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PROVISION OF HEALTH CARE TO INDIGENTS: FAILURES AT THE LOCAL LEVEL IN LIGHT OF DECREASED FEDERAL ASSISTANCE

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I. INTRODUCTION

Health care for indigent¹ residents of decaying urban centers, already in short supply, is becoming increasingly inaccessible.² Many inner-city public hospitals have either eliminated services³ or relo-

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1. "Indigent" and "poor," as used in this Note, refer to persons not carrying private health insurance and unable to pay for health care from personal assets. The Hill-Burton Act, discussed *infra* at notes 109-32 and accompanying text, requires participating hospitals to provide care for persons unable to pay for services, including those that are "otherwise self-supporting but unable to pay the full charge for needed [medical] services." 42 C.F.R. § 53.111(g)(1) (1984). Medicaid and Medicare, discussed *infra* at notes 133-65 and accompanying text, allows states to establish recipient qualifications with regard to income levels. 42 U.S.C. §§ 1396a-1396p (1982).

2. See, e.g., Hermann, *The Poor: Their Medical Needs and the Health Services Available to Them*, 399 ANNALS 12 (1972); Levison, *The Challenge of Hospital Services for the Poor*, 399 ANNALS 22 (1972).

3. See, e.g., *United States v. Bexar County*, 484 F. Supp. 855, 858 (W.D. Tex. 1980) (challenge to closure of the last remaining inpatient service); *NAACP v. Wilmington Medical Center, Inc.*, 426 F. Supp. 919, 922 nn.1 & 2 (D. Del. 1977) [hereinafter cited as *Wilmington I*] (challenge to proposed closing of 75% of current bed capacity at urban facility), *aff'd*, 584 F.2d 619 (3d Cir. 1978).

Urban public hospitals provide important services both to indigents and to society at large. For indigents, these hospitals serve as a surrogate family physician, with outpatient services comprising the bulk of total patient care programs. Urban public hospital emergency rooms handle twice the number of cases handled by suburban

cated to suburban areas.⁴ Thus, the poor, the elderly, and racial minorities that now constitute a large percentage of the urban population⁵ must seek medical care from private resources.⁶ At the

hospitals. Even though urban public facilities represent less than 2% of all community hospitals, they provide 20% of all hospital medical training. Goff, *The Plight of the Urban Hospital*, 4 J. HEALTH POL., POL'Y & L. 657, 658 (1980).

Unfortunately, many urban hospitals are "antiquated, overcrowded, dangerous, and in a degrading state." S. REP. NO. 1285, 93d Cong., 2d Sess. 59 (1974), reprinted in 1974 U.S. CODE CONG. & AD. NEWS 7842, 7879. Congress, therefore, listed modernization of dilapidated urban hospitals as a prime concern in the National Health Planning and Resource Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (codified and amended in scattered sections of 42 U.S.C.).

4. See *infra* text accompanying notes 12-102. One survey of 17 major American cities showed that between 1937 and 1977, in one-half of all cities studied, one-third of all urban hospitals either closed or relocated. The survey included the cities of Baltimore, Boston, Buffalo, Chicago, Cincinnati, Cleveland, Columbus (Ohio), Detroit, Indianapolis, Kansas City, Milwaukee, New York (Bronx and Brooklyn), Newark, Philadelphia, Pittsburgh, St. Louis, and Washington, D.C. Note, *Maintaining Health Care in the Inner City: Title VI and Hospital Relocations*, 55 N.Y.U. L. REV. 271, 274 n.19 (1980) [hereinafter cited as Note, *Maintaining Health Care*].

See generally Friedman, *The End of the Line: When a Hospital Closes*, 52 HOSPITALS 69, 74 (1978) (discussing inadequate hospital facilities in some areas); Note, *Maladjusted Health Care Services: Restructuring the Current Regulatory System*, 6 AM. J. L. & MED. 407 (1980).

5. This demographic phenomenon is the result of the exodus from inner cities of middle-class Americans, industries, and jobs. See generally U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE, HEALTH UNITED STATES 5-7 (1979) (inner city racial minorities are impoverished disproportionately); U.S. BUREAU OF THE CENSUS, DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 18 (1977) (racial minorities are a large percentage of urban population); Levin, *Neighborhood Development and the Displacement of the Elderly*, 18 URBAN L. ANN. 223, 228 n.9 (1980) (the majority of elderly Americans live in urban areas), citing R. STRUYK, THE HOUSING SITUATION OF ELDERLY AMERICANS 7, Table 1 (1976).

The poor, the elderly, and racial minorities often have greater health needs. See, e.g., Lang, *Poor Woman and Health Care*, 14 CLEARINGHOUSE REV. 1056 (1981) (citing studies that show that women need more health care than men; poor women rely on emergency rooms and out-patient clinics for this care; nonwhite women are experiencing an increasingly higher rate of cervical cancer; and infant mortality rates are increasing among blacks); U.S. DEP'T. OF HEALTH, EDUCATION AND WELFARE, HEALTH UNITED STATES 1979 73 (1980); U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE, HEALTH STATUS OF MINORITIES AND LOW-INCOME GROUPS 11-12 (1979) (greater reliance on out-patient clinics and emergency rooms among non-whites than whites); CONGRESSIONAL BUDGET OFFICE, HEALTH DIFFERENTIALS BETWEEN WHITE AND NONWHITE AMERICANS xi (1977) (nonwhites have a 70% higher infant mortality rate).

6. The private health care resources on which this Note focuses are non-public facilities, not private health practitioners. This Note does not address fees and services of health care personnel, such as doctors.

For a discussion of how the flight of doctors and middle-class patients to the sub-

same time, federal and state governments are reducing drastically financial assistance to private health care providers for their services to the poor.⁷ To compensate, some private hospitals have attempted to limit free or government-reimbursed care to the poor—with alarming results.⁸

This Note discusses local, state, and federal attempts to provide indigent city-dwellers with access to adequate health care. It also discusses the framework through which an aggrieved health care seeker might obtain legal redress. The Note addresses legal challenges aimed at local decisions to close or relocate urban public hospitals.⁹ It next examines developments in the federal mechanism of providing health care assistance to the states.¹⁰ The Note concludes with a summary of the present status and future outlook of indigent health care in light of the current administration's federal funding cutbacks.¹¹

II. CHALLENGING THE RELOCATION OR CLOSURE OF INNER-CITY PUBLIC HOSPITALS

A. *Challenges Under Title VI*

Congress passed the Civil Rights Act of 1964¹² to bolster the Supreme Court's ruling that the fourteenth amendment¹³ forbids "separate but equal" treatment of the races by states.¹⁴ In Title VI¹⁵

urbs has inspired many of the hospital relocation decisions, see HEW Hospital Site Location Study, *reprinted in* Brief for Appellants at xxx-xxxi, *NAACP v. Wilmington Medical Center, Inc.*, 599 F.2d 1247 (3d Cir. 1979) [hereinafter cited as *Wilmington III*] *on remand*, 491 F. Supp. 290 (D. Del. 1980), *aff'd*, 657 F.2d 1322 (3d Cir. 1981).

7. See *infra* text accompanying notes 103-65 for discussion of federal and state assistance schemes. See *infra* note 143 and accompanying text for an overview of federal cutbacks.

8. See, e.g., Heires, *Expectant Mother Turned Away from Hospital*, *Belleville News Democrat*, Feb. 22, 1983, at 1, col. 3 (private, suburban hospital's policy denies treatment to indigent patients that reside outside the township because the hospital feared it was exceeding its state-allotted limit for Medicaid reimbursement).

9. See *infra* text accompanying notes 12-102.

10. See *infra* text accompanying notes 103-65.

11. See *infra* text accompanying notes 166-71.

12. Pub. L. No. 88-352, 78 Stat. 241 (1964).

13. U.S. CONST. amend. XIV, §§ 1, 5. Section one provides that a state shall not "deny to any person within its jurisdiction the equal protection of laws." *Id.* § 1. Section five grants Congress the power "to enforce, by appropriate legislation, the provisions of this article." *Id.* § 5.

14. See *Brown v. Board of Educ.*, 347 U.S. 483 (1954). See also H.R. REP. NO.

of the Act, Congress ordered the denial or termination of federal funds to programs¹⁶ that practiced racial discrimination.¹⁷ Title VI authorizes federal administrative agencies such as the Department of Health and Human Services (HHS)¹⁸ to promulgate regulations to implement its provisions.¹⁹ The rules and conduct of these agencies are subject to judicial review.²⁰

Virtually all hospitals receive some federal funding through the Hill-Burton Act,²¹ which provides construction assistance,²² or the Social Security Act.²³ Thus, plaintiffs have chosen Title VI as their weapon for challenging the constitutionality of hospital closures or

914, 88th Cong., 1st Sess. 2 (1963), for the broad congressional purpose behind the Civil Rights Act of 1964.

15. 42 U.S.C. §§ 2000d-2000d-6 (1982). *See generally* Dunn, *Title VI, The Guidelines and School Desegregation in the South*, 53 VA. L. REV. 42, 42-45 (1967); Comment, *Title VI of the Civil Rights Act of 1964—Implementation and Impact*, 36 GEO. WASH. L. REV. 824, 887-970 (1968) (discussing Title VI).

16. Section 601 of Title VI provides that “[n]o person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.” 42 U.S.C. § 2000d (1982).

