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## Will the Use of Racial Statistics in Public Health Surveillance Survive Equal Protection Challenges - A Prolegomenon for the Future

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## ARTICLES

### **WILL THE USE OF RACIAL STATISTICS IN PUBLIC HEALTH SURVEILLANCE SURVIVE EQUAL PROTECTION CHALLENGES? A PROLEGOMENON FOR THE FUTURE**

CHRISTOPHER OGOLLA\*

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#### I. INTRODUCTION

In 1993, the Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia convened an expert workshop to address the role of race and ethnicity in public health surveillance.<sup>1</sup> The workshop fo-

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1. Centers for Disease Control and Prevention, *Use of Race and Ethnicity in Public Health Surveillance. Summary of the CDC/ATSDR Workshop*, MORBIDITY AND MORTALITY WEEKLY REPORT 42 (RR-10) (1993).

cused on the limitations of the use of race and ethnicity in public health surveillance and the problems that persisted because of those limitations.<sup>2</sup> A decade and a half later, questions still abound about classification by race, color, or ethnicity in public health.<sup>3</sup> Of particular interest is the legal debate on whether the use of racial and ethnic data in public health surveillance<sup>4</sup> violates the Equal Protection guarantees of the Fifth and Fourteenth Amendments of the United States Constitution.<sup>5</sup> Courts have increasingly held that public entities cannot discriminate on the basis of race,<sup>6</sup> yet the use of race in both medical research and public health surveillance is widely accepted.<sup>7</sup>

This paper first describes the role of the federal government in public health activities and explains how race is used in public health surveillance. The paper then discusses the legal basis for public health surveillance as well as the legal pitfalls involved in the collection of racial statistics by public health practitioners.<sup>8</sup> The issue of racial classification in public health surveillance has been of continuing concern to many public health agencies. Voter initiatives in states like California, Michigan, and Washington demonstrate that the issue remains of crucial importance. Moreover, a recent Supreme Court of the United States (Supreme Court) case indicates that the federal courts are likely to take a more conservative and stricter look at the use of racial statistics by governmental agencies, including those charged with public health activities.<sup>9</sup> Against this background, the paper recommends the inclusion of public health attorneys and other lawyers in the initial drafting, formulation, testing, and implementation of data collection instruments. Attorneys are familiar with the constitutional principles

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2. *Id.*

3. INST. OF MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE* (Brian D. Smedley, Adrienne Y. Stith & Alan R. Nelson eds., National Academies Press) (2003), [http://books.nap.edu/openbook.php?record\\_id=10260&page=R1](http://books.nap.edu/openbook.php?record_id=10260&page=R1).

4. WORLD HEALTH ORGANIZATION, *IMMUNIZATION SURVEILLANCE, ASSESSMENT AND MONITORING* (2008), [http://www.who.int/immunization\\_monitoring/burden/routine\\_surveillance/en/index.html](http://www.who.int/immunization_monitoring/burden/routine_surveillance/en/index.html) (last visited Sept. 26, 2008) (defining "public health surveillance" as the "ongoing, systematic collection, analysis and interpretation of health-related data essential to the planning, implementation, and evaluation of public health practice.").

5. U.S. CONST. amend. XIV, § 1 (providing in part, "nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.").

6. See *Grutter v. Bollinger*, 539 U.S. 306 (2003); *Bakke v. Regents of Univ. of Cal.*, 438 U.S. 265 (1978); *Brown v. Bd. of Ed.*, 347 U.S. 483 (1954).

7. Erik Lilquist & Charles Sullivan, *The Law and Genetics of Racial Profiling in Medicine*, 39 HARV. C. R.-C.L. L. REV. 391 (2004) (noting that "even more dramatic is the increasing acceptance among researchers and clinicians of race as an appropriate focus of medical study and treatment.").

8. See generally U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *THE PUBLIC HEALTH WORKFORCE: AN AGENDA FOR THE 21ST CENTURY*, <http://www.health.gov/phfunctions/pubhlth.pdf>.

9. *Parents Involved in Cmty. Sch. v. Seattle Sch. Dist. No. 1*, 127 S.Ct. 2738 (2007).

of equal protection and due process; standards of review; the powers and duties of the states; the limitations on the powers of the states to constrain the autonomy, privacy, liberty, proprietary, or other legally protected interests of individuals in order to assure the health of a population; and the limitations on the duties of the states to assure the health of a population.<sup>10</sup> The paper also suggests that; unlike education, public employment, and contracting; health is an important area where collection of data by race is needed, especially in an effort to understand and eliminate racial and health disparities.

