

# Affirmative Action and the Allocation of Health Care

LESLIE PICKERING FRANCIS, PH.D., J.D.

## Abstract

The justifications of affirmative action, the compensatory, corrective and redistributive, have been widely recognized in legal thinking. They have been applied, principally, to employment practices. They can also be applied to health care. Arguments for affirmative action in health care allocation shift the burden of proof to those who deny that racism is the root cause of differential morbidity and mortality experienced by, for example, African Americans. At the very least, these arguments mandate much needed research into the causes of minorities' poor health. Without such research, racism remains the presumptive cause of, and affirmative action the appropriate remedy for, the health care problems minorities face. **Key Words:** Affirmative action, race, allocation of health care, law and medicine, public health, medical ethics.

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AFFIRMATIVE ACTION, despite its current unpopularity, is an illuminating doctrine to apply to significant contemporary data about minority encounters with the health care system in the United States, or so I will argue here. To develop this argument, I begin with a brief account of affirmative action. I then explain the principal justifications that have been offered for affirmative action. Next, I outline the typical structure of legal cases in which affirmative action was mandated as a remedy for patterns of discrimination, and show how several recent studies of the distribution of health care by race reveal an analogous structure. Finally, I note that the racial differences have not been extensively reported or discussed in the press. My conclusion is that there is a case to be made for examining whether current racially differentiated patterns in the distribution of health care reflect discrimination or reflect other factors—in other words, a case for considering affirmative action in the inspection of current health care practices.

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Professor of Philosophy and Professor of Law, Adjunct Professor of Internal Medicine, Division of Medical Ethics, University of Utah, Salt Lake City, UT.

Address correspondence to Leslie Pickering Francis, Ph.D., J.D., Department of Philosophy, University of Utah, Salt Lake City, UT 84112.

## I. Affirmative Action

The phrase “affirmative action” means: positive steps, steps in an affirmative direction, to end discrimination. The phrase made its debut in an executive order issued by President Kennedy in 1961, directing agencies in the executive branch of government to take “affirmative action” to end discrimination against blacks in their contracting practices (1). The phrase was picked up in the remedy section of Title VII, the employment discrimination title of the Civil Rights Act of 1964 (2). The exact language of Title VII is that, after a finding of discrimination, courts may order remedies such as back pay “. . . and such affirmative action as may be deemed appropriate.” Affirmative action is now middle-aged: a little over 35 years old, dated from the Executive Order, a little under 35 years old, dated from the Civil Rights Act of 1964. But affirmative action has not settled into a comfortable middle age; it is perhaps more controversial today than at any time in its lifespan.

In its most general sense, “affirmative action” was a catch-all phrase inserted into the Civil Rights Act to effect a variety of positive steps intended to remedy discrimination. Many of the first steps taken under the rubric of affirmative

action involved efforts to open opportunities to historically excluded groups. They included such actions as advertising positions widely, so that anyone interested and qualified had a reasonable opportunity to find out about them and apply for them; reevaluating announced job "qualifications," to ensure that they were genuine requirements for job performance; and establishing training and other educational programs, so that those who had not had the opportunity to become qualified for certain occupations became able to acquire the relevant skills. Each of these strategies has potential analogies for patient care. The analogy to advertising the availability of positions might be publicizing the availability of care and how to access it, so that people who might not otherwise know about such opportunities as low cost mammograms or immunizations would learn of them. The analogy to reevaluating job qualifications might be scrutinizing patient selection criteria to ensure that they are medically warranted; reevaluating the role of sex in access to clinical trials is an example of such scrutiny. The analogy to training and education might be special efforts to educate target populations about health risks or health behaviors; an example would be the efforts to educate African American men about their risks of prostate cancer and the availability of screening tests (3). Because they strive to make opportunities more widely known and accessible, such programs have been less controversial than the race-conscious selection procedures for employment and education that are under attack today. One federal appellate court, however, has very recently concluded that even opportunity-expanding programs are constitutionally problematic because they consume resources that could be spent on opportunities for all, and because they may push employers into achieving targets or quotas (4).