17. *Id.* § 2000d-1. Because Title VI sets forth conditions for Congress’ disbursement of tax revenues for the general welfare, Congress enacted Title VI under the auspices of Article I, § 8 of the U.S. Constitution, not § 5 of the fourteenth amendment. *See* II STATUTORY HISTORY OF THE UNITED STATES 1019 (B. Schwartz ed. 1970); Note, *The Prima Facie Case and Remedies in Title VI Hospital Relocation Cases*, 65 CORNELL L. REV. 689, 696 n.30 (1980).

18. Until 1980, HHS existed as the Department of Health, Education, and Welfare (HEW). For the sake of clarity and consistency, this Note shall hereinafter refer only to HHS.

19. *See* 42 U.S.C. § 2000d-1 (1982).

20. *Id.* § 2000d-2. This provision does not explicitly grant a private cause of action to individuals desiring to challenge alleged violations of Title VI. Many courts, however, have inferred this right. *See infra* notes 27-37 and accompanying text.

21. 42 U.S.C. § 291c (1982).

22. *See infra* notes 109-32 and accompanying text for further discussion of the Hill-Burton construction grant scheme.

23. 42 U.S.C. §§ 301-1397f (1982). Most hospitals participate in the Medicare program. *See, e.g.,* Rose, *Challenging the Relocation and Closure of Inner-City Hospitals—Analysis Methodologies and Limitations*, 16 CLEARINGHOUSE REV. 102, 105 (1982). Under the Medicare program, the federal government provides funding to states for reimbursing hospitals that treat the elderly. 42 U.S.C. §§ 1395-1395qq (1982). Title VI applies to this type of indirect assistance. *Id.* § 2000d. Title VI requirements apply even when the recipient program receives no net financial gain from federal reimbursement. *See* Bob Jones Univ. v. Johnson, 396 F. Supp. 597, 603 n.21 (D.S.C. 1974), *aff’d per curiam*, 529 F.2d 514 (4th Cir. 1975).

relocations resulting in disparate health care services to minorities.²⁴ HHS regulations²⁵ promulgated under Title VI prohibit recipients of federal funding from making site selections that have discriminatory effects.²⁶ Therefore, plaintiffs have asserted that the relocation of hospital services to predominately white suburbs violates Title VI. Plaintiffs must overcome three major obstacles before they can prevail on a Title VI challenge. First, they must convince courts to recognize a private right of action under Title VI. Second, they must persuade courts that they need not exhaust administrative remedies before filing suit. Finally, in the absence of evidence of racial animus they must convince courts that proof of a disparate racial impact suffices to establish a prima facie case under Title VI.

I. Private Right of Action Under Title VI

Title VI requires the HHS Office of Civil Rights to investigate individual plaintiffs' complaints.²⁷ The Act fails to specify, however, whether groups or individuals may bring a private cause of action under Title VI in federal court.²⁸ The United States Supreme Court has not ruled directly on this question, but in *Cannon v. University of Chicago*,²⁹ the Court assumed that a private cause of action does exist under Title VI.³⁰ The *Cannon* Court announced that a private cause of action for sex discrimination could be implied under Title IX of the Education Amendments of 1972³¹ because Congress intended Title IX to track Title VI.³² In reaching its conclusion, the Court discussed at length the purposes behind Title VI that command the inference of a private cause of action.³³

24. See *infra* notes 68-92 and accompanying text.

25. See *supra* note 18.

26. See 45 C.F.R. § 80.3(b)(3) (1984). Administrative regulations are legislative rather than interpretive when Congress has delegated its legislative power to an agency. See *Chrysler Corp. v. Brown*, 441 U.S. 281, 302 (1979); *General Elec. Co. v. Gilbert*, 429 U.S. 125, 141 (1976); Koch, *Public Procedures for the Promulgation of Interpretive Rules and General Statements of Policy*, 64 GEO. L.J. 1047, 1047-49 (1976).

27. See 45 C.F.R. § 80.7 (1984).

28. See 42 U.S.C. § 2000d-1 (1982).

29. 441 U.S. 677 (1979).

30. *Id.* at 694-96.

31. 20 U.S.C. §§ 1681-1686 (1982).

32. 441 U.S. at 694-96.

33. *Id.* at 704 n.36.

In *Regents of the University of California v. Bakke*,³⁴ Justice Stevens, joined by Justices Burger, Stewart, and Rehnquist, suggested that enforcement of the “personal federal rights” embodied in Title VI would be hampered severely if private individuals could not sue under the Act.³⁵ Lower federal courts, including the Third Circuit Court of Appeals, in a hospital closure case,³⁶ have supported the inference of a private right of action under Title VI.³⁷

2. Exhaustion of Administrative Remedies

Although most courts addressing the issue agree that Title VI affords a private right of action, it remains unclear whether an aggrieved party must first exhaust all available administrative remedies.³⁸ While Title VI clearly provides administrative remedies, the Act does not explicitly require exhaustion of these remedies before seeking judicial resolution.³⁹ Lower federal courts are split over this issue in hospital relocation cases.⁴⁰ The *Cannon* Court’s

34. 438 U.S. 265 (1978).

35. *Id.* at 419-20 (concurring in part, dissenting in part). Justices Powell, Marshall, Brennan, and Blackmun found it unnecessary to resolve the question of a private cause of action under Title VI because the question was not litigated below. They assumed a private right of action to exist only for the purposes of this case. *Id.* at 283-84 (Powell, J., announcing the opinion of the Court); *Id.* at 328 (opinion of Brennan, White, Marshall, and Blackmun, J.J., dissenting). Justice White did not join this portion of Justice Brennan’s dissent because he believes that no private right of action exists under Title VI. *Id.* at 328 n.8.

See also Cort v. Ash, 422 U.S. 66, 78 (1975) (setting forth four relevant factors for determining whether a private right of action is implicit in a statute).

36. *See Wilmington III*, 599 F.2d 1247 (3d Cir. 1979).

37. *See* Bossier Parish School Bd. v. Lemon, 370 F.2d 847, 852 (5th Cir.), *cert. denied*, 388 U.S. 911 (1967); Brown v. New Haven Civil Serv. Bd., 474 F. Supp. 1256, 1264 (D. Conn. 1979); Guardians Ass’n v. Civil Serv. Comm’n, 466 F. Supp. 1273, 1285 (S.D.N.Y. 1979), *aff’d in part and vacated in part*, 633 F.2d 232 (2d Cir. 1980), *aff’d*, 463 U.S. 82 (1983), *cert. denied*, 103 S. Ct. 3568 (1983); Blackshear Residents Org. v. Housing Auth., 347 F. Supp. 1138, 1146, 1150 (W.D. Tex. 1971) (by implication); Hawthorne v. Kenbridge Recreation Ass’n, 341 F. Supp. 1382, 1383-84 (E.D. Va. 1972) (by implication); Gautreaux v. Chicago Hous. Auth., 265 F. Supp. 582, 583-84 (N.D. Ill. 1967). *But see* Clark v. Louisa County School Bd., 472 F. Supp. 321, 323 (E.D. Va. 1979).

38. Lower courts have required plaintiffs seeking termination of funds to go first through administrative channels. *See, e.g.*, Caulfield v. Board of Educ., 583 F.2d 605 (2d Cir. 1978); Santiago v. City of Philadelphia, 435 F. Supp. 136 (E.D. Pa. 1977).

39. *See* 42 U.S.C. § 2000d-1 (1982).

40. *See* Jackson v. Conway, 476 F. Supp. 896 (E.D. Mo. 1979) (refusing to enjoin a St. Louis hospital closure until HHS first investigates the complaint), *aff’d*, 620 F.2d

presumption of a private right of action may overrule implicitly those lower court decisions requiring exhaustion.⁴¹ Nevertheless, some courts have suggested that the administrative agencies have more expertise in these matters and, therefore, have "primary jurisdiction."⁴² HHS generally leaves cases of Title VI violations against individuals to the courts, reserving its limited enforcement capabilities to complaints of systematic discrimination.⁴³

3. Appropriate Legal Standard for Proving a Violation of Title VI: Discriminatory Intent vs. Disparate Impact

In fourteenth amendment equal protection challenges based on racial discrimination, plaintiffs must prove that a racially discriminatory purpose motivated the challenged conduct before the courts will evaluate the conduct under "strict scrutiny" analysis.⁴⁴ Neither discriminatory impact itself,⁴⁵ nor the foreseeability of such impact necessarily supports a conclusion of discriminatory intent.⁴⁶

Proof that racial animus motivated a public hospital's closure or relocation clearly would support a Title VI challenge.⁴⁷ This evi-

680 (8th Cir. 1980); *Wilmington I*, 426 F. Supp. at 924-25 (plaintiffs were required to exhaust administrative remedies unless HHS "could not or would not" act on plaintiffs' complaint), *aff'd*, 584 F.2d 619 (3d Cir. 1978). *But see* *Bryan v. Koch*, 627 F.2d 612, 620 (2d Cir. 1980) (exhaustion of administrative remedy not required); *United States v. Bexar County*, 484 F. Supp. 855, 860 (W.D. Tex. 1980) (no exhaustion required).