## II. IS RACIAL SURVEILLANCE ACCEPTABLE?

Public health surveillance depends on the collection of racial and ethnic data. Such data are used by epidemiologists and policy makers to monitor trends over time at the national, state, and local levels; to evaluate programs; to understand the etiologic process and identify points of intervention; and to monitor and enforce laws against discrimination.<sup>11</sup> Unlike education, public employment and public contracting, public health is an area where collection of data by race is needed. Nowhere is this need more urgent than in the elimination of health disparities. For example, the Department of Health and Human Services (DHHS) stated in a report that

although racial and ethnic minority groups have experienced substantial improvements in social and economic well-being during the second half of this century, health disparities between groups persist and in, some cases, have widened. Blacks, Hispanics, Asian, and Native Hawaiian or other Pacific Islanders (especially new immigrants and refugees), and American Indians/Alaska Native populations continue to experience social and economic disadvantages in many arenas.<sup>12</sup>

Additionally, “[t]he poverty rate for non-Hispanic whites remains well below that for U.S. racial and ethnic minorities.”<sup>13</sup> “Although many of the disparities in poverty rates can be explained by differences in factors such as age distribution, family structure, and educational attainment, substantial differentials persist even among individuals with similar characteristics.”<sup>14</sup> For example, “[i]n 1997, 8.6

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10. LAWRENCE GOSTIN, *PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT* (Univ. of California Press 2000).

11. Olivia Carter-Pokras et al., Letter to the Editor, *RE: “Four-Year Review of the Use of Race and Ethnicity in Epidemiologic and Public Health Research,”* AM. J. EPIDEMIOLOGY 403-04 (2004).

12. HHS DATA COUNCIL WORKING GROUP ON RACIAL AND ETHNIC DATA & THE DATA WORK GROUP OF THE HHS INITIATIVE TO ELIMINATE RACIAL AND ETHNIC DISPARITIES IN HEALTH, *IMPROVING THE COLLECTION AND USE OF RACIAL AND ETHNIC DATA IN HHS* (1999), <http://aspe.hhs.gov/datacncl/racercpt/chap2.htm>.

13. *Id.*

14. *Id.*

percent of non-Hispanic whites lived in poverty compared to 26.5 percent of Blacks, 14 percent of Asian, Native Hawaiian, or other Pacific Islanders, 27.9 percent of Mexican Americans, and 34.2 percent of Puerto Ricans.”<sup>15</sup> The Institute of Medicine released a report in 2002 which stated that

standardized data collection . . . is critically important in the effort to understand and eliminate racial and ethnic disparities in healthcare. Having data on patient and provider race and ethnicity would allow researchers to better disentangle factors that are associated with healthcare disparities. In addition, collecting appropriate data related to racial or ethnic differences in the process, structure and outcomes of care can help identify discriminatory practices, whether they are the result of intentional behaviors and attitudes, or unintended—but no less harmful—biases or policies that result in racial or ethnic differences in care that cannot be justified by patient preferences or clinical need.<sup>16</sup>

Both the DHHS and the Institute of Medicine offer the above justifications as to why the use of racial statistics is acceptable in public health research and activities in general.<sup>17</sup>

On the other hand, some critics contend that an overemphasis on race and genetics in health research masks the socioeconomic factors that cause many of today’s diseases.<sup>18</sup> Others contend that the use of racial statistics in health surveillance sometimes leads to misclassifications that underestimate the problems the data is supposed to solve.<sup>19</sup> Furthermore, the critics observe, race based programs are disfavored by the Supreme Court. In *Adarand Constructors, Inc v. Peña*, Justice Scalia, concurring in part and concurring in the judgment, stated that “to pursue the concept of racial entitlement—even for the most admirable and benign purposes—is to reinforce and preserve for future mischief the way of thinking that produced race slavery, race privilege and race hatred. In the eyes of government, we are just one race here. It is American.”<sup>20</sup> Similarly, Chief Justice Roberts in *Parents Involved in Cmty. Sch. v. Seattle Sch. Dist. No. 1 et. al.*, observed that “at the heart of the Constitution’s guarantee of equal protection lies the simple command that the government must treat citizens as individuals,

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15. *Id.*

16. INST. OF MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE*, *supra* note 3, at 215.

17. *See id.* *See also generally* HHS, *supra* note 12.

18. Jonathan Kahn, *Getting the Numbers Right. Statistical Mischief and Racial Profiling in Heart Failure Research*, 46 PERSPECTIVES IN BIOLOGY AND MED. 473-83 (2004).

19. *See generally* Douglas A. Thoroughman et al., *Racial Misclassification of American Indians in Oklahoma State Surveillance Data for Sexually Transmitted Diseases*, 155 AM. J. EPIDEMIOLOGY 1137-41 (2002).

20. 515 U.S. 200, 239 (1995).

not as simply components of a racial, religious, sexual, or national class.”<sup>21</sup>

Importing these arguments into public health may not be correct. What critics of the use of racial statistics may fail to grasp is that public health does not focus on an individual but on the population. This distinction is important in the sense that public health activities are designed to assure the health of a population and are rarely designed for any one individual.<sup>22</sup> On the other hand, discrimination focuses on each individual as a member of a particular racial group. Additionally, health disparities correlate with race, and a solution for the former necessarily entails the use of the latter.<sup>23</sup> Furthermore, even though the Supreme Court disfavors race based programs, it has neither been presented with, nor had to decide on the constitutionality of racial surveillance. This leaves the door open for public health practitioners to use race based statistics in planning, implementing, and evaluating public health programs.