Affirmative action orders also mandated race-conscious selection procedures such as employment goals and even specified percentages in situations of persistent employment discrimination. Ending such race-conscious selection procedures has been the chief target of contemporary opponents of affirmative action. The controversy over goals—or quotas, in the eyes of their critics—has been heated indeed. Proponents argue that under some circumstances it is permissible to take race into account, as one factor among others, in making employment or other decisions. Some opponents claim that it is always unfair to consider race in such decisions (5). Whatever position is taken about race-conscious selection, however, it is important to remember that affirmative action

refers to the whole panoply of other positive steps against discrimination, a fact which should not be forgotten in the heat of the current battle over race-conscious selection.

Many examples of the possible relevance of affirmative action to health care surely warrant discussion. The use of race in making decisions about admission to medical school was the issue in *Bakke*, the case that still stands for the proposition that diversity is a compelling interest for state systems of higher education (6). Although infrequently litigated, questions have been raised about the employment of minority physicians and other health practitioners on medical school faculties, in managed care organizations, and in other practice settings. Equity in the selection of research subjects is required by federal regulations. Proposals have been put forward by President Clinton to target funding for the improvement of minority health status. Any of these proposals warrants careful examination and discussion. My goal in this article, however, is to argue that there are lessons to be learned from affirmative action in analyzing data showing racial differences in the health care received by whites and by African Americans.

## II. Justifications for Affirmative Action

"Opportunity goods," goods that affect individuals' basic chances in life, are especially important from the standpoint of justice. Without opportunity goods, people have little or a greatly reduced chance of leading a satisfying life. Otherwise quite divergent positions about justice agree on the importance of opportunity goods. To be sure, egalitarians will be concerned about the distribution of any important goods, not just opportunity goods. But those who favor equality of opportunity, or even more limited fairness in the distribution of opportunities, will see opportunity goods as central to justice. Opportunity goods give us a chance in life, make of it what we will.

Education and health care are both opportunity goods. Without education, the range of available life choices may be quite limited. Without health care, people may find themselves with impairments or illnesses that limit their life chances. Even undiagnosed hearing loss or myopia may be devastating to a child's ability to learn and thus limit the child's chances in life. Moreover, these are both goods that it may be unreasonable to expect people to provide for themselves. Both are provided through complex, interconnected systems. Health care especially—

but even education, particularly where there are special needs—involves large and not entirely predictable expenditures. And both are particularly important for the life chances of children, a population who cannot be expected to provide these goods for themselves.

In Congressional debates leading to the passage of the Civil Rights Act of 1964, concern about opportunity goods was paramount (7). The principal goals of the Act were eliminating discrimination in employment, education, and public accommodations. At the time of the Act's passage, three principal kinds of arguments were offered for the need to remedy discrimination. The first argument was the history of discrimination against blacks and the felt need to make amends for this history as well as for particular acts of discrimination. This "compensatory" argument sees affirmative action as a way of trying to make up for actual harm. It is most persuasive in the case of an identified victim and perpetrator; critics of the widespread use of compensation as an argument for affirmative action typically contend that many of the beneficiaries of affirmative action had not been harmed, and many of those affected negatively by affirmative action were not themselves responsible for any harm.

The second argument offered in the Congressional debates was the imperative to bring ongoing practices of discrimination to an end. This "corrective" argument contends that there are some practices of discrimination which can only be rooted out by imposing affirmative obligations on those who engage in the practices. If, for example, an employer makes hiring decisions on highly subjective criteria, and the data suggest that the employer selects whites more frequently than would be expected without covert discrimination, setting employment targets might be recommended as a way to force the employer to come to terms with potential inequities in the selection process. Corrective arguments for affirmative action claim that race-based criteria should be used as an antidote to race-based discrimination, not that race is a relevant factor absent the need for correction.

