the 33 states that had used confidential, name-based reporting of HIV and AIDS since 2001.

48. Black Americans living with HIV have not seen equal benefits from AIDS treatment: from 2000 to 2004, deaths among whites living with HIV declined 19 % compared to 7 % for blacks. Survival time after an AIDS diagnosis is lower on average for blacks than for other racial/ethnic groups.[40]

Key Recommendations

1) Adopt National Action Plan on Racial Discrimination

The US government has made piecemeal efforts to reduce racial disparities in health and education but its disconnected approach to policy fails to address the systemic nature of the problem and the interconnectedness of rights. Additionally, no federal agency is accountable for reducing racial disparities despite public dollars being allocated to various programs. Victims of racial discrimination need and deserve an ambitious, innovative, and practical approach to contemporary forms of racial discrimination.

In line with the Vienna Declaration and Programme of Action, and modeled after other federal programs, the US should adopt a national action plan to reduce racial disparities which includes a national strategy with clear, reachable targets, a budget allocation, and measurable indicators. It should also encourage state jurisdictions to adopt such action plans and create a federal inter-agency working group, which includes civil society participation, to oversee implementation and report on its progress.

The federal racial disparities reduction strategy must include:

---

38 Phil Ferolito. "Dealing with Diabetes." Yakima Herald. Available at http://www.yakima-herald.com/stories/2008/05/27/dealing-with-diabetes

39 Los Angeles County Department of Public Health, Office of Women's Health. *Health Indicators for Women in Los Angeles County: Highlighting Disparities by Ethnicity and Poverty Level,* February 2010.

40 Chris Collins. "Improving Outcomes: Blueprint for a National AIDS Plan for the United States". Open Society Institute. 2007.

- Long-term strategic planning with appropriate funding;
- Consultation with stakeholders, including civil society;
- Federal coordination across national, state, and local agencies;
- Public benchmarks in key areas and steps for reaching long and short term objectives.
- Key areas of concern must include: poverty, employment, incarceration, health, housing, and education.

2) Ensure compliance with the obligations under ICERD:

- Adopt, where necessary, a definition of discrimination that complies with the definition found in article 1 of ICERD and General Recommendation XI.
- Implement a process by which policies and practices are reviewed for discriminatory impact. The Committee recommends that the State party consider the establishment of an independent national human rights institution in accordance with the Paris Principles (General Assembly resolution 48/134 of 20 December 1993, annex) and ICERD General Recommendation 17 which recommends that State parties establish national commissions or other appropriate bodies to promote respect for the enjoyment of rights set out in Article 5. This could be done by passing legislation to establish such a body, which could be created by restructuring and strengthening the existing U.S. Commission on Civil Rights, and converting it into an effective U.S. Commission on Civil and Human Rights.[41]
- The Committee and civil society encourage the state to adopt and strengthen the use of special measures when circumstances warrant their use as a tool to eliminate the persistent disparities in the enjoyment of human rights and fundamental freedoms and ensure the adequate development and protection of members of racial, ethnic and national minorities. The 2001 Committee report noted with disappointment the US's contrary viewpoint that the Convention merely permits, rather than requires, affirmative action measures aimed at developing and protection minority groups.

3) Ensure the full implementation of Committee recommendations from 2008 and 2001- including but not limited to:

- Adoption of the End Racial Profiling Act
- Adopt the Civil Rights Act of 2009
- Eliminate the National Entry and Exit Registration System (NEERS)
- Adopt the United Nations Declaration on the Rights of Indigenous Peoples (A/RES/61/295) as a guide to interpreting its Convention obligations with respect to indigenous people (para 500; arts. 5 (d) (v), 5 (e) (iv), and 5 (e) (vi)).

4) Ensure full implementation of ICERD throughout its jurisdiction, including at the state and local levels, including:

- Adopt implementing legislation at the federal level to ensure the justiciability of rights afforded under ICERD, including taking into consideration recommendations by the Committee in 2001 & 2008 to reconsider allowing for the optional declaration provided for in article 14 of the Convention.
- Implement meaningful efforts to coordinate compliance initiatives at the state and local level.
- Ensure public and private awareness of the Convention's rights and educate public officials at every level of obligations under ICERD.

---

41 Summary of Human Rights at Home: A Domestic Policy Blueprint for the New Administration, authored by Professor Catherine Powell of Fordham Law School and released by the American Constitution Society for Law and Policy. The full Blueprint is available at http://www.acslaw.org/files/C%20Powell%20Blueprint.pdf.

APPENDIX:
Unequal Health Outcomes in the United States: racial and ethnic disparities in health care treatment and access, the role of social and environmental determinants of health, and the responsibility of the state

Submitted by the CERD Working Group on Health and Environmental Health[1]

Table of Contents

---

[1]Submitted by*Organizations*The Opportunity Agenda—Poverty & Race Research Action Council—National Health Law Program—Center for American Progress—Center for Reproductive Rights—New York Lawyers for the Public Interest—Families USA—Physicians for Human Rights—Alliance for Healthy Homes— Center for Social Inclusion—Out of Many, One—Summit Health Institute for Research and Education, Inc. (SHIRE)—Community Catalyst—Lawyers Committee for Civil Rights Under Law—Ipas— National Economic & Social Rights Initiative—Uplift International—Generations Ahead—Natural Resources Defense Council—PolicyLink—The Praxis Project—Kirwan Institute for the Study of Race and Ethnicity—Medical-Legal Partnership for Children at Boston Medical Center—Kellogg Health Scholars Program—Environmental Justice Resource Center at Clark Atlanta University*Individuals*Dolores Acevedo-Garcia, Harvard School of Public Health—Ana V. Diez-Roux, University of Michigan—Jack Geiger, City University of New York Medical School—Rachel D. Godsil, Seton Hall University School of Law—Professor Sherman James, Duke University—Nancy Krieger, Harvard School of Public Health—Vernellia R. Randall, University of Dayton Law School—David Barton Smith, Temple University—David R. Williams, Harvard School of Public Health

Foreword

When the United States ratified the Convention on the Elimination of All Forms of Racial Discrimination in 1994, it agreed to submit periodic state reports to the Committee on the Elimination of Racial Discrimination, the U.N. body charged with monitoring State compliance with the Convention. The Committee will next review the United States government's progress in implementing CERD during its 72nd Session in February 2008. The United States submitted a Periodic Report to the Committee in April 2007 in anticipation of this review.

Unfortunately, the U.S. report fails to adequately discuss how racial discrimination prevents the enjoyment of the right to health and environmental health for people of color in the United States, nor does the report accept state responsibility for respecting, protecting, and fulfilling equal access to these rights.

This report, *Unequal Health Outcomes in the United States*, makes clear that racial discrimination in health care access and treatment is a human rights violation that deserves serious attention from both the CERD Committee and policymakers in the United States. Originally conceived as a "shadow report" to the 2007 U.S. Periodic Report, this report was written by a coalition of experts in the fields of health policy and environmental justice, including academics and members of civil society organizations working to advance the right to health and the right to a healthy environment in the United States. This report highlights:

- The extent of racial discrimination in the areas of health and environmental health, as demonstrated by persistent racial disparities in access to health care and quality of health care;
- Causes of racial discrimination, with a focus on government policies that create and exacerbate racial discrimination; and
- The adequacy of the government response to health disparities, as well as recommended actions for all levels of government to eliminate racial discrimination in health and environmental health.
- A shorter version of this report was submitted to the Committee in December 2007 as part of a joint civil society shadow report coordinated by the U.S. Human Rights Network. The joint shadow report will be made available on the Network's website (www.ushrnetwork.org).

A. Introduction: The U.S. government's failure to enforce its obligations under CERD

It is now widely recognized that racial and ethnic disparities in health outcomes in the U.S. are caused not only by structural inequities in our health care systems, but also by a wide range of social and environmental determinants of health. The Convention on the Elimination of All Forms of Racial Discrimination (CERD) recognizes and encompasses this dual analysis in the area of public health.

Article 5 of CERD provides that "States Parties undertake to prohibit and to eliminate racial discrimination in all its forms" in the right to "public health" and "medical care." Public health has been interpreted by the

Special Rapporteur on the Right to Health to include not only health care systems but also the underlying social and environmental factors affecting health:

The right to health is an inclusive right, extending not only to timely and appropriate health care, but also to the *underlying determinants of health*, such as access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information... [1]

Public health is a broad concept that includes elements such as: (1) maternal, child and reproductive health; (2) healthy workplace and natural environments; (3) prevention, treatment, and control of diseases; and (4) access to safe water.[2] Because environmental conditions and other social determinants of health are included in the scope of "public health" as it pertains to Article 5(e) (iv) of CERD, once a government learns that a seemingly neutral environmental law or regulation has a discriminatory effect, it must remedy the discriminatory situation.[3]

The CERD Committee, in its 2001 Concluding Observations to the last U.S. Periodic Report specifically noted its concern for racial disparities in health by stating, "the Committee is concerned about persistent disparities in the enjoyment of, in particular, the right to... public and private health care."[4] The Committee also reminded the United States that "the adoption of special measures by States parties when the circumstances so warrant, such as in the case of persistent disparities, is an obligation stemming from article 2, paragraph 2, of the Convention."[5] Although the rights to health care and public health are not recognized under U.S. federal law,[6] in its 2007 CERD Report, the U.S. stated that its federal and state laws complied with CERD requirements that the "right to health" be enjoyed on a non-discriminatory basis.[7] Additionally, in the 2007 State Report, the U.S. addressed environmental justice, implicitly acknowledging that environmental racism is within the scope of CERD.[8]

The CERD Committee has made it clear that the reporting obligation under Article 1 requires States par ties to provide full information to the Committee on the racial and ethnic groups within their territory. In addition, "[c]ertain criteria should be uniformly applied to all groups, in particular the number of persons concerned, and their being of a race, colour, descent or national or ethnic origin different from the majority or from other groups within the population."[9] Moreover, reports of States parties should include data that address multiple forms of discrimination faced by certain ethnic or racial groups, including non-citizens[10] and indigenous peoples.[11] Finally, in recognition of the fact that "certain forms of racial discrimination may be directed towards women specifically because of their gender" or may "have a unique and specific impact on women," States parties havevthe responsibility to address the intersection between race and gender.[12] Failure to honor this reporting obligation constitutes a separate violation of Article 2. In itsvv2001 Concluding Observations to the U.S. government, the Committee recommended that "the next State party report contain socio-economic data, disaggregated by race, ethnic origin and gender . . . ."[13]

The retreat on judicial remedies

Perhaps the most important state obligation under CERD is providing the right to *challenge* disparate racial outcomes and *enforce* anti-discrimination standards in domestic courts or tribunals.[14] These rights have been severely curtailed in U.S. courts since the last U.S. Report was submitted to the CERD Committee in 2000. Before proceeding with a review of general U.S. compliance with CERD's health and environmental standards, we will first review this overarching enforcement issue.

Title VI of the Civil Rights Act of 1964[15] offered the promise of aiding the government's efforts to eliminate racial discrimination, as the Act prohibits, "on the ground of race, color, or national origin, [that any person] be excluded from participation in,be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."[16] However, despite the enactment of Title VI, subsequent judicial interpretation of the Equal Protection Clause and Title VI has significantly limited the ability of citizens and the executive branch of government to eliminate racial discrimination in the United States.[17] Currently, proof of discriminatory animus (intent) is required before a finding of discrimination will be made under the Title VI statute and citizens are no longer permitted to enforce its implementing regulations, which until 2001 permitted court challenges to government policies with a discriminatory impact.[18,19] This limitation prevents the United States from meeting its obligations as a state party to CERD, including its commitment to prohibit not only racially discriminatory intent but also racially discriminatory impact in governmental action, government supported programs, and government policies.[20]

At the time the United States ratified CERD in 1994, Title VI regulations were available in the courts as a remedy for discriminatory government policies that were not necessarily "intentional" in nature. Thus, most CERD obligations were enforce able through Title VI, a fact upon which the Senate relied in its reservations and declarations to the treaty,[21] including the caveat that it is not "self-executing."[22] Both the Clinton administration and the Senate adopted this declaration after finding that existing U.S. law provides extensive protections and remedies sufficient to satisfy the requirements of the present Convention. Moreover, federal, state and local laws already provide a comprehensive basis for challenging discriminatory conduct by private actors. Given the adequacy of the provisions already present in U.S. law, there is no discernible need for the establishment of additional causes of action or new avenues of litigation in order to guarantee compliance with the essential obligations assumed by the United States under the Convention. . . . Declaring the convention to be non-self-executing in no way lessens the obligation of the United States to comply with its provisions as a matter of international law.[23]

Additionally, under CERD, the government has the duty to "review governmental, national and local policies, and to amend, rescind or nullify any laws and regulations which have the effect of creating or perpetuating racial discrimination wherever it exists."[24] On this point, the Administration proposed a clarification that the Senate foreign relations committee adopted in its report to the full Senate:[25] "[w]ith respect to the second obligation of Article 2(1) (c), practices that have discrimi natory effects are prohibited by certain federal civil rights statutes, even in the absence of any discriminatory intent underlying those practices. . . . This is true of . . . the federal regulations implementing Title VI of the 1964 Civil Rights Act...."[26]

As ratified, even with reservations, CERD was a commitment by the United States to, at a minimum, use contemporary (1994) domestic law to end racial discrimination. Since then, however, the Supreme Court has even further limited protections for racial minorities. In *Sandoval,*[27] the Court failed to mention CERD or its legislative history when it held that it was not the intent of Congress that individuals should be able to sue to enforce the disparate impact regulations promulgated under § 602 of Title VI.[28]

In *Sandoval*, the Court found that there is no rights-creating language in § 602,[29]and that Congress had not subsequently explicitly approved of the disparate impact regulations[30] promulgated by the Department of Justice (DOJ).[31] Thus, it reasoned, the only right for private enforcement of Title VI comes from § 601. Since the Court had decided in *Bakke*[32] that disparate impact is not prohibited by § 601, it concluded that Congress could not have intended the cause of action found in that section to extend to regulations that do prohibit discriminatory impact.[33] The Court did, however, leave open the possibility of government enforcement of

these regulations.[34]

There is no indication in the record of *Sandoval* that the Court ever considered the 1994 ratification of CERD by Congress, much less Congress' understanding that the Title VI regulations were indeed enforceable by individuals—an understanding that led it and the Administration to conclude that it was therefore unnecessary to create a new cause of action to enforce CERD's prohibition against unintentional conduct that has an impermissible disparate racial impact.[35] Congress' explicit approval of the regulations, as they had been interpreted and applied in *Guardians*[36] to afford relief to private litigants who had proven only unintentional disparate impact, directly undermines the Court's reasoning and conclusion in *Sandoval.*

In combination, the decision in *Sandoval* and the federal government's failure to act as CERD requires in situations like those that gave rise to *Sandoval* have greatly curtailed the ability to eliminate racial discrimination in the United States. *Sandoval* is merely the most recent example of the historic animosity of the court system to eliminating practices that have racially discriminatory impacts. Because intent is always hard to prove, many discriminatory policies cannot be successfully addressed. The United States government, for its part, has been complicit in, if not implicitly supportive of, this narrow judicial interpretation. Neither Congress nor the executive branch has pointed out the legislative history of CERD, nor have they made significant efforts to change the law to allow for private individuals to bring suits advancing the elimination of disparate racial impact under Title VI or its implementing regulations after *Sandoval*. Further, the Department of Justice has not brought a single case under the Title VI disparate impact regulations since *Sandoval*.[37] The dramatic limiting of the applicability of Title VI and its implementing regulations has led to ongoing racial discrimination in many areas, including environmental justice and access to healthcare.

Disparate environmental impact and its effects on health has been one area in which racial discrimination continues in the United States. *South Camden*[38] highlights this line of cases. The predominately minority neighborhood of Waterfront South[39] contained "two Superfund sites, several contaminated and abandoned industrial sites, and many currently operating facilities, including chemical companies, waste facilities, food processing companies, automotive shops, and a petroleum coke transfer station."[40] Additionally, permits had been granted for a sewage treatment plant, a trash-to-steam incinerator, and a coal-generation power plant. Thus, the neighborhood, which is "one of 23 Camden neighborhoods, hosts 20% of the city's contaminated sites and, on average, has more than twice the number of facilities with permits to emit air pollution than exist in the area encompassed within a typical New Jersey zip code."[41]

St. Lawrence Cement Company applied to open a facility to process ground blast furnace slag in Waterfront South. TheNew Jersey Department of Environmental Protection (NJDEP) granted the facility a permit after St. Lawrence conducted an air quality impact analysis without consider ing the racially disparate adverse impact of the facility. A preliminary injunction was granted based on the disparate impact regulations issued by the EPA under § 602 of Title VI. This injunction was dissolved, however, after *Sandoval*, as the court held that the disparate impact regulations went beyond the Title VI statute.[42] Thus, despite the overwhelming evidence of disparate racial impact and the high existing concentration of polluting industries, the NJDEP's decision to issue the permit was allowed to stand.

Sandoval has also crippled the ability of citizens to challenge hospital closures that leave entire minority neighborhoods without accessible acute health care. The closure of St. Mary's Hospital in Central Brooklyn illustrates this point all too well. Central Brooklyn's population is 80% African-American, 11% Hispanic, and 29% foreign-born; it has an infant mortality rate double that of the New York City (NYC) average; and it has

only 104 certified obstetric beds for a population of over 175,000 women.[43] Additionally, Central Brooklyn had diabetes hospitalizations and deaths 200% higher than the NYC average in 2001, asthma hospitalizations 65% greater than the NYC average in 2001, and mental health hospitalization 35% above the NYC average in 2003-04.[44] Despite these healthcare disparities and the demonstration of a lack of other healthcare resources in Central Brooklyn, St. Mary's was allowed to shutdown. Again, this demonstrates that studies, reports, conferences, and awareness of these health disparities do little good if one cannot access healthcare and cannot prevent the decrease of healthcare resources in an area with a disproportionate disease burden.

ENDNOTES

1 ECOSOC, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Report of the Special Rapporteur, Paul Hunt*, 59th Sess., ¶ 25, UN Doc. E/CN.4/2003/58 (2003) (emphasis added).
2 *Id.* at ¶ 25.
3 Neil A.F. Popovic, *Pursuing Environmental Justice with International Human Rights and State Constitutions*, 15 Stan. envtl. U.J. 338, 354 (1996).
4 Committee on the Elimination of Racial Discrimination (CERD), *Concluding Observations: United States of America,* 59th Sess., ¶ 398, U.N. Doc. A/56/18 (2001).
5 *Id.* at ¶ 399.
6 CERD, *Sixth Periodic Reports of States Parties Due in 2005: Addendum: United States of America*, U.N. CERD, 72nd Sess., ¶331 (Advance Edited Version), U.N. Doc. CERD/C/USA/6 (2007), *available at* http://www.ohchr.org/english/bodies/cerd/docs/AdvanceVersion/cerd_c_usa6.doc [hereinafter 2007 U.S. Report].
7 *Id.* at ¶ 345.
8 *Id.* at ¶ 264.
9 *Reporting of persons belonging to different races, national/ethnic groups, or indigenous peoples (Art. 1)*, U.N. CERD, 55th Sess., Annex 5, Gen. Rec. No. 24 ¶ 2, U.N. Doc. A/54/18 (1999); *see also Demographic composition of the population (Art. 9)*, U.N. CERD, 8th Sess., Gen. Rec. No. 4, U.N. Doc. A/901 8 (1973) ("[i]nvit[ing] States parties to endeavour to include in their reports under article 9 relevant information on the demographic composition of the population referred to in the provisions of article 1 of the Convention.").
10 CERD, *Gen. Rec. No. 11: Non-Citizens (Article 1), 4*2nd Sess., ¶ 2, U.N. Doc. A/46/18 (1993); CERD, Gen. Rec. No. 30, ¶ 5, U.N. Doc. CERD/C/64/Misc.1 1 /rev.3 (2004).
11 CERD, *Gen. Rec. No. 23: Indigenous Peoples,* 51st Sess., U.N. Doc. A/52/1 8, Annex V at 122 (1997).
12 CERD, *Gen. Rec. No. 25: Gender Related Aspects of Racial Discrimination,* 56th Sess., U.N. Doc. A/55/18, Annex 5 (2000) Human Rights Committee (HRC), *Gen. Comment No. 28: Equality of Rights between Men and Women (article 3),* 68th Sess., U.N. Doc. CCPR/C/21 /Rev.1 /Add.1 0 (2000) (explaining States parties' obligation to report on gender-disaggregated data such as birth rates, pregnancy and childbirth-related deaths of women, and infant mortality rates); Committee on
the Elimination of All Forms of Discrimination Against Women (CEDAW), *Gen. Rec. No. 9: Statistical data concerning the situation of women,* 8th Sess., U.N. Doc. A/44/38 (1989); CEDAW, *Gen. Rec. No. 24: Women and Health (article 12),*
20th Sess., U.N. Doc. A/54/38/Rev.1 (1999) (recommending that national statistical services responsible for social and economic surveys collect and disaggregate data by gender, and calling for data disaggregated by sex in the area of health care in order to evaluate the impact of health policies, plans, and laws on women).
13 CERD, Concluding Observations: United States of America, 59th Sess., ¶ 403, U.N. Doc. A/56/18 (2001).
14 International Convention on the Elimination of All Forms of Racial Discrimination, art. 6, G.A. res. 2106

(XX), Annex, 20 U.N. GAOR Supp. (No. 14) at 47, U.N. Doc. A/601 4 (1966), 660 U.N.T.S. 195, *entered into force* Jan. 4, 1969 [hereinafter CERD].
15 42 U.S.C. §2000d *et seq*.
16 42 U.S.C. §2000d.
17 *See* Washington v. Davis, 426 U.S. 229 (1976) (finding that the Equal Protection Clause of the Fourteenth Amendment only prohibits intentional discrimination) and *Regents of the University of* California v. Bakke, 438 U.S. 265, 287, 325, 328 (1978) (finding that Title VI only prohibits what the Equal Protection Clause prohibits).
18 *See* Alexander v. Sandoval, 532 U.S. 275, 293 (2001) ("Neither as originally enacted nor as later amended does Title VI display an intent to create a freestanding private right of action to enforce regulations promulgated under § 602. We therefore hold that no such right of action exists.") (footnote omitted).
19 However, the government may be able to enforce the disparate impact regulations. *See* S. Camden Citizens in Action v. N.J. Dep't of Envtl. Prot., 274 F.3d 771, 775 (3d. Cir. 2001). .
20 CERD, *supra* note 14, arts. 2(1)(a)-(c).
21 *See* 140 Cong. Rec. S7634-02 (daily ed., June 24, 1994) (U.S. Reservations, Declarations, and Understandings, International Convention on the Elimination of All Forms of Racial Discrimination), *available at* http://www1.umn.edu/humanrts/usdocs/racialres.html.
22 *Id.* at ¶ III.
23 *Third Periodic Reports of States Parties Due in 1999: Addendum: United States of America*, U.N. CERD, 59th Sess. ¶¶ 171-72, U.N. Doc. CERD/C/351 /Add.1 (2000), *available at* http://www.unhchr.ch/tbs/doc.nsf/898586b1 dc7b4043c1 256a450044f331 /4c02eba071 d735f4c1 256a1 700588ba0/$FILE/G0044926.pdf [hereinafter 2000 U.S. Report].
24 CERD, *supra* note 14, art. 2(1)(c). In ratifying CERD, the U.S. reserved that "[t]o the extent . . . that the Convention calls for a broader regulation of private conduct, the United States does not accept any obligation under this Convention to enact legislation or take other measures . . . with respect to private conduct except as mandated by the Constitution and laws of the United States." 140 CONG. REC. S7634-02(2).
25 In the CERD ratification process, there were a number of clarifications proposed by the Administration that the Senate foreign relations committee adopted in its report to the full Senate. CiaIBO1ne PEii, COim. ON FO1nIcN REiATIONS, INTERNATIONAi CONVEI'tION ON ThE EiIMINATION OF Aii FORMS Or R&CIai DISCRIMINATION, S. EXEC. ReP. NO. 103-29, at 27-32 (1994).
26 S. EXEC. REP. NO. 103-29, at 28-29.
27 Alexander v. Sandoval, 532 U.S. 275 (2001)
28 *See supra* notes 18, 19.
29 Sandoval, 532 U.S. at 288-89 ("We therefore begin (and find that we can end) our search for Congress's intent with the text and structure of Title VI. Section 602 authorizes federal agencies 'to effectuate the provisions of [§ 601] . . . by issuing rules, regulations, or orders of general applicability.' 42 U.S.C. § 2000d-1. It is immediately clear that the 'rights-creating' language so critical to the Court's analysis in *Cannon* of § 601, see 441 U.S. at 690 n. 13, is completely absent from § 602.)
30 28 C.F.R. § 42.101 et seq.
31 Sandoval, 532 U.S. at 293 ("Neither as originally enacted nor as later amended does Title VI display an intent to create a freestanding private right of action to enforce regulations promulgated under § 602. We therefore hold that no such right of action exists.").
32 Univ. of CA Regents v. Bakke, 438 U.S. 265 (1978).
33 *Id.* at 285 ("It is clear now that the disparate-impact regulations do not simply apply § 601 -- since they indeed forbid conduct that § 601 permits -- and therefore clear that the private right of action to enforce § 601 does not include a private right to enforce these regulations.")
34 Sandoval, 532 U.S. at 289-90.