### III. THE FEDERAL GOVERNMENT AND PUBLIC HEALTH SURVEILLANCE

The preservation of public health is one of the duties that devolve on the states as sovereign powers.<sup>24</sup> The police powers of the state extend to the protection of the lives, limbs, health, comfort, and quiet of all persons.<sup>25</sup> Under the Tenth Amendment of the U.S. Constitution, powers not delegated to the United States are reserved to the states.<sup>26</sup> Although the federal government has no police powers per se, it exercises health powers in the areas it controls.<sup>27</sup> Article 1, Section 8, Clause 17 of the U.S. Constitution gives the federal government authority over places purchased or ceded.<sup>28</sup> Similarly, Article 1, Section 8, Clause 18 gives Congress powers “to make all laws which shall be necessary and proper for carrying into execution the foregoing powers.”<sup>29</sup> In exercise of these powers, the federal government provides for the healthcare of particular classes of persons—such as

21. 127 S.Ct. at 2757 (citing *Miller v. Johnson*, 515 U.S. 900, 911 (1995)).

22. See generally GOSTIN, *supra* note 10.

23. See generally Michael J. Fine et al., *The Role of Race and Genetics in Health Disparities Research*, 95 AM. J. PUBLIC HEALTH 2125-28 (2005), <http://www.pubmedcentral.nih.gov/article/render.fcgi?artid=1449495>.

24. 39 AM. JUR. 2D *Health* § 1.

25. See Glen H. Reynolds and David B. Kopel, *The Evolving Police Power: Some Observations for A New Century* 27 HASTINGS CONST. L.Q. 511 (2000).

26. U.S. CONST. amend. X.

27. U.S. CONST. art. I, § 8, cls. 17-18.

28. U.S. CONST. art. I, § 8, cl. 17.

29. U.S. CONST. art. I, § 8, cl. 18.

Indians, victims of poverty, and children—for whom it has special responsibilities.<sup>30</sup>

The federal government protects and promotes national public health and safety by funding health research under the auspices of federal agencies, by enabling regulations relating to foreign and interstate commerce, and by provisions establishing federal financial aid to state and local health programs.<sup>31</sup> Title 42, the Public Health and Welfare of the United States Code, provides authority to federal officials regarding public health and safety.<sup>32</sup> Congress, through the DHHS, created bodies such as the Public Health Service<sup>33</sup> and a number of research institutes to administer programs with respect to particular areas of health research,<sup>34</sup> for example, the National Center on Minority Health and Health Disparities.<sup>35</sup> The public health functions of the DHHS extend to quarantine regulations, regulation of biological products, control and management of hospitals, and the medical care and treatment of various categories of persons.<sup>36</sup> These functions involve broad powers to establish and enforce health standards as well as public health surveillance. In public health surveillance, both the state and federal governments often have concurrent jurisdiction in promoting the best use of public health resources.<sup>37</sup>

#### IV. STANDARDS FOR THE CLASSIFICATION OF FEDERAL DATA ON RACE

Generally, public health surveillance is “the ongoing, systematic, collection, analysis, and interpretation of outcome specific data essential to the planning, implementation and evaluation of public health practice and closely integrated with the timely dissemination of these data to public health practitioners responsible for prevention and control.”<sup>38</sup> Public health surveillance activities are generally authorized by legislators and carried out by public health officials.<sup>39</sup> The collection of race and ethnic statistics has been an important component of

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30. 39A C.J.S. *Health and Environment* § 3 (2006).

31. *Id.*

32. 42 U.S.C. § 1 (repealed 1944). *See also* 42 U.S.C. § 202 (2008).

33. *Id.*

34. 39A C.J.S. *Health and Environment* § 3 (2006).

35. 42 U.S.C. § 287c-31.

36. 39 AM. JUR. 2D *Health* §15 (2007).

37. *Id.* at n.8.

38. ROBERT HAHN & DONNA STROUP, RACE AND ETHNICITY IN PUBLIC HEALTH SURVEILLANCE: CRITERIA FOR THE SCIENTIFIC USE OF SOCIAL CATEGORIES, CDC-ATDSR WORKSHOP, PUB. HEALTH REPS. 109: 7-15 (1994), available at <http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1402237&blobtype=pdf>.

39. Centers for Disease Control and Prevention, *Updated Guidelines for Evaluating Public Health Surveillance Systems*, MORBIDITY AND MORTALITY WEEKLY REPORT, 50 (RR13), 1-35 (2001).

public health surveillance efforts used to identify differences in health status among racial and ethnic minorities.<sup>40</sup> This information is collected by local, state, and federal health agencies.<sup>41</sup> According to the CDC's *Updated Guidelines for Evaluating Public Health Surveillance Systems*,<sup>42</sup> data from a public health surveillance system can be used to:

1. guide immediate action for cases of public health importance;
2. measure the burden of a disease (or other health-related event), including changes in related factors, the identification of populations at high risk, and the identification of new or emerging health concerns;
3. monitor trends in the burden of a disease (or other health-related event), including the detection of epidemics (outbreaks) and pandemics;
4. guide the planning, implementation, and evaluation of programs to prevent and control disease, injury, or adverse exposure;
5. evaluate public policy;
6. detect changes in health practices and the effects of these changes;
7. prioritize the allocation of health resources;
8. describe the clinical course of disease; and
9. provide a basis for epidemiologic research.<sup>43</sup>