The third argument for affirmative action offered in the Congressional debates was redistributive: that the maldistribution of basic opportunity goods, by race, should cease. Members of Congress argued that it was unjust to allow a situation to persist in which white Americans had far better opportunities than African Americans. This argument was quite frankly "redistributive," along racial lines. Although this redistributive argument

was taken seriously in 1964, it has been rejected by the current Supreme Court as a basis for affirmative action (8). Race-based redistributions of a limited good, in the view of the Supreme Court, are not narrowly tailored to further a compelling state purpose. In courts today, compensatory arguments remain viable if they are limited to identified victims; and corrective arguments will prevail on the basis of a showing of ongoing discrimination (9). It is important to emphasize that these are really very different arguments: the idea that affirmative action is needed as a corrective is rooted in the idea that there are discriminatory practices that must be ended, whereas the idea that affirmative action is important because of the maldistribution of opportunities is rooted in a more general picture of justice in society. Differential health status by race would, for example, show that there is a general maldistribution of opportunities by race, for any of a number of possible reasons, related or not to discrimination. Unexplained racial differences in the treatment patients receive might, on the other hand, raise an inference of discrimination in need of correction.

### III. Affirmative Action as a Corrective

A typical corrective lawsuit would proceed according to the following pattern. The plaintiff would allege that there is ongoing discrimination in a workplace. In order to get the case started, and avoid losing on a motion for summary judgment, the plaintiff would have to bring in enough facts to warrant an inference of discrimination. This is called the plaintiff's *prima facie* case; it may be made out by a statistical showing of significant differences by race. Disparate hiring or promotion statistics that are otherwise unexplained would be a typical showing. Thus it would raise an inference of discrimination to show that despite similar numbers of black and white applicants meeting initial screening criteria, 70% of new hires were white.

Next, the employer may respond to this *prima facie* case by showing that there was a nondiscriminatory explanation for the differences. Perhaps when qualifications were looked at more carefully, the whites scored higher. Or perhaps blacks were offered the jobs in similar numbers to whites, but declined to take them. Or perhaps blacks dropped out of the pool voluntarily before offers were made, in pursuit of better opportunities elsewhere. Any of these, or many other showings, would suffice to meet the plaintiff's *prima facie* case with the response that there was a legitimate reason for the differences at issue.

Finally, the plaintiffs may respond by showing that the employer's reason was "merely pretextual." To make this showing, the plaintiffs must bring out evidence that the defendant's proffered reason really masked a more problematic, discriminatory reason. For example, the plaintiff might show that the supposedly better qualifications of the whites weren't borne out in fact, that the criterion relied on wasn't really related to likely job performance, or that the criterion was really only a blind for discrimination. Or, the plaintiff might show that blacks did not really drop out of the applicant pool voluntarily, but did so for problematic reasons—for example, comments in an interview that discouraged them from continuing with the application process.

Here are some statistics from some of the best-known cases alleging a pattern and practice of employment discrimination:

1. In a suit against T.I.M.E. Freight Company and the Teamsters' Union, the plaintiffs showed that of 6472 employees, 5% were black, and 4% were Hispanic. Of the 6472 total employees, 1828 were line drivers, the highest paid position; of these line drivers, 0.4% were black, and 0.3% were Hispanic. Employees in the lowest paid divisions, city operations and service, included 83% of the blacks employed by the company, 78% of the Hispanics employed, but only 39% of the whites employed (10).
2. In a suit against Local 28 of the Sheet Metal Workers' Union, the local serving metropolitan New York City, the plaintiffs showed that 3.9% of union members were black, compared with an estimated 29% of blacks in the relevant labor pool (11).
3. In a suit against Duke Power Company, the plaintiffs showed that 34% of the white males in the relevant labor pool (in North Carolina) had high school diplomas, but only 12% of the blacks did. The Court concluded that it was prima facie discriminatory to require a diploma for employment, without any further explanation of its job-relatedness (12).
4. In a suit against the Lackawanna, NY, plant of Bethlehem Steel, the plaintiffs showed that 20% of newly hired white workers, but 50% of newly hired black workers, were assigned to work in the coke ovens, the hottest and dirtiest departments at the plant. Seniority and transfer policies then combined to lock black employees into their original department of hire (13).
5. Lest it be thought that these cases are merely of historical interest, compare this to the situation involving firefighters in the city of Chicago. As of 1974, only 4% of Chicago firefighters have been black and only 0.5% Hispanic, figures that had persisted since the 1950s, although nearly a third of the city's population were black. In 1986, it was still the case that only 2.6% of firefighter captains were black, and only 1% were Hispanic, despite the fact that by this time a majority of the city's population were black. Just last year, the Seventh Circuit, in an opinion authored by Judge Posner, concluded that an affirmative action plan for promotions was justified, given the city's history of discrimination (14).