35 *See* Pell, *supra* note 25.
36 Guardians Assn v. Civil Service Comm'n N.Y.C, 463 U.S. 582 (1993).
37 *See* Civil Rights Div. Appellate Section, U.S. Dep't of Justice, Briefs and Opinions, http://usdoj.gov/crt/app/briefs.htm. The Department has, however, defended one case during this time challenging the government's ability to prohibit disparate impact. *See* Colwell v. United States HHS, 2005 U.S. Dist. LEXIS 6556 (S.D.Cal. 2005).
38 S. Camden Citizens in Action v. N.J. Dep't of Envtl. Prot., 274 F.3d 771 (3d. Cir. 2001).
39 The demographic makeup of Waterfront South at the time of the case was 63% African-American, 28.3% Hispanic, and 9% white residents.
40 S. Camden, 274 F.3d at 775.
41 *Id.*
42 *Id.* at 790.
43 COMM. TO SAVE OUi HeaithCA1e, IMPORTANT FACTS ABOUT ThE Heaith Or CEnrrai BROOKiYN (2006) http://www. nylpi.org/pub/CSOH_Factsheet_PH_revision_11_27.pdf; *contra* 2007 U.S. Report to CERD, *supra* note 6, at ¶ 109 ("Maternal and Child Health Block Grants deliver health care to pregnant women and to children . . . These legislated responsibilities are consistent with the current emphasis of HHS on reducing racial differences, building capacity and infrastructure for child health, and ensuring quality care."). Even as funding to increase healthcare delivery and build infrastructure is increased, access to healthcare in minority areas is decreasing, as illustrated by the closure of St. Mary's Hospital.
44 CSOH FACT ShEFr; *contra* 2007 U.S. Report, *supra* note 6, at ¶ 257 ("The new Medicare Modernization Act has significant potential to reduce racial and ethnic disparities among U.S. seniors, as Medicare will now cover preventive medicine, including screenings for heart disease, cancer, depression, and diabetes—conditions that disproportionately affect racial and ethnic minorities."). Again, even as Medicare benefits improve, minority seniors' access to healthcare delivery services decrease. Without access to actual providers, a theoretical increase in insurance coverage of benefits is meaningless.

B. The extent of racial health disparities in the U.S.

The U.S. report acknowledges that "a number of disparities in the prevalence of certain diseases and conditions among racial and ethnic groups . . . continue to exist."[1] Specifically, the U.S. report notes that "for American Indians and Alaska Natives, the prevalence of diabetes is more than twice that for all adults in the United States, and for African Americans, the age-adjusted death rate for cancer was approximately 25 percent higher than for White Americans in 2001. Disparities are also seen in women's health issues, such as infant mortality and low birthweight. Although infant mortality decreased among all races during the 1980–2000 time period, the Black-White gap in infant mortality widened. During the same period, however, the Black-White gap with regard to low birthweight infants decreased."[2]

But the report downplays the effect of health disparities on the life span of racial and ethnic minorities and fails to document how pervasive these health disparities are. For example, while the life expectancy gap between the African Americans and whites has narrowed slightly,[3] African Americans still can expect to live 6-10 fewer years than whites and face higher rates of illness and mortality.[4] In terms of lives, this gap is staggering: a recent analysis of 1991 to 2000 mortality data concluded that had mortality rates of African Americans been equivalent to that of whites in this time period, over 880,000 deaths would have been averted.[5]

Furthermore, racial and ethnic gaps exist across a range of health conditions, not just the ones identified in the U.S. report. African Americans, American Indians, and Pacific Islanders face some of the most persistent and pervasive disparities relative to Whites and Asian Americans. They experience a disproportionate burden of poor health in problems ranging from infant mortality and diabetes to cardiac disease, HIV/AIDS, and other illnesses.[6] And while some racial and ethnic groups—such as Hispanics and Asian Americans—have better overall health status than national averages, they suffer disproportionately from some diseases such as diabetes, and tend to experience poorer health outcomes the longer they and their descendents live in the United States—particularly along some measures, such as cancer, infant mortality, and heart disease.[7]

Racial and ethnic groups also report suffering from poor health at higher rates than whites. American Indian/Alaska Natives, for example, are over twice as likely to report being in fair or poor health as compared to whites. And 14.6% of African Americans report being in fair or poor health as compared to only 8% of whites. Latinos increasingly face chronic diseases such as diabetes and are almost as likely as African Americans and American Indians or Alaska Natives to report being in fair or poor health. As Figure 1 shows, 13.3% of Latino respondents to the National Health Interview Survey reported being in fair or poor health, a share exceeded only by African Americans (14.6%) and American Indians/Alaska Natives (16.5%).[8]

The U.S. report also fails to document how the health status of subpopulations within racial groups varies considerably on the basis of nationality, immigration status, and other factors. For example, Vietnamese American men have liver cancer and ie from it at a rate seven times higher than that of non-Hispanic white men.[9] Vietnamese women have the highest rate of cervical cancer of any racial or ethnic group,[10] and the incidence rate of cervical cancer among Mexican and Puerto Rican women is two to three times that of white women.[11] Native Hawaiians have the highest rate of death from breast cancer of any racial or ethnic group, and it is the leading cause of death among Filipinas.[12]

As the United States concedes in its report to the CERD Committee, "the Black- White gap in infant mortality widened" in the United States between 1980 and 2000.[13] In fact, during that time period the black-white ratio of

infant mortality increased 25 percent even as the overall infant mortality rate declined.[14] In addition, African American infants are two to three times more likely than white infants to have low birthweight—a key indicator of infant mortality.[15] Racial and ethnic group differences persist even when socioeconomic factors are considered. For example, as Figure 2 shows, infant mortality rates—considered one of the most sensitive indicators of population health—are higher among African Americans and Ameri can Indians/Alaska Natives than among other racial or ethnic groups, even when comparing mothers at similar levels of educational attainment. Infant mortality rates decline as mothers' education level rises for all racial and ethnic groups, but education does not erase the racial gap. Despite their high socioeconomic status, African American women with college or graduate degrees face infant mortality rates that are higher even than among white women with less than a high school education.[16]

Moreover, women of color in the United States fare significantly worse than white women in every aspect of reproductive health. The maternal mortality rates in the United States are the highest among western developed nations[17] due to the shockingly high rates of mortality among women of color. African American women are nearly four times more likely to die in childbirth than white women.[18] This disparity is largely attributable to the fact that women of color, especially those who are low-income, disproportionately lack access to prenatal care that is essential for healthy birth outcomes.[19]

The prevalence of many sexually transmitted infections (STIs), particularly HIV/AIDS, has reached epidemic proportions among women of color. African American women are infected with HIV/AIDS at a rate 23 times that of white women[20] and comprised 66 % of the new HIV infections among women in 2005.[21] AIDS is also the leading cause of death for African American women aged 25 to 34.[22] Latinas also have 4 times the rate of AIDS diagnosis as white women.[23] Together, African American women and Latinas account for 82 % of reported female AIDS cases even though they only constitute 24 % of the U.S. female population.[24] Moreover, while the rate of HIV/AIDS diagnoses declined among other racial and ethnic groups between 2001 and 2004, it increased among Asian Pacific Islanders (from 55% to 66%) and American Indians/Alaskan Natives (from 52% to 68%).[25]

Similar disparities exist for other STIs. The rate of gonorrhea among African American women is 14 times higher than among white women.[26] The prevalence of chlamydia, an infection with particularly severe long-term health consequences for women, is 7 times higher among African American women, 4 times higher among American Indian/Alaskan Natives, and twice as high among Latinas as among white women.[27] Notably, these disparities have been widening in recent years. For example, from 2001 to 2005 the gonorrhea rate increased by 28 % among American Indian/Alaskan Natives, compared to a 19.7 % increase for whites.[28]

ENDNOTES

1 CERD, *Sixth Periodic Reports of States Parties Due in 2005: Addendum: United States of America,* U.N. CERD, 72nd Sess., ¶ 258 (Advance Edited Version), U.N. Doc. CERD/C/USA/6 (2007), *available at* http://www.ohchr.org/english/bodies/cerd/docs/AdvanceVersion/cerd_c_usa6.doc [hereinafter 2007 U.S. Report].

2 *Id.*

3 Sam Harper et al., *Trends in the Black-White Life Expectancy Gap in the United States, 1983-2003*, 297 JAMA 1224, 1224- 32 (2007).

4 NAT'l cTR. FoR Health STKrIsTIcs, u.S. DEp'T oi Health & HuMan Servs.. Health, uNrrED STATES, 2006 (2007).

5 S.H. Woolf et al., *The health impact of resolving racial disparities: An analysis of US mortality data*, 94 Ari.

J. puB. Health 2078, 2078-81 (2004).
6 NAT'l cTR. FoR Health STArIsTIcs, *supra* note 4.
7 *Id.*
8 *Id.*
9 Melissa McCracken et al., *Cancer incidence, mortality, and associated risk factors among Asian Americans of Chinese, Filipino, Vietnamese, Korean, and Japanese ethnicities*, 57 cA: A cANcER J. FoR clINIcIANS 190, 190-205 (2007).
10 NAT'l Asian pAc. AM. woMEN'S FoRuM, REclAIMING cHoIcE, BRoADENING thE MovEMENT: SExuAl AND REpRoDucTIvE JuSTIcE and ASian pAcIFIc AMERIcAN woMEN—A NATIoNAl AGENDA FoR AcTIoN 4 (2005), *available at* http://www. napawf.org/file/issues/RJPolicy_Agenda.pdf; NKr'l INSTS. oF Health (NIH), woMEN oF coloR Health DATA BooK: ADolEScENTS To SENIoRS 96-97 (3d ed. 2006).
11 Nat'l Latina Inst. for Reproductive Health, *Issue Brief, Reproductive Health of Latinas in the U.S.* (Mar. 2002), *available at* http://www.latinainstitute.org/pdf/ReproHealth.pdf.
12 Office of Minority Health, Dep't Health & Human Servs., *Health Status of Asian American and Pacific Islander Women, available at* http://www.omhrc.gov/templates/content.aspx?ID=3721 (last modified Apr. 20, 2007).
13 2007 U.S. Report, *supra* note 1, at ¶ 258.
14 Ctrs. for Disease Control, 51 MMwR wily. No. 27, 589-592 (July 12, 2002).
15 *Id.*
16 NAT'l ctr. FoR HEAlTH STATISTIcS, *supra* note 6.
17 woRlD HEAlth oRG., MAte1nal Mo1tality IN 2000: ESTIMAteS DEvElopED By wHo, uNIcEF, uFpA (2004), *available at* http://www.who.int/reproductive-health/global_monitoring/RHRxmls/RHRmainpage.htmpublications/maternal_mortality_2000/index.html (last viewed Oct. 31, 2007).
18 Nat'l Ctr. for Health Statistics, Ctrs. for Disease Control, *Maternal Mortality and Related Concepts*, vITAl Hnalth STat., Feb. 2007, at 8.
19 AGENcy FoR HEAlthcARE RESEARcH & QuAlITy, NATIoNAl HealthcA1n DISpARITIES Repoit, 2006, at 160 (2006), available at http://www.ahrq.gov/qual/nhdr06/nhdr06.htm. (stating that "the proportion women who initiated prenatal care in the first trimester was significantly lower" among all major ethnic groups compared with white women) [hereinafter 2006 NatIoNal HealthcaRn DISpARITIES RepoRT]; NIH, woMEN oF coloR HEAlth DATA BooK, supra note 10, at 99.
20 Ctrs. for Disease Control, Fact Sheet, HIV/AIDS among African Americans 2 (rev'd June 2007), *available at* http://www. cdc.gov/hiv/topics/aa/resources/factsheets/pdf/aa.pdf (last viewed Oct. 31, 2007).
21 Ctrs. for Disease Control, Fact Sheet, HIV/AIDS among Women 3 (rev'd June 2007), *available at* http://www.cdc. gov/hiv/topics/women/resources/factsheets/pdf/women.pdf [hereinafter HIV/AIDS among Women].
22 U.S. Dep't of Health & Human Servs., AIDS and Women (Dec. 2004), *available at* http://www.hab.hrsa.gov (last viewed Oct. 11, 2007).
23 HIV/AIDS among Women, *supra* note 21, at 2; *see also* Kaiser Family Found., HIV/AIDS Policy Fact Sheet: Latinos and HIV/AIDS (Dec. 2006), *available at* http://www.kff.org/hivaids/upload/6007-03.pdf.
24 HIV/AIDS among Women, *supra* note 21, at 2; *see also* U.S. Dep't of Health & Human Servs., African-Americans and HIV/AIDS in the United States (June 2006), *available at* http://www.hab.hrsa.gov.
25 HIV/AIDS among Women, *supra* note 21, at 3.
26 Ctrs. for Disease Control, STD Surveillance 2005—Special Focus Profiles: Racial and Ethnic Minorities, http://www. cdc.gov/std/stats/minorities.htm.
27 *Id.*

28 *Id.*

C. Causes of racial health disparities in the U.S.

1. Health care system access and unequal treatment

Access to quality care is critical to the health of racial and ethnic minorities in the United States. And in its 2001 Concluding Observations, the Committee expressed concern about "persistent disparities in the enjoyment of . . . access to public and private health care" in the U.S.[1] But in its 2007 report, the U.S. contends that the country's health care system provides "strong overall care" and "[s]ubstantial progress in addressing disparities in . . . access to health care has been made over the years."[2] These assertions belie the extensive racial and ethnic disparities in health care that persist to date.

Health care disparities are not new—they are a relic of segregation and inadequate health care for communities of color. Like access to other opportunities, health care for minorities suffered from government inattention (and in some cases, government imposed inequality) for over 100 years after the end of the Civil War. Less than 40 years ago, minorities routinely received inequitable care in segregated settings, if care was received at all.[3] Today, communities of color continue to experience significant disparities relative to whites in both access to care and in the quality of care received.

The National Healthcare Disparities Report (NHDR), [4] prepared and released annually by the U.S. Agency for Healthcare Research and Quality, is an authoritative source for the documentation of access and quality gaps. Across a range of measures of health care access, the agency's 2006 report found that access for some groups, such as African Americans and American Indians, was the same or worse than for whites. Latinos experienced the greatest access problems of all ethnic groups; they received equivalent care as whites in only 17% of the measures, while the remaining access measures were overwhelmingly poorer for Latinos (83%) . When examined over time, the study found that access to care was improving on most measures for African Americans, American Indians and Asian Americans, but that access to care worsened for Latinos on 80% of study measures.

With regard to health care quality, minority groups again faired poorly relative to whites: African Americans and Latinos receive poorer quality care than whites on 73% and 77% of measures, respectively, and Asian Americans and American Indians received poorer care on 32% and 41% of measures, respectively. The quality of care for American Indians worsened over time relative to whites on 40% of measures, while the quality gap worsened on 30% and 35% of measures for African Americans and Asian Americans, respectively. These growing access and quality gaps are not trivial. For example, from 1999 to 2004 the proportion of adults age 65 and over who did not receive a pneumonia vaccine decreased for whites (from 48% to 41%) but increased for Asians (from 59% to 65%), and from 2000 to 2003 colorectal cancer screening rates increased for whites while falling off sharply for American Indians and Alaska Natives.[5]

And a substantial body of evidence demonstrates that racial and ethnic minorities receive a lower quality and intensity of health care than white patients, even when they are insured at the same levels and present with the same types of health problems.[6] Below are a few examples from the research literature:

- Insured African-American patients are less likely than insured whites to receive many potentially life-

saving or life-extending procedures, particularly high-tech care, such as cardiac catheterization, bypass graft surgery,[7] or kidney transplantation.[8]

- Black cancer patients fail to get the same combinations of surgical and chemotherapy treatments that white patients with the same disease presentation receive.[9]
- African-American heart patients are less likely than white patients to receive diagnostic procedures, revascularization procedures, and thrombolytic therapy, even when they have similar patient characteristics.[10]
- Even routine care suffers. Black and Latino patients are less likely than whites to receive aspirin upon discharge following a heart attack, to receive appropriate care for pneumonia, and to have pain— such as the kind resulting from broken bones—appropriately treated.[11]
- Minorities are more likely to receive undesirable treatment than whites, such as limb amputation for diabetes.[12]
- Poor women of color disproportionately lack prenatal care. White women are much more likely to access prenatal care in their first trimester than most women of color.[13] Women of color often receive fewer services and insufficient health-promotion education during their prenatal visits.[14]

Causal factors include the policies and practices of health care systems, the legal and regulatory context in which they operate, and the behavior of people who work in them are also involved.[15] These factors are explained in more detail below.

Sources of Insurance Coverage. In its landmark series on the causes and consequences of uninsurance, the Institute of Medicine concluded that the availability and quality of health care in the United States suffers when large segments of the population lack health insurance.[16] Racial and ethnic minority and immigrant communities are disproportionately uninsured (see Figure 1), making them especially vulnerable to health crises.

For example:

- While about 21 percent of white Americans were uninsured at any point in 2002, communities of color were more likely to be uninsured at any point (including 28 percent of African Americans, 44 percent of Hispanic Americans, 24 percent of Asian Americans and Pacific Islanders, and 33 percent of American Indians and Alaska Natives), and are more likely to be dependant upon public sources of health insurance.[17]
- While Hispanic children constitute less than one-fifth of children in the United States, they represent over one-third of uninsured children.[18] And among children in fair or poor health who lack insurance (nearly 570,000 children in 2002), over two-thirds are Hispanic.[19]
- More than 11 million immigrants were uninsured in 2003, contributing to one- quarter of the U.S. uninsured.[20] Between 1998 and 2003 immigrants accounted for 86 percent of the growth in the uninsured population.[21]
- Foreign-born people are 2.5 times more likely than the native-born to lack health insurance, a gap that remains unchanged since 1993.[22]
- Women of color are more likely to be uninsured than white women. 37 percent of Latinas, 20 percent African-American women, and 36 percent of Asian Pacific Islander women are uninsured compared to 16 percent of white women.[23]

The crisis of health insurance disproportionately hurts low-income families and communities of color in no small part because health insurance in the United States remains linked to employment. Higher- paying jobs tend to offer more comprehensive health benefit packages, while lower-paying jobs—jobs disproportionately occupied by people of color—tend to offer only limited health benefits, if offered at all, that are often accompanied by high cost-sharing arrangements with employees. Moreover, as noted above, racial and ethnic

minorities are disproportionately dependent on public insurance sources, such as Medicaid (see Figure 2). While Medicaid has been vital for expanding access to health insurance, its limited benefit package and low reimbursement rates have a negative impact on health care access and quality among its beneficiaries. Moreover, there are significant racial and ethnic disparities in per-patient expenditures in the Medicaid program. While the data displayed in Figure 3 are from 1998 (the federal Centers for Medicare and Medicaid Services has not released updated data), they show striking disparities in per-patient expenditures that are contrary to what would be expected given the generally higher rates of illness experienced by some racial and ethnic minority groups.[24]

Quality of Care. These economic pressures can sustain a form of "medical apartheid"—that is, separate and unequal care for low-income and minority patients.[25] For example, physicians who serve predominantly racial and ethnic minority patients are slightly less likely to possess board certification, and have greater difficulties accessing high-quality specialists, diagnostic imaging, and non-emergency admission of their patients to the hospital than physicians who serve predominantly non-minority patients.[26] A recent study of over 300,000 patients treated at 123 hospitals across the country found that minorities were disproportionately likely to receive care in lower- quality hospitals, a problem that explained the largest share of disparities.[27] American Indians and Alaskan Natives experience greatly compromised care in Indian Health Service facilities, receiving much lower rates of preventative screenings such as pap tests and mammography compared to the non-Native population.[28]

Inequitable Distribution of Health Care Resources. The geographic mal-distribution of services exacerbates this problem. Racial and ethnic minorities are more likely to live in segregated, high-poverty communities, communities that have historically suffered from a lack of health care investment. The result too often is that institutions that serve communities of color often have fewer resources for patient care than institutions serving non-minority communities. For example, a study of the availability of pain medication revealed that only one in four pharmacies located in predominantly non-white neighborhoods carried adequate supplies, compared to 72% of pharmacies in predominantly white neighborhoods.[29] Nearly one in five Latinas (18%) and one in ten African- American women reported not seeking needed health care in the last year due to transportation problems, compared to 5% of white women.[30] And historically, hospital closures have disproportionately affected communities of color and low-income communities, exacerbating problems that people in these communities face accessing health care because of low rates of health insurance and other economic problems.[31] These problems are the by-product of residential segregation and economic pressures that reward the concentration of services in outer suburbs and wealthier communities, and create disincentives for practice in urban centers.[32]

Regular Source of Health Care. Having a regular source of health care—a local physician, clinic, or health center that patients can consider their "medical home"—is important, particularly for individuals who face or are at risk for chronic illness. When patients are able to see a health care provider consistently, they are better able to build trusting relationships, ask questions, and give and receive information. Patients who lack a regular source of health care often report miscommunication, misdiagnoses, and greater frustration about their ability to receive needed care.[33] The uninsured and underinsured, many racial and ethnic minorities, people who are not proficient in English, those who live in rural communities, and those who are low income are more likely to report not having a regular source of health care.[34] Yet the regular-source-of-health-care gap among racial/ethnic and income groups is growing:

- African Americans, Hispanics, and the poor and near poor (of all racial and ethnic groups) are more likely than white non-poor groups to face barriers to having a regular source of health care. These gaps have

increased since 2000. Over 42 percent of Hispanic poor and 37 percent of Hispanic non-poor people lacked a regular source of health care in 2001 and 2002, an increase of more than 30 percent and 18 percent, respectively, since 1995 and 1 996.[35]

- During this same period, the percentage of poor and near-poor African Americans and whites without a regular source of health care went largely unchanged. But these groups were up to 75 percent more likely than non-poor African Americans and whites to lack a regular source of health care in 2001 and 2002.[36]
- The percentage of Hispanics from all income groups who lacked a regular source of health care increased between 1993 and 2002, despite a 15 percent decline over the same period in the ranks of white poor individuals who lacked a regular source of health care.[37]
- African American and Hispanic patients are nearly twice as likely as whites to report having a "non-mainstream" usual source of care (e.g., a hospital-based provider), rather than a private physician.[38]

Language Barriers. More than 46 million people in the United States speak a language other than English. Of those, more than 35 million speak English "well" or "very well," but over 10 million speak the language "not well" or "not at all."[39] Individuals with limited English proficiency are less likely than those with strong English language skills to have a regular source of primary care or to receive preventive care. Moreover, they tend to be less satisfied with the care they receive, are more likely to report overall problems with care, and may be at increased risk of experiencing medical errors.[40] The quality of their health care therefore depends on the ability of medical professionals to effectively communicate. But many health care organizations do not provide adequate interpretation services:

- Nearly half of Latinos who are primary speakers of Spanish report having difficulty communicating with doctors or other health care providers because of language barriers.[41]
- Over one in five non-English speaking patients avoid seeking medical help altogether because of language barriers.[42]
- People needing translation services receive fewer preventative services, such as treatment for asthma[43] or screenings for cervical and breast cancer,[44] and they are more likely to fail to understand directions for prescriptions and follow- up care.[45]

The Clinical Encounter. Aspects of the clinical encounter—the interaction between patients, their providers, and the health systems in which care is delivered—can play a powerful role in contributing to health care inequality. Patients and providers bring a range of expectations, preferences, and biases to the clinical encounter that can be expressed both directly and indirectly. For example, at least part of the disparity results from biases and stereotypes that health care providers may carry about racial and ethnic minorities. Experimental studies confirm that physicians can hold a host of negative beliefs about minority patients. They are presumed to be more likely to abuse drugs or alcohol and to be less educated. They are not expected to comply with physicians' instructions, to want an active lifestyle or to participate in rehabilitation if prescribed. Doctors are likely to consider white patients more "pleasant" and "rational" than black patients, and to prefer white patients as "the kind of person I could see myself being friends with." These kinds of stereotypes and biases are often unconscious, the IOM reported, but nonetheless can influence physicians' decisions regarding when and what treatments to offer.[46] More recent research confirms that implicit biases (that is unconscious biases that may reflect racial socialization) influence medical professionals' decision-making. For example, Green and colleagues assessed the relationship between implicit biases (as measured by a widely-accepted computer-based test of the speed with which individuals make associations between people and concepts) and physicians' decisions regarding the use of thrombolysis (i.e., clot-busting medications) among hypothetical patients in the midst of a heart attack. While physicians reported no explicit preference for white versus black patients or differences in perceived cooperativeness, scores on implicit association tests revealed a preference favoring

white Americans and implicit stereotypes of black Americans as less cooperative with medical procedures, and less cooperative generally. More importantly, physicians' pro-white implicit biases significantly predicted their likelihood of treating white patients and not treating black patients with thrombolysis.[47]

2. Social and community-level determinants of health

Disparities in access to quality health care are not the only factors that contribute to the racial and ethnic gaps in health status. The neighborhood and community contexts in which people live powerfully shape access to health care resources and health behaviors, as well as health risks. Many people of color live in neighborhoods that are largely segregated from white Americans, and the communities in which they reside differ significantly on a number of important social, economic, and environmental conditions in ways that can negatively influence health. People of color are also exposed to additional health risks in the form of racism and discrimination, which present stressors that are exacerbated by residential segregation. These dynamics are explored below. Neighborhood factors influence health in several ways. They exert direct effects on both physical and mental health throughneighborhood conditions such as levels of crime and violence, overcrowding, and environmental exposures. Neighborhood conditions also indirectly influence health, in that the conditions of neighborhoods can either support or discourage healthy behaviors, such as exercise, proper nutrition, and the development of strong social supports. The quality and availability of health care resources, as noted above, also varies by neighborhood racial, ethnic, and socioeconomic status, with low-income communities and communities of color often facing a relative paucity of such resources. Finally, neighborhood conditions structure and influence individual opportunity in ways that affect health. It is well known that population health status improves with each ascending step of the socioeconomic gradient. To the extent that neighborhoods suffer from poor schools, poor access to jobs and employment, inadequate public services such as transportation, and a lack of economic investment—all problems that disproportionately burden communities of color—the opportunity for individuals to advance economically, and therefore improve health status, is constrained.[48]

Neighborhood residential segregation is a key mechanism that perpetuates community and social determinants of racial and ethnic health disparities. While the nation has made great progress in reducing racial and ethnic residential segregation, the problem persists, particularly for African Americans and Hispanics. One of the most established measures of racial and ethnic residential segregation is the dissimilarity index, which can be understood as the percentage of a group's population that would have to change residence in order for the group to be evenly distributed across neighborhoods in a metropolitan area. A score of 0 is equivalent to integration representative of the total population, and a score of 100 indicates complete segregation. African Americans remain the most segregated racial/ethnic group in America, with a dissimilarity score of 64 as of 2000 (meaning 64% of black people would have to move if they were to be integrated into the population), though blacks are less isolated than in 1980, when they scored a 73. Hispanics scored 50 in 1980 and 51 in 2000, while Asians measured as the most integrated at 40 in 1980 and 41 in 2000.[49] Importantly, individuals do not have equal opportunities to select the communities they reside in. The prac tice of segregation is reliant on institutional discrimination in the real estate and housing finance market, government policy and individual interpersonal discrimination.[50] Whites have the strongest preference of any race to live in a neighborhood without racial outsiders, and among all races and ethnicities, blacks are the most likely to be subject to discrimination.[51] Residential segregation harms the health of people of color in multiple ways. Segregation channels non-whites into areas with limited financial and human resources, and such neighborhoods are home to poor public education, inadequate health care, toxic living conditions, and higher rates of disorder, crime, and incarceration. As a result, people of color often live in neighborhoods isolated from both the institutional and cultural resources needed to promote health. And while individual behaviors certainly impact health outcomes, neigh-

borhoods not only constrain behavioral choices, they affect residents' health in ways that have nothing to do with individual behaviors. For example, majority-minority communities are less likely then predominantly white communities to have major grocery stores with fresh, low-cost fruits and vegetables, making it more difficult for residents of these communities to have healthy diets, even if they desire to do so. This, as well as other examples of the impact of residential segregation on health, is described below:

Pollution and Toxic Waste—Over half (56%) of the residents in neighborhoods with commercial hazardous waste facilities are people of color. Thus, percentages of people of color as a whole are 1.9 times greater in waste facility host neighborhoods than in non-host areas. Poverty rates in waste facility neighborhoods are 1.5 times greater than in neighborhoods without facilities.[52]

Poor Nutrition—Low-income neighborhoods of color, often lack health-enhancing resources such as supermarkets and other sources of low-cost, nutritious food. One study showed that white Americans are five times more likely to live in census tracts with supermarkets than black Americans, and whites have three times greater access to private transportation to black Americans in similar communities.[53] So not only do whites live closer to places with the right foods, they have more resources to make nutritious choices than people of color. The availability of nutritious foods in local markets is closely tied to dietary habits and health outcomes; the more people know about nutrition, the more access they have to healthy food, and the more nutritious foods they consume.[54]

Poor Quality Housing and Public Spaces— Crowding, substandard housing, elevated noise level, decreased ability to regulate temperature and humidity, and elevated exposure to noxious pollutants and allergens, such as lead, smog, and dust mites, are all common in poor, segregated communities. Lack of recreational facilities, such as parks, gymnasiums, and swimming pools in segregated neighborhoods, can discourage and impede physical exercise.[55]

Poor Public Education—Between 1995 and 2004, public school districts spent $504 billion in capital expenditures, but the money was not spent equitably. The poorest districts spent an average of $4,800 per student, while the richest districts spent $9,361 per student. The purpose of spending also differed by class level, as poor schools were more likely to receive funds for basic structural repairs to counteract physical decay, and wealthy schools were more likely to receive funds for educational enhancements, such as science labs. Racial spending disparities present themselves as well, as predominantly minority districts invested the least amount per student ($5,172), and predominantly white districts invested the most ($7,102). The physical conditions of schools, such as air quality and temperature, influence property values, turnover in teacher employment, and student learning, so poor schools serving people of color present mutually reinforcing disadvantages for students, teachers, and neighborhood residents alike.[56]

Disorder, Crime and Violence—As a result of concentrated poverty and collective inability to exert social control, segregated communities face higher rates of crime and violence, which both directly affect health by increasing risk for injury and death, and indirectly affect health by limiting economic investment and increasing social isolation.[57]

The Criminal Justice System and Incarceration—African Americans, Latinos, and American Indians are disproportionately penalized and imprisoned by the criminal justice system, and impoverished urban communities with high rates of arrest and imprisonment do not develop the social bonds and networks needed to maintain order. At the national level, blacks are currently incarcerated at a rate 5.6 times that of whites, while

the Hispanic rate of incarceration is 1.8 times that of whites.[58] One out of every fourteen black children has at least one parent in prison, a rate that far outpaces white children.[59] Families torn apart by incarceration have less human and financial resources for childrearing, and children in disadvantaged neighborhoods have fewer stewards for healthy socialization.

3. The health effects of race based discrimination, bias, and racial prejudice

In addition to structural inequality perpetuated by residential segregation, people of color face interpersonal barriers to achievement, productivity, and social integration. This notion of interpersonal racism goes beyond the structural, institutional factors that align to channel people of color towards undesirable neighborhoods and socioeconomic outcomes. Interpersonal racism refers to daily interactions during which people of color are denied access or degraded based on their race or ethnicity.

There is increasing evidence that race- based discrimination is not only emotionally hurtful, but physiologically damaging to minority Americans. A growing body of research, using innovative methods, is beginning to uncover the toll. For example, perceived race-based discrimination is positively associated with smoking among African Americans, and smokers find the experience of discrimination more stressful. Additionally, repeated subjection to race-based discrimination is associated with higher blood pressure levels and more frequent diagnoses of hypertension.[60] In one study, black women who reported that they had been victims of racial discrimination were 31% more likely to develop breast cancer than those who did not.[61] Experiences of racial discrimination also are associated with poor health among Asian Americans. Over 2,000 participants in a recent national survey were asked about their experiences with discrimination and their health histories. Researchers found that everyday discrimination was associated with a variety of health conditions, such as chronic cardiovascular, respiratory, and pain-related health issues. Filipinos reported the highest level of discrimination, followed by Chinese-Americans and Vietnamese-Americans.[62]

New models offer mechanisms to explain how racialized behavior and institutions affect health. These models "locate health disparities in the external influences of social space and the internal effects of body and brain functioning."[63] They suggest that harmful effects of discrimination are the result of chronic experiences of race-based discrimination, both actual and perceived. These process set into motion physiological responses (e.g. elevated blood pressure and heart rate, production of biochemical reactions, hypervigilance) that deteriorate health (see text box for a glossary of race and health terms). Importantly, these stress- ors can be both chronic and acute. Chronic stress associated with financial and caretaking pressures, fear of violent victimization, grief, and frustration and anger brought on as a reaction to consistent discrimination, has deleterious health effects that continue even when residents from segregated neighborhoods are relocated to a safer residential areas.[64] Chronic stress can lead to increased risk for coronary health disease, chronic inflamation, cognitive impairment, substance abuse and the erosion of mental health, and has demonstrable health effects on other mental and physical processes.[65] For example, the study of Klag et al. shows that a darker skin color correlates with a higher rate of hypertension which was due to biological effects of stress-related outcomes to accessing valued social goods such as housing.[66] The racial health disparity was not biological or genetic in origin.
Race-related stress operates to wear down health in several ways. From a developmental perspective, the influence of negative environments associated with structural racism and residential segrega tion has a profound and negative effect on health and development of young children. Childhood exposure to conditions of violence, coupled poor education, and negative social connectedness - particularly early childhood exposure to these conditions—is associated with changes in brain functioning and physiological responses. Unhealthy social spaces associated with segregation serves as the "structural lattice" for maintaining discrimination. In addition,

intergenerational and life-span effects of race discrimination suggest that the health effects of racism carry forward over timein individuals and across generations. For example, low birth weight, which is more prevalent among African Americans and American Indians than other groups, is shaped by the mothers' socioeconomic conditions, and affects the long-term health of the developing infant, despite generally improving opportunities and better environments for minorities.[67]

Internalized racism also negatively affects the health of people of color. Internalized racism refers to the acceptance, by marginalized racial populations, of the negative societal beliefs and stereotypes about themselves—"the normative cultural characterization of the superiority of Whiteness and devaluing of Blackness, combined with the economic disadvantages of Blacks, can lead to the perception of self as worthless and powerless."[68] For example, internalized racism exhibited byblacks who exhibit racial prejudice towards other blacks, is positively associated with alcohol use and psychological stress. Studies have found a positive association between a scale capturing internalized racism and alcohol consumption. Internalized racism was also positively related to psychological distress even after adjustment for stress, social support, religious orientation, SES, marital status, and physical health.

ENDNOTES

1 CERD, *Concluding Observations: United States of America*, 59th Sess., ¶ 398, U.N. Doc. A/56/18 (2001).
2 CERD, *Sixth Periodic Reports of States Parties Due in 2005: Addendum: United States of America,* U.N. CERD, 72nd Sess., ¶¶ 258, 332 (Advance Edited Version), U.N. Doc. CERD/C/USA/6 (2007), *available at* http://www.ohchr.org/english/ bodies/cerd/docs/AdvanceVersion/cerd_c_usa6.doc [hereinafter 2007 U.S. Report].
3 DaVId B. SMIth, Hearth CAre DIVIdED: R&CE anm HEALING A NKrION (1999).
4 AGENCY FOR HearthCA1n RESEARCH & QUalItY, NATIONAL HearthCaRn DISParIrIES RePOit, 2006 at 160 (2006), *available at* http://www.ahrq.gov/qual/nhdr06/nhdr06.htm. [hereinafter 2006 NATIONAL HealiiiCA1n DISPARITIES RePORT]
5 *Id.*
6 INST. OF MEDICINE, UneQUal TREATMENT: CONFRONTING RACIAL and E1hnIC DISPARITIES In Hearth CAre (2003) [IieReInavrER IOM, UNnqUal TrEATMENT]
7 Kaiser Family Found. & Am. Coll. of Cardiology, Racial/Ethnic Differences in Cardiac Care: The Weight of the Evidence, Oct. 2002.
8 A.C. Klassen et al., *Relationship Between Patients' Perceptions of Disadvantage and Discrimination and Listing for Kidney Transplantation*, 92 AM. J. PUBLIC Hnarrn (2002).
9 IOM, UneQUal Trearment, *supra* note 6.
10 Kaiser Family Found. & Am. Coll. of Cardiology, *supra* note 7.
11 IOM, UneQUal TrEATMENT, *supra* note 6.
12 *Id.*
13 NAT'L INSTS. OF Healiii (NIH), WOmeN OF COLOR HeaLth DKrA BOOK: ADOLESCENTS TO SENIORS 99 (3d ed. 2006); *see also* 2006 NKrIONal HearthCA1n DISPARITIES REPORT, *supra* note 4, at 160 ("the proportion women who initiated prenatal care in the first trimester was significantly lower" among all major ethnic groups compared with white women).
14 Ctrs. for Disease Control, Pregnancy-Related Mortality Surveillance—United States, 1991-1999, 52(SS02), at 1-8 (Feb. 2003).
15 IOM, UneQUal TrEATmeNT, *supra* note 6.
16 INST. OF MEDICIne, HIDDEN COSTS, VALUE LOST: UNINSURANCE In AMERICA (2003).

17 2006 NKrIONal HearthCA1n DISPARITIES RePORT, *supra* note 4.
18 Robert Wood Johnson Found., Going Without: America's Uninsured Children (Aug. 2005), www.rwjf.org.
19 Urban Inst., Fast Facts on Welfare Policy (July 2005), www.urban.org.
20 The uninsurance rate among immigrants increased dramatically in the late-1990s, following passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which imposed a five-year limit on most new immigrants' ability to participate in public health insurance programs. Prior to and shortly following passage of the Act (between 1994 and 1998), immigrants accounted for about one-third of the increase in the number of uninsured individuals.
21 Employee Benefit Research Inst., The Impact of Immigration on Health Insurance Coverage in the United States, (Employee Benefit Research Institute Notes, 26, No. 6, 2005).
22 U.S. CENSUS BUneaU, INCOme, POVERTY, anm HEALTH INSURANCE COVE1aGE IN thE UnI1eD STAteS: 2004 (2005).
23 KAISER FAMILY FOUnd., RACIaL and ErhnIC DISParItIES IN WOMEN'S HEALTH COVE1aGE and ACCESS TO CAirn (2004), *available at* http://www.kff.org/womenshealth/7018.cfm; NKr'L ASIan PAC. AM. WOMEN'S FORUM, RECLaIMING CHOICE, BROADENING THE MOVEmeNT: SEXUAL AND REPRODUCTIVE JUSTICE and ASIan PACIFIC AMERICAN WOMEN—A NKrIONal AGENDA FOR ACTION 10 (2005), *available at* http://www.napawf.org/file/issues/RJPolicy_Agenda.pdf [hereinafter NAPAWF Report].
24 NAT'L Ctr. FOR HEALTH STATISTICS, DEP'T OF HEALTH & HUMAN SERVS., Health, UnI1eD STATES, 2003 (2003), *available at* http://www.cdc.gov/nchs/data/hus/hus03.pdf.
25 BRONX HEALTH REACH, SEPARAte and UNEQUAL: MEDICAL APARTHEID IN NEw YORK CItY (2005), *available at* http:// www.institute2000.org/policy/medical_apartheid.pdf.
26 P.B. Bach et al., *Primary care physicians who treat blacks and whites*, 351 NEw ENG. J. MED. 575, 575-84 (2004).
27 R. Hasnain-Wynia et al., *Disparities in health care are driven by where minority patients seek care*, 167 ARCHIVES OF INrE1nAL MED. 1233, 1233-39 (2007).
28 Yvette Roubideaux, *A Review of the Quality of Health Care for American Indians and Alaskan Natives*, (Commonwealth Fund, Commonwealth Fund Publication, Sept. 2004), *available at* http://www.cmwf.org/publicatios/publications_show. htm?doc_id=239464.
29 R.S. Morrison et al., *"We Don't Carry That"— Failure of Pharmacies in Predominantly Nonwhite Neighborhoods to Stock Opioid Analgesics*, 342 NEw ENG. J. MeD. 1023, 1023-26 (2000).
30 KAISER FAMIiY FOUnm., R&CIai anm E1hnIC DISParIiIeS IN WOMEN'S Heaith COVE1aGE Mnm ACCiSS TO CARE, *supra* note 23.
31 A. SAGER & D. SOCOiar, BOSTON UNIV. SCH. Or PUB. Heaith, CiOSING HOSPITAiS IN NEW YO1uK STAte WON'T SAVE MOneY BUT WIii HarM ACCESS TO Hnaith Care (2006), *available at* http://dcc2.bumc.bu.edu/hs/Sager%20Hospital%2 0Closings%20Short%20Report%2020Nov06.pdf.
32 David B. Smith, Eliminating Disparities in Treatment and the Struggle to End Segregation (Commonwealth Fund, Commonwealth Fund Publication No. 775, 2005), *available at* http://www.cmwf.org/usr_doc/775_Smith_ending_disparities_in_treatment.pdf [hereinafter Smith, Eliminating Disparities].
33 KaISER FArIiY FOUnm., KiY FACTS: RACE, EthNICItY, & Heaith CA1ue (2003).
34 *Id.*
35 *Id.*
36 *Id.*
37 *Id.*
38 Marsha Lillie-Blanton et al., *Site of medical care: Do racial and ethnic differences persist?*, 1 Yaie J. Hnairn

POi'Y, L., & ETHICS 1, 1-17 (2001).
39 U.S. Census Bureau, Table, Ability to Speak English by Language Spoken at Home (2007), *available at* http://www. census.gov/population/cen2000/phc-t37/tab01a.pdf.
40 IOM, UNEQUAi TrEATMENT, *supra* note 6.
41 Pew Hispanic Ctr. & Kaiser Family Found., Survey Brief About the 2002 National Survey of Latinos (2004), www.kff.org.
42 *Id.*
43 LEIGHTON KU, KAISER FAMIiY FOUnd., HOW RACE/EthNICITY, IMMIGRATION STATUS and LANGUAGE AFFECT Heaith INSURANCE COVERAGE, ACCESS TO CAre and QUAiITY OF CA1ue AMONG thE LOW-INCOME POPUiATION 5 (2003), *available at* http://www.kff.org/uninsured/kcmu4132report.cfm.
44 Kaiser Family Found., Studies Indicate Minorities Use Fewer Preventive Care Services Than Whites, DAIiY RiP., Aug. 15, 2007.
45 NAPAWF Report, *supra* note 23, at 11-12.
46 IOM, UneQUAi TrEATMENT, *supra* note 6.
47 A.R. Green et al., *Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients*, 22 J. Gen. Internal Med. 1231, 1231-38 (2007).
48 JOInT Ctr. Heaith POiICY INST. & POiICYLINK, BUIiDING STRONGER COMMUNITIES FOR BETteR HEAiTH (2004), *available at* http://www.policylink.org/pdfs/JointCenter-Communities.pdf.
49 JOHN ICEiAND ET Ai., U.S. CENSUS BUREAU, RACIai anm EthNIC RESIDENTIai SEGREGAtION In thE UNITED STATES: 1980- 2000 (2002).
50 DOUGiAS S. MASSEY & NanCY DENTON. AMERICAN APArtilEId (1993).
51 JOHN ICEiAND, U.S. CENSUS BUneaU, BeYOnd BiaCK AND WHIte: METROPOiITAN RESIDENTIai SEGREGATION In MUiTIEthNIC AmerICa (2002).
52 ROBERT D. BUiiard ET Ai., TOXIC WASteS AND RaCE AT TWENTY: 1987-2007 (2007) (report prepared for the United Church of Christ Justice and Witness Ministries).
53 Kimberly Morland et al., *The Contextual Effect of the Local Food Environment on Residents' Diets: The Atherosclerosis Risk in Communities Study*, 92(11) Ari. J. PUB. Heaith (2002).
54 *Id.*
55 David R. Williams & Chiquita Collins, *Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health„* 116 PUB. Hnaith RiP. 405, 405-16 (2001).
56 MA1Y W. FIiArdO ET Ai., BUIiDInG EDUC. SUCCESS TOGEthER (BEST), GROWrH anm DISParItY: A DECADE OF U.S. PUBiIC SCHOOi CONSTRUCTION (2006).
57 Jeffrey Morenoff et al., *Neighborhood Inequality, Collective Efficacy, and the Spatial Dynamics of Urban Violence*, 39 CrIMINOiOGY 517, 517-60 (2001).
58 MarC MAUER & RYan S. KING, SENTENCING PROJECT, UneVEN JUSTICE: STAte RateS OF INCARCERATION BY RaCE AND ETHNICITY (2007), *available at* http://sentencingproject.org/Admin/Documents/publications/rd_stateratesofincbyraceandethnicity.pdf.
59 Marc Mauer, Thinking About Prison and its Impact on the 21st Century, Lecture at Ohio State University (Apr. 14, 2004), *available at* http://www.sentencingproject.org/Admin/Documents/publications/inc_osu_reckless.pdf.
60 Vickie M. Mays et al., *Race, Race-Based Discrimination, and Health Outcomes Among African Americans*, 58 ANN. REV. OF PSYCHOiOGY (2007).
61 Teletia R. Taylor et al., *Racial Discrimination and Breast Cancer Incidence in Black Women*, 166(1) AM. J. EpidEMioloCy (2007).
62 G.C. Gee et al., *A nationwide study of discrimination and chronic health conditions among Asian Americans*,

97 AM. J. puB. Health 1275, 1275-82 (2007).
63 Mays et al., *supra* note 60.
64 Douglas S. Massey et al., *The Continuing Consequences of Segregation: Family Stress and College Performance*, 85(5) Soc. Sci. Q. (2004).
65 Mays et al., *supra* note 60.
66 Mj. Klag et al., *The association of skin color with blood pressure in US blacks with low socioeconomic status*, 265 JAMA 559, 559-602 (1991).
67 *Id.*
68 D.R. Williams, *Racism and Health*, *in* ClosiNC the Gap: IMpRoviNG thE Hearth or MiNority ELDERs ic thE NEw MilLENNiuM (K.E. Whitfield ed., 2004).