41. *See* *Bryan v. Koch*, 627 F.2d 612, 620 (2d Cir. 1980) (citing *Cannon* to support the lack of an exhaustion requirement). *See also* *Wilmington III*, 599 F.2d at 1250 n.10 (holding that a private right of action exists under Title VI and that plaintiffs need not first exhaust administrative remedies to assert a claim).

42. *See* *Jackson v. Conway*, 476 F. Supp. 896, 904 (E.D. Mo. 1979); *Wilmington I*, 426 F. Supp. at 924. *See generally* *Rose*, *supra* note 23, at 106.

43. *See* *Cannon v. University of Chicago*, 441 U.S. 677, 706-08 (1979). *See also* Note, *Maintaining Health Care*, *supra* note 4, at 280 n.48.

44. *See* *Washington v. Davis*, 426 U.S. 229, 239-42 (1976). When courts invoke strict scrutiny analysis to decide the constitutionality of state action, they nearly always hold that the state action violates the equal protection clause. *See* Gunther, *Foreward: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection*, 86 HARV. L. REV. 1, 8 (1972).

45. *See, e.g.*, *Village of Arlington Heights v. Metropolitan Hous. Dev. Corp.*, 429 U.S. 252, 270 (1977); *Washington v. Davis*, 426 U.S. 229, 240 (1976); *Bryan v. Koch*, 492 F. Supp. 212, 217-18 (S.D.N.Y. 1980), *aff'd*, 627 F.2d 612 (2d Cir. 1980).

46. *See, e.g.*, *Personnel Admin. of Mass. v. Feeney*, 442 U.S. 256, 279 n.25 (1979) (foreseeability of adverse impact is a proper consideration but in itself insufficient to show discriminatory purpose).

47. *See* 42 U.S.C. § 2000d (1982).

dence is usually difficult to obtain because hospital board members or city officials rarely allow racial remarks to be recorded for public scrutiny.⁴⁸ In *Bryan v. Koch*,⁴⁹ a recent case challenging the closure of a New York City public hospital, the plaintiffs offered data concerning the closure's potential impact on minorities as well as the city's failure to provide alternative access to health care. The district court flatly refused to accept this as evidence proving racial animus.⁵⁰

Like the fourteenth amendment, Title VI fails to define explicitly the scope of its proscription of discriminatory conduct by federally funded institutions.⁵¹ Strong evidence, however, supports inferring a discriminatory impact standard rather than the more exacting discriminatory intent standard. First, HHS regulations promulgated under Title VI clearly forbid federally funded programs from making site selections that will have a discriminatory effect.⁵² Second, legis-

48. See *Rose*, *supra* note 23, at 109 n.85 (author suggests examination of minutes and documents produced by hospital board members for evidence of racial motive).

49. 492 F. Supp. 212 (S.D.N.Y. 1980), *aff'd*, 627 F.2d 612 (2d Cir. 1980).

50. *Id.* at 219, 223 (discriminatory intent is not shown by evidence that travel to alternative facilities is unduly difficult). See also *NAACP v. Wilmington Medical Center, Inc.*, 491 F. Supp. 290, 313 n.181 (D. Del. 1980) (on remand from *Wilmington III*, court held isolated racist statements by board of directors was insufficient evidence of discriminatory intent), *aff'd*, 657 F.2d 1322 (3d Cir. 1981).

51. See 42 U.S.C. § 2000d (1982). See *supra* note 16 for text of the Act. Agency regulations promulgated under Title VI also broadly prohibit all forms of unequal access to federal program benefits. See, e.g., 7 C.F.R. § 15.3 (1984) (Agriculture Dep't); 13 C.F.R. §§ 112.3-.7 (1984) (SBA); 15 C.F.R. § 8.4 (1984) (Commerce Dep't); 45 C.F.R. § 80.3 (1984) (HHS); 45 C.F.R. § 1010.10 (1984) (O.E.O.). A 1970 Report of the United States Commission on Civil Rights concluded that despite the lack of statutory guidance on the meaning of the term "discrimination," agency regulations uniformly have spelled out specific practices that fall within the meaning of the term and are thereby prohibited. These include the following: Any difference in quality, quantity, or the manner in which the benefit is provided; standards or requirements for participation that have as their purpose or that have the effect of excluding members of certain racial or ethnic minorities; construction of a facility in a location with the purpose or effect of excluding individuals from the benefits of any program on the grounds of race, color, or national origin. U.S. COMM'N ON CIVIL RIGHTS, FEDERAL CIVIL RIGHTS ENFORCEMENT EFFORT 559-60 (1970).

52. 45 C.F.R. § 80.3(b)(3) (1984) (as authorized by 42 U.S.C. § 2000d-1 (1982)) provides:

In determining the site or location of a facilities [sic], an applicant or recipient may not make selections with the effect of excluding individuals from, denying them the benefits of, or subjecting them to discrimination under any programs to which this regulation applies, on the ground of race, color, or national origin; or with the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the Act or this regulation.

Id.

lative debate prior to Title VI's enactment indicates the congressional intent to avoid sponsoring any activity resulting in racial discrimination.⁵³

Although the Supreme Court has not ruled directly on a hospital closure challenge under Title VI, recent holdings indicate the Court's movement towards adopting the discriminatory impact standard for Title VI violations. In 1974, the Supreme Court, in *Lau v. Nichols*,⁵⁴ held that a school board's failure to establish a remedial language program had a discriminatory effect on non-English speaking students.⁵⁵ The Court unanimously declared this disparate impact a violation of Title VI, even without a showing of purposeful discrimination.⁵⁶ In its rationale, the Court stressed both the remedial purpose of the Civil Rights Act as expressed in HHS guidelines⁵⁷

53. See, e.g., 110 CONG. REC. 13,334 (1964) (remarks of Sen. Pastore) ("This is the reason why we have Title VI in this bill, to protect the taxpayers' money, to make sure that here in America, where we collect taxes from all our people, we spend this money for the benefit of all of our people."). See generally *Civil Rights—The President's Program, 1963: Hearings Before the Senate Comm. on the Judiciary*, 88th Cong., 1st Sess. (1963); *Civil Rights: Hearings Before Subcomm. No. 5 of the House Comm. on the Judiciary*, 88th Cong., 1st Sess. (1963).

Remarks of the President and the United States Attorney General during the debate over Title VI also support use of a disparate impact standard. During hearings before a subcommittee of the House Judiciary Committee, Attorney General Robert F. Kennedy stated:

Title VI deals with a related problem [to that confronted by Title VII]. Many programs and activities carried on by State and local governmental authorities and by private enterprises receive financial assistance or backing from the Federal Government. The benefits of such programs and activities unquestionably should be available to eligible recipients without regard to race or color.

Hearings on Miscellaneous Proposals Regarding the Civil Rights of Persons Within the Jurisdiction of the United States Before Subcomm. No. 5 of the House Comm. on the Judiciary, 88th Cong., 1st Sess. 1381 (1963) [hereinafter cited as 1963 *House Hearings*]. President Kennedy stated: "Simple justice requires that public funds, to which all taxpayers of all races contribute, not be spent in any fashion which encourages, entrenches, subsidizes or results in racial discrimination." President's Message on Civil Rights and Job Opportunities, June 19, 1963, reprinted in 1963 *House Hearings*, *supra*, at 1454.

54. 414 U.S. 563 (1974).

55. *Id.* at 568.

56. *Id.* at 569.

57. *Id.* at 567 (citing HHS guidelines that stipulate that recipients of federal aid may not "[r]estrict an individual in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service, financial aid, or benefit under the program." 45 C.F.R. § 80.3(b)(1)(iv) (1984)). In further support of the Court's use of the impact standard is the HHS regulation providing that a "recipient, in determining the types of services . . . which will be provided . . . may not utilize criteria or meth-

and in Congress' broad constitutional authority to set the terms on which it will grant federal funds to the states.⁵⁸

In 1978, the *Bakke*⁵⁹ decision shed some doubt on the Supreme Court's seemingly clear preference for the disparate impact standard expressed in *Lau*.⁶⁰ In *Bakke*, the Court grappled with the question of whether Title VI forbids a state medical school's purposeful discrimination in the form of an affirmative action program designed to remedy past discrimination.⁶¹ In dictum, five Justices asserted that a Title VI violation arises only from conduct that would violate the fourteenth amendment.⁶² Thus, some lower courts have reasoned that *Bakke* overrules *Lau* and that Title VI plaintiffs must show discriminatory intent.⁶³

ods of administration which . . . have the effect of defeating or substantially impairing accomplishment of the objectives of the program" 45 C.F.R. § 80.3(b)(2) (1984).

58. 414 U.S. at 568-69. The Court quoted Senator Humphrey's remarks during floor debates on the Civil Rights Act of 1964: "Simple justice requires that public funds to which all taxpayers of all races contribute, not be spent in any fashion which encourages, entrenches, subsidizes, or results in racial discrimination." 110 CONG. REC. 6543 (1964) (Sen. Humphrey quoting from President Kennedy's message to Congress, June 19, 1963).

59. 438 U.S. 265 (1978).

60. In *Bakke*, Justices Brennan, White, Marshall, and Blackmun joined Justice Powell in the dictum that only conduct forbidden under the fourteenth amendment—that is, intentional discrimination—is forbidden under Title VI. *Id.* at 287. In *Lau*, however, Justices Powell, Brennan, Marshall, and Rehnquist joined Justice Douglas' majority opinion finding a violation of Title VI despite the absence of proof of intentional discrimination. 414 U.S. at 569.