Much of the public health surveillance data collected by government agencies conforms to the *Revised Minimum Standards for the Classification of Federal Data on Race and Ethnicity*, issued by the Office of Management and Budget (OMB) in 1997.<sup>44</sup> The standards

were developed in cooperation with Federal agencies to provide consistent data on race and ethnicity throughout the Federal Government. Development of the data standards stemmed in large measure from new responsibilities to enforce civil rights laws. Data were needed to monitor equal access in housing, education, employment, and other areas, for populations that historically had experienced discrimination and differential treatment because of their race or ethnicity.<sup>45</sup>

40. Centers for Disease Control and Prevention, *supra* note 1.

41. *Id.*

42. Centers for Disease Control and Prevention, *supra* note 38.

43. *Id.*

44. Revisions to the Standards for Classification of Federal Data on Race and Ethnicity, 62 Fed. Reg. 58,782-90 (1997). See also OFFICE OF MGMT. & BUDGET, OMB BULL. No. 00-02, GUIDANCE ON AGGREGATION AND ALLOCATION OF DATA ON RACE FOR USE IN CIVIL RIGHTS MONITORING AND ENFORCEMENT (2000), available at <http://www.whitehouse.gov/omb/bulletins/b00-02.html>.

45. 62 Fed. Reg. at 58,782.



The categories<sup>46</sup> developed by OMB were not anthropologic or scientifically based designations, but instead were categories that described the socio-cultural construct of our society.<sup>47</sup> Whereas these categories may be relevant in the health arena for studies of diseases such as diabetes, heart disease, HIV/Aids and other Sexually Transmitted Infections,<sup>48</sup> they may not necessarily work in the policy arena. The longstanding controversy over the use of affirmative action for promotion of African, Hispanic, and Asian American civil rights is a case in point.<sup>49</sup>

Generally, racial categories used in public health surveillance are: White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or other Pacific Highlander.<sup>50</sup> The OMB Standards included two ethnic categories, namely Hispanic or Latino and not Hispanic or Latino.<sup>51</sup> The DHHS, of which CDC is a part, adopted these standardized categories for its agencies. To help assess various health related data, including public health surveillance and research, agencies report statistics using these standardized categories.<sup>52</sup> Most state health departments use these same standards since they are required to report the same information to the CDC using these categories.<sup>53</sup>

## V. LEGAL BASIS FOR PUBLIC HEALTH SURVEILLANCE IN GENERAL

Legal considerations for Public Health Surveillance generally include:

- (1) protection available under state or federal law during and after the investigation for the records collected and generated in relation to the investigation;
- (2) confidentiality provisions for medical and other information;
- (3) required reporting of particular diseases or conditions;
- (4) status of information in investigative files on the Federal Freedom

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46. *Id.* (stating the revised standards had five minimum categories for data on race: American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White).

47. U.S. FOOD AND DRUG ADMIN., GUIDANCE FOR INDUSTRY COLLECTION OF RACE AND ETHNICITY DATA IN CLINICAL TRIALS (2005), available at <http://www.fda.gov/Cder/guidance/5656fnl.htm#>.

48. See Claudia Dreifus, *A Conversation with Herman Taylor: Mississippi's 'Heart Man' Examines Links Between Race and Disease*, N.Y. TIMES, Feb. 7, 2006.

49. See generally THE AFFIRMATIVE ACTION DEBATE (George E. Curry, ed., Harper Collins) (1998) (discussing affirmative action issues in detail).

50. 62 Fed. Reg. at 58,782.

51. Catherine Sorenson, Betty Wood & Edward Prince, *Race and Ethnicity Data: Developing A Common Language for Public Health Surveillance*, CAL. J. HEALTH PROMOTION (1) Hawaii 91-104 (2003).

52. U.S. FOOD AND DRUG ADMIN., *supra* note 46.

53. See generally Standards for Classification of Federal Data on Race and Ethnicity, 60 Fed. Reg. 44,674, 44,678 (1995).

of Information Act (FOIA) 5 U.S.C. § 552 or state FOIA counterparts and; (5) the possible applicability of federal or state human subjects research regulations. . . .<sup>54</sup>

The major source of legal authority for public health interventions is “police power,” defined as the inherent authority of all sovereign governments to enact laws and promote laws that safeguard the health, welfare, and morals of its citizens.<sup>55</sup> Case law tends to side with the broad police powers of the state and give deference to health officers in providing legal justification for public health activities, including surveillance. Some examples are *Jacobson v. Massachusetts*,<sup>56</sup> *Nebbia v. New York*,<sup>57</sup> and *Simon v. Sargent*.<sup>58</sup>

In *Jacobson*, the Supreme Court “recognized the right of a state to pass sanitary laws, laws for the protection of life, liberty, health, or property within its limits, laws to prevent persons and animals suffering under contagious or infectious diseases, or convicts, from coming within its borders.”<sup>59</sup> *Jacobson* challenged a Massachusetts law that required everyone to be vaccinated against smallpox.<sup>60</sup> *Jacobson*, who refused to submit to a small pox vaccination pursuant to the statute, argued that the Massachusetts law was unconstitutional.<sup>61</sup> Writing for the Court, Justice Harlan noted that “the police power of a state must be held to embrace, at least, such reasonable regulations established directly by legislative enactments, as will protect the public health and the public safety.”<sup>62</sup>

Similarly, in *Nebbia*, the Supreme Court held that a defendant was not deprived of his equal protection rights because of the government regulation of milk prices by the New York Milk Control Board.<sup>63</sup> There, the New York Legislature passed a Milk Control Law that established a Milk Control Board with the power to fix minimum and maximum milk retail prices charged by stores to consumers.<sup>64</sup> *Nebbia* was convicted for selling two quarts of milk below the minimum price

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54. Verla S. Neslund, Richard A. Goodman & David W. Fleming, *Frontline Public Health: Surveillance and Outbreak Investigations*, in *LAW IN PUBLIC HEALTH PRACTICE* 143-59, 153 (Richard A. Goodman et al. eds. 2003).