D. The role of government policies in creating and perpetuating health disparities

1. Historical actions of government: Segregated and unequal health care

Up until the 1950's racial segregation and discrimination in health care in the United States was a matter of government policy.[1] The *Plessy v. Ferguson* decision (1896) endorsed the development of state and local "Jim Crow" laws requiring the separation of the races. These laws were applied to health care as well as to schools and other public accommodations and produced grossly unequal services subsidized with tax dollars. Hospital accommodations were so limited for blacks in 1946 that only 45% of all black babies were born in a hospital in contrast to 87% of all white babies.[2] In the North where state and local Jim Crow laws did not require segregation, tolerance of discrimination in housing and in the admissions and referral practices of physicians and hospitals assured almost an equivalent degree of segregation and unequal care. In Chicago for example, 71% of all black deaths took place at Cook County Hospital, while the sixty voluntary hospitals that provided the care for the vast majority of Chicago's white population accounted for less than 8% of the city's black hospital deaths.[3] The 1946 Hill-Burton legislation provided federal funding for construction of racially exclusionary hospitals. It represented the only piece of federal legislation in the 20th century to explicitly condone such practices. As such, Hill-Burton served as a precedent that tied the hands of the executive branch in imposing nondiscriminatory restrictions on the use of federal funds that was not overturned by the federal courts until 1964.

Increasing federal support of medical training and research after World War II helped reinforce the long established pattern of relying on low-income minority communities for "clinical material." The often cited example of the resulting abuses, the Tuskegee syphilis study, assigned black patients without their knowledge to a non treatment group so that the natural course of the disease could be observed. It was not a rogue criminal enterprise. The Tuskegee study reflected commonly accepted and unquestioned practices supported by the federal government that continued unchallenged until the 1970's.[4] The legacy of these practices continues to undermine the trust of minority communities in the medical services they receive.

The autonomy assured individual physicians and the pervasive reliance on voluntary organizations in the provision of medical services helped further insulate publicly funded discriminatory practices in health care against any social accountability. While federal and local public facilities were required to begin to integrate in the 1950's, the bulk of hospital care and federal support went to voluntary organizations outside the reach of federal laws and regulations. It was not until 1964 that the federal courts ruled that these voluntary hospitals, by virtue of their participating in state Hill-Burton planning and funding, were an "arm of the state" and thus

subject to the equal protection provisions of the Fourteenth Amendment.[5]

The 2007 United States Periodic Report to CERD omits the government's long history of repro ductive coercion of women of color. The most egregious example of this coercion occurred in the early and middle part of the 20th century, where thousands of African American, Puerto Rican, and Native American women were sterilized without their full knowledge or informed consent.[6] In the 1 970s the federal government used threats and misinformation to coerce thousands of Native American women into being sterilized shortly after childbirth.[7] Also during this time period, federal officials tricked illiterate African American women on welfare to consent to the sterilization of their daughters, and doctors consented to perform abortions or deliver babies only if the Medicaid patient "consented" to sterilization.[8]

This coercive legacy continues today through laws and policies that seek to influence or control women of color's reproductive choices. For example, the government has aggressively promoted the use of long-acting and irreversible forms of contraception among women of color.[9] Although federal laws have been amended to require informed consent prior to sterilization, the federal government still funds sterilization under Medicaid[10] while severely restricting public funding for abortion.[11] These paternalistic policies influence low-income women of color who may desire children to get sterilized, while simultaneously deterring poor women who seek abortions from having safe, timely, and affordable procedures.

2. Ongoing government policy

a. Retreat on monitoring and enforcement of racial disparities

The United Nations approval of the International Convention on the Elimination of All Forms of Racial Discrimination (CERD) in 1965 coincided with the high water mark of efforts by the United States government to eliminate discrimination in health services. However, the protections that began to be put in place with the passage of the 1964 Civil Rights Act andwith the implementation of the Medicare program in 1966 were eroded by a cumulative series of government decisions reflecting a basic policy shift.

An initial executive branch decision exempted physicians receiving federal funds from the Medicare program from compliance with the nondiscriminatory provisions of Title VI of the 1964 Civil Rights Act. Thus, physicians have never been compelled to comply or even submit signed assurances of nondiscrimination as facilities have. The nondiscriminatory compliance of health facilities without compliance by those who make all the critical decisions about how patients will be cared for, treated or even admitted has undermined the goal of equal treatment.

In spite of the 1964 non-discrimination requirement, the federal executive branch has chosen not to collect any information to monitor compliance. More than forty years since the nondiscriminatory requirements were imposed by law on any party receiving public funding to provide health care, information has yet to be collected that could determine whether these providers have complied with this requirement. Public support for health care now exceeds one trillion dollars a year. While this amount exceeds the gross national product of most of the UN member countries, there is no non-discriminatory accountability.

The U.S. has failed to budget adequate resources to the Office for Civil Rights, the federal agency responsible for enforcing compliance with Title VI. No resources have ever been allocated to a testing program, generally the only way to effectively enforce compliance. Little staffing is available, even to investigate complaints.

OCR's limited budget has forced the shift in its role from what was initially envisioned as one of advocacy, investigation and enforcement to that of a passive arbitrator of disputes and a hollow bureaucratic shell. Federal legislation and decisions of the executive branch to pursue market-related approaches in health care threaten to erode most of the previous gains in reducing racial disparities in access to care (see detailed discussion in subsection (c) below). Government policies have created increased financial incentives for providers to expand services to the affluent and predominantly white geographic areas and reduce services to low-income and predominantly minority areas. Earlier federal government efforts to plan and pay for services based on need have been abandoned. The Medicare program that originally provided a single standard of universal coverage for the elderly has been fragmented into a complex assortment of plans that create financial incentives for low-and-moderate income consumers to select different plans than the more affluent. The effect is an increasing re-segregation of care and greater racial disparities in services. For example, Medicare beneficiaries must now choose between health plans that offer: 1) limited choice and access to providers but fewer out of pocket costs or, 2) more open access and choice of providers but more out of pocket costs. The inevitable effect of this is to redistribute beneficiaries across these different Medicare plans on the basis of income, undermining the original purpose of this Civil Rights era legislation to assure an equal standard of care to all.

b. Failure of U.S. law to protect racial and ethnic minorities from disproportionate environmental burdens

A ground-breaking study published in the *National Law Journal* in 1992 exposed significant racial disparities in environmental enforcement. Among other things, the study revealed a "racial divide in the waythe U.S. government cleans up toxic waste sites and punishes polluters. White communities see faster action, better results and stiffer penalties than communities where blacks, Hispanics and other minorities live."[12] The study also found that communities of color overall, regardless of income, received less protection than white communities. Penalties collected under the hazardous waste laws like the sup erfund law were about 500 percent higher in white communities than in communities of color. Overall, penalties collected in white communities were nearly 50 percent higher than in communities of color, providing a weaker deterrent to would-be violators of the law. In other words, a polluter would be more likely to take the risk of polluting in a community of color than in a white community because the penalties would probably be significantly lower. According to the *National Law Journal* study, it takes 20 percent longer to get contaminated sites that are in neighborhoods of color added to the official list of sites to be cleaned up with superfund money. [13]

2007 marks the 20th anniversary of the 1987 landmark report, *Toxic Wastes and Race in the United States*, which found that race was the most significant predictor in forecasting where the nation's commercial hazard ous waste facilities are sited. Twenty years later, researchers have concluded that "race continues to be an independent predictor of where hazardous wastes are located, and it is a stronger predictor than income, education and other socioeconomic indicators.[14] Using 2000 U.S. Census Bureau data, the update report, *Toxic Wastes and Race at Twenty,* found disparities to be greater than in the original 1987 study. People of color now comprise 56 percent of the population living within three kilometers (1.8 miles) of the nation's 413 commercial hazardous waste facilities. People of color comprise 69 percent of the population living in neighborhoods with clustered hazardous waste facilities. The comprehensive study found that the slow government response to environmental racism unnecessarily jeopardizes the health and welfare of the most vulnerable populations in the United Sates. "Government officials have knowingly allowed people of color families near Superfund sites, other contaminated waste sites and polluting industrial facilities to be poisoned with. . . a host of . . . deadly chemicals. Having the facts and failing to respond is explicitly discriminatory and tantamount to an immoral "human experiment."[15]

Racial disparities in housing conditions contribute to racial disparities in rates of environmentally related diseases such as lead poisoning and asthma. Lead poisoning is caused by the build-up of lead in the bloodstream. The most common high dose sources of lead exposure for U.S. children are lead-based paint and lead-contaminated house dust and soil.[16] Unlike lead poisoning, there are a number of environmental factors associated with the onset of asthma and asthma attacks. Exposure to airborne allergens from dust mites, cockroaches and pets have been identified as a major environmental risk factor in the development of asthma in children, as an important determinant of asthma severity in children, and possibly as a key variable in accounting for the observed increase in the prevalence and severity of asthma in children observed over the past two decades.[17]

Data from the 2005 American Housing Survey[18] reveals disparities in housing conditions related to lead poisoning and asthma. The following table illustrates the percentage of all housing units occupied by blacks, Hispanics and all others,[19] and compares them to the percentage of unitswhere problems of peeling paint and rats and mice were reported by lack, Hispanic and all others. In both cases the percentages reported by black and Hispanic Households is larger than the number of all housing units occupied by those groups.

Racial disparities in lead poisoning rates and asthma prevalence are well documented. According to the U.S. Centers for Disease Control and Prevention (CDC), overall, non-Hispanic blacks and Mexican Americans had higher percentages of elevated blood lead levels (BLLs) (1.4% and 1.5%, respectively) than non-Hispanic whites (0.5%). Among subpopulations, non-Hispanic blacks aged 1–5 years and aged >60 years had the highest prevalence of elevated BLLs (3.1% and 3.4%, respectively).[20]

A 2005 analysis of asthma related data by the CDC reveals racial disparities in the rates of prevalence, treatment and mortality for asthma. Puerto Ricans had a current asthma prevalence rate 125% higher than non-Hispanic whites and 80% higher than non-Hispanic blacks; and, when only race is considered, American Indians and Alaska Natives and black people had a 25% higher prevalence than whites.[21] In terms of treatment, blacks had an outpatient visit rate about 18% higher than whites; the emergency room visit rate for blacks was 350% higher than that for whites; and the asthma hospitalization rate for blacks was 240% higher than for whites.[22] Asthma death rates are significantly higher for people of color than for whites: Puerto Ricans were the most likely to die from asthma and had asthma death rate 360% higher than non- Hispanic whites; and Non-Hispanic blacks had an asthma death rate 200% higher than non-Hispanic whites.[23]

c. Ongoing government policies that restrict health care access

Recent government policies have further perpetuated disparities in health care access for many racial and ethnic minorities—namely, in health care coverage. Research has shown that individuals with health insurance—regardless of race, income, education or other socioeconomic factors—have greater access to the health care system and are more likely to receive care when needed.[24] Yet, federal policies such as the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, i.e. welfare reform, and the Deficit Reduction Act of 2005 have negatively affected the health insurance status of many in our most vulnerable populations, especially low-income people of color, by altering eligibility requirements, enrollment processes, and cost-sharing limits for the country's health coverage safety-net programs, Medicaid and the State Children's Health Insurance Program (SCHIP).

i. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996

The Personal Responsibility and Work opportunity Reconciliation Act of 1996 (PRWORA) reformed the welfare system in the United States. The intent of the program was to provide incentives for welfare enrollees to enter the labor force. The framers of PRWORA intended to not negatively alter the public health insurance safety-net programs, i.e. Medicaid and SCHIP; however, administrative problems and new eligibility barriers have undermined this intention.

Additional Administrative Burden: Aid to Families with Dependent Children (AFDC) was the name of the welfare program before PRWORA implemented the Temporary Assistance for Needy Families (TANF). Prior to PRWORA, welfare eligibility was linked to eligibility for Medicaid and other means-tested programs such as food stamps. However, PRWORA decoupled eligibility for Medicaid and SCHIP from eligibility for welfare benefits and caused many to lose their health care benefits. Social programs in general have a higher take-up rate when enrollment is automatic.[25] Therefore, having to complete a separate application process for Medicaid and SCHIP may contribute to the loss of health care benefits for many minority children and families.

Eligibility Barriers: Another key element of PRWORA is the implementation of a five-year ban on eligibility for Medicaid, SCHIP, and other public benefits pro grams for recent immigrants.[26] This law restricts legal immigrants arriving after August 22, 1996, from federally-matched Medicaid and SCHIP coverage for the first five years in residence. Prior to this act, permanent legal immigrants had the same access to public benefits as did U.S. citizens.[27] Five years after passage of the law, non-elderly immigrant adults have experienced a 36 percent decline in coverage.[28] Today, about 40 percent of all documented permanent residents in the United States entered after August 22, 1996 and have been subject to this prohibition.[29]

The same law has had a similar effect on immigrant children. Legal and illegal immigrant children are more likely to be uninsured than citizen children. Roughly 1.5 million of the 6 million uninsured children who are otherwise eligible for Medicaid or SCHIP are excluded from the programs due to their immigration status.[30] From 1995 to 2005, the uninsured rate for citizen children declined to 15 percent from 19 percent as Medicaid and SCHIP enrollment increased by 17 percent. In contrast, during this same time period the uninsured rate for documented immigrant children increased to 48 percent from44 percent, while Medicaid and SCHIP coverage declined by 17 percent.[31]

Recognizing the importance of providing health coverage to the immigrant population, 21 states and the District of Columbia now use state-only funds to offer basic health services to documented children and pregnant women who otherwise would be prohibited from enrolling in a public health insurance program due to the five-year limit.[32] States that traditionally have large populations of immigrants, such as California, New York, and Texas, are among them,[33] but the federal policy has left many immigrant women and children in other states without any health insurance whatsoever. Over the past 15 years, immigrants are increasingly locating in "new growth" states, such as Arkansas, North Carolina, and Iowa. Most of these states do not offer state-funded coverage to documented immigrant children and pregnant women during their first five years and are therefore leaving these populations vulnerable to health risks.[34]

The original purpose of SCHIP was to cover uninsured children of families who were ineligible for Medicaid but whose incomes fell below 200% of the federal poverty level. However, as a result of the Medicaid exclusion on undocumented immigrants and the five-year bar on Medicaid enrollment for legal residents, there was

growing concern that low-income women, particularly immigrants, lacked any access to pre-natal coverage. In 2002, members of Congress sought to increase SCHIP funding in order to cover prenatal care for women in families with incomes below 200% of the federal poverty level. However,the Bush administration pre-empted this debate and changed federal regulations to expand SCHIP coverage to the fetus rather than to the pregnant woman carrying it.[35] While the extension of S CHIP to cover the fetus now does allow more immigrant women to receive prenatal care, this policy has been controversial because it requires doctors to treat the fetus separately from the mother. Leading professional medical associations oppose insuring the fetus alone because the policy narrows the scope of prenatal, delivery, and postpartum care to cover only those services directly related to the health of the fetus, not to other medical conditions affecting the health of the mother.[36] Currently, nine states have opted to provide coverage to unborn fetuses under their SCHIP programs. The federal policy has also prompted some states, such as Michigan, to scale back the package of pregnancy-related services under state- funded programs that previously provided women with comprehensive prenatal care.[37]

ii. The Deficit Reduction Act of 2005

On February 8, 2006, President Bush signed the Deficit Reduction Act of 2005 (DRA) into law.[38] This legislation is the most significant set of changes to Medicaid's coverage structure since its 1965 enactment, redefining the minimum coverage rules that states must meet in order to receive federal funds. Without these rules states could modify their programs in ways that could negatively affect the country's most vulnerable populations. Besides benefit standards, the law also altered eligibility regarding citizenship documentation requirements and out-of-pocket costs, such as health insurance premiums and increased cost-sharing.[39]

Citizenship Documentation Requirement: Medicaid law requires individuals to be United States citizens or to have legal residency status for at least five years (per PRWORA) to be eligible for Medicaid or SCHIP coverage. Those deemed ineligible due to immigration status may receive coverage for emergency care only, including childbirth but not prenatal care. *Undocumented* immigrants and immigrants residing in the U.S. on a temporary basis, such as those with a work or school visa, are not eligible for the safety-net programs. Prior to the DRA, citizens could verbally confirm their citizenship status and the status of their children when applying or when re-determining eligibility for the program. Legal residents were required to provide written proof of legal status.

Yet even with the five-year ban on public benefit eligibility for recent documented immigrants, a popular myth persists that ineligible documented and undocumented immigrants continue to enroll in Medicaid and S CHIP.[40] Proponents of the citizenship documentation requirement claimed that it was necessary to curtail the problem of undocumented immigrants securing Medicaid by falsely declaring themselves to be U.S. citizens. However, there was no evidence at the time of development of the legislation that this problem existed. In fact, Mark McClellan, head of the Center for Medicare and Medicaid Services, noted that the report released by the Inspector General of Health and Human Services "does not find particular problems regarding false allegations of citizenship, nor are we aware of any."[41]

Nevertheless, on July 1, 2006, as part of the Deficit Reduction Act of 2005, a federal law was enacted requiring U.S. citizens to present proof of their citizenship and identity, such as a U.S. passport or birth certificate, when applying for Medicaid coverage or seeking to renew their coverage.[42] While the intent of this law was ostensibly to keep ineligible immigrants from enrolling in Medicaid, it has in-creased the administrative burden for U.S. citizens as well as documented immigrants eligible for coverage.[43]

Recent data shows that the new law actually has the biggest impact on poor U.S. citizens, especially African Americans.[44] This group lacks documentation of their citizenship and the financial means to afford the application process. Migra tion trends show that nearly 80 percent of undocumented immigrants are from Mexico, Central America, or Latin America. Therefore, one would think that if the documentation requirement was actually preventing undocumented immigrants from unlawfully enrolling in Medicaid, then the coverage rate for Hispanic children would actually decline. Yet data from Alabama, Kansas and Virginia are showing that Hispanic children are the least affected by the new requirement.

In Alabama, after six months of implementing the requirement, 3,500 children previously enrolled in Medicaid were removed from the program from failure to meet the documentation requirement. Of those, 105 children (3%) were Hispanic compared to 2,100 (60%) were African American.[45] Kansas found similar results. After 9 months of enforcing the requirement, His panic children enrolled in child Medicaid dropped by 2.2 percent or 308 children while enrollment dropped by 9.1 percent or 1,274 African American children.[46]

Virginia, on the other hand, saw an increase in enrollment of Hispanic children and a decline in enrollment of African American children after 9 months of enforcing the requirement. Enrollment of African American children declined by nearly 5 percent compared to an increase in enrollment of Hispanic children by 4.4 percent.[47] This continued increase of Hispanic child enrollment during this time may be explained by the concentrated outreach efforts to enroll eligible children in Medicaid in Hispanic communities throughout Virginia.[48]

These preliminary results demonstrate the this newly implemented law has negative repercussions in health coverage for African American children whose parents may find difficulty producing a certified birth certificate or passport due to losing the original, delay in getting a duplicate copy, or being unable to afford duplicates. Depending on the state, it can cost $5 to $23 to attain a copy of a certified birth certificate or $87 to $97 for a passport. In the meantime, these children do not have health coverage and are therefore unlikely to receive needed preventive and primary care services in a crucial time in their development. The new policy is also deterring Medicaid enrollment of legal residents.[49] Some eligible immigrants believe that they must show proof of citizenship, not just legal status, in order to obtain coverage once otherwise eligible.[50]

Three-quarters of states report that the DRA has increased the administrative burden for those already eligible for coverage and caused significant delays in processing applications.[51] The delay and difficulty in procuring documentation is particularly burdensome on low-income women needing time-sensitive services such as prenatal care.[52] While 30 states grant presumptive eligibility to pregnant women, 20 states deny prenatal care unless a woman provides documentation of citizenship.[53] This creates delays in care that impact both women and their children. States are reporting that the documentation requirement has led to a decrease in the number of individuals enrolling in Medicaid's family planning eligibility expansion programs, which serve two million low-income people with no other source of family planning coverage.[54] This is because young, poor mothers may be deterred from seeking family planningservices due to the hassle of traveling to a government office and the related expenses of application fees, lost wages, transportation and child care.[55] Women of color are disproportionately impacted because they comprise the majority of Medicaid beneficiaries.[56]

Additionally, these rules may not only affect health care consumers but providers as well. Health care administrators fear that the documentation rules could negatively affect safety-net providers such as health centers, children's hospitals, public hospitals, health departments, and pediatric practices that serve large Medicaid populations. If many of their patients lose coverage, these providers might experience revenue

declines large enough to affect their ability to provide services in general. The loss of coverage also might impinge on health care providers' ability to arrange for specialty care and other services that require referrals.[57]

Increased Out-of-Pocket Costs: Before the DRA, Medicaid enrollees paid limited out-of-pocket costs for the health care services they received. Current law ensured that cost sharing protections were in place that reflected the limited incomes and considerable health care needs of Medicaid enrollees. For example, African Americans, Hispanics, and American Indian/Alaska Natives are twice as likely to have fam ily incomes less than 200 percent of the federal poverty level as whites. In 2005, this equated to a little more than $39,000 for a family of four.[58] For these reasons, state Medicaid agencies were prohibited from charging premiums and enrollment fees for most program enrollees. Cost-sharing was prohibited for children; however, they could impose up to $3 copayments for prescription drugs for parents.[59] Furthermore, the high rates of people of color living in poverty also help to explain their likelihood of Medicaid enrollment, lack of job-based health insurance, and their inability to afford private health insurance. People of color are less likely to have employer provided health insurance largely because of the types of work they have, i.e. service sector, temporary agencies, agriculture, construction, etc.—these sectors are less likely than other sectors to offer health insurance to their employees. Rising health insurance premiums and cost-sharing obligations prevent low- income individuals from enrolling in employer-based insurance when offered or purchasing private insurance.[60]

For example, the Oregon Health Plan (OHP) or Oregon's Medicaid program increased out-of-pocket costs for its enrollees. In 2003, studies suggested that cost-sharing increases led to a large reduction in OHP enrollment. Those who left the program reported "inferior access to needed care, used primary care less often, and used hospital emergency rooms more often."[61]

Yet even with these findings, the DRA gives states increased flexibility of imposing premiums, cost-sharing, or both. The law removed the statutory bar on denying care to Medicaid recipients who are unable to afford cost sharing. This means states may now charge Medicaid recipients for certain services and deny them health care if they are unable to pay for the gap in coverage. For example, Medicaid recipients may now be charged at family planning visits for certain contraceptives or drugs needed to treat sexually transmitted infections.[62] This provision poses financial burdens for low- income families and creates the risk that some enrollees will not seek services when necessary. States can also now choose to impose premiums on children and parents if their family income is above 150 percent of the federal poverty level or roughly $31,000 for a family of four. States can also require prepayment of premiums before one can be enrolled in Medicaid, therebydeterring low-income families from enrolling. And Medicaid coverage can be terminated—even for children—if premiums are not paid within 60 days of the due date.[63] Exemptions from cost-sharing are only available for the very poor—families with incomes below 100 percent of the federal poverty level, or 150 percent of the poverty level in the case of premiums.[64]

The DRA gives states flexibility in setting cost-sharing guidelines as well. If an enrollee's family income is between 100 percent and 150 percent of the federal poverty level, cost-sharing, such as copayments, cannot exceed 10 percent of the cost of the service or item and total cost-sharing cannot exceed 5 percent of family income. If the enrollee's family income is above 150 percent of the federal poverty level, like families with lower incomes, total cost-sharing cannot exceed 5 percent of family income. However, cost- sharing can be as much as 20 percent of the cost of the service or item.[65]

Benefit Standards: Medicaid law provides two categories of benefits: mandatory or optional. Mandatory benefits include but are not limited to inpatient and outpatient physician services, physician services and

preventive services included in Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for individuals under 21. Optional services include dental and prescription drugs. States then can determine the services amount, duration, and scope.