61. 438 U.S. at 269-271.

62. *Id.* at 287 (opinion of Powell, J., announcing the judgment of the Court); *id.* at 352 (opinion of Brennan, J., joined by Justices White, Marshall, and Blackmun, concurring in the judgment in part and dissenting in part). The remaining four Justices did not consider this specific issue, although they concurred with Justice Powell's invalidation of the university's concededly discriminatory admissions policy. *Id.* at 417. Justice Brennan argued that the school's racial quota, as a remedial measure, did not violate Title VI because "Title VI prohibits only those uses of racial criteria that would violate the fourteenth amendment." *Id.* at 378 (Brennan, J., concurring in the judgment in part and dissenting in part).

63. The Second Circuit has displayed considerable confusion over the meaning of the *Bakke* dictum. Compare Board of Educ. v. Califano, 584 F.2d 576, 589 (2d Cir. 1978), *aff'd sub nom.* Board of Educ. v. Harris, 444 U.S. 130 (1979) and Guardians Ass'n v. Civil Serv. Comm'n, 466 F. Supp. 1273, 1285 (S.D.N.Y. 1979), *aff'd in part and vacated in part*, 633 F.2d 232 (2d Cir. 1980), *aff'd*, 463 U.S. 82 (1983), *cert. denied*, 103 S. Ct. 3568 (1983) with Lora v. Board of Educ., 623 F.2d 248, 250 (2d Cir. 1980) and Parents Ass'n v. Ambach, 598 F.2d 705, 715-16 (2d Cir. 1979). Compare Bryan v.

In *Guardians Association v. Civil Service Commission*,⁶⁴ the Supreme Court did not firmly resolve the intent versus impact issue. *Guardians*, however, demonstrates that *Lau* and the *Bakke* dictum are consistent to the extent that they both uphold the remedial objective of Title VI.⁶⁵ Two basic propositions emerge from the six different opinions authored in *Guardians*, addressing the constitutionality of police officer lay-offs based on seniority. First, plaintiffs asserting a violation of Title VI and its implementing regulations need not prove discriminatory intent.⁶⁶ Second, victims of Title VI discrimination cannot recover compensatory damages without establishing discriminatory intent.⁶⁷ Considering that *Guardians* is a fractionalized plurality opinion and that it does not directly address the possibility of awarding injunctive relief for Title VI discriminatory impact victims, it is unclear whether *Guardians* lends much support to plaintiffs in hospital closure suits.

Koch, 492 F. Supp. 212, 230-32, 234 (S.D.N.Y. 1980) with *Bryan v. Koch*, 627 F.2d 612 (2d Cir. 1980).

64. 463 U.S. 82 (1983). For a discussion of *Guardians*, see Comment, *Confusion Surrounding Title VI and the Discriminatory Intent Requirement: Guardians Association v. Civil Service Commission*, 27 WASH. U. J. URB. & CONTEMP. L. 391 (1984).

65. *Id.* See also *Fullilove v. Klutznick*, 448 U.S. 448, 479 (1980) (discussing with approval the *Lau* holding and noting that HHS regulations aimed at eradicating disparate impacts are a constitutional exercise of Congress' spending power). Significantly, Justices White and Powell, who contended in *Bakke* that Title VI mandates a discriminatory intent standard, joined in the *Klutznick* majority.

66. In *Guardians*, the Second Circuit had reversed the district court's award of relief under Title VI for lack of proof of discriminatory intent. Justice White, writing for the Court, affirmed the denial of compensatory relief, but disagreed with the Second Circuit's reading of *Bakke* as extending the reach of Title VI to intentional discrimination in affirmative action programs. 463 U.S. at 83-96. Justice Marshall, in his dissent from the judgment that denies relief, agreed with Justice White regarding the discriminatory impact standard. Justices Stevens, Brennan, and Blackmun rejected Justice White's and Justice Marshall's impact standard, maintaining that *Bakke* does overrule *Lau* on this point. Nevertheless, these three Justices would award compensatory relief because Title VI federal regulations prohibit the use of federal funds in programs having discriminatory effects. *Id.* at 110-116.

67. Justices White and Rehnquist rejected the appropriateness of make-whole remedies, preferring the notion that recipients of federal funds must choose between complying and receiving funds versus not complying and losing funds. *Id.* at 88-96. Justice O'Connor agreed with the end result of no compensation and would require proof of intentional discrimination. *Id.* at 98-100. Justices Powell and Burger joined with Justice O'Connor, but would not allow a private cause of action under Title VI. *Id.* at 96-98.

4. Actual Disposition of Title VI Challenges to Hospital Relocations and Closures

When courts proceed on the assumption that plaintiffs need show only a disparate impact to establish a prima facie case for a Title VI violation, defendants may then attempt to avoid liability for their allegedly illegal conduct with proof of justifying circumstances.⁶⁸ In hospital closure cases, hospital administrators or city officials consistently offer "fiscal necessity" in defense of their decisions to abandon urban locations.⁶⁹ Courts are reluctant to become entangled in the political and financial complexities of municipal fiscal allocation and, therefore, generally do not require exhaustive evidence that relocating health services is truly the course of last resort.⁷⁰

In *NAACP v. Wilmington Medical Center, Inc.*,⁷¹ the plaintiffs brought a class action suit challenging the medical center's plan to

68. See, e.g., *Board of Educ. v. Harris*, 444 U.S. 130, 151 (1979) (educational necessity may be a defense to an action brought under the Emergency School Aid Act); *Metropolitan Hous. Dev. Corp. v. Village of Arlington Heights*, 558 F.2d 1283, 1290 (7th Cir. 1977) (determining Title VIII violations through a balancing test for evaluating discriminatory effects), cert. denied, 434 U.S. 1025 (1978); cf. *Griggs v. Duke Power Co.*, 401 U.S. 424, 431 (1971) (no liability under Title VII if practices are justified by business necessity).

69. See, e.g., *NAACP v. Wilmington Medical Center Inc.*, 491 F. Supp. 290, 315-16 (D. Del. 1980), *aff'd*, 657 F.2d 1322 (3d Cir. 1981). The district court required defendants to show that the relocation plan would "in theory and in practice serve a legitimate bona fide interest [of the Medical Center] and [the Medical Center] must show that no alternative course of action could be adopted that would enable that interest to be served with a lesser discriminatory impact." *Id.* (adopting the Third Circuit's formulation of this test in *Resident Advisory Bd. v. Rizzo*, 564 F.2d 126, 149 (3d Cir. 1977), cert. denied *sub nom.* *Whitman Area Improvement Council v. Resident Advisory Bd.*, 435 U.S. 908 (1978)). In *Wilmington III*, the Third Circuit Court of Appeals accepted financial constraints as a "legitimate bona fide interest of the medical center." 599 F.2d at 1247.

70. See, e.g., *Bryan v. Koch*, 627 F.2d 612, 619 (2d Cir. 1980) (concluding that defendant city need not assess all alternatives to hospital closure in the context of total municipal financing; the city need only make an adequate inquiry into which hospital it can close and still afford to provide public health care). See generally Note, *Maintaining Health Care*, *supra* note 4, at 302 (arguing that even when financial necessity compels hospital relocation, Title VI mandates every effort to maintain health care at the original site).

71. *Wilmington I*, 426 F. Supp. 919 (D. Del. 1977) (action stayed pending HHS investigation and report), *aff'd*, 584 F.2d 619 (3d Cir. 1978); *NAACP v. Wilmington Medical Center, Inc.*, 453 F. Supp. 280 (D. Del. 1978) [hereinafter cited as *Wilmington II*] (affirming HHS's findings as not arbitrary or capricious), *vacated and remanded*, 599 F.2d 1247 (3d Cir. 1979) (plaintiffs entitled to de novo review), *on remand*, *Wilmington III*, 491 F. Supp. 290 (D. Del. 1980), *aff'd*, 657 F.2d 1322 (3d Cir. 1981).

replace two city hospitals with a new suburban facility.⁷² The Delaware federal district court refused to recognize a private right of action under Title VI and ordered the Secretary of HHS to investigate the charge of discriminatory impact.⁷³ Although HHS found that the plan would have a disparate impact on racial minorities and the handicapped,⁷⁴ the district court ruled that the impact was not great enough to merit injunctive relief.⁷⁵ The Third Circuit Court of Appeals affirmed.⁷⁶ HHS subsequently interpreted its own regulations to require that federally assisted hospitals mitigate the adverse affects of relocation.⁷⁷

In *Bryan v. Koch*,⁷⁸ the plaintiffs challenged the city's contemplated closure of one of thirteen inner-city public hospitals.⁷⁹ The New

72. *Wilmington I*, 426 F. Supp. at 922. The plan contemplated construction of a new \$60 million, 800 bed tertiary care facility in a suburban area eight miles from the city. The plaintiffs feared that although the Medical Center planned to renovate one out of the three urban hospitals, the new suburban facility would drain too many resources from the urban hospital. *Id.* at 922.

73. *Id.* at 924 n.8 (noting that site determination having discriminatory effects is "specifically proscribed by the secretary's regulations" in 45 C.F.R. § 80.3(b)(3) (1984)). See also *supra* notes 38-43 and accompanying text for exhaustion of remedies discussion.