55. James J. Misrahi, Gene W. Matthews & Richard E. Hoffman, *Legal Authorities for Interventions During Public Health Emergencies*, in *LAW IN PUBLIC HEALTH PRACTICE* 195-210 (Richard A. Goodman et al. eds. 2003) (citing LAWRENCE GOSTIN, *PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT* (Univ. of California Press 2000)).

56. *Jacobson v. Mass.*, 197 U.S. 11 (1905).

57. *Nebbia v. N.Y.*, 291 U.S. 502 (1934).

58. *Simon v. Sargent*, 346 F. Supp. 277 (D. Mass. 1972), *aff'd*, 409 U.S. 1020 (1972).

59. *Jacobson*, 197 U.S. at 28.

60. *Id.* at 13-14.

61. *Id.* at 14.

62. *Id.* at 25.

63. *Nebbia*, 291 U.S. at 518.

64. *Id.* at 515.

set by a Milk Control Board.<sup>65</sup> *Nebbia* contended that the order violated the Equal Protection Clause and the Due Process Clause of the Fourteenth Amendment.<sup>66</sup> Writing for the majority, Justice Roberts asserted that

So far as the requirement of due process is concerned, and in the absence of other constitutional restriction, a state is free to adopt whatever economic policy may reasonably be deemed to promote public welfare and to enforce that policy by legislation adapted to its purpose. The courts are without authority either to declare such policy, or, when it is declared by the legislature, to override it. If the laws passed are seen to have a reasonable relation to a proper legislative purpose, and are neither arbitrary nor discriminatory, the requirements of due process are satisfied, and judicial determination to that effect renders a court *functus officio*.<sup>67</sup>

In *Simon v. Sargent*, plaintiff challenged a Massachusetts law that required motorcycle riders to wear helmets on the grounds that the provision was violative of his due process rights.<sup>68</sup> The court found that the section requiring motorcyclists to wear protective headgear, which conformed to certain minimum standards, bore a real and substantial relation to public health and general welfare and was a valid exercise of police power.<sup>69</sup> The court observed that, when a motorcyclist who is not wearing a helmet gets injured, society bears the cost;

The public has an interest in minimizing the resources directly involved. From the moment of injury, society picks the person up off the highway; delivers him to a municipal hospital and municipal doctors; provides him with unemployment compensation if, after recovery, he cannot replace his lost job; and, if the injury causes permanent disability, may assume responsibility for his and his family's subsistence. We do not understand a state of mind that permits plaintiff to think that only he himself is concerned.<sup>70</sup>

When it comes to race and health, the controlling federal statute is Title VI of the Civil Rights Act of 1964 (the Act).<sup>71</sup> The Act prohibits discrimination on the basis of race, color, or national origin by any

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65. JEROME A. BARON, ET AL., CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES, CASES AND MATERIALS 423 (6th ed. 2005).

66. *Nebbia*, 291 U.S. at 515. See also U.S. CONST. amend XIV (providing in part, "nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws").

67. *Nebbia* 291 U.S. at 516.

68. *Sargent*, 346 F. Supp. at 279.

69. *Id.*

70. *Id.*

71. 42 U.S.C.A. § 2000d (2008) (stating, "No person in the United States, shall, on the ground of race, color or national origin, be excluded from participation, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.").

program or agency receiving federal funds.<sup>72</sup> The Act casts a wide net by covering such areas as housing, education, employment, and medical care.<sup>73</sup> More specifically, the regulations promulgated by the DHHS under Title VI of the Act address the impact of practices or policies that make no reference to members of racial or ethnic groups but have discriminatory impact on them.<sup>74</sup> Discriminatory impact focuses on results rather than intent.<sup>75</sup> Another important area of law is Title VII of the Act,<sup>76</sup> which prohibits discrimination by covered employers on the basis of race, color, religion, sex, or national origin.<sup>77</sup>

A number of cases challenged the disproportionate impact of policies on those affected by Title VII.<sup>78</sup> For example, in *NAACP v. Med. Ctr.* the court held that “a disproportionate impact or effect is simply an additional method of demonstrating impermissible discrimination under Title VII.”<sup>79</sup> A “prima facie case could be established under the impact theory if the plaintiff demonstrates that a facially neutral policy disproportionately affected persons protected by Title VII.”<sup>80</sup> The complaining party must “show that other . . . selection devices, without a similarly undesirable . . . effect, would also serve the . . . legitimate interest.”<sup>81</sup> In that case, the medical center, which was located in the city, planned to relocate its main facility to a suburb while keeping its city location operating with fewer beds.<sup>82</sup> Appellants—various minority, handicapped, and elderly organizations—challenged the medical center’s reorganization plan and claimed violations under Title VI of the Act among others.<sup>83</sup> The trial court found that appellants failed to prove discrimination under federal law.<sup>84</sup> The circuit court affirmed the reasoning that appellants failed to show any intentional discrimination or discriminatory impact and therefore failed to satisfy their burden of proving the case.<sup>85</sup>

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72. *Id.*

73. 45 C.F.R. §§ 80.1-80.3 (2008).