Under the DRA, there are no longer mandatory benefits. Instead, states may replace the existing Medicaid benefit package for children and certain other groups with "benchmark" coverage or coverage that is comparable to the coverage provided by the largest commercial HMO in the state. Additionally, EPSDT would no longer be mandatory but included as "wrap around" coverage to children under 19.

By 2015, the Congressional Budget Office estimates that the benefit reduction would affect 1.6 million enrollees, many of whom are people of color.[66] Even more startling is that comprehensive benchmark plans often do not cover key Medicaid services. For the first time ever, federal law allows states to offer stripped-down benefit packages that do not have to include family planning.[67] This provision would affect large numbers of Medicaid enrollees, including the nearly 14 million parents enrolled in the program, as well as postpartum women who had a Medicaid-funded birth.[68] Moreover, Medicaid's EPSDT benefits have created more uniform and comprehensive coverage for children across all states; however, the DRA changes make it likely that children will not receive these necessary services. Providing more limited benefits could result in unmet health care needs and make it more difficult for beneficiaries to access care as they are likely to have difficulty paying for uncovered services.[69]

d. Unequal access to sexual and reproductive rights for women of color

Current racial disparities in reproductive health have arisen in large part from the government's history of social, legal, and economic oppression and control over women of color's reproduction, from laws that targeted them for sterilization to current state welfare policies that deter them from reproducing. Yet rather than address these widening disparities, the federal and state governments continue to create and exacerbate inequalities through policies that limit access to reproductive rights. The government discriminates against women of color by imposing legal and policy restrictions on access to sexual and reproductive health services, as well as by inadequately funding public health insurance programs on which a disproportionate number of women of color rely. Women of color have limited recourse to address violations of their reproductive rights because the U.S. legal system has interpreted these rights through the lens of individual liberty and privacy as protected only by the federal constitution.[70] Therefore, restrictions on reproductive rights are deemed unconstitutional only when they interfere with a woman's private choices about her reproductive health. The U.S. legal system does not, however, take into account how forces such as racism, sexism, or poverty constrain women's reproductive options.[71] Moreover, the government has refused to accept any obligation to go beyond the courts' limited interpretation, which is reflected in federal policies that deny equal access to reproductive health care, including resources or services needed by women of color to make adequate reproductive choices.

This section describes how the U.S. violates its Article 5(e) (iv) obligation to respect, protect, and fulfill equal access to sexual and reproductive health care. It first analyzes federal policies imposed through the two main federal health insurance programs that affect reproductive health care access for millions of low-income women of color. Next, it highlights how federal and state policies promote racial inequalities in two key areas of reproductive health, first by increasing disparities in maternal mortality and second by interfering with women of color's access to their constitutional right to an abortion.

i. Lack of access to health insurance

Medicaid: Medicaid is the most comprehensive government program offering health insurance coverage to eligible low-income people, including 7.4 million women of reproductive age.[72] This joint federal-state insurance program reimburses health care providers for an array of services, including family planning services and supplies, preventive screenings, prenatal and delivery services.[73] Women of color disproportionately rely on Medicaid because they are more likely to work in low-wage jobs that do not offer employer-based health insurance, and therefore more likely to be uninsured than white women.[74] Foreign born and American Indian/Alaskan Native women are also over twice as likely to be uninsured as white women.[75] In total, women of color constitute 51% of the uninsured, despite representing only 32% of population.[76]

Medicaid is therefore the primary provider of reproductive health care for poor women of color in the U.S. Latinas are twice as likely and African Americans are nearly three times as likely to be on Medicaid as white women.[77] Consequently, inefficiencies in the Medicaid system have a greater impact on women of color than on white women.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) and the Deficit Reduction Act of 2005 (DRA) have eroded access to reproductive health care for the women of color who rely on public health insurance. These laws have raised Medicaid eligibility standards to exclude many immigrants and low-income women, and for the first time allowed states to increase cost-sharing measures for recipients and decrease the mandatory package of benefits states must offer. The government has also imposed burdensome citizenship documentation requirements that deter Medicaid enrollment among qualified applicants. All of these measures have disproportionately impacted women of color because they are more likely to rely on Medicaid than white women.

First, the five-year bar on Medicaid enrollment for legal immigrants (discussed inSection D(2)(c) above) excludes reproductive health access for immigrant women who are legal residents. The policy also deters many eligible immigrant women from enrolling in Medicaid for fear of jeopardizing their immigration status. As a result of PRWORA's five-year exclusion of legal immigrant women, by 2001 Medicaid coverage for recent immigrant women had decreased by almost half.[78] The enrollment rate of long-standing resident women declined by the same proportion, even though many states continued to cover that group.[79] Accordingly, many immigrant women cannot access prenatal or postpartum care, family planning services and supplies, and treatment for reproductive system cancers.

Second, as described in Section D(2)(c), the DRA removed the previous federal prohibition on cost-sharing measures, which has resulted in some states requiring out-of-pocket payments by recipients for certain medications obtained during family planning visits, including contraceptives or drugs needed to treat sexually transmitted infections.[80]

Third, the DRA permits states to scale back their benefits packages to exclude family planning to certain groups of Medicaid recipients, including parents and postpartum women.[81] Finally, the DRA's citizenship documentation requirement disproportionately impacts Medicaid enrollment for poor African Americans, impeding black women's access to reproductive health services through Medicaid.[82]

Title X: Another way the U.S. Government has failed to provide women of color equal access to sexual and reproductive health care is through underfunding of the Title X program. Congress created Title X of the Public Health Service Act in order to fill the gap in family planning services for low-income women who do not

meet income eligibility requirements for Medicaid but who cannot afford private health insurance.[83] This program funds direct reproductive health care services, including family planning and preventive health screenings, as well as outreach and education to vulnerable populations, such as non-native English speakers.[84] Title X provides at least some funding to 7,500 family planning clinics nationwide that offer services to 6.6 million low-income women.[85] Low-income women of color constitute nearly 40 percent of the population receiving contraceptive services through Title X[86] and are dependent on the program to provide affordable reproductive health services.

For many years, however, Congress has failed to fund the Title X program at the level necessary to meet the reproductive health needs of its target population. According to the Guttmacher Institute, funding is now 61 percent lower in inflation-adjusted dollars than in 1980.[87]

Underfunding makes it difficult for clinics to meet the reproductive health needs of its target population. Clinics are treating more patients who are ineligible for Medicaid, while costs of services, newer technologies for diagnostic tests, and contraceptive supplies are rising significantly.[88] The combination of rising demand and fewer financial resources strains clinic budgets as they try to provide a range of contraceptives and meet critical family planning needs.[89]

Title X clinics are struggling to meet the health needs of new and hard-to-reach populations, including the rising numbers of immigrants ineligible for Medicaid and non-native English speakers.[90] A study by the Guttmacher Institute revealed that Title X clinics reported an average cost increase of 58 percent from 2001–2004 for language assistance services.[91] Outreach, including language services and culturally appropriate materials, is critical for ensuring thatvulnerable groups of women receive care. For example, many Asian Pacific Islander (API) women avoid HIV testing because they lack a translator or fear being stig matized by a life-threatening disease, even though they may perceive themselves at high risk of infection.[92] The delay in testing leads to later diagnoses that make treatment more difficult or increase the possibility of HIV transmission. Notably, the HIV infection rate among API women has doubled in recent years even as the general rate declines.[93] Similarly, although Latinas face a cervical cancer rate twice that of white women, language barriers and cultural differences with U.S. doctors prevent them from obtaining a pap smear that could detect the disease at an earlier and more treatable stage.[94] In order to effectively meet the future needs of these populations, Title X clinics will require sufficient resources for materials and personnel.[95]

ii. Maternal mortality

The U.S. has one of the highest rates of maternal mortality among western developed nations and ranks 30th in the world in its maternal mortality rate.[96] The WHO estimates the U.S. maternal mortality is 17 deaths per 100,000 live births, compared to 6 per 100,000 live births for Canada, 8 for Australia, and 4 for Spain.[97] Racial disparities in maternal mortality help explain why this rate is so high. African American women are nearly four times more likely to die in childbirth than white women (30.5 vs. 8.7 deaths per 100,000 live births).[98] Notably, the U.S. government failed to include these statistics in its 2007 report to CERD, despite having included them in its 2000 report,[99] and despite the lack of progress in reducing the racial disparity since that time.[100]

Access to prenatal care has been proven to reduce the risk of maternal mortality; studies reveal that women who receive no prenatal care are three to four times more likely to die in childbirth than women who received any prenatal care.[101] Black, American Indian/Alaskan Native, and Latina women are more likely to receive late or no prenatal care compared to white women.[102] Studies have shown that the inability of black women to access

prenatal services increases their risk of maternal mortality, which is already high due to a greater propensity to suffer from diseases and medical conditions aggravated by pregnancy, such as hypertension, diabetes, or obesity.[103] Lack of access to prenatal care has also been shown to raise the risk of pregnancy complications for Latinas, resulting in a higher rate of maternal mortality than white women (8 versus 5.8 deaths per 100,000 live births, respectively).[104]

Women of color face barriers to prenatal care such as insufficient funds, lack of insurance, and inability to get an appointment with a provider.[105] With the cost of an uncomplicated pregnancy and hospital birth averaging $7,600,[106] the lack of insurance is perhaps the most significant deterrent to pregnancy care for low-income women of color. Government policies have exacerbated, rather than mitigated, these barriers. For example, a new Medicaid/ SCHIP policy bars legal residents residing in the U.S. for under 5 years and undocumented immigrants from receiving prenatal care through Medicaid.[107] In addition, the DRA citizenship documentation requirement has been shown to disproportionately impact African Americans.[108] Moreover, twenty states have exercised the prerogative now available under the DRA to deny prenatal care unless a woman provides documentation of citizenship.[109] This policy negatively impacts both women and their children. SCHIP's policy extending health insurance coverage to the fetus rather than the pregnant woman[110] restricts immigrant women's ability to accesspostpartum care—an additional measure proven to reduce the risk of maternal mortality—because coverage of the woman ends once the fetus is delivered. Meanwhile, underfunding of Title X leaves clinics with fewer resources to provide prenatal care for low-income women ineligible for Medicaid. Lack of funding also threatens family planning clinics' ability to find especially vulnerable populations, such as non-English speakers, and provide them with prenatal care.[111]

iii. Abortion

Federal and state laws banning public funding of abortion, combined with the burden of navigating the public insurance system for an abortion that is covered, effectively deprives low-income women of their right to an abortion. Women of color are disproportionately impacted by this policy scheme because they are more likely to be uninsured or on Medicaid. Federal public funding of abortion is prohibited except in limited circumstances. This includes most notably Medicaid funding for abortions, which is banned under the Hyde Amendment except in cases of life endangerment, rape, and incest. States have the power to extend state Medicaid funding for abortion beyond what is covered by federal Medicaid, but the majority of states (33) fail to provide such coverage.[112] Even where a woman qualifies for a Medicaid-funded abortion, she can have difficulty obtaining one because "[a]bortion providers report difficulties in getting approval for coverage; patients and doctors are often unaware of the rules for Medicaid funding; and, states needlessly impose pre-authorization requirements that impede timely approval and reimbursement."[113] Additionally, providers in some states do not take Medicaid because of the program's low reimbursement rates and burdensome procedures.[114]

For many women on Medicaid, obtaining the funds necessary to have an abortion is extremely difficult. Studies have shown that between 18–35 percent of women who would have had an abortion if funding had been available instead carried their pregnancies to term.[115] Funding restrictions on abortion also have serious health implications for poor women. Medicaid-eligible women wait on average 3-4 weeks longer than other women to have an abortion because of difficulties they have in obtaining necessary funds.[116] One study found 22 percent of women on Medicaid who had abortions in the second trimester would have done so in the first if Medicaid provided funding.[117] This delay not only potentially increases the cost of the abortion, but increases risks associated with the procedure.

In addition to restrictions on funding, states with the poorest populations are also more often than not at the forefront of enacting restrictions aimed at making abortions more difficult to obtain.[118] Since 1995, state legislatures across the country have enacted over 500 laws to restrict access to abortion.[119] This includes mandatory delay and biased counsel ing requirements, restrictions on health professionals who provide abortions, and restrictions on minors' ability to access abortion.[120] Notably, the states with the most restrictive abortion polices also contain significant populations of color, creating a reality where poor women of color face the most obstacles in accessing safe abortion care.

For instance, Mississippi is the poorest state in the country, with the highest African American population; it also has enacted some of the most restrictive abortion laws in the United States.[121] The lone abortion clinic in Mississippi is three hours from the rural Delta, where the poorest women in the state live. The mandatory 24 hourwaiting period in Mississippi[122] adds the expense of lodging or a second round trip from the Delta to Jackson to the costs of obtaining the procedure, which makes the costs of obtaining an abortion prohibitively higher. Because there is no public funding for elective abortions in Mississippi except in very limited cases,[123] these women often cannot afford the prohibitive costs of travel and lodging to reach the clinic and pay for the procedure. Moreover, even for the few women who are able to pull together the financial resources to travel to the clinic, the difficulty of doing so will likely delay her abortion procedure, either increasing the health risks associated with the procedure, or perhaps preventing her from being able to obtain an abortion at all.

e. The emerging frontier: Genetic discrimination and the impact of new technologies

Emerging genetic technologies (genetic, reproductive and biomedical) have the potential to greatly advance scientific and medical knowledge in the treatment of disease. At the same time, these technologies carry social, ethical and legal implications which have the ability to undermine public health initiatives, possibly deepen health disparities and leave people in the United States susceptible to genetic discrimination. The history of genetic discrimination in the United States is unfortunately tied to racial discrimination.
During the 1 970s, sickle cell screening programs were developed to identify individuals with sickle cell trait in an effort to reduce the incidence of sickle cell disease. Currently, 1 in 12 African Americans is a carrier for sickle cell anemia.[124] In the past however, this information was used by insurance companies to either deny health insurance coverage to African Americans, or in the alternative, charge higher rates to African Americans who were merely carriers of the gene.[125] African Americans further suffered discrimination from the Air Force Academy and the airline industry where sickle-cell carrier status was used to exclude African Americans from the academy, flight training, and flight personnel positions.
Unfortunately, genetic discrimination amongst racial minorities continues. In 1998 the U.S. Ninth Circuit Court of Appeals decided that Lawrence Berkeley National Laboratory in California violated the American Disability Act when it secretly tested African American employees for sickle cell anemia and then conditioned hiring based upon this testing.

The past ten years has seen a dramatic increase in the number of tests available for genetic conditions. Currently there are over 1,000 genetic tests in use. These tests open up the possibility that employers and insurers will use genetic information in a discriminatory matter. Of utmost concern is that in the United States, which lacks a universal health insurance coverage plan, many individuals, particularly those of color, could still be susceptible to discrimination. The Council for Responsible Genetics reports that as many as five hundred cases have been documented where individuals have been barred from employment or lost health and life insurance due to a perceived genetic abnormality.[126] Ironically, the majority of Americans receive their health care through their

employer, so if an individual is discriminated against and not hired due to their genetic make-up, it increases the barriers to accessing affordable health care coverage for that person.Laws addressing genetic discrimination vary by state. The restrictions on the use of genetic information in health insurance address a range of issues, from restrict ing health insurers from requiring genetic testing of applicants to using genetic information to determine eligibility for a particular health insurance plan. What is most problematic is that the state laws do not govern the use of genetic information in employer-sponsored health benefit plans where more than 59.7 percent of American receives their health care.[127] Overall, 47 states do offer some type of protection from insurance discrimination. Yet this patchwork of legislation sidesteps the issue of whether employers and insurance companies should even have access to genetic information.

At the federal level, laws such as the Americans with Disabilities Act (ADA) and the Health Insurance Portability and Accountability Act (HIPAA) do not explicitly prohibit an employer from requiring employees to take a genetic test as a condition of employment, nor do they deny private insurers from denying insurance to individuals depending upon what one's genetic information may reveal. Current federal legislation, the Genetic Information Non-Discrimination Act (GINA) was passed by the House of Representatives on April 25, 2007, yet still has to be considered by the Senate.

The emerging genetic technology of genetic testing provides a pathway for genetic discrimination that could deepen existing racial health disparities. The United States government must take proactive action by passing legislation such as GINA to ensure this does not happen.

ENDNOTES

1 David B. SMITh, Healih cAre DividED: RacE and HEAlING A NATIoN (1999).
2 Albert W. Dent, *Hospital Services and Facilities Available to Negroes in the United States*, 18 J. NEGRo EDuc. 326, 326-32 (1949).
3 City of Chi. Comm'n on Human Relations, Distribution of Negro Births and Deaths in Chicago Hospitals, 1954 (1955).
4 JAMEs H. Jones, Bad BlooD: ThE TuS1eGEE SyphIlIS Experiment (1981).
5 Simkins v. Moses H. Cone Memorial Hospital, F.2d 959 (4th Cir.1963), cert. denied, 376 U.S. 938 (1964).
6 *See generally* DoRoThy RoBERTS, KIllING ThE BlacK BoDy: RAcE, REpRoDucTIoN and thE MEanTNG or LIBERTy (1997); Iris Lopez, *Agency and Constraint: Sterilization and Reproductive Freedom Among Puerto Rican Women in New York City, in* SITuATED LivEs: GENDER and culTure IN EvERyDAy Life 157-75 (Louise Lamphere et al. eds. 1997); Charlotte Rutherford, *Reproductive Freedoms and African-American Women,* 4 yalE J.L. & FEMINISM 255 (1992); Berta E. Hernandez, *To Bear or Not to Bear: Reproductive Freedom as an International Human Right*, 17 BRoo1ly1, J. Inr'l L. 309 (1992); Pamela D. Bridgewater, *Reproductive Freedom as Civil Freedom: The Thirteenth Amendment's Role in the Struggle for Reproductive Rights,* 3 J. GENDER & JuSTIcE 401 (2000).
7 Am. Ii'mian polIcy Revriw coMM'N, REport oN Ii'mian hEAlth: FINAl REpoRT To ThE AMERIcAN Ii'mian polIcy REvnew coimISSIoN (1976); Jael Sillrran ET Al., uNDIvIDED RIGhTS: woMEN oF coloR oRGANIzE FoR REpRoDucTivE JuSTIcE 111-12 (2004).
8 Rutherford, *supra* note 6, at 273-74.
9 Madeline Henley, Comment, *The Creation and Perpetuation of the Mother/Body Myth: Judicial and Legislative Enlistment of Norplant,* 41 Burr. L. REv. 703, 747-58 (1993); Bonnie Steinbock, *The Concept of Coercion and Long-Term Contraceptives, in* coERcED conr1acEpTIoN? Moral and polIcy chAllENGES oF LoNG-AcTING BIRTh coNTRol (1996).
10 42 C.F.R. §§ 441.253-.254 (1991).

11 42 CFR §§ 441.202-.203 (1991).
12 Marianne Lavelle & Marcia Coyle, *Unequal Protection: The Racial Divide in Environmental Law,* NAT'l L.J., Sept. 21, 1992.
13 *See* LuXE w. cole & ShEilA R. FoSteR, FRoM thE GRouND up: ENvIRoNMENTAl RacISM AND ThE RISE oF thE ENvIRoNMENTAl JuSTIcE MovEMENT 57 (2001).
14 RoBERT D. Bullard ET Al., ToxIc wASteS And RacE AT Twinty: 1987-2007 (2007) (report prepared for the United Church of Christ Justice and Witness Ministries).
15 *Id*.
16 cTRS. FoR DISease contRol & pREvENTIoN, preventinG LeaD poISoNING IN youNG chIlDREN 1 (2005), *available at* http://www.cdc.gov/nceh/lead/publications/PrevLeadPoisoning.pdf (last accessed Nov. 7, 2007).
17 Brian P. Leaderer et al., *Dust Mite, Cockroach, Cat, and Dog Allergen Concentrations in Homes of Asthmatic Children in the Northeastern United States: Impact of Socioeconomic Factors and Population Density*, 110 ENvT'l. HEAlTh pERSp. 419 (2002), *available at* http://www.ehponline.org/members/2002/110p419-425leaderer/EHP110p419PDF.PDF (last accessed Nov. 7, 2007).
18 u.S. DEp'T oF HouS. & uRban DEv., AMERIcAN HouSinG SuRvEy FoR ThE uNIteD STAteS: 2005, at 42 tbl.2-1, 58 tbl.2- 7 (2006) (Introductory Characteristics—Occupied Units and Additional Indicators of Housing Quality—Occupied Units), *available at* http://www.census.gov/prod/2006pubs/h150-05.pdf (last accessed Nov. 7, 2007).
19 All Others includes Non-Hispanic White, Native American, and Asian / Pacific Islander households and households of more than one race.
20 Ctrs. for Disease Control & Prevention, *Blood Lead Levels—United States, 1999-2002,* 54 MoRBidITy & MortalIIy weEKly. Rip. 513 (May 27, 2005), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5420a5.htm (last accessed Nov. 7, 2007).
21 Lara Akinbami, Ctrs. for Disease Control & Prevention, Asthma Prevalence, Health Care Use and Mortality: United States, 2003-05, http://www.cdc.gov/nchs/products/pubs/pubd/hestats/ashtma03-05/asthma03-05.htm (last accessed Nov. 7, 2007).
22 *Id.*
23 *Id.*
24 Marsha. Lillie-Blanton & Catherine Hoffman, *The Role of Health Insurance Coverage in Reducing Racial/Ethnic Disparities in Health Care*, 24 Health Arr. 398 (2005).
25 Janet Currie, The Take-Up of Social Benefits (National Bureau of Economic Research, NBER Working Paper #10488, May 2004).
26 H.R. REp. No. 104-725 (1996).
27 Dana P. Goldman et al., *Immigrants and the Cost of Medical Care*, 25 HEAlTh AFFAIRS 1700, 1700-11 (2006).
28 Leighton Ku, Ctr. on Budget & Policy Priorities, Reducing Disparities in Health Coverage for Legal Immigrant Children and Pregnant Women, Apr. 27, 2007, http://www.cbpp.org/4-20-07health2.htm [hereinafter Ku, Reducing Disparities in Health].
29 Leighton Ku, Ctr. on Budget & Policy Priorities, Why Immigrants Lack Adequate Access to Health Care and Health Insurance, Sept. 2006, http://www.migrationinformation.org/Feature/display.cfm?id=417 [hereinafter Ku, Why Immigrants Lack Adequate Access].
30 Lisa Dubay et al, *Medicaid At The Ten-Year Anniversary of SCHIP: Looking Back and Moving Forward*, 26 Health AFFAIRS 370, 370-81 (2007).
31 Ku, Reducing Disparities in Health, *supra* note 28.