74. See Letter of Findings Concerning Wilmington Medical Center's Plan Omega, from Dewey Dodds, Director, Office of Civil Rights, Region IV, Dep't of Health, Education, and Welfare to James A. Harding President, Wilmington Medical Center, Inc. (July 5, 1977) [hereinafter cited as Letter of Findings] (stressing the inconvenience of travel to the suburban facility as well as the unaffordability and unavailability of public or private transportation). See also *Wilmington II*, 453 F. Supp. at 312.

75. *Wilmington II*, 453 F. Supp. at 341.

76. *Wilmington III*, 599 F.2d at 1247.

77. See Letter of Findings, *supra* note 74. More specifically, the medical center's "important non-race related goals were 1) to meet the need for suburban hospital beds; 2) to capture part of the revenues going to other suburban hospitals; 3) to respond to economies of scale." *Id.* at 20-21.

HHS and the Medical Center entered into covenants designed to mitigate the disparate racial impact. *Wilmington II*, 453 F. Supp. at 292. This spawned more litigation. *Id.* at 310-30 (district court rejected plaintiffs' argument that mitigating assurances were insufficient and invalid); *Wilmington III*, 599 F.2d 1247 (3d Cir. 1979) (remanding case for trial de novo on the merits notwithstanding the administrative investigation); 491 F. Supp. at 318 (D. Del. 1980) (district court ruled for plaintiffs).

Despite the increase in costs resulting from the five-year delay of litigation, the Medical Center intends to proceed with construction. See Rose, *supra* note 23, at 104.

78. 494 F. Supp. 212 (S.D.N.Y. 1980), *aff'd*, 627 F.2d 612 (2d Cir. 1980).

79. *Id.* at 215-16. The hospital in question, Sydenham Hospital, is located in Har-

York federal district court required the plaintiffs to establish that discriminatory intent motivated the hospital's closure.⁸⁰ Finding no proof of racial animus, the court ruled that the fiscal necessity of closing the hospital justified any shortcoming in the plan.⁸¹ The Second Circuit Court of Appeals⁸² agreed that the hospital's closure would have a disproportionately adverse impact on blacks and Hispanics.⁸³ The court noted, however, that this hospital constituted the smallest and oldest facility in the city's hospital system. Moreover, Harlem residents could obtain alternative emergency care at another public facility.⁸⁴

In ruling that the city's alleged financial constraints adequately justified closure, the *Bryan* court declined to examine the city's general approach to fiscal management.⁸⁵ The dissenting judge asserted that the city offered no evidence of rational decision-making.⁸⁶ Although he agreed that fund allocations for public programs are essentially legislative decisions, the dissenting judge contended that courts should require cities to evaluate health care alternatives with more attention to social impact than to financial feasibility.⁸⁷

lem. New York City's public hospital system constituted over 10% of the city's entire expense budget for fiscal year 1980—about \$1.2 billion. *Id.*

80. *Id.* at 236. The court characterized this case as a "dilatatory tactic to prevent a painful but purely political decision." *Id.* at 217.

81. *Id.* at 223, 237-38.

82. *Bryan*, 627 F.2d 612 (2d Cir. 1980).

83. *Id.* at 617 (98% of Sydenham's patients belonged to racial minorities, while 66% of the patients served by the entire municipal system were members of racial minority groups).

84. *Id.* at 617-18. The court declared that saving money per se could not justify the hospital's closure and that the city would have to justify closing this particular hospital on other grounds. *Id.* The court based its reasoning on *Griggs v. Duke Power Co.*, 401 U.S. 424 (1971), in which the defendants had to show that an employment test having a disparate racial impact was a useful way to select employees for a particular job. *See id.*

85. 627 F.2d at 619.

86. *Id.* at 621 (Kearse, J., dissenting). Judge Kearse suggested a two-phase evaluation of the purported justification: 1) examine the process by which the defendant reaches its chosen course of action and 2) if the defendant followed a rational course, inquire into the substantive merits of the decision. Judge Kearse criticized the city for taking an unreasonably narrow view of the range of possible alternatives to closing the hospital. He also noted that the nearby voluntary hospitals often did not admit uninsured patients. *Id.* at 624, 626-27 (Kearse, J., dissenting).

87. *Id.* at 628 (Kearse, J., dissenting). *See Note, Intent or Impact: Proving Discrimination Under Title VI of the Civil Rights Act of 1964*, 80 MICH. L. REV. 1095, 1109 (1982) (criticizing the majority's failure to clearly enunciate defendant's responsibility

In *United States v. Bexar County*,⁸⁸ low-income minority women challenged the proposed relocation of maternity services provided by a county hospital district from a dilapidated inner-city hospital to a suburban facility eleven miles away.⁸⁹ The plaintiffs contended that the district's relocation of maternity services would violate its promise to maintain obstetric and gynecology facilities in the city in exchange for the legislative authority and funds to construct the new suburban facility.⁹⁰ The court accepted the hospital district's justification that consolidating all services at one site would result in better overall health care than splitting funds between a inner-city and suburban site.⁹¹ The court declined to order a tax increase to finance the urban facility's maintenance.⁹²

B. *Alternative Administrative and Political Resources*

In light of the general unwillingness of courts to scrutinize public fund allocations, other methods for challenging proposed urban hospital closures may be more effective than a constitutional attack. Also, appropriate relief in a private Title VI action remains undefined. The Supreme Court and most lower courts, however, support injunctive or declaratory relief.⁹³ In *Heath v. Charlotte-Mecklenberg*

for rebutting plaintiff's prima facie case); Note, *Maintaining Health Care*, *supra* note 4, at 292-302 (arguing that defendant hospitals and cities have a duty to mitigate the racial impact of financially motivated relocations or closures).

88. 484 F. Supp. 855 (W.D. Tex. 1980).

89. *Id.* at 858.

90. *Id.*

91. *Id.* at 859.

92. *Id.* In closing, the court refused to characterize this litigation as "frivolous" or "instituted in bad faith;" rather, it served as a useful ventilation of disagreement and as a forum for achieving a better understanding of the political and economic issues. *Id.* at 861.

93. *See, e.g.*, *Lau v. Nichols*, 414 U.S. 563 (1974); *Serna v. Portales Mun. Schools*, 499 F.2d 1147 (10th Cir. 1974); *Bossler Parish School Bd. v. Lemon*, 370 F.2d 847 (5th Cir. 1967), *cert. denied*, 388 U.S. 911 (1967).

Courts are split over the propriety of awarding damages. *Compare* *Boxall v. Sequoias Union High School Dist.*, 464 F. Supp. 1104, 1112 (N.D. Cal. 1979) (damages not allowed in Title VI suits) *and* *Rendon v. Utah State Dep't of Employment Sec. Job Serv.*, 454 F. Supp. 534, 536 (D. Utah 1978) (damages not allowed in Title VI suits) *with* *Gilliam v. City of Omaha*, 388 F. Supp. 842, 847 (D. Neb. 1975) (court has subject-matter jurisdiction over Title VI suit for damages) *and* *Flanagan v. President & Directors of Georgetown College*, 417 F. Supp. 377, 385 (D.D.C. 1976) (assuming that damages would be appropriate) *and* *Chambers v. Omaha Pub. School Dist.*, 536 F.2d 222, 225 n.2 (8th Cir. 1976) (court expressed no view about damages relief). *See*

Hospital Authority,⁹⁴ the plaintiffs used the policies behind the National Health Planning Act of 1974⁹⁵ to convince a district court to enjoin the proposed transfer of inner-city hospital services.⁹⁶ The plaintiffs successfully argued that the National Health Planning Act, which seeks to maintain an even distribution of medical services, requires health facilities to obtain certificates-of-need before relocating services.⁹⁷ The defendant hospital authority had failed to obtain a certificate of need. The court agreed that the transfer would work irreparable harm upon the plaintiff class in a manner contrary to the Health Act's objectives.⁹⁸

Recently, some aggrieved urban residents have achieved greater success in saving their hospitals by filing complaints with HHS rather than bringing suit in federal court.⁹⁹ In these cases, hospital authorities contemplated leaving inner-city sites despite assurances to HHS that they would continue to serve the urban needy in return for Hill-Burton construction funds.¹⁰⁰ By insisting that HHS enforce these

generally Note, *supra* note 17, at 711-13 (arguing that in hospital cases, injunction is proper relief because it involves a court "investigation" and it gives hospitals an opportunity to comply with HHS regulations before termination of funds; damages, on the other hand, merely deplete the hospital's already short supply of funds).

94. No. C-C-81-193 (W.D.N.C. June 22, 1981) (order granting injunction), discussed in Rose, *supra* note 23, at 105.

95. 42 U.S.C. § 399k (1982).

96. No. C-C-81-193 (W.D.N.C. June 22, 1981) (order granting injunction).

97. HHS regulations authorized by the Act set forth the following requirements for issuance of a certificate of need:

The need that the population served or to be served has for the services proposed to be offered or expanded, and the extent to which all residents of the area, and in particular low-income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups, and the elderly, are likely to have access to those services.

In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the need that the population presently served has for the service, the extent to which that need will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination, or relocation of the service on the ability of low-income persons, racial and ethnic minorities, women, handicapped persons, and other under-served groups, and the elderly, to obtain needed health care.