74. Panel on Racial and Ethnic Disparities in Medical Care, Physicians for Human Rights, *The Right to Equal Treatment: An Action Plan to End Racial and Ethnic Disparities in Clinical Diagnosis and Treatment In the United States* 17 (2003).

75. *Id.* at 19.

76. 42 U.S.C. § 2000e(3).

77. *Id.* at 25.

78. See generally Daniel K Hampton, *Title VI Challenges by Private Parties to the Location of Health Care Facilities: Toward a Just and Effective Action*, 37 B. C. L. REV. 517 (1996) and Richard J. Zall, Note, *Maintaining Health Care in the Inner City: Title VI and Hospital Relocations*, 55 N.Y.U. L. REV. 271 (1980).

79. *NAACP v. Med. Ctr.*, 657 F.2d 1322, 1334 (3rd Cir. 1981).

80. *Id.* at 1333. (citing *Albemarle Paper Co. v. Moody*, 422 U.S. 405, 425 (1975)).

81. *Id.* (quoting *Albemarle Paper Co. v. Moody*, 422 U.S. 405, 425 (1975)).

82. *Id.* at 1324.

83. *Id.*

84. *Id.* at 1326.

85. *Id.* at 1337.

Similarly, in *Bryan v. Koch*, the court held that Title VI of the Act does not prohibit conduct which has a disproportionate racial impact or effect without conduct motivated by a racially discriminatory purpose.<sup>86</sup> There, plaintiffs brought suit against the mayor of New York City to preclude closing a city hospital which served a population that consisted of 98% minority group members.<sup>87</sup> The court reasoned that the evidence presented by the City sustained a determination that it made an appropriate choice to close a hospital in response to financial difficulties and that it was not required by Title VI to consider alternatives to avoid a disparate racial impact other than to assess all of the municipal hospitals in order to select one or more for closing.<sup>88</sup>

Although the above cited cases were not decided on public health grounds, they dealt with health facilities that offered health care to minority groups who felt that relocation would have a disproportionate racial impact. Having access to care is a major determinant of health; therefore, any barriers would have significant impact on public health.<sup>89</sup>

In general, courts accept the government's assertions of the need to protect public welfare. However, the government may discriminate against groups of people, but it must have a compelling reason to do so.<sup>90</sup> For Title VI and VII challenges however, "discrimination attributable to socio-economic status alone" is not enough.<sup>91</sup> For health discrimination, "there must be evidence that the disparate impact, for example health outcome, is causally related to the defendant's facially neutral policy."<sup>92</sup>

Unlike medical care which focuses mostly on Title VI and VII causes of actions, the use of race in public health surveillance is most likely to be challenged on Equal Protection grounds. This is the concept that similarly situated persons should be treated similarly by the government.<sup>93</sup> However, as discussed in part two, the policy and legal issues posed by racial surveillance in the public health arena demonstrate that racial surveillance may not necessarily amount to racial discrimination given that there may be legitimate public policy reasons for using racial classification in gathering public health information.

86. *Bryan v. Koch*, 627 F.2d 612, 619-20 (2nd Cir. 1980).

87. *Id.* at 617.

88. *Id.* at 620-21.

89. AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, U.S. DEP'T OF HEALTH AND HUMAN SERV., NATIONAL HEALTHCARE DISPARITIES 9 (2003), <http://www.ahrq.gov/qual/nhdr03/nhdr2003.pdf>.

90. *See, e.g., NAACP*, 657 F.2d 1322 (1981) (holding that, although certain groups were negatively impacted, the relocation of a hospital was in the best interest of the communities).

91. Panel on Racial and Ethnic Disparities in Medical Care, *supra* note 73, at 19.

92. *Id.*

93. *Jew Ho v. Williamson*, 103 F. 10 (C.C. Cal. 1900).

Indeed the Supreme Court has allowed the use of racial classifications only if it is needed or promotes a narrow goal.<sup>94</sup> The Supreme Court has held that “‘all racial classifications must be analyzed by a reviewing court under strict scrutiny standard . . . .’”<sup>95</sup>

## VI. RACIAL CLASSIFICATION AND STRICT SCRUTINY

The Supreme Court uses various standards of review depending upon the alleged harm inflicted by the racial classification and the characteristics of that classification.<sup>96</sup> The three common standards used in equal protection cases are rational basis, intermediate scrutiny, and strict scrutiny.<sup>97</sup> Generally, the choice of one standard of review over another hinges on:

- (1) the importance of the alleged or, in the case of the rational basis test, conceivable government interest realized by the classification (“compelling,” “substantial,” or “legitimate”); and (2) whether and how the classification at issue is likely to realize that interest (that is, strict scrutiny requires the statute be narrowly tailored and essential to achieving a compelling government interest).<sup>98</sup>

Legal controversies that challenge the states’ powers to regulate health, welfare, and morals of their citizens are reviewed under the rational basis standard.<sup>99</sup> For example, in state quarantine laws, the legislatures, under the police powers of the states, have the authority to establish quarantine regulations for the protection of the public’s health and welfare.<sup>100</sup> To warrant detention of a person in quarantine, it only is necessary that there be probable cause to believe that the person has an infectious disease which is communicable.<sup>101</sup>

However, the use of the rational basis test for suits involving infectious diseases can sometimes be disadvantageous to the patients.<sup>102</sup>

94. See *Adarand Constructors, Inc. v. Peña*, 515 U.S. 200, 202 (1995) (holding that “[w]hen race-based action is necessary to further a compelling interest, such action is within constitutional constraints if it satisfies the ‘narrow tailoring’ test . . .”).

95. *Parents Involved in Cmty. Sch. v. Seattle Sch. Dist. No. 1 et. al.*, 127 S.Ct 2738, 2762 (2007) (quoting *Adarand Constructors, Inc. v. Peña*, 515 U.S. 200, 227 (1995)).

96. Peter M. Cicchino, *Reason and the Rule of Law: Should Bare Assertions of “Public Morality” Qualify as Legitimate Government Interests for the Purpose of Equal Protection Review?*, 87 GEO. L.J. 139, 145 (1998).

97. ERWIN CHEMEKINSKY, *CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES* 671-72 (3rd ed. 2006).

98. Cicchino, *supra* note 95, at 144-45.

99. CHEMEKINSKY, *supra* note 96, at 677.

100. See *Ex Parte James*, 181 S.W.2d 83, 84 (Tex. Crim. App. 1944) (holding that state government has the right to “quarantine against contagious and communicable diseases.”).

101. *Ex Parte Martin*, 188 P.2d 287, 290-91 (Cal. Ct. App. 1948). See also *Ex Parte James* at 84 (holding that the Government has a right, under its police power, to quarantine against contagious and venereal communicable diseases).

102. See, e.g., *Jasa v. Douglass County*, 510 N.W.2d 281 (Neb. 1994) (holding that choosing not to collect epidemiological information was within agency discretion. There, a minor, by and

For example, in *New York State Soc. of Surgeons v. Axelrod*,<sup>103</sup> the court held that the refusal of the Commissioner of Health and the New York State Public Health Council to add human immunodeficiency virus (HIV) to the lists of communicable and sexually transmissible diseases was reasonable and rational.<sup>104</sup> In that case, petitioners, four medical organizations, sent a letter to the Commissioner of Health requesting that infection with HIV to be added to the lists of communicable and sexually transmissible diseases pursuant to Public Health Law § 225(5)(h).<sup>105</sup> The Commissioner denied the request on the ground that designation would be contrary to the health of the public because it would discourage cooperation of affected individuals and would lead to the loss of confidentiality for those infected with the disease.<sup>106</sup> The court agreed with the Commissioner reasoning that, under the terms of the statute, the Commissioner had discretion to determine the diseases to be designated as reportable.<sup>107</sup> The court observed that:

there are valid reasons for giving the Commissioner discretion in these matters. Placement of any disease on the communicable or sexually transmitted disease lists triggers statutory provisions relating to isolation and quarantine, reporting, mandatory testing and contact tracing. . .provisions which, for public health reasons, may not be appropriate in dealing with every type of communicable or sexually transmissible disease.<sup>108</sup>

Because the court used the rational basis test, the Commissioner's actions were not found unreasonable or capricious. The rate of HIV/AIDS in the U.S. is significantly higher among minorities than whites.<sup>109</sup> In New York, for example, as of December 2005, there were 45.2% cases of blacks living with HIV and AIDS compared to

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through his parents filed suit under Neb. Rev. Stat. § 13-901 et seq. (2007) against Douglas County, alleging that its department of health failed to take appropriate steps with respect to the presence of bacterial meningitis in a day-care facility, causing the minor to suffer permanent disability. The court concluded that, where a health officer must make a judgmental decision within a regulatory framework, the decision is not a ministerial act but a discretionary function.).

103. *New York State Soc. of Surgeons v. Axelrod*, 572 N.E.2d 605 (N.Y. 1991).

104. *Id.* See also *Whalen v. Roe*, 429 U.S. 589 (1977) (upholding a New York state public health reporting law on the grounds that the statute was a product of an orderly and rational legislative decision).

105. *Id.* See N.Y. State Public Health Law § 225(5)(h) (McKinney 2008) (providing in pertinent part that the Sanitary Code may designate the communicable diseases which are dangerous to the public health).

106. *Id.*

107. *Id.* at 684.

108. *Id.*

109. Isabel M. Estrada Portales, *Aids Among Minorities*, OFFICE OF MINORITY HEALTH, Dec. 11, 2006, <http://www.omhrc.gov/templates/content.aspx?ID=4338>.