32 *Id.*
33 Meredith I. KING, cTR. FoR AM. pRoGRESS, IMMIGRANTS IN thE u.S. Health cA1ue SySTEM: FivE MythS ThAT MiSINFoRM Ihe Arerican puBlIc (2007), *available at* http://www.americanprogress.org/issues/2007/06/pdf/immigrant_health_report.pdf.
34 Ku, Reducing Disparities in Health, *supra* note 28.
35 In February 2002, HHS announced it would redefine the meaning of an eligible "child" to include "any period of time from conception to birth up to age 19. 42 C.F.R. § 457 (2002).
36 *See, e.g.,* Comm. on Ethics, Am. Coll. of Obstetricians & Gynecologists (ACOG), Committee Opinion: Maternal Decision-Making, Ethics, and the Law, at 4 (Committee Opinion No. 321, Nov. 2005), *available at* http://www.acog. org/from_home/publications/ethics/co321 .pdf (criticizing the law for "its failure to address the health needs of women, but also for its failure to achieve the narrow goal of improving child health because it ignores the fact that maternal and neonatal interests converge.").
37 Nat'l Immigration Law Ctr., Issue Brief: Prenatal Coverage for Immigrants through the State Children's Health Insurance Program, at 1 (June 2003),*available at* http://www.nilc.org/immspbs/health/Issue_Briefs/Prenatal%20coverage%20 through%20SCHIP.pdf.
38 White House, Press Release, Fact Sheet: President Bush Signs the Deficit Reduction Act, www.whitehouse.gov/news/ releases/2006/02/print/20060208-9.html.
39 Sara Rosenbaum & Anne R. Marcus, *The Deficit Reduction Act of 2005: An Overview of Key Medicaid Provisions and Their Implications for Early Childhood Development Services* (Commonwealth Fund, Oct. 2006), *available at* http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=409144.
40 King, *supra* note 33.
41 Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Self-declaration of U.S. Citizenship for Medicaid, July 2005.
42 Donna Cohen Ross, *New Medicaid Citizenship Documentation Requirement Is Taking A Toll: States Report Enrollment is Down and Administrative Costs are Up* (Ctr. on Budget & Pol'y Priorities, Feb. 2007).
43 U.S. Government Accountability Office, *Medicaid: States Reported that Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens* (June 2007); Ross, *supra* note 42.
44 Donna Cohen Ross, *Medicaid Documentation Requirement Disproportionately Harms Non-Hispanics, New Data Show: Rule Mostly Hurts U.S. Citizen Children, Not Undocumented Immigrants* (Ctr. on Budget & Pol'y Priorities, July 2007).
45 Data from the Alabama Medicaid Agency, as of May 21, 2007.
46 Data from the Kansas Health Policy Authority, June 2007.
47 Ross, *Documentation Requirement*, *supra* note 44.
48 *Id.*
49 Adam Sonfield, *The Impact of Anti-Immigrant Policy on Publicly Subsidized Reproductive Health Care*, GuTTMAchER pol'y REv., Winter 2007 (noting the enrollment rate among legal residents fell from 26% to 17% between 1994 and 2005).
50 The federal government clarified after the passage of the Personal Responsibility and Work Opportunity Act that getting Medicaid or SCHIP benefits would not make an immigrant ineligible fore permanent residency. However, distrust and fear remains in the immigrant community; Ku, *Why Immigrants Lack Adequate Access, supra* note 29.
51 U.S. Gov't Accountability Office, *Medicaid: States Reported that Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens* (June 2007).
52 Sonfield, *supra* note 49, at 7.
53 *Id.*

54 Kaiser Family Found. & Alan Guttmacher Inst., *Medicaid's Role in Family Planning, Women's Issue Brief: An Update on Women's Health Policy* 8-9 (Oct. 2007) *available at* http://www.guttmacher.org/pubs/IB_medicaidFP.pdf.
55 Sonfield, *supra* note 49, at 7.
56 KAISER FArIlY FOumm., KEY FACTS: RACE, ETHNICITY, & MEDICal CAre 15 (2007), *available at* http://www.kff.org/minorityhealth/upload/6069-02.pdf (showing 55% of Medicaid beneficiaries are people of color); *see also* NAT'L CTR. FOR Hnalth STATISTICS, U.S. DEP'r Or Hnalth & HuMan SERvS.. Health, UNITED STATES, 2006 at 398 (2007) (showing that women comprise 13.9% of Medicaid beneficiaries compared to 11% of men).
57 Rosembaum & Marcus, *supra* note 39.
58 KaISER FAMILY FOund., KeY FACTS, *supra* note 56.
59 Kaiser Family Found., Deficit Reduction Act of 2005: Implications for Medicaid (Feb. 2005).
60 *See*, *e.g.*, Econ. Research Initiative on the Uninsured, Jobs Lacking Coverage Biggest Reason for Immigrants' Low Insured Rates (Economic Research Initiative on the Uninsured, No. 11, Mar. 2006); Families USA, Improving Health Coverage and Access for African Americans, Jan. 2006, *available at* http://www.familiesusa.org/assets/pdfs/minorityhealth-tool-kit/AfrAm-fact-sheet.pdf.
61 Bill J. Wright et al., *The Impact of Increased Cost Sharing on Medicaid Enrollees*, 24 HEALTH AFFAIRS 1106 (2005).
62 Rachel Benson Gold, *New Federal Authority to Impose Medicaid Family Planning Cuts: A Deal States Should Refuse*, GurrM-- ACHER POL'Y REv., Spring 2006, at 2-6 [hereinafter Gold, *New Federal Authority*].
63 Rosenbaum & Marcus, *supra* note 39.
64 *Id.*
65 *Id.*
66 Kaiser Family Found., Deficit Reduction Act of 2006, *supra* note 59.
67 Gold, *New Federal Authority, supra* note 62.
68 *Id.*
69 Meredith I. King, Ctr. for Am. Progress, The SCHIP Shortfall Crisis: Ramifications for Minority Children (Mar. 2007).
70 *See, e.g.,* Griswold v. Connecticut, 381 U.S. 479 (1965); Roe v. Wade, 410 U.S. 113 (1973); Harris v. McRae, 448 U.S. 297 (1980), Planned Parenthood of Southeastern Pa v. Casey, 505 U.S. 883 (1992), Stenberg v. Carhart, 530 U.S. 914 (2000), Gonzales v. Carhart, 550 U.S. ___ (2007), 127 S.Ct. 1610.
71 *See* Harris, 448 U.S. at 316-17 (holding that poor women may not challenge the restriction on federal funding for an abortion as a violation of their constitutional right to an abortion because "[t]he financial constraints that restrict an indigent woman's ability to enjoy the full range of constitutionally protected freedom of choice are the product not of governmental intrusion on access to abortions, but rather of her indigency.").
72 *More Reproductive-Age Women Covered by Medicaid—But More Are Also Uninsured*, GuTTMACHER POL'Y REv., Winter 2007,
available at http://www.guttmacher.org/pubs/gpr/10/1/gpr100124.html.
73 Rachel Benson Gold, *Immigrants and Medicaid after Welfare Reform*, GuTTMACHER REP. ON PuB. POL'Y, May 2003, at 6-9, *available at* http://www.guttmacher.org/pubs/tgr/06/2/gr060206.html (last viewed Sept. 11, 2007).
74 KAISER FArIlY FOumm., RACIaL AND ETHNIC DISPARITIES IN WOMEN'S HEALth COver&cE and ACCESS TO CA1ue 2 (2004), *available at* http://www.kff.org/womenshealth/7018.cfm.
75 Kaiser Family Found., Fact Sheet, Women's Health Insurance Coverage (Feb. 2007), *available at* http://www.kff. org/womenshealth/upload/6000_05.pdf.
76 *Id*. at 2; NAT'L INSTS. OF HEALth (NIH), WOMEN OF COLOR Hearth DATA BOOK:

ADOLESCENTS TO SENIORS 96-97 (3d ed. 2006).
77 KAISER FArIlY FOumm., RACIaL AND ETHNIC DISPARITIES IN WOMEN'S HEALth COvERAGE and ACCESS TO CAre, *supra* note 74, at 2.
78 Gold, *New Federal Authority, supra* note 62, at 7.
79 *Id.*
80 *Id.* at 3; Vernon Smith et al., *Low Medicaid Spending Growth Amid Rebounding State Revenues: Results from a 50-State Medicaid Budget Survey* 7, 33 (Kaiser Family Found., 2006), *available at* http://www.kff.org/medicaid/7569.cfm (discussing Kentucky's FY 2007 plan to impose higher cost sharing, and, along with Rhode Island, Kentucky's plan to make copayments enforceable so that beneficiaries would be denied services if they could not pay providers or pharmacists).
81 Gold, *New Federal Authority, supra* note 62, at 2-3.
82 Leighton Ku et al., *Survey Indicates Deficit Reduction Act Jeopardizes Medicaid Coverage for 3 to 5 Million U.S. Citizens* (Ctr. on Budget & Pol'y Priorities, Feb. 17, 2006), *at* http://www.cbpp.org/1-26-06health.htm; Sonfield, supra note 49, at 7-11.
83 In most states, women with dependent children will qualify for Medicaid if they earn less than 67% of the federal poverty level for working parents, while women would be able to obtain services at a Title X funded clinic if they have an income up to 250% of the federal poverty level. Jennifer J. Frost et al., Estimating the Impact of Serving New Clients by Expanding Funding for Title X (Guttmacher Institute, Occasional Report No. 33, Nov. 2006), *available at* http://www.guttmacher.org/pubs/2006/11/16/or33.pdf.
84 Rachel Benson Gold, *Stronger Together: Medicaid, Title X Bring Different Strengths to Family Planning Effort,* Guttmacher Pol'y Rev. 13, 15 (Spring 2007), *available at* http://www.guttmacher.org/pubs/gpr/10/2/gpr100213.html.
85 Frost et al., *supra* note 83, at 9.
86 Non-Hispanic whites comprise 61% of clients, Hispanics are 14%, Blacks are 19% and Asians/other races are 7% of the clients served by Title X clinics. Guttmacher Inst., Facts in Brief: Title X and the U.S. Family Planning Effort 3 (1997), *available at* http://www.guttmacher.org/pubs/ib16.html.
87 Gold, *Stronger Together, supra* note 84, at 15.
88 ADAM SONFIEiD ET Ai., GUTTMACHER INST., COST PinSSUinS ON TITiE X FAMIiY PiaN?ING G1aN11ES, FY 2001-2004, at 2 (2006), *available at* http://www.guttmacher.org/pubs/2006/08/01/CPTX.pdf (last visited Sept. 11, 2007).
89 Frost et al., *supra* note 83, at 11-12.
90 Gold, *Stronger Together*, *supra* note 84, at 18; Cynthia Dailard, *Challenges Facing Family Planning Clinics and Title X,* GUTTMACHER ReP. ON PUB. POi'Y (Spring 2001), *available at* http://www.guttmacher.org/pubs/tgr/04/2/gr040208.pdf.
91 SONFIEiD Ft Ai., *supra* note 88, at 4.
92 Ctrs. for Disease Control, Fact Sheet: HIV/AIDS among Asians and Pacific Islanders 3-4 (May 2007), *available at* http://www.cdc.gov/hiv/resources/factsheets/API.htm (last viewed Sept. 11, 2007).
93 Ctrs. for Disease Control, Fact Sheet: HIV/AIDS among Asians and Pacific Islanders 3-4 (May 2007), *available at* http://www.cdc.gov/hiv/resources/factsheets/API.htm (last viewed Sept. 11, 2007); Ctrs. for Disease Control, Fact Sheet, HIV/AIDS among Women 3 (rev'd June 2007), *available at* http://www.cdc.gov/hiv/topics/women/resources/ factsheets/pdf/women.pdf.
94 NAT'i LATINA INST. FOR REPRODUCTIVE HIaiiii, A NATIONAi LATINA AGENDA FOR REPRODUCTIVE JUSTICE 3-4 (2005), http://www.latinainstitute.org/programs/documents/FinalAgenda-4.pdf [hereinafter NLIRH Report].
95 Dailard, *supra* note 90, at 11.
96 Myra J. Tucker et al., *The Black-White Disparity in Pregnancy-Related Mortality from 5 Conditions:*

Differences in Prevalence and Case-Fatality Rates, 97 Ari. J. PUB. Hnairn 247-51, 248 (2007) (citing WORiD Hnaith ORG. (WHO), MarERNAi MO1taiItY IN 2000: ESTIMATES DEVEiOPED BY WHO, UNICEF, UFPA (2004)), *available at* http://www.who.int/reproductive-health/publications/maternal_mortality_2000/index.html.
97 WORiD Heaith ORG. (WHO), MATERNAi MO1taiItY IN 2000: ESTIMAteS DEVEiOPED BY WHO, UNICEF, UFPA 22-26 (2004).
98 Ctrs. for Disease Control, Nat'l Ctr. for Health Statistics, Ctrs. for Disease Control, *Maternal Mortality and Related Concepts*, Vital Health Stat., Feb. 2007, at 8.
99 *Third Periodic Reports of States Parties Due in 1999: Addendum: United States of America*, U.N. CERD, 59th Sess. ¶ 326, U.N. Doc. CERD/C/351/Add.1 (2000), *available at* http://www.unhchr.ch.
100 Myra J. Tucker et al., *The Black-White Disparity in Pregnancy-Related Mortality from 5 Conditions: Differences in Prevalence and Case-Fatality Rates,* 97 AM. J. PUB. Heaith 247-51, 247 (2007) (stating that "[f]or the past 5 decades, Black women have consistently experienced an almost 4 times greater risk of death from pregnancy complications than have White women.").
101 Ctrs. for Disease Control, Press Release, Pregnancy-Related Mortality Surveillance—United States, 1991-1999 (2003), *available at* http://www.cdc.gov/od/oc/media/pressrel/fs030220.htm.
102 AGENCY FOR HEAiTHCARB RESEARCH & QUAiITY, NATIONAi HeaithCA1n DISPARITIES RePOit, 2006, at 160 (2006) (finding that "the proportion women who initiated prenatal care in the first trimester was significantly lower" in all major racial/ethnic groups compared to white women); *see also* CTRS FOR DISEASE CONTROi, NATIONAi VITAi STATISTICS REPORTS, BIrtIS: FINai DATA FOR 2004 69 (2006) (revealing that Blacks and Hispanics are more than twice as likely to receive late or no prenatal care compared to white women) (showing data from 41 states that reveals Blacks (5.7%) and Hispanics (5.4%) were much more likely to have late or no prenatal care than whites (2.2%)).
103 Tucker et al., *supra* note 100, at 250.
104 NLIRH Report, *supra* note 94, at 4.
105 Kauthar B. Umar, Office of Minority Health Res. Ctr., *Maternal Mortality: African Americans Remain at Higher Risk*, Closing the Gap, Maternal Health (Jan./Feb. 2004), *available at* http://www.omhrc.gov/assets/pdf/checked/ Maternal%20Mortality--African%20Americans%20Remain%20at%20Higher%20Risk.pdf.
106 U.S. Dep't of Health & Human Servs., *Health Care Expenditures for Uncomplicated Pregnancies* 6 (Aug. 2007), *available at* http://www.meps.ahrq.gov/mepsweb/data_files/publications/rf27/rf27.pdf (last viewed Nov. 1, 2007).
107 Ku, Reducing Disparities in Health, *supra* note 28, at 2.
108 Ku et al., Survey Indicates DRA Jeopardizes Medical Coverage, *supra* note 82.
109 *Id.*
110 110 *See* 42 C.F.R. § 457.10 (2002); NLIRH Report, *supra* note 94, at 13.
111 Dailard, *supra* note 90, at 11.
112 Guttmacher Inst., State Policies in Brief: An Overview of Abortion Laws (Oct. 1, 2007), *available at* http://www. guttmacher.org/statecenter/spibs/spib_OAL.pdf.
113 SA1a R. Sills e'r Al., NARAL/Ny Founm. & NAT'l HEAlTH LAw pRoGRAM, pRoTEcTING REpRoDucTIvE HEAlTH cARE FoR Low-INcoME woMEN 1-2 (2002), *available at* http://www.healthlaw.org/library.cfm?fa=download&resourceID=66 1 49&print.
114 *Id.* at 2.
115 S. Henshaw & L. Finer, *The Accessibility of Abortion Services in the United States, 2001,* 35 pERsp. oN SExuAl & REpRoDucTIvE Hnalth 16, 23 (2003).
116 H. Boonstra, *The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States*,

GuTTMAcHER pol'y REv. Winter 2007, at 12-16, *available at* http://www.guttmacher.org/pubs/gpr/10/1/gpr100112.html.
117 Henshaw & Finer, *supra* note 115, at 23.
118 The ten poorest states in order of largest percentage of persons below poverty level are: Mississippi, Louisiana, New Mexico, West Virginia, Texas, Arkansas, Alabama, Kentucky, Oklahoma and South Carolina. The District of Columbia ranks between Louisiana and New Mexico. U.S. Census Bureau, *Percent of People Below Poverty Level in the Past 12 Months (For Whom Poverty Status Is Determined): 2005*, 2005 Ari. cMty. SuRvey tbl. R1 701 *available at* http://www.census. gov/compendia/statab/ranks/rank34.htm. Of these ten states, eight (MS, LA, TX, AL, AK, KY, OK, SC) have passed significant restrictions on abortion, including legislation to outlaw abortion. NARAL pRo-cHoIcE AMERIcA, wHo DEcIDEs?: THE Sr.&ius oF woMEN's RepRoDucTivE HEAlTH IN the uN1teD STATEs 1-2 (2007), *available at* http://www. prochoiceamerica.org/choice-action-center/in_your_state/who-decides/introduction/who_decides_2007_full.pdf.
119 NARAL, Who Decides?, *supra* note 118, at 7.
120 *See generally id.*
121 In 2007, 98% of Mississippi counties had no abortion provider. Eighty-six percent of Mississippi women lived in these counties. In the South census region, where Mississippi is located, 32% of women having abortions traveled at least 50 miles, and 10% traveled more than 100 miles. In Mississippi, the following restrictions on abortion were in effect as of August 2007: the parents of a minor must consent before an abortion is provided; a woman must receive in-person state-directed counseling that includes information designed to discourage her from having an abortion, and then wait 24 hours before the procedure is provided; public funding is available for abortion only in cases of life endangerment, rape, incest or fetal abnormality. Abortion is covered in insurance policies for public employees only in cases of life endangerment, rape or incest, or fetal abnormality. Guttmacher Inst., State Facts about Abortion: Mississippi (2006), http://www.guttmacher.org/pubs/sfaa/print/mississippi.html (last viewed Sept. 11, 2007).
122 Miss. Code Ann. § 41-41-33 (2007).
123 *Id.* at § 41-41-91.
124 B.B. Robinson, *Addressing the Most Painful Discrimination*, cNSNEws.coM, http://www.cnsnews.com/news/viewstory. asp?Page=/Commentary/archive/200706/COM2007061 9a.html.
125 Kathy L. Hudson et al., *Genetic Discrimination and Health Insurance*, vHL FAMIly FoRuM, *available at* http://www.vhl. org/newsletter/vhl1 996/96aqinsu.htm.
126 Council for Responsible Genetics, Genetic Testing, Discrimination, and Privacy, http://www.gene-watch.org/programs/privacy.html.
127 Steven Reinberg, *Record Number of Americans Lack Health Insurance*, u.S. NEws & woRlD REp., Aug. 28, 2007, *available at* http://health.usnews.com/usnews/health/healthday/070828/record-number-of-americans-lack-health-insurance. htm.%20Closings%20Short%20Report%2020Nov06.pdf.

E. THE ADEQUACY OF THE GOVERNMENT RESPONSE TO RACIAL HEALTH DISPARITIES

1. Health care system responses

The US government must comply with CERD and reform the health care system to remedy racial and ethnic disparities in health. The steps taken by the government to date are clearly inadequate. In its 2007 report, the

U.S. asserts that "the U.S. Commission on Civil Rights conducts studies and makes recommendations concerning civil rights issues"[1] but does not mention any steps taken to implement these recommendations. Similarly, the U.S. report claims that the federal government is "mov[ing] forward on a number of IOM's recommendations [in the 2003 *Unequal Treatment* report]," but includes only vague steps that the Department is taking.[2] A review of congressional hearings and legislation reveals that little has been done to remedy the disparities cited in the *Unequal Treatment* report. The U.S. is violating its obligations under CERD by shirking its responsibility and failing to implement these recommendations.

Although the U.S. cites programs, such as Healthy People 2010, as evidence of its efforts to eliminate health disparities affecting racial and ethnic minority populations,[5] the results of these initiatives have been mixed and the government has undermined their efficacy. In the Midcourse Review of Healthy People 2010, for example, the government deleted three key objectives: (1) the expansion of access to clinical preventative services for people of color, (2) increased the number of local health departments with culturally appropriate and linguistically competent community health promotion and disease preventions programs, and (3) improved data collection.[4] These objectives were included in the original Healthy People 2010 report to help remedy racial and ethnic health disparities.

In addition, the Department of Health and Human Services' Initiative to Eliminate Racial and Ethnic Disparities in Health, which the U.S. report cites, set the goal of reducing racial and ethnic health status disparities in six chronic health conditions, including diabetes, HIV, and infant mortality. But a 2006 report by the Center for Disease Control shows the U.S. has made little progress in these areas.[5] These programs reflect an ineffective, piecemeal approach to remedying systemic disparities in health status and access to health care.