42 C.F.R. § 122.412(a)(3) (1984).

98. No. C-C-81-193 (W.D.N.C. June 22, 1981) (order granting injunction).

99. *See, e.g.,* Cook v. Ochsner Found. Hosp., 61 F.R.D. 354 (E.D. La. 1972), *cited in* Rose, *supra* note 23, at 106 n.38 (holding hospitals receiving Medicare are bound to their Hill-Burton assurances).

100. *See, e.g.,* Jackson v. Conway, 476 F. Supp. 896 (E.D. Mo. 1979) (court in-

assurances, the plaintiffs prevented hospital closure and, in one case, even obtained the hospital's agreement to finance major renovations and new services at the urban facility.¹⁰¹ In addition, in at least one city, organized social outcry over the threatened loss of an urban hospital has prompted increased political and governmental concern.¹⁰²

III. STATE AND FEDERAL EFFORTS TO INCREASE INDIGENT ACCESS TO PRIVATELY PROVIDED HEALTH CARE

When neither Title VI challenges nor administrative remedial efforts succeed in maintaining public health care in the city, the urban poor often are forced to seek charity care at private facilities.¹⁰³ As the cost of providing health care spirals,¹⁰⁴ private not-for-profit hospitals claim they increasingly are unable to provide services to those that require them on a less than fully compensated basis.¹⁰⁵ As a result, many private hospitals have adopted the policy of reducing free or federally reimbursed care to poor people.¹⁰⁶

sisted that the plaintiffs exhaust administrative remedy by seeking HHS investigation of St. Louis' inner-city facility, Homer G. Phillips Hospital), *aff'd*, 620 F.2d 680 (8th Cir. 1980).

101. See *Terry v. Methodist Hosp. of Gary*, Case Nos. H-76-373 & H-77-154, par. 5 (N.D. Ind. June 5, 1979) (consent decree).

102. See Mulvanny & Wood, *Opposition to Hospital Closings: The Role of Attorneys in Coalitions*, 14 CLEARINGHOUSE REV. 1228 (1981). The article discusses the efforts of citizens, politicians, and attorneys directed against closure of Christian Welfare Hospital in East St. Louis, Illinois. After the coalition convinced HHS to reject the hospital's application for closure, a group of black doctors, with the coalition's approval, assumed control of the hospital and presently operate it on a day-to-day basis. See *Rose*, *supra* note 23, at 105.

On the other hand, even when HHS's response seems inadequate, courts may defer to the agency's perceived expertise. See *supra* notes 42-43 and accompanying text.

103. See *supra* notes 8, 97.

104. See, e.g., Gibson & Fisher, *National Health Care Expenditures, Fiscal Year 1977*, SOC. SECURITY BULL. July 1978, at 5 (Table 1), 15 (Table 5) (Annual national health care expenditures increased from \$69.2 billion in 1970 to \$162.6 billion in 1977; according to the Health Care Financing Administration of HHS, the increase in "outlays" is attributed to rapid increases in health care prices, rather than to an increasing population or general cost of living.). See generally Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 YALE L.J. 243, 244 n.4 (1978).

105. See, e.g., *American Hosp. Ass'n v. Harris*, 625 F.2d 1328, 1344 (8th Cir. 1980) (hospital challenging HHS's expansion of free care obligations).

106. See INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCE, *HEALTH CARE IN A CONTEXT OF CIVIL RIGHTS* 209 (1981) (noting that the reluctance of many institutions to provide government-sponsored care results in discrimination against minorities and handicapped as well as other welfare recipients).

As city governments and private health care providers continue to claim financial inability to care for the poor, the governmental responsibility for financing such care passes to the state and federal levels.¹⁰⁷ Congress has enacted two major pieces of legislation in an attempt to equalize access to health care: the Hill-Burton Act, and the Medicare and Medicaid statutes.¹⁰⁸

A. *The Hill-Burton and Subsequent National Health Planning Acts*

The Hill-Burton Act of 1946¹⁰⁹ constitutes the federal government's initial attempt to address urban health care inequities.¹¹⁰ Congress sought to remedy problems such as bed shortages and racist hospital practices.¹¹¹ Under the Act, Congress has financed construction and expansion of hospitals that have agreed to provide "reasonable amounts" of "uncompensated" and "community" services.¹¹² Congress focused on urban health care in 1964 when it amended the

107. See Rosenblatt, *supra* note 104, at 243, 287 (until 1965, when Medicare and Medicaid were established, local governments were primarily responsible for providing government-sponsored health care for the poor).

For an intriguing argument that courts should avoid lodging too much "affirmative responsibility" upon the government for providing health care, see Blumstein, *Rationing Medical Resources: A Constitutional, Legal and Policy Analysis*, 59 TEX. L. REV. 1345, 1362 (1981) [hereinafter cited as Blumstein, *Rationing Medical Resources*]; Blumstein, *Constitutional Perspectives on Governmental Decisions Affecting Human Life and Health*, 40 LAW & CONTEMP. PROBS. 231, 233 (1976) [hereinafter cited as Blumstein, *Constitutional Perspectives*].

108. See *infra* notes 109-149 and accompanying text.

109. 42 U.S.C. § 291c(e) (1982).

110. See, e.g., President Truman's Message to Congress on Health Legislation, 1945 U.S. CODE CONG. & AD. NEWS 1143. See also Wing, *The Community Service Obligation of Hill-Burton Health Facilities*, 23 B.C.L. REV. 577, 584 n. 32 (1982) (exhaustive legislative history). See generally Chapman & Talmadge, *Historical and Political Background of Federal Health Care Legislation*, 35 LAW & CONTEMP. PROBS. 334 (1970) (describing federal government's limited role in delivery of medical care prior to 1946).

111. See Pub. L. No. 79-725, § 2, 60 Stat. 1041 (1946) (current version at 42 U.S.C. § 291c (1982)).

112. See 42 U.S.C. § 291c(e) (1982). See generally Wing, *supra* note 110; Rose, *Federal Regulation of Services to the Poor Under the Hill-Burton Act: Realities and Pitfalls*, 7 NW. U.L. REV. 168 (1975); Rosenblatt, *supra* note 104; Note, *The Hill-Burton Act, 1946-1980: Asynchrony in the Delivery of Health Care to the Poor*, 39 MD. L. REV. 316 (1979); Note, *Due Process for Hill-Burton Assisted Facilities*, 32 VAND. L. REV. 1469 (1979). These commentators differ in their analysis of whether "uncompensated service" and "community service" provide different statutory bases for charity care obligations.

Act to emphasize modernization and renovation of existing facilities rather than new construction.¹¹³ Responsibility for regulating and enforcing the Act's provisions rests with HHS.¹¹⁴

In 1972, HHS drafted regulations defining the vague "uncompensated care" requirement.¹¹⁵ Provision of free services equivalent to either three percent of a hospital's operating costs or ten percent of its federal assistance under the Act would establish "presumptive compliance." Alternatively, a hospital could certify its intention to adopt an "open door" policy to all indigents seeking care.¹¹⁶ In *Corum v. Beth Israel Medical Center*,¹¹⁷ a federal district court ruled that Hill-Burton hospitals may not include bad debts incurred from otherwise solvent patients as "uncompensated service."¹¹⁸ Accordingly, HHS amended its regulations in 1975 to forbid post-care eligibility determinations.¹¹⁹

Other litigation helped to define hospitals' community service obligations. Following a district court's decision in *Cook v. Ochsner Foundation Hospital*,¹²⁰ HHS issued regulations in 1974 mandating participation in state Medicaid programs by Hill-Burton hospitals.¹²¹ The new rules also authorized state agencies to administer and monitor community service assurances.¹²²

Although Congress authorized the Secretary of HHS to implement uncompensated care and community service assurance provisions in 1965, the Department failed to issue any regulations pertaining to

113. See Pub. L. No. 88-443, § 3, 78 Stat. 457 (1964) (currently codified at 42 U.S.C. § 291j (1982)). See also Wing, *supra* note 110, at 586-87; S. REP. NO. 1274, 88th Cong., 2d Sess. 2, reprinted in 1964 U.S. CODE CONG. & AD. NEWS 2800, 2802-03.

114. See 42 U.S.C. § 202 (1982). Prior to 1966, this responsibility rested with the Surgeon General. See Pub. L. No. 88-443, 78 Stat. 447 (1964).

115. See 42 C.F.R. § 53.111(d) (1984).

116. *Id.* These regulations also incorporate the Act's exception to the obligation to provide uncompensated care if it is "not feasible from a financial viewpoint." 42 U.S.C. § 291c(e) (1982). But see Rose, *supra* note 112, at 170 (noting that no grantee ever has been permitted to waive the obligation).

117. 373 F. Supp. 550 (S.D.N.Y. 1974).

118. *Id.* at 557.

119. 42 C.F.R. § 53.111(f)(1) (1984).

120. 61 F.R.D. 354 (E.D. La. 1972). The court declared that exclusion of persons covered by Medicaid constituted a violation of the "community service" obligation. *Id.* at 361.

121. 42 C.F.R. § 53.113(d)(2) (1984).