22.5% of whites.<sup>110</sup> Not including HIV/AIDS in the reportable disease list may have a discriminatory impact. One could, therefore, argue that the use of the rational basis standard, in reviewing discriminatory impact in public health surveillance, may sometimes be ineffective. This is more so with diseases whose prevalence rates are higher in some racial groups than others.<sup>111</sup>

On the other hand, discrimination based on race or national origin is subject to strict scrutiny standard.<sup>112</sup> Under strict scrutiny, a law is upheld if it is proved necessary to achieve a compelling government purpose.<sup>113</sup> This principle was reinforced in *Grutter v. Bollinger*<sup>114</sup> where the Supreme Court held that a narrowly tailored use by public schools of race in admissions decisions to further a compelling interest in educational benefits of a diverse student body did not violate the Fourteenth Amendment's Equal Protection Clause.<sup>115</sup> Here, the Court approved racial classification where its benefits were limited to diversity in education.<sup>116</sup>

Applying the same principle to public health, courts would not have a problem with racial classification if there were a close fit between racial classification and a compelling state interest. In *Regents of University of California v. Bakke*, the Court held that "racial and ethnic distinctions of any sort are inherently suspect and thus call for the most exacting judicial examination."<sup>117</sup> In the same opinion, Justice Powell explained that, in some situations, the state's interest in facilitating the healthcare of its citizens could be sufficiently compelling to support the use of suspect classification. Chief Justice Roberts reiterated this point in the majority opinion of *Parents Involved in Community Schools v. Seattle School District No.1 et al.*<sup>118</sup> In that case, the majority stated that, in evaluating the use of racial classifications in the school context, two interests that qualify as compelling are the interest of remedying the effects of past discrimination and the interest in diversity in higher education.<sup>119</sup>

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110. New York State Department of Health, Bureau of HIV/AIDS Epidemiology, New York State HIV/AIDS Surveillance Annual Report (2007), [http://www.health.state.ny.us/diseases/aids/statistics/annual/2005/2005-12\\_annual\\_surveillance\\_report.pdf](http://www.health.state.ny.us/diseases/aids/statistics/annual/2005/2005-12_annual_surveillance_report.pdf).

111. *Id.*

112. ERWIN CHEMERINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES 645 (2d ed. 1999).

113. *Id.*

114. *Grutter v. Bollinger*, 539 U.S. 306 (2003).

115. *Id.* at 329-31.

116. Erik Lilquist and Charles Sullivan, Comment, *The Law and Genetics of Racial Profiling in Medicine*, 39 HARV. C.R.-C.L. L. REV. 391, 443 (2004).

117. *Regents of Univ. of Cal. v. Bakke*, 438 U.S. 265, 291 (1978).

118. *Parents Involved in Cmty. Sch. v. Seattle Sch. Dist. No. 1 et al.*, 127 S.Ct. 2738, 2752 (2007).

119. *Id.*



These interests may not necessarily apply to public health activities, yet because racial classification is involved, strict scrutiny still applies. Public health practitioners, therefore, have to create their own compelling interests in order to justify the use of racial classification.<sup>120</sup> One interest that has been cited as compelling in the field of public health is addressing the problem of health disparities. In 2000, Congress enacted the Minority Health and Health Disparities Research and Education Act<sup>121</sup> which directed the National Academies of Science to:

conduct a comprehensive study of the Department of Health and Human Services' data collection systems and practices, and any data collection or reporting systems required under any of the programs or activities of the Department, relating to the collection of data on race or ethnicity, including other Federal data collection systems (such as the Social Security Administration) with which the Department interacts to collect relevant data on race and ethnicity and prepare and submit a report that (1) identifies the data needed to support efforts to evaluate the effects of socioeconomic status, race and ethnicity on access to health care and other services and on disparity in health and other social outcomes and the data needed to enforce existing protections for equal access to health care; and (2) examines the effectiveness of the systems and practices of the Department of Health and Human Services described in subsection (a), including pilot and demonstration projects of the Department, and the effectiveness of selected systems and practices of other Federal, State, and tribal agencies and the private sector, in collecting and analyzing such data, (3) contains recommendations for ensuring that the Department of Health and Human Services, in administering its entire array of programs and activities, collects, or causes to be collected, reliable and complete information relating to race and ethnicity; and (4) includes projections about the costs associated with the implementation of the recommendations described in paragraph (3), and the possible effects of the costs on program operations.<sup>122</sup>

By ratifying this Act, Congress seemed to provide a reason that is sufficiently compelling to support the use of suspect classification in the collection of data relating to race and ethnicity as determinants of health disparities. But health disparities, without more, may be too amorphous to support the use of racial statistics in public health activities. To withstand exact judicial scrutiny, the use of race in public health activities, including surveillance, should be narrowly tailored to further a compelling interest in seeking to remedy—for example, past

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120. Minority Health and Health Disparities Research and Education Act, Pub.L.No. 106-525, § 301, 114 Stat. 2495, 2507-2509 (2000).

121. *Id.*

122. *Id.*

societal discrimination in health services—and not violate the Fourteenth Amendment’s Equal Protection guarantee. In the Equal Protection area, the use of racial statistics is likely to run afoul of the law.

## VII. LEGAL PITFALLS OF USING RACE IN PUBLIC HEALTH