Office of Minority Health (OMH)—The OMH is intended to act as the focal point for addressing health disparities on the federal level. However, according to the Office of Management and Budget, OMH has only recently developed an overall plan and indicators to measure progress. OMH has seen its budget repeatedly cut ($56M for FY 2006 to $44 for FY2008) ,[6] although in June 2007, Congress introduced the Minority Health Improvement and Health Disparity Elimination Act (MHIHDEA), which would strengthen OMH fund-ing. One area of research in which OMH has been active is that of strengthening local capacity under the community health worker model. OMH has announced its intent to fund capacity-building[7] and promote partnerships with minority community health organizations to improve both access and utilization.[8]

Office of Civil Rights (OCR)—In the wake of *Alexander v. Sandoval* and the limits it imposed on Title VI "disparate impact" claims, the OCR represents one of the few alternatives for those plaintiffs who seek to prosecute discrimination but lack the ability to directly prove discriminatory intent. However, over the last decade OCR's staff and budgets have been cut, and its prominence in this arena has suffered.[9] Independent assessments of OCR have questioned the overall direction of the office; in 2004, the U.S. Commission on Civil Rights reported that the organization lacked a "clear agenda."[10] Since then, as evidenced by an estimation of OCR's activity via simple literature searches, it appears that OCR has turned its attention to HIPAA and protected health information as a priority over issues of health disparity. While this has great health consequences for some minorities (such as American Indian tribes, due to their unique governmental status[11]), broader health disparity issues appear to have remained in the background.

The National Institute of Health's (NIH) National Center on Minority Health and Health Disparities (NCMHD)—The NCMHD functions as the NIH, but specific to health disparity issues: it coordinates and plans minority health disparity research. NCMHD has been prominent in promoting research and furthering discus-

sion of health disparity issues by sponsoring conferences. The recently introduced MHIHDEA would provide enhanced funding and further strengthen its role.[12]

Centers for Medicare and Medicaid Services (CMS)—CMS administrates Medicare and Medicaid. By virtue of Medicare's prominent position in our health system and its history as a tool of social change, CMS holds the potential to pioneer health disparities reduction. Carolyn Clancy, Director of the Agency for Healthcare Research and Quality, has suggested that CMS use the existing Medicare infrastructure to directly involve communities in education about health disparities, following the model of its efforts to promote the Medicare Part D plan. Likewise, CMS might require providers to collect data on health disparity, thereby greatly simplifying research efforts,[13] or directly fund research itself. CMS' network of oversight could be used to combat provider bias or oversee quality of care.

To date, however, CMS has done none of these things, and observers have noted that health disparity issues currently do not appear to be of a high priority. None of CMS' Government Performance and Results Act documents over the past half-decade have listed disparity issues as one of its priority goals, and in any respect CMS does not appear organized to effectively address those issues. Within CMS, no office of minority health or similarly central organization exists,[14] and consequently there is no budget dedicated to such as office to fund initiatives or involve external organizations.[15]

Overall, the magnitude of the federal health system response to this point has been somewhat uninspiring. However, it remains apparent that the bureaucratic framework for an effective response exists.

2. Environmental justice responses

The US CERD report's discussion of the government's efforts to address environmental justice consists of three short paragraphs. The brevity of this section reflects the scant amount of work by the US government to address environmental justice. Significantly, the lead agency addressing environmental justice, the U.S. Environmental Protection Agency (EPA), has been cited by other federal bodies for its failures to implement various legal mandates on environmental justice and for failing to provide meaningful redress to those who complain of environmental injustices. Moreover, EPA's inaction has lead other federal agencies to ignore or analyze away disparate environmental impacts on minority communities. The lack of redress for victims of environmental injustice also exists at the state level, where few states have laws that provide redress for victims of environmental injustice.

a. The EPA is not implementing Executive Order 12898

Executive Order 12898, adopted in 1994, requires that "each Federal agency shall make achieving environmental justice part of its mission by identifying and addressing, as appropriate, disproportionately high and adverse human health or environmental effects of its programs, policies, and activities on minority populations and low-income populations in the United States and its territories." Ten years later, on March 1, 2004, the Office of the Inspector General (OIG) of the U.S. Environmental Protection Agency (EPA) issued an evaluation report, which concluded that EPA had failed to integrate environmental justice into its daily operations, it had failed to identify low-income and minority populations, and it had failed to establish criteria for defining disproportionate impact. The OIG also found that in restating its commitment to environmental justice in 2001, EPA failed to place emphasis on low-income and minority communities, which was the intent of the executive order. TheOIG found that EPA had failed utterly to articulate a clear vision, a comprehensive

plan, or performance measures against which agency accomplishments could be measured.[16] The OIG issued a second report in 2006 finding that EPA still had not established criteria or evaluated its programs to determine whether they were creating a disproportionate adverse environmental impact on the nations low- income and minority populations.[17] EPA's failure to act has directly impacted minority populations within the United States. For example, people of color make up the majority (5 6%) of those living in nearby neighborhoods of the nation's 413 commercial hazardous waste facilities, and race continues to be an independent predictor of the location of such facilities.[18]

b. The EPA's Title VI complaint process fails to provide meaningful redress to victims of environmental injustice

Like most federal agencies, EPA's Title VI regulations not only bar recipients of federal funds from engaging in acts of intentional discrimination but also bar recipients from using criteria or methods that have the effect of subjecting individuals to discrimination on the basis of race, color, or national origin.[19] EPA's process for investigating Title VI complaints are set forth in agency regulations[20] and a draft administrative guidance published in the Federal Register on June 27, 2000.[21] While EPA has a framework in place for victims of environmental injustice to seek redress, that framework has not provided those victims with meaningful redress.

In 2003, the United States Commission on Civil Rights ("USCCR") issued a report that studied the effectiveness of EPA's Title VI Complaint Program.[22] USC CR compiled statistics on Title VI complaints filed with EPA. Of the 124 complaints filed with EPA by January 1, 2002 only 13 cases (10.5%) were processed by the agency in compliance with the agency's 20 day processing rule; and all 13 cases were rejected by the agency for investigation for failure to meet the agency's regulatory requirements.[23] By June 30, 2003 EPA had received a total of 136 Title VI complaints, and of that total, 75 were rejected, 26 were dismissed, and the remaining 35 complaints were accepted by the agency for further action.[24] Of 35 complaints acted upon by EPA, only 2 were informally resolved by EPA and another 2 were referred to another agency, with the remaining 31 complaints in some stage of EPA review.[25] The small number of timely processed complaints coupled with an even smaller number of resolved complaints strongly suggests that EPA's administrative process for handling Title VI fails to provide meaningful relief to victims of environmental injustice.

Noting that the U.S. Supreme Court's decision in *Alexander v. Sandoval*[26] gave environmental justice complainants "one less avenue of redress,"[27] USCCR made a series of recommendations to improve EPA's Title VI Complaint Program. Those recommendations included: EPA's (and other federal agencies having jurisdiction over environmental justice issues) issuing a final Title VI guidance on processing Title VI complaints and methods to improve permitting programs; EPA's conducting independent analyses of adverse disparate impacts in order to determine if they are actually present in a given community; establishing a guideline for its state funding recipients that incorporates an inclusive definition of adverse disparate impact; and conducting Title VI compliance reviews where periodically EPA would review the number and type of Title VI complaints and ensure their funding recipients are complying with their Title VI obligations.[28] To date, none of these recommendationshas been implemented by EPA or other federal agencies.

c. Judicial deference to agencies' consideration of environmentaljustice impacts fails to insure agencies properly consider disparate impacts

In response to Executive Order 11298, many federal agencies began incorporating an "environmental justice analysis" into Environmental Impact Statements mandated by the National Environmental Policy Act (NEPA).

NEPA requires all federal agencies to prepare detailed environmental impact statements ("EIS") for "every recommendation or report on proposals for legislation and other major Federal Actions significantly affecting the quality of the human environment . . . ."[29] The impacts to be considered by federal agencies under NEPA are "ecological (such as the effects on natural resources and on the components, structures, and functioning of affected ecosystems), aesthetic, historic, cultural, economic, social, or health, whether direct, indirect, or cumulative."[30] However, the agency need only consider economic and social effects to t2he extent that they are interrelated with the physical environmental effects of an action.[31]

As noted above,[32] EPA has failed to establish criteria to determine the existence of disproportionate adverse environmental impact on the nation's low-income and minority populations. Thus, agencies have developed their own approaches to conducting an environmental justice analysis under NEPA. Frequently, the agency's analysis of environmental justice impacts fails to properly analyze the disproportionate environmental burdens of proposed federal actions on minority communities. A case in point was the Federal Aviation Administration's ("FAA") environmental justice analysis of a proposed runway expansion at Boston's Logan Airport. The FAA's environmental justice analysis failed to compare the demographics and environmental impacts on the population of those living in the airport's im mediate vicinity (34% minority) with the population residing in the greater Boston metropolitan area that actually used the airport (85% white.)[33] Instead, the agency compared the population of the immediate area (calling it the "actually affected area") to that of one county in the Greater Boston area, Suffolk County (calling it the "potentially affected area"), where the minority population was considerably higher (48% minority). The analyses concluded that significant noise impacts would not fall disproportionately on minorities. The City of Boston challenged the FAA's environmental justice analysis in federal court, claiming that the FAA erred by not comparing the demographics of the population immediately surrounding the airport to that of the airport's service area. The Court ruled it had jurisdiction to review the FAA's environmental justice analysis because the agency exercised its discretion to include the analysis in its NEPA evaluation. However, the Court failed to overturn the FAA's analysis finding that the "FAA's choice among reasonable analytical methodologies is entitled to deference from this court."[24]

Judicial deference given to environmental justice analyses such as the FAA's is not surprising given the lack of criteria on how agencies should conduct those analyses. EPA is the federal agency best suited to develop those criteria, but it has failed to do so in spite of its obligations under Executive Order 12898. Until standards are promulgated, courts will continue to defer to the agency's choice of methodology, no matter how flawed, so long as the agency can convince a court that the methodology used in its environmental justice analysis is "reasonable and adequately explained."[35]*d. Victims of environmental injustice lack redress at the state level*
Under federal law, every state environmental agency must establish a grievance procedure to resolve complaints alleging discrimination on the basis of race, color or national origin under Title VI of the Civil Rights Act of 1964, including complaints regarding actions that allegedly have discriminatory impacts.[36] However, as of 2004, only four state environmental agencies had adopted formal discrimination complaint procedures (Alabama, Connecticut, Illinois and Louisiana) . [37] The absence of Title VI grievance procedures at the state level deprives environmental justice complainants of another avenue for redress.

With the exception of California, no state has any laws that provide redress for actions by state agencies or recipients of state funds that have the effect of discriminating on the basis of race, color or national origin. California has a state law similar to Title VI that bans discrimination on the basis of race, color, national origin and "ethnic group identification" in "any program or activity that is conducted, operated, or administered by the state or by any state agency, is funded directly by the state, or receives any financial assistance from the state."[38] Regulations implementing California's version of Title VI define unlawful discrimination to include actions that

"have the purpose or effect of subjecting a person to discrimination . . . ," including the issuance of permits or selection of sites or location of facilities.[39] Unlike regulations implementing Title VI, regulations implementing California's version of Title VI can be enforced by private parties in an action seeking injunctive relief.[40] While states generally do not provide legal redress for government actions that impose disproportionate environmental burdens on communities of color, several states have enacted legislation requiring their respective state environmental agencies to take certain actions to promote environmental justice.[41] In Rhode Island, the state's Department of Environmental Management must consider the effects that contaminated site clean-ups would have on the populations surrounding each site and the issues of environmental equity for low-income and racial minority populations.[42] Similarly, in Kentucky, the state environmental agency must consider both the social and economic effects of issuing a certificate of environmental safety and public necessityfor the siting of a facility.[43] The state of Arkansas enacted a law that prohibits the siting of landfills within twelve miles of each other. More specifically, it states that there is a "rebuttable presumption against permitting the construction or operation of any high impact solid waste management facility within twelve miles of any existing high impact solid waste management facility."[44] Even though there are exceptions to this presumption, the purpose underlying the statute is to avoid the concentration of solid waste disposal facilities in low-income and minority communities.

ENDNOTES

1 CERD, *Sixth Periodic Reports of States Parties Due in 2005: Addendum: United States of America,* U.N. CERD, 72nd Sess., ¶ 284 (Advance Edited Version), U.N. Doc. CERD/C/USA/6 (2007), *available at* http://www.ohchr.org/english/bodies/cerd/docs/AdvanceVersion/cerd_c_usa6.doc [hereinafter 2007 U.S. Report].
2 *Id.* at ¶ 261.
3 *Id.* at ¶ 262.
4 Office of Disease Prevention & Health Promotion, U.S. Dep't of Health & Human Servs., *Appendix D: Healthy People 2010 Objectives and Subobjectives Dropped at Midcourse Review*, HealthY PEOPIE 2010 MIdCOURSE REVIEw, D-1, D-2, D-5, *available at* http://www.healthypeople.gov/data/midcourse/pdf/Appendix%20D.pdf.
5 NAT'I CTR. FOR HEAITh STArISTICS, U.S. DEP'T Or Health & HUMan SerVS.. HnaIth, UNITED STATES, 2006 (2007).
6 Detailed information on HHS-OMH assessment. ExpectMore.gov, Health and Human Services - Office for Civil Rights, http://www.whitehouse.gov/omb/expectmore/detail/10003523.2005.html.
7 *American Indian/Alaska Native Health Disparities Program*, Federal Register Extracts: Health and Human Services Department Documents and Publications (July 6, 2007).
8 *Community Partnerships To Eliminate Health Disparities Demonstration Grant Program*, Federal Register Extracts Health and Human Services Department Documents and Publications (June 11, 2007).
9 Dayna B. Matthew, *Disastrous Disasters: Restoring Civil Rights Protections for Victims of the State in Natural Disasters*, 2 J. Health & Biomed. L. 213 (2006).
10 U.S. COMM'N ON CIVII RIGhTS, TeN-YEAR CheCK-UP: H.&VE FEDERAI AGENCIES RESPONDED TO CIVII RIGhTS ReCOMMENDATIONS, VOI. IV (2004), *available at* http://www.eric.ed.gov/ERICDocs/data/ericdocs2sql/content_storage_01/0000019b/80/28/0e/36.pdf [hereinafter TeN-Year ChECK-UP, VOI. IV].
11 Starla K. Roels, *HIPAA and Patient Privacy: Tribal Policies as Added Means for Addressing Indian Health Disparities*, 31 AM. IndIan L. REV. 1 (2006).
12 *Kennedy, Cochran Introduce Bill to Eliminate Health Disparities*, STAteS NEwS SerV., June 7, 2007.

13 Olga Pierce, *Medicare vs. the race gap*, UPI, Jan. 29, 2007.
14 Although CMS has an Office of Equal Opportunity and Civil Rights (OEOCR), it exists primarily to address employment opportunity discrimination, while Medicare-related civil rights complaints are referred to the Office of Civil Rights.
15 Timothy S. Jost, *Racial and Ethnic Disparities in Medicare: What the Department of Health and Human Services and the Centers for Medicare and Medicaid Services Can, and Should, Do*, 9 DEPAUI J. HEAITh CA1ue L. 667 (2005).
16 OFFICE OF ThE INSPECTOR GEN., U.S. ENVTI. PROT. AGENCY, EVAIUATION RiPOrt: EPA NEEDS TO CONSISteNTIY IMPIEMENT ThE INTENT OF ThE ExECUtIVE ORDER ON ENVIRONMENTAI JUSTICE, RePOit NO. 2004-P-00007 (2004), *available at* http://www.epa.gov/oig/reports/2004/20040301-2004-P-00007.pdf.
17 Office of the Inspector Gen., U.S. Envtl. Prot. Agency, Evaluation Report: EPA Needs to Conduct Environmental Justice Reviews of Its Programs, Policies, and Activities, Report No. 2006-P-00034 (2006), *available at* http://www.epa.gov/oig/ reports/2006/2006091 8-2006-P-00034.pdf [hereinafter OIG, EPA Evaluation].
18 *See* ROBERT D. BUII.rd et AI., TOxIC WASteS AND RACE AT TwintY: 1987-2007 (2007).
19 40 C.F.R. §§ 7.30, 7.35 (2007).
20 40 C.F.R. §120 (2007).
21 *See* Draft Revised Guidance for Investigating Title VI Administrative Complaints Challenging Permits, 65 Fed. Reg.39650, 39667-86 (proposed June 27, 2000), *available at* http://www.epa.gov/ocr/docs/frn_t6_pub06272000.pdf..
22 U.S. CIVII RIGhTS COMM'N, NOT IN MY BACKYARD: ExECUtIVE OrdER 12898 AI'd TITIE VI AS TOIIS FOR AChIEVING ENVIRONMENTAI JUSTICE (2003), *available at* www.usccr.gov/pubs/envjust/ej0104.pdf [hereinafter USCCR 2003].
23 *Id.* at 57.
24 *Id.* at 58.
25 *Id.*
26 532 U.S. 275 (2001).
27 USCCR 2003, *supra* note 10, at 76.
28 *Id.* at 77-78.
29 42 U.S.C. §4332 (2007).
30 40 C.F.R. §1508.8 (2007).
31 40 C.F.R. §1508.14 (2007).
32 *See* OIG, EPA Evaluation, *supra* note 17.
33 According to 2000 census data, whites comprised 85% of the population of the Boston-Worcester-Lawrence-LowellBrockton, Mass. Standard Metropolitan Statistical Area (SMSA) (5,147,035 out of a total population of 6,057,826) (derived from Census 2000 Summary File 1 (SF 1) 100-Percent Data on U.S. Census web site, www.census.gov on Nov. 7, 2007).
34 Cmtys. Against Runway Expansion, Inc. v. FAA, 355 F.3d 678, 689 (D.C. Cir. 2004)
35 *Id.*
36 40 C.F.R. § 7.90(a) (2007) ("Each recipient shall adopt grievance procedures that assure the prompt and fair resolution of complaints which allege violations of this part.").
37 R.I. Legal Servs., Environmental Justice for States: A Guide for Developing Environmental Justice Programs for State Environmental Justice Agencies, at 32 (Report to the U.S. Environmental Protection Agency, Grant No. 98197001 2006), *available at* http://www.dem.ri.gov/envequity/pdf/rilsrept.pdf (last accessed Nov. 7, 2007); Srnth et Al., *supra* note 218.

38 cal. Gov'T coDE §11135(a) (2007).
39 cal. coDE RECs. tit. 22 §§98101 (i), (j) (2007).
40 cal. Gov'T coDE §11139 (2007).
41 *See* Ar. BAR Ass'N ET Al., ENvIRoNMENTAl JusTIcE FoR All: A Fifry STATE Survey or LegIslatioN, polIcies, And INITL&- TIvE (Steven Bonnorris ed., 2004), *available at* http://www.abanet.org/irr/committees/environmental/statestudy.pdf (last accessed Nov. 7, 2007).
42 R.I. GEN. LAws §23-19.14-5 (2006).
43 KAN. STAT. ANN. §224.46-830 (2006).
44 ARK. STAT. ANN. § 8-6-1504 (2006).

F. Key U.S. actions needed to address health disparities

1. Health care system recommendations

Both the federal and state government must undertake far reaching structural reforms to comply with CERD and eliminate racial disparities in health status and medical care. The United States Senate ratified CERD with the understanding that "this Convention shall be implemented by the Federal Government to the extent that it exercises jurisdiction over the matters covered therein, and otherwise by the state and local governments. To the extent that state and local governments exercise jurisdiction over such matters, the Federal Government shall, as necessary, take appropriate measures to ensure the fulfillment of this Convention."[1] In the U.S., states and the federal government share the responsibility of regulating public health and health care. As a result, both levels of government have an affirmative obligation to fulfill the requirements of CERD.

Outlined below are steps that the federal government and state governments must take to alleviate health disparities and ensure that all Americans have equal access to quality medical care.

a. Federal government

Health care reform

The high percentage of uninsured people of color makes clear that the U.S. must establish a system of universal coverage which allows all Americans, regardless of race, ethnicity, or immigration status, to access quality health care. Such a system will greatly reduce financial barriers to effective and equitable distribution of health care resources, because it will equalize incentives for hospitals, health care systems, and private providers to serve a range of communities regardless of their wealth or poverty.

The federal government must also assess how policies to expand access (i.e. affordability standards and individual mandates to purchase insurance) may differentially affect communities of color, immigrants, and low-income populations.[2] And it must promote equal access to health insurance by expanding public insurance programs to cover people regardless of immigration status, citizenship status, and documentation status.[3] Creating a distinction in access to health care between immigrants exacerbates health disparities.

Data collection and analysis

The federal government should ensure that public and private health systems monitor racial and ethnic,

language status, and income-based health care disparities. The federal government must assure that the Centers of Medicaid and Medicare and other federal agencies that finance health care services engage in systematic, periodic analysis of racial disparities in the clinical care programs they support, using standard quality assurance measures.[4]

Data collection must be as inclusive as possible—if national estimates are not available, the federal government should look to community studies and state/local data on minority groups.[5] And the federal government should conduct community specific studies to determine the health care issues specific to certain ethic groups, and to various regions of the country.[6]

The data collected by federal health programs needs to reflect the diversity of the U.S., population.[7] Much of the data currently collected still focuses primarily on the differences between blacks and whites. For example, in the mid-course review of the Healthy People 2010, the data discussed is predominantly black/white.[8]
Data collection should include immigrant communities with a special recognition of their unique status, including cultural differences, special health needs, and financial concerns.[9] And the Department of Health and Human Services should expand its data collection for Hispanic, Asian, Hawaiian, and other Pacific Islander and American Indians and Alaska Native populations. The Department should also improve collection of data on language to ensure full participation in health communications and on economic and social environments to tackle the structural and environmental causes of health disparities.[10]As mandated by the Healthcare Research and Quality Act of 1999, the government should analyze data on health disparities and deliver reports that provide an accurate representation of health disparities in the U.S. Since it became public that the first HHS report on national health care disparities in 2003 was sanitized in a political cover up, subsequent reports have more accurately depicted the status of racial and ethnic health disparities in the U.S.

Finally, the federal government should mandate that states follow a uniform process in their data collection that includes information on patient's race, ethnicity and primary language.[11] Given that some states have non-discrimination laws that apply to health care settings and require state diligence to enforce, state requirements to collect and report standardized data are an important benchmark for state efforts to reduce health care inequality.

Cultural competency and language barriers

Federally funded health professionals should be trained in cross-cultural medicine to improve provider-patient communication and eliminate pervasive racial and ethnic disparities in medical care. The federal government should encourage private professionals and administrators to receive training on cultural factors that influence health care, and design care to accommodate those factors.[12]

The federal government should take steps to increase the racial and ethnic diversity of health care providers by reducing or eliminating financial barriers to health professions education for low-income students, strengthen magnet science programs in urban high schools, and, consistent with the U.S. Supreme Court's ruling in the 2004 *Grutter v. Bollinger* decision, support the consideration of applicants' race or ethnicity as one of many relevant factors in higher education admissions decisions.