Now compare with these cases successfully alleging employment discrimination, some of the recent data concerning differences in treatment by race. The question to bear in mind is whether these statistics are sufficiently parallel to the employment statistics, so that they would at least look analogous to a prima facie case.

1. A Duke University study of patients with obstructive coronary disease showed marginal differences between blacks and whites in the rates of angioplasty, but significant differences in the rates of bypass surgery. Controlling for such factors as age, sex, disease status, comorbidities, date of treatment (between 1984 and 1992), and insurance status, blacks were 32% less likely to undergo bypass surgery than whites, and 35% less likely to undergo any revascularization procedure at all. Yet blacks had a higher five-year mortality rate overall (27% compared with 20%) (15).
2. A sample of the Medicare population receiving primary total hip replacement between 1986 and 1989 revealed that blacks were 53% as likely to receive the procedure as whites (16).
3. A study of mammography rates among black and white women enrolled in the Medicare program in ten different states revealed that black women had mammography at just over half the rate of white women (9% to 15%). These differences persisted, controlling for age, income, and frequency of visits to primary care physicians (17).
4. A study of the use of bone marrow transplantation in leukemia and lymphoma showed that, controlling for factors such as disease type and

insurance status, black patients were 51–53% as likely as whites to receive transplantation for leukemia, and 34–45% as likely to receive transplantation for lymphoma. This study was conducted from hospital discharge records in the states of California, Massachusetts, New York, and Maryland, for the years 1988 and 1991 (18).

To be sure, there may be many explanations for these differences in the use of treatment. Each of these studies controls for certain obvious differences, such as insurance status, disease severity, or comorbidities. One might hypothesize many further explanations for the differences that are not captured by such variables. Black patients may be more suspicious about the motives of health care providers, particularly when highly interventionist or expensive forms of care are offered; given the legacy of Tuskegee, such suspicions would not be surprising. Black patients may prefer less aggressive forms of care. There may be resistance to technologies such as X-rays used in mammography. All of these would be nondiscriminatory reasons for the differences, at least on the surface. All I am contending is that these data are comparable to the data used in lawsuits alleging a pattern of discrimination to establish a plaintiff's prima facie case. If the data are significant in this way, the burden should then fall on the health care professions to examine further what explanations might be offered for the differences, and to inspect carefully whether the explanations are benign or conceal aspects of discrimination in one respect or another.

Indeed, the authors of these studies do suggest the need for further investigation. The authors of the study of coronary revascularization procedures, for example, observe that race may only be a surrogate for other socioeconomic factors not captured by their demographic information, such as family support structures. Patient preferences may also play a role. The authors caution that further investigation is necessary to explore the possible relevance of such factors. At the same time, however, they observe the need to consider whether subtle factors in the physician-patient relationship are also affecting patient utilization of therapies: “. . . we did not have access to information on the patients' preferences regarding therapy. Future investigations must clearly be directed at determining how patients assess the risks and benefits of cardiac interventions and how their interactions with physicians may affect that assessment.” (15).