122. *Id.* § 53.113(f) (1984).

these provisions until 1972.¹²³ Even after HHS issued the regulations, however, specific enforcement power rested with the state agencies.¹²⁴ This reduced HHS's role to ensuring that state health plans reflect Hill-Burton hospital assurances. Consequently, HHS enforcement efforts remained lax.¹²⁵

In 1974, Congress enacted Title XVI of the Public Health Services Act to provide stricter enforcement of hospital assurances.¹²⁶ Title XVI was introduced to replace the Hill-Burton Act as a source of funds to hospitals.¹²⁷ In 1980, the American Hospital Association unsuccessfully sought to enjoin¹²⁸ HHS regulations promulgated in the wake of Title XVI because they expanded the hospitals' community service obligations¹²⁹ beyond those to which it had originally "contracted" under Hill-Burton.¹³⁰ The Hospital Association was not awarded the injunction because it failed to prove the likelihood of success on the merits.¹³¹ In partial dissent, however, one Seventh Circuit Court of Appeals judge characterized the new regulations as "administrative overkill," especially in light of current financial constraints facing hospitals.¹³²

123. See generally *Davis v. Ball Memorial Hosp.*, 640 F.2d 30, 32 (7th Cir. 1980); *American Hosp. Ass'n v. Harris*, 625 F.2d 1328, 1337 (7th Cir. 1980).

124. See *supra* note 122 and accompanying text.

125. See S. REP. NO. 93-1285, 93d Cong., 2d Sess., reprinted in 1974 U.S. CODE CONG. & AD. NEWS 7842, 7900, cited in *Davis v. Ball Memorial Hosp.*, 640 F.2d 30, 32 (7th Cir. 1980).

126. See Pub. L. No. 93-641, 88 Stat. 2225 (1974) (codified at 42 U.S.C. § 300k (1982)).

127. For an overview of permissible uses of funds, see 42 U.S.C. §§ 300g(a)(1), 300r(a), & 300r(b) (1982). The most notable change from earlier Hill-Burton priorities is the allowance of federal financial assistance to convert or discontinue the use of health facilities. See also Wing, *supra* note 110, at 588 n.54 (labels this approach "reverse Hill-Burton").

128. See *American Hosp. Ass'n v. Harris*, 625 F.2d 1328 (7th Cir. 1980).

129. See, e.g., 42 C.F.R. §§ 124.503(b), .509(b), .603(d)(1), .603(d)(2) (1984).

130. 625 F.2d at 1330. See generally *Euresti v. Stenner*, 458 F.2d 1115 (10th Cir. 1972) (relationship between Hill-Burton hospitals and the relevant administrative agency is contractual in nature).

131. 625 F.2d at 1332-38. The American Hospital Association also failed to show that the increased obligations would cause its member organizations irreparable harm. *Id.*

132. *Id.* at 1344 (Pell, C.J., concurring in part and dissenting in part). Chief Judge Pell also argued that the court should require HHS to honor the original contractual terms. *Id.* at 1338-42.

B. *Medicaid and Medicare*

1. The Statutory Scheme

As the accessibility and quality of privately provided health care improved during the Hill-Burton era,¹³³ neglected public hospitals became "dumping grounds" for the inner-city poor.¹³⁴ Congress enacted the Medicare¹³⁵ and Medicaid¹³⁶ laws with the aim of ameliorating this dual system of health care.¹³⁷ The Medicare scheme authorized federal reimbursement to those providing health care to persons over age sixty-five.¹³⁸ Congress hoped this legislation would motivate hospitals to comply with Title VI nondiscrimination re-

133. By 1974, the federal government had assisted construction and modernization projects worth over \$14.5 billion through grants and loans totaling over \$5 billion. CAMBRIDGE RESEARCH INSTITUTE, TRENDS AFFECTING THE U.S. HEALTH CARE SYSTEM 91-95 (1976) (commissioned by HHS). See also figures cited in S. REP. NO. 1285, 93d Cong., 2d Sess. 14-18, reprinted in 1974 U.S. CODE CONG. & AD. NEWS 7842-49.

Approximately 40% of the nation's current acute care bed supply has received financial assistance through the Hill-Burton program. AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS: 1979 (1980). See also Wing, *supra* note 110, at 557 n.6; Wing & Craige, *Health Care Regulations: Dilemma of a Partially Developed Public Policy*, 57 N.C.L. REV. 1165, 1169-72 (1979).

134. See HOSPITALS, July 1, 1970, at 54. HOSPITALS is the official publication of the American Hospital Association.

135. Pub. L. No. 89-97, 79 Stat. 291 (1965) (codified as amended at 42 U.S.C. § 1395 (1982)).

136. Pub. L. No. 89-97, 79 Stat. 343 (1965) (codified as amended at 42 U.S.C. § 1396 (1982)).

137. See, e.g., Blumstein & Zubkoff, *Public Choice in Health: Problems, Politics and Perspectives on Formulating National Health Policy*, 4 J. HEALTH POL., POL'Y & L. 382, 384 (1979) (assessing Medicaid and Medicare as reflections of perceived governmental responsibility to distribute the wealth); 1 REPORT OF THE NATIONAL ADVISORY COMMISSION OF HEALTH MANPOWER 34-36 (Nov. 1967) (noting that the U.S. has declined in relation to other modern industrial nations in providing adequate quality health care to its citizens). See generally T. MARMOR & J. MARMOR, POLITICS OF MEDICARE (1973).

138. See 42 U.S.C. § 1395(d) (1982) (number of reimbursable hospital care days). The Act permits the exclusion of numerous services from coverage, such as: 1) Routine physical checkups; 2) eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; 3) hearing aids or examinations; 4) immunizations; 5) custodial care; 6) the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth; 7) treatment of flat foot conditions; and 8) personal comfort items. A broad exclusion is provided for expenses for services "which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." *Id.* §1395y(a)(1).

See generally COMMERCE CLEARING HOUSE, 1978 SOCIAL SECURITY AND MEDI-

quirements.¹³⁹ The Medicaid statute encourages states to establish a reimbursement scheme for providers of health care to the poor.¹⁴⁰ To participate in the grant-in-aid program, a state must comply with a few federally mandated requirements for the provision of basic health care.¹⁴¹ States have wide discretion in determining the nature and amount of coverage for optional services.¹⁴²

Recent and proposed reductions in federal funding,¹⁴³ as well as public pressure on states to trim spending programs, have led to widespread state Medicaid cutbacks.¹⁴⁴ The Medicaid Act establishes two groups of needy persons. The first is the "categorically needy," which includes needy persons with dependent children, the aged, the blind, and the disabled.¹⁴⁵ The second is the "medically needy," which encompasses all other persons meeting stated poverty levels.¹⁴⁶ Participating states are not required to extend coverage to

CARE EXPLAINED ¶ 601 (1978); Butler, *An Advocate's Guide to the Medicare Program*, 8 CLEARINGHOUSE REV. 831 (1975).

139. See VI UNITED STATES COMMISSION ON CIVIL RIGHTS, THE FEDERAL CIVIL RIGHTS ENFORCEMENT EFFORT 118-19 (1974) (hospitals are subject to Title VI, but covered physicians are not); U.S. COMMISSION ON CIVIL RIGHTS, HEW AND TITLE VI, A REPORT ON THE DEVELOPMENT OF THE ORGANIZATION, POLICIES, AND COMPLIANCE PROCEDURES OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 44 (1974).

140. See 42 U.S.C. § 1396a (1982).

141. *Id.* §§ 1396a(a)(10)(A), 1396d(a)(1)-(5) (state must provide five basic services: in-patient hospital care, out-patient hospital care, laboratory and x-ray services, skilled nursing home care, and physicians' services).

142. *Id.* §§ 1396a(10)(A), 1396d(a)(12) (state may opt to exclude coverage of drugs, dental services, eyeglasses, and hearing aids).

143. See, e.g., PROPOSED FEDERAL 1983 HEALTH CUTS, 16 CLEARINGHOUSE REV. 32 (1983) (Reagan Administration proposed reductions in federal spending for Medicaid by \$2.2 billion and for Medicare by \$3.1 billion in fiscal year 1983, among other cuts in health care programs; reductions in federal funding in fiscal year 1982 totaled \$0.9 billion).

144. See, e.g., Rosenblatt, *supra* note 104, at 294-303 (states responded to public pressure for health cost-control by reducing Medicaid programs); *The Closing and Divestiture of Public Hospitals: Public Responsibility for Health Care of Indigents*, 9 CLEARINGHOUSE REV. 174 (1975) (California cutbacks in Medi-Cal increased the burden on county hospitals). See also MEDICAID BUREAU, HEALTH CARE FINANCING ADMINISTRATION, DEPT OF HEW, DATA ON THE MEDICAID PROGRAM: ELIGIBILITY, SERVICES, EXPENDITURES: FISCAL YEAR 1966-77 14-18 (1977); Illinois State Medical Society, Letter to Members (Mar. 4, 1983) (announcing state's 7.5% across-the-board fee cut for all health care providers).

145. 42 U.S.C. § 1396a(a)(10)(A) (1982).