The Department of Health and Human Services must initiate a campaign to ensure that information is made publicly available concerning rights to equal access to quality healthcare. [13]

The Office of Civil Rights must develop easy to understand guidelines, in multiple languages, for people who use health care facilities (particularly immigrants) on their rights, responsibilities and entitlement to care. OCR should also work with community organizations, advocacy groups and relocation sponsors to disseminate these guidelines and information.[14]

Civil rights laws

The federal government must considerably step up civil rights enforcement in the health care sphere. The Department of Justice can initiate litigation on behalf of an agency, like the U.S. Department of Health and Human Services (HHS), for a violation of Title VI.[15] And HHS's Office of Civil Rights (OCR) has the power to initiate an investigation of a recipient of federal funds, like the New York State Department of Health, and require the recipient to create a plan to remedy discrimination.[16]

These agencies have, however, been slow to engage in necessary field investigations and other activities to ensure the equitable distribution of health care resources.[17] OCR has "hardly developed its title VI enforcement program since 1980," according to the bipartisan U.S. Commission on Civil Rights.[18] The Commission expressed concern that OCR had not instituted a system of on-site visits or data collection, and recommended that it collect information regarding "the race, color, or national origin of the population served" and "the location of existing or proposed facilitiesand information on whether the location will have the effect of denying access to any person on the basis of prohibited discrimination."[19]

The Office of Civil Rights must increase its enforcement efforts and identify and remedy Title VI, Title IX, and Hill-Burton Act violations.[20] The federal government must invest in OCR, provide it with the necessary staff and resources to address disparities in health care, and encourage it to take action to address disparities in the quality of health care in the United States.[21]

The federal government can also strengthen civil rights agencies' capacity to investigate racial or ethnic disparities in health through the creation of an Office on Health Disparities in the Civil Rights Division of the Department of Justice (which already has offices dedicated to housing, employment and education)[22] and/or in the HHS Office of Civil Rights.[23] These special units should be charged with focusing on racial and ethnic disparities in quality of clinical treatment and should be assessing data on disparities in quality of care.

Finally, while strong government enforcement of civil rights laws is necessary to ensure compliance with CERD, the Convention also requires that courts be available to individuals who have suffered from intentional or unintentional discrimination. In *Alexander v. Sandoval*, the U.S. Supreme Court ruled that individuals do not have the right to sue to enforce the Title VI disparate impact regulation, because the statute did not specify a private right of action. Congress should ensure that every statute protecting civil rights specifically authorizes individuals to bring civil suits in federal court to redress violations of the law.[24] Similarly, Congress should clarify the legal right of Medicaid recipients to force state compliance with the Medicaid Act.[25] The judicial system is an important recourse for Medicaid recipients who face barriers to accessing care. But recent court cases have "jeopardiz[ed] the ability of Medical beneficiaries to go to court."[26]programs are evaluated to determine their potential impact on the health status of affected communities.

b. State governments

Health impact assessment

In order to ensure that federal funds for health care are distributed fairly and equitably, HHS should require funding recipients, like state health departments, to review how a potential policy, such as a hospital opening or closing, will impact racial and ethnic communities *before*, rather than after, programs are finalized and implemented.[27] HHS should require a disparate impact analysis as a substantive compliance condition, as opposed to a post-complaint enforcement response.[28]

HHS leadership should convene an Interagency Task Force to examine systemic practices that underlie the structure and operation of modern health care.[29] Particular attention should be paid to the features governing the location and functioning of health care entities. This task force should begin developing a department-wide strategy for civil rights enforcement, not limited to individual complaint investigation, which would establish prospective standards of conduct to guide programs and providers in understanding how civil rights regulations apply in a health care context.[30] HHS should also address the underlying structures that foster racism, including elusive barriers like prejudice, stereotyping and cultural ignorance.[31]

And the federal government should integrate a *Health Impact Assessment* (H IA) Tool into the domestic policy agenda to determine the effect that new legislation will have on the health of people of color.[32] The impact tool, which includes mechanisms for public participation, could be used by federal, state, and local agencies to ensure that all decisions and **Health care reform**

States have it in their power to develop systems of universal coverage. The Commonwealth of Massachusetts, for example, recently passed legislation to develop a near-universal access system. And the state is now taking steps to ensure that the coverage system addresses equity concerns, by expanding data collection and taking other steps to tackle health disparities. Other states should follow suit.

Data collection

State Departments of Health should collect data and monitor disparities in health care access and quality on the basis of income, race, ethnicity, gender, primary language, and immigration status. As the U.S. Commission on Civil Rights emphasized in its 2002 report, states must establish "quality assurance measures to ensure that minorities and women benefit equally from state recipients' programs."[33] State agencies are already required to implement a Title VI compliance program, including data collection and record maintenance, to ensure that both Departments of Health and the facilities to which Departments of Health convey federal assistance meet the nondiscrimination requirements of Title VI of the Civil Rights Act of 1 964.[34] Collection of this information provides the foundation for addressing disparities in access to health care.

Certificate of need

States must ensure that their Departments of Health consider the public's health needs in decisions affecting hospitals and clinics. Obtaining a Certificate of Need—the regulatory prerequisite for service changes in many states—should be contingent on evidence that the changes sought would reduce racial and economic health care inequality.[35]

Historically, the purpose of the Certificate of Need (CON) process has been to control health care costs and ensure that capital and technology investments in the health care industry reflect community needs. In most states that employ CON, the process has required hospitals or other health care institutions that seek to establish

or expand services to submit proposals so that state boards can evaluate projects to eliminate unnecessary duplication of services and ensure that investments strategically address health care needs. But the process has met significant resistance and criticism for its failure as a cost-containment measure. The CON process, however, has great potential to encourage a better distribution of health care resources, reflect community and statewide need. States should re-evaluate, and in some cases reinvigorate CoN through new policies that ensure accountability for the use of public funds.

Community health planning

Community health planning seeks to strengthen communities by actively involving residents in the planning, evaluation, and implementation of the health care and public health programs in their communities. The 1974 National Health Planning Law sought to create and support a network of state health systems agencies, but federal funding was cut from the program, and most states' have halted their health planning efforts. States must examine strategies to reinvigorate local health planning agencies. Without health planning, market forces often dictate the distribution of re-sources, leaving low-income communities of color without adequate quality health care. States should consider reinstituting and funding community-based health planning and should include health disparities reduction efforts as part of the mission of these planning agencies.

Cultural competency and a diverse health care work force

Most states are experiencing rapid growth in the population of racial and ethnic minority and language minority residents. Already, four states and the District of Columbia are "majority minority," and nearly one in two U.S. residents will be a person of color by mid-century. These demographic changes require that the health professions keep pace by training future and current providers to manage diversity in their practice. Some states have taken action to address this need—as of 2005, New Jersey required that all physicians practicing in the state must attain minimal cultural competency training as a condition of licensure. Other states should follow suit.

States must work to increase the racial and ethnic diversity of the health care workforce. Studies, including a 2004 Commonwealth Fund report, demonstrate that racial and ethnic minority health care providers are more likely to work in minority and medically underserved communities, and that patients of color are more likely to be satisfied with care provided by a diverse group of professionals.[36] Furthermore, increased diversity at the top levels of hospital administration can have a positive impact on the care provided, including more culturally and linguistically appropriate services.[37]

Investment in underserved communities

Low-income and minority communities often have the most pressing need for health care services, but they are served by a dwindling number of providers and institutions that lack resources to expand and improve services. States have attempted to address this imbalance by providing incentives, such as funds for graduate medical education programs that focus on underserved populations, tuition reimbursement and loan forgiveness programs that require service in health professional shortage areas, and they should continue providing such incentives.

In addition, states should support "safety net" hospitals and reduce the financial vulnerability of health care institutions serving poor and minority communities. These "safety net" institutions may fare better in states where near-universal health insurance coverage proposals are enacted and where health insurance expansions

are realized, but they will likely continue to face financial vulnerability until universal coverage is achieved.[38]

Review and increase Medicaid rates

Low reimbursement rates under state Medicaid programs are a major problem that leads to both inadequate and unequal health care services. When reimbursement rates are too low, health care providers have little incentive to serve individual Medicaid patients or whole communities that desperately need care. States should review and increase Medicaid reimbursement rates for crucial primary, prenatal, and maternal health care services.

Challenge exclusionary and discriminatory practices

States should encourage their Attorney General's Offices to challenge systemic inequities in the health care system. Attorney Generals possess broad authority under *parens patrie* standing, which provides states with the ability to sue to protect the healthof their residents.[39] States should also encourage their human rights and civil rights commissions to initiate investigations, file complaints, and conduct studies in order to prevent and eliminate discrimination.

In addition, a number of states, including Texas, Oregon, Minnesota, California, and Washington, have established task forces to identify strategies for eliminating health care disparities.[40] And thirty states have established offices of minority health to stimulate and coordinate state programs that directly or indirectly address needs of racial and ethnic minority groups. Other states should follow suit, establishing both task forces to eliminate disparities and offices of minority health to coordinate state programs.

2. Environmental justice recommendations

a. Amend Title VI 601 to define discrimination in accord with ICERD
(Discussed above under health recommendations)
b. Codify Executive Order 12898 on environmentaljustice and implement Office of Inspector General recommendations to EPA by passing Environmental Justice Act of 2007 (HR 1103)
To remedy many of the deficiencies of the U.S. Government in the area of environmental justice Congress should enact the Environmental Justice Act of 2007, H.R. 1103, introduced by Representative Hilda Solis (D. CA) . This legislation:
● Codifies the 1994 Executive Order on environmental justice, Executive Order 12898, to ensure that low-income and minority communities have meaningful involvement in the implementation and enforcement of environmental laws and
access to public information relating to human health and environmental planning, regulations and enforcement.
Provides for judicial review of agencies' actions regarding implementation of the Executive Order.
Requires the EPA to fully implement recommendations identified by the Office of the Inspector General (2004 and 2006) and the Government Accountability Office (2005).
Develops reporting requirements, such that the EPA shall provide Congress with regular updates on the implementation of the Inspector General and Government Accountability Office recommendations, and on the inclusion of environmental justice into the EPA's emergency command response structure.
c. Congress should hold hearings on EPA's response to contamination in minority communities
Given the disproportionately high number of toxic waste sites in minority communities, Congress should hold hearings on EPA's response to toxic contamination in those communities, such as post-Katrina New Orleans.
d. EPA should implement the U.S. Commission on Civil Rights' recommendations regarding Title VI

complaint process

The U.S. Commission on Civil Rights' recommendations regarding the investiga-tion of environmentally-related civil rights complaints under Title VI of the Civil Rights Act should be implemented. These recommendations include:

EPA's (and other federal agencies having jurisdiction over environmental justice issues) issuing a final Title VI guidance on processing Title VI complaints and methods to improve permitting programs;

EPA's conducting independent analyses of adverse disparate impacts in order to determine if they are actually present in a given community;

EPA's establishing a guideline for its state funding recipients that incorporate an inclusive definition of adverse disparate impact; and

conducting Title VI compliance reviews where periodically EPA would review the number and type of Title VI complaints and ensure their funding recipients are complying with their Title VI obligations.[41]

e. EPA should require state-by-state assessments (report cards) on environmentaljustice

From 1993 to the present, nearly three dozen states have expressly addressed environmental justice.[42] However, little is known about the efficacy of these laws
and whether these laws are being enforced. EPA should require all state environmental agencies to evaluate and report on their progress made on environmental justice.

ENDNOTES

1 140 Cong. Rec. 14326 (1994) (U.S. Reservations, Declarations, and Understandings, International Convention on the Elimination of All Forms of Racial Discrimination). The record notes that the United States would implement the Covenant "to the extent that it exercises jurisdiction over the matters covered therein, otherwise by the state and local governments. To the extent that state and local governments exercise jurisdiction over such matters, the Federal Government, shall, as necessary, take appropriate measures to ensure the fulfillment of this Convention." *Id.* § III. Scholars have interpreted this statement to mean that although the federal government will not encourage states to enforce human rights treaties, it accepts that states are responsible for implementing them. Martha Davis, *Realizing Domestic Social Justice Through International Human Rights: Part I: The Spirit of Our Times: State Constitutions and International Human Rights*, 30 N.y.u. REv. L. & Soc. chanGE 359, 364 (2006).

2 INsT. or MEDIcIne, uNEQuAl TreatMenr: coNfroNTrNG R&cial anm Eihnic DISpAriTIES IN Health cAre (2003) [hereinafter IoM, uneQuAl TrEATMENT]

3 *Id.*

4 pANEl oN R&cial & Eihnic DISpARITIES IN MEDIcAl cAre, physicians FoR HuMAN RIGhTS, ThE RIGhT To EQuAl TREATMENT: AN AcTIoN plAN To Ei'm R&cial anm E1hnIc DISpAriTIES IN clINIcAl DIAGNoSIS AND TREATMENT IN ThE uNITED STATES 4 (2003), *available at* http://physiciansforhumanrights.org/library/report-equaltreatment-2003.html.

5 u.S. coim'N oN civil RIGhTS, ThE HEAlTh cA1ue chAllENGE: AckNowlEDGING DI pARITy, co1,iqontING HEAlTh DIScRIMINATIoN AND ENSuRING EQuAlITy, vol. I, at 193 (1999).

6 *Id.* at 191.

7 *Id.*

8 Office of Disease Prevention & Health Promotion, U.S. Dep't of Health & Human Servs., *Executive Summary*, Hialthy pEoplE 2010 MidcouRSE REviEw 13, available at http://www.healthypeople.gov/data/midcourse/pdf/ExecutiveSummary.pdf.

9 u.S. coim'N oN civil RIGhTS, ThE Health cA1ue chAllENGE, vol. I, *supra* note 5.

10 Letter from John Lumpkin, Chair, National Committee on Vital and Health Statistics, to Tommy Thompson,

Secretary, U.S. Department of Health and Human Services (Mar. 27, 2003), *available at* http://www.ncvhs.hhs.gov/030327lt.htm.
11 Panel on Racial & Ethnic Disparities in Medical Care, *supra* note 4, at 33.
12 INST. oF MEDIcINE, uneQuml TrEATMENT, *supra* note 2, at 203.
13 u.S. coim'N oN civil RIGhTS, ThE Health cA1ue chAllENGE: AckNowlEDGING DISparity, co1,iqontING HEAlth DIScRIMINATIoN and ENSuRING EQuAlITy, vol. II, at 278 (1999).
14 u.S. coim'N oN civil RIGhTS, ThE Health cA1ue chAllENGE, vol. I, *supra* note 5, at 195.
15 *See* 45 C.F.R. § 80.8 (1) (2006). The guidelines for enforcement of Title VI recognize that "[c]ompliance with the nondiscrimination mandate of title VI may often be obtained more promptly by appropriate court action than by hearings and termination of assistance. Possibilities of judicial enforcement include (1) a suit to obtain specific enforcement of assurances, covenants running with federally provided property, statements or compliance or desegregation plans filed pursuant to agency regulations, (2) a suit to enforce compliance with other titles of the 1964 Act, other Civil Rights Acts, or constitutional or statutory provisions requiring nondiscrimination, and (3) initiation of, or intervention or other participation in, a suit for other relief designed to secure compliance." 28 C.F.R. § 50.3 (2006) (DOJ Guidelines for Title VI Enforcement).
16 *See*, *e.g.*, Caufield v. Bd. of Educ. of the City of New York, 486 F. Supp. 862 (E.D.N.Y. 1979), *aff'd* 632 F.2d 999 (2d Cir. 1980) (explaining that OCR sent a letter to the Chancellor of the New York City Schools alleging noncompliance with Titles VI and IX in the schools' employment practices and that the Chancellor responded by ordering an internal investigation).
17 u.S. coim'N oN civil RIGhTS, TeN-yEAR check-up: H.&vi FEDERAl AGENcIES RESpoNDED To civil RiGhTS REcoM-- MENDATIoNS, vol. IV (2004); U.S. coMM'N oN civil RIGhTS, TeN-yEAR chEck-up: HAvm FEDERAl AGENcIES RESpoNDED To civil RiGhTS REcoMMENDATIoNS, vol. II (2002); U.S. coMM'N oN civnl RIGhTS, FEDERAl TitlE vI ENFoRcEMENT To ENSuRE NoNDIScRIMINATIoN IN FEDERAlly ASSISTED pRoGRAMS 18 (1996); *see also* Marianne Engelman Lado, *Unfinished Agenda: The Need for Civil Rights Litigation to Address Race Discrimination and Inequalities in Health Care Delivery,* 6 Tnx. F. oN C.L. & C.R. 1, 26-33 (2001).
18 u.S. coim'N oN civil RIGhTS, ThE Health cA1ue chAllENGE, vol. II, *supra* note 13, at 77. In 2004, the Commission reported that HHS's Office of Civil Rights had failed to improve its compliance reviews since the Commission's 1996 and 1999 evaluations. u .S. coMM'N oN civil RIGhTS, TeN-yEAR chEck-up, vol. Iv, *supra* note 17, at xi.
19 u .S. coim'N oN civil RIGhTS, TeN-yEAR chEck-up, vol. Iv, *supra* note 17, at 1 44-45. The Department of Justice coordination regulations mandate that federal agencies collect sufficient data "to permit effective enforcement of title VI." *See*, e.g., 28 C.F.R. § 42.406(a)(2006). The Department of Justice's coordination regulations describe specific implementation, compliance, and enforcement obligations of federal funding agencies under Title VI. *See* 28 C.F.R. §§ 42.401 - 42.415 (2006). Every agency that extends federal financial assistance covered by Title VI is subject to the Coordination Regulations and Title VI Guidelines issued by the Department of Justice. *See* Civil Rights Div., U.S. Dep't of Justice, Title VI Legal Manual, *available at* http://www.usdoj.gov/crt/cor/coord/vimanual.htm#XIII.%20Department%20of%20Justic e%20Role%20Under%20Title%20VI.
20 u.S. coMM'N oN cIvIL RIGhTS, ThE HeaLth cA1ue challeNGE, voL. I, *supra* note 5, at 202.
21 Panel on Racial & Ethnic Disparities in Medical Care, *supra* note 4, at 2.
22 *Id.* at 4.
23 *Id.* at 33.
24 wILLIAM L. TAyLoR ET AL., cITIzENs' coMM'N oN cIvIL RIGhTS & cTR. FoR AM. pRoGRESS, ThE ERoSIoN or civil RIGhTS: DEcLINING cIvIL RIGhTS ENFoRcEMENT uNDER thE Bush A rmcIstrKtioN 9 (2007).

25 Jane Perkins, *Health Care: The Civil Rights Rollback: It's Bad for Your Health*, *in* AwAKENING FRoM ThE Dieari, cIvIL RIGhTS uNDER SIEGE and thE NEw STRuGGLE FoR EQuAL JuSTIcE 179 (Denise C. Morgan et al., eds. 2006).
26 *Id.* at 184.
27 Note, *After Sandoval: Judicial Challenges and Administrative Possibilities in Title VI Enforcement*, 116 HArv. L. REv. 1774, 1792 (Apr. 2003).
28 *Id.* at 1792.
29 Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare System*, 3 yalE J. HeaLth poLIcy L. & EThIcS 215, 246-48 (2003) (offering as a model the interagency task force established after the Supreme Court's
decision in Olmstead v. L.C., 527 U.S. 581 (1999), with the goal of moving federally assisted programs closer to the goal of community integration under the Americans with Disabilities Act through a systemic examination of federal policies).
30 *Id.*
31 u.S. coMM'N oN civil RIGhTS, ThE HEALTh cA1ue chALLENGE, voL. I, *supra* note 5, at 203.
32 Ctrs. for Disease Control, Health Impact Assessments, http://www.cdc.gov/healthyplaces/hia.htm.
33 u.S. coMM'N oN civil RIGhTS, ThE HeaLth cA1ue chALLENGE, voL. I, *supra* note 5, at 20.
34 28 C.F.R. § 42.410 (2006) (DOJ Coordination regulations).
35 David B. Smith, Eliminating Disparities in Treatment and the Struggle to End Segregation (Commonwealth Fund, Commonwealth Fund Publication No. 775, 2005), *available at* http://www.cmwf.org/usr_doc/775_Smith_ending_disparities_in_treatment.pdf [hereinafter Smith, Eliminating Disparities] at 17 ("Currently, specialized services such as open-heart surgery are moving from the inner suburbs of most urban areas to the outer ones, following white flight and urban sprawl. Market and convenience justifications mask a resegregation of care that increases the cost of health care and reduces its quality.").
36 Lisa A. Cooper & Neil R. Powe, Disparities in Patient Experiences, Health Care Processes, and Outcomes: The Role of Patient-Provider Racial, Ethnic, and Language Concordance (Commonwealth Fund, Commonwealth Fund Publication No. 753, July 2004), *available at* http://www.cmwf.org/usr_doc/Cooper_disparities_in_patient_experiences_753.pdf.
37 Annerrn FuENTES, pRLDEF, coI'mitioN cRITIcAL: ThE ABSENcE oF LATINoS AmoNG poLIcyMAKERS IN NEw yo1uk cITy'S voLuNTARy HoSpITalS 3, 8-9 (2004), at http://www.prldef.org/Archives_Webpages/Policy/PDF/Condition_Critical.pdf.
38 INST. oF MEDIcINE, uneQual Treatment, *supra* note 2.
39 Dennis D. Parker, *State Reform Strategies*, *in* AwAXENING FRoM thE Dieari 317, 322 (Denise Morgan et al., eds., 2006). States have brought civil rights cases alleging discrimination in housing, public accommodations, access to health care, and employment, under *parens patriae* standing.
40 *See* Manh&TTAN BoRouGh p1nSidEnt'S coMM'N To cloSE thE Healih DividE at iii, 23-29 (2004); *see also* Office of Health Equity, Pa. Department of Health, http://www.dsf.health.state.pa.us/health/cwp/view.asp?a=186&Q=244282. For more information about charity care funds, see Judy Wessler, Bad Debt/Charity Care Analysis (on file); *see also* Hearth LAw uNIT, LEGAL Aid Soc'y oF N.y., STAte SEcRET 2005: How GovERNMENT STATuTES AND HoSpITalS' voLunTARy EFFoRTS FAil To pRotecT uNINSuRED anm uNDERINSuRED pATIENTS (2005), *at* http://www.legal-aid.org/SupportDocumentIndex.htm?docid=1 1 9&catid=43.
41 U.S. commission on Civil Rights, The HeaLth cAre challeNGE, vol.1, *supra* note 5, at 77-78.
42 RoBERT D. Bullard ET AL., ToXIc wASteS AND RAcE AT TwENTy: 1987-2007, Xiv (2007).

ACKNOWLEDGEMENTS

This report was developed by a committee of experts on health and environmental health law and policy, working for the most part in domestic U.S. organizations involved in health care access, public health, and environmental justice. The primary authors of the report are listed below:

Brian D. Smedley, Sabrineh Ardalan, Khadine Bennett, Kevin Hsu The Opportunity Agenda
Philip Tegeler, Nkiru Azikiwe, Tori Gordon Poverty & Race Research Action Council
Meredith King Center for American Progress
Steve Hitov National Health Law Program
Katrina Anderson Center for Reproductive Rights
Steve Fischbach Rhode Island Legal Services
Veronica Eady, Nisha Agarwal New York Lawyers for Public Interest
David Barton Smith Temple University
Eric Liao Physicians for Human Rights
Jamie Brooks Center for Genetics and Society
Carol Ray Out of Many, One

Thanks also to the Poverty & Race Research Action Council (PRRAC) for hosting and coordinating the health/environmental health working group, and to the Opportunity Agenda and the Center for Reproductive Rights for their support for the public release of the report. Special thanks to the Center for American Progress for providing donated layout services for the report, and to the W.K. Kellogg Foundation for its ongoing support of PRRAC's health disparities work. Finally, congratulations to the U.S. Human Rights Network for its successful effort to coordinate submissions to the U.N. CERD Committee from a wide variety of U.S. advocacy groups.