This observation might be put in the structure of an employment discrimination lawsuit, in the following way. The data about different rates of use of therapy by race establish a prima facie case of discrimination. The burden then shifts to health care providers to explore whether there are legitimate, nondiscriminatory explanations for the differences. It appears that there may be: differences in patient preferences, in patient attitudes toward the health care system, and in the more subtle demographic factors that support patients undergoing difficult care regimens. Whether such explanations are forthcoming, of course, at the present time requires further investigation. But suppose that they are; this still would not end the matter. For the burden then shifts back to those alleging discrimination to show that the apparently nondiscriminatory explanations are pretextual. And here, too, there are issues worthy of investigation. Suppose, for example, that a white physician offers mammography to a black woman. She refuses. He accepts the refusal without further comment. Perhaps he accepts all such refusals from patients without comment, but perhaps race matters in the encounter. The physician may be able to work in more encouraging ways with his white patients to enable understanding of the reasons for the recommendation of mammography. He may be able to allay their fears more successfully. He may have a better or more sympathetic understanding of what lies behind care refusals from his white patients. Or, he may be a little more willing to believe that black women are less likely to accept mammography anyway, so further discussion would be a waste of his time. In short, what I am suggesting is that the burden of proof lies on the medical profession to investigate further the explanations for the differences in utilization, and then to at least consider whether these explanations in turn mask problematic effects of race.

Two final observations are worth making. First, although these studies were all published in major medical journals, they appear not to have drawn journalistic interest. LEXIS searches I have conducted indicate that although the *New York Times* reports regularly on medical research, none of these studies was reported in the *Times* when it appeared. Indeed, racial variations in the use of health care have not been much reported by the *Times*. In 1997, only three of the stories concerning health care that appeared on the front page of the Sunday edition raised issues of race. None of the stories by Gina Kolata, a frequent reporter on health care issues, raised questions of race; only two of the “Personal Health” columns

by Jane Brody noted race as a factor in the occurrence of health conditions. Only one story by Lawrence Altman, on improved blood pressure control and the reduction in stroke deaths, noted differences by race. Treatment of HIV was a notable exception; in 1997, the Times ran significant coverage of a study by Columbia University's School of Public Health showing significant differences in access by race to combined drug therapies. This lack of journalistic interest, I would suggest, both fails to raise the issue of the need for further research, and fails to educate patients and the health care community about important aspects of the distribution of health care.

Second, even if ultimate investigation of the differences in the use of health care by race reveals nondiscriminatory explanations, this only pushes the question of affirmative action back a step. To be sure, affirmative action would not be justified on the basis of the need to correct ongoing discrimination. But racial differences in the receipt of care, and in resulting health outcomes, would remain. As I indicated above, redistributive arguments for affirmative action were part of the original justification for the Civil Rights Act of 1964; health care is an important opportunity good and thus there are reasons for concern when one group in society fares worse with respect to care utilization and outcome. "Affirmative action" includes a wide variety of positive steps to try to ameliorate racial differences, including education. Suppose it does turn out that blacks are less willing to opt for interventionist care because they are more suspicious of the health care system and more reluctant to experience encounters with it. The appropriate responses might be efforts to dispel the suspicions, to increase levels of comfort with health care encounters, and to educate black patients about what care involves and why it might be helpful—in short, all forms of affirmation action.

#### IV. Conclusion

Health care is an important opportunity good. Arguments for affirmative action include compensation, correction, and redistribution. In an employment discrimination lawsuit seeking affirmative action as a corrective remedy for a pattern of ongoing discrimination, the plaintiffs would allege statistically significant differences by race, thus shifting the burden of proof to defendants for a nondiscriminatory explanation; if a nondiscriminatory explanation is presented, the burden would

then shift back to the plaintiffs to show that the explanation is merely pretextual. Several recent studies of patient utilization of health care by race appear to show statistical differences by race that, were they offered in an employment case, would be sufficient to shift the burden of proof to defendants for a nondiscriminatory explanation. Further research is imperative to improve our understanding of the differences in utilization of care by race. It is also important to consider whether explanations such as difference in patient preferences by race reflect subtle differences in the nature of encounters with the health care system and, if so, to take affirmative steps to reduce these differences. Equality of opportunity requires no less.

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