146. *Id.* § 1396a(a)(10)(C).

the medically needy.¹⁴⁷ The federal statute does not limit the states' ability to exclude various services from Medicaid coverage. Congress' frequent references to the words "amount, scope and duration" in the statute expressly permit states to exercise considerable discretion in this area.¹⁴⁸ The statute, however, does forbid limitations that fall more heavily on the medically needy than on the categorically needy.¹⁴⁹

2. Constitutional Issues in Challenges to Reduced Service Coverage

The Supreme Court has deferred to the states' discretionary determinations of which services to include in the optional medically needy category. In *Harris v. McRae*,¹⁵⁰ the Court considered whether a state's denial of Medicaid funds for nontherapeutic and medically necessary abortions established poverty as an unconstitutional barrier to abortion procurement in light of *Roe v. Wade*.¹⁵¹ In *Roe*, the Court declined to outlaw abortion by announcing the constitutionally protected right of a woman to decide, free from governmental interference, to terminate her pregnancy.¹⁵² The *McRae* Court did not read *Roe* as creating a right to abort, but as forbidding states from preventing all legal access to obtaining an abortion.¹⁵³ The Court concluded that denial of Medicaid funding for nontherapeutic and medically necessary abortions did not create the plaintiff's obstacle to obtaining an abortion—her impoverished condition.¹⁵⁴ Furthermore, the Court supported the state's right to choose between

147. *Id.*

148. *See, e.g., id.* § 1396a(a)(10)(B) (1982).

149. *See, e.g., Schweiker v. Hogan*, 455 U.S. 1013 (1982) (in terms of their ability to provide for essential medical services, the wealthy and the poor are not similarly situated).

150. 448 U.S. 297 (1980). *See Comment, Refusal to Fund Constitutionally Protected Right Held Valid: Harris v. McRae*, 59 WASH. U.L.Q. 247 (1981) (discussing *McRae*).

151. 410 U.S. 113 (1973).

152. *Id.* at 120.

153. 448 U.S. at 318. The court explained that a woman has the freedom to make choices regarding her health, but this does not establish "an entitlement to such funds as may be necessary to realize all the advantages of that freedom." *Id.*

154. *Id.* at 316. *See also Maher v. Roe*, 432 U.S. 464 (1977) (fundamental need, alone, does not merit provision of abortion to impoverished woman); *Beal v. Doe*, 432 U.S. 438 (1977) (state may exclude abortion from Medicaid coverage because it is not a necessity).

competing demands for limited public funds.¹⁵⁵

Successful challenges to a state's Medicaid cutback depends on whether the aggrieved party had a legitimate claim to eliminated health services.¹⁵⁶ In *Memorial Hospital v. Maricopa County*,¹⁵⁷ the Supreme Court characterized health care as a basic necessity of life.¹⁵⁸ Only compelling state interests can support statutory restrictions imposed on access to health services.¹⁵⁹

A person has a constitutionally protected property interest in health care, though, only when a source independent of the Constitution, such as state law, creates an understanding that the property interest exists.¹⁶⁰ In *Rosado v. Wyman*,¹⁶¹ the Supreme Court determined that persons statutorily eligible to receive particular state benefits have a property interest that the government can eliminate only upon compliance with basic due process requirements.¹⁶² In *Board of Regents v. Roth*,¹⁶³ however, the Court restricted due process protection to entitlements presently enjoyed by a complainant as opposed to his or her unilateral expectations.¹⁶⁴ Thus, states must afford due process procedures only to established recipients of newly

155. 448 U.S. at 318. *See also* *Dandridge v. Williams*, 397 U.S. 471, 485 (1970) (requiring only a "rational basis" for classification limiting receipt of welfare benefits).

156. *See, e.g., McRae*, 448 U.S. at 318.

157. 415 U.S. 250 (1974).

158. *Id.* at 259. The plaintiff, an asthmatic indigent who had just moved to Arizona, challenged a county ordinance conditioning free health care on a year's residency.

159. *Id.* at 259.

160. *See, e.g., Davis v. Ball*, 640 F.2d 30 (1980) (indigents have enforceable interest in free health care as created by Hill-Burton Act, even though the Act does not define eligibility of recipients).

161. 397 U.S. 397 (1970).

162. *Id.* at 405-06, 420-23.

163. 408 U.S. 564 (1972).

164. *Id.* at 577 (holding that a teacher had no legally enforceable claim to re-employment after expiration of his contract). *See also* *Greenholtz v. Inmates of Neb. Penal and Correctional Complex*, 442 U.S. 1 (1979) (no entitlement to parole from valid sentence unless a statute explicitly grants it); *Meachum v. Fano*, 427 U.S. 215 (1976) (no entitlement to a hearing to challenge a transfer from one prison to another because no state law creates the right to remain in a particular prison). *But see* *Morissett v. Brewer*, 408 U.S. 471 (1972) (parole revocation determination does require due process procedures). *Cf.* *Paul v. Davis*, 424 U.S. 693 (1973) (distinguished present enjoyment of a liberty not guaranteed by the constitution such as reputation, from the constitutional guaranty of freedom which is embodied in parole).

restricted services. A person not already covered by Medicaid cannot bring a successful challenge to a state's changes in eligibility requirements.¹⁶⁵ As more people become unable to afford private health insurance; and, as states make eligibility for Medicaid coverage more difficult for low-income wage earners, more people may require public hospital services.¹⁶⁶

IV. ANALYSIS AND CONCLUSION

Traditionally, cities have shouldered the burden of providing free, albeit inadequate, health care for their indigent residents. Reduced tax revenues that result from demographic changes make this responsibility increasingly difficult to fulfill. Arguably, city governments should allocate a greater portion of limited resources to health care needs and courts should enforce this duty more stringently on Title VI grounds. As a practical matter, though, courts are reluctant to scrutinize complex legislative funding decisions. Administrative remedies based on a less theoretical model may yield more tangible results, yet insufficient financial resources remain the final insurmountable hurdle. Meanwhile, city residents are losing the political and legal fight to save their public hospitals.¹⁶⁷

Congressional attempts to ameliorate health care inequities have not succeeded and possibly have led to new inequities. The present administration proposed to make further reductions in federal funding to state Medicare and Medicaid programs.¹⁶⁸ Currently, private health care providers are responding to indigents and persons covered by Medicare and Medicaid.¹⁶⁹ The administration's pro-competitive scheme¹⁷⁰ contemplates that market-place incentives, rather

165. See generally Blumstein, *Rationing Medical Resources*, *supra* note 107, at 1373-75; Note, *Welfare, Due Process, and "Brutal Needs:" The Requirement of a Prior Hearing in State-Wide Benefit Reductions*, 34 VAND. L. REV. 173 (1981).

166. See, e.g., L. ADAY, R. ANDERSON, & G. FLEMING, *HEALTH CARE IN THE U.S. EQUITABLE FOR WHOM?* (1980); K. DAVIS & C. SCHOEN, *HEALTH AND THE WAR ON POVERTY: A TEN-YEAR APPRAISAL* 41 (1978); DAVIS & REYNOLDS, *THE IMPACT OF MEDICARE AND MEDICAID ON ACCESS TO MEDICAL CARE IN THE ROLE OF HEALTH INSURANCE IN THE HEALTH SERVICES SECTOR* 391-92 (1976).

167. See *supra* notes 1-102 and accompanying text.

168. See, e.g., Wall St. J., Jan. 19, 1985, at 33, col. 4 (New Medicare system will no longer pay all doctor-ordered medical costs for the elderly, but will reimburse at fixed rates; and hospitals that exceed these rates will have to absorb the extra costs.).

169. See *supra* notes 103-65 and accompanying text.

170. See *Proposed Federal 1983 Health Cuts*, 16 CLEARINGHOUSE REV. 32 (1982).

than governmental regulations will induce private health care providers to contain spiraling costs.¹⁷¹ In light of recent developments, it remains highly unlikely that private health care providers will provide health care to indigents in an equitable and humane manner. For indigents to receive the care they rightfully deserve, the federal government must reverse the current trend by significantly increasing funding for health care programs.

171. As health care costs become increasingly burdensome, focus on cost containment has superseded the concern over equal access. See, e.g., Schwartz, *We Need to Ration Medicare*, NEWSWEEK, Feb. 8, 1982, at 13; ASPEN SYSTEMS CORPORATION HEALTH LAW CENTER, PROBLEMS IN HOSPITAL LAW 22 (1974). Again, the question becomes one of free market incentives versus increased government regulation. Although many scholars have addressed this issue as a purely economic matter, two writers in particular have engaged in a provocative weighing of the legal issues underlying socio-economic realities of health care provision. James Blumstein has argued, in essence, that the inequitable distribution of health care is a product of an uneven income distribution. He feels that the market can achieve its own balance if there is less interference by third party reimbursers and by government regulation. See Blumstein, *Rationing Medical Resources*, *supra* note 107, at 1370. See also Blumstein & Sloan, *Redefining Government's Role in Health Care: Is a Dose of Competition What the Doctor Should Order?*, 34 VAND. L. REV. 849 (1981); Blumstein & Zubkoff, *supra* note 137, at 385; Blumstein, *Constitutional Perspectives*, *supra* note 107, at 250.

Rand Rosenblatt, on the other hand, rejects the free market view as a consumer product approach. He is critical of weak government regulations that have only shifted greater power to private providers while reinforcing the dual track system. See generally Rosenblatt, *Rationing "Normal" Health Care: The Hidden Legal Issue*, 59 TEX. L. REV. 1401 (1981); Rosenblatt, *Dual Track Health Care—The Decline of the Medicaid Cure*, 44 U. CIN. L. REV. 643 (1975); Rosenblatt, *supra* note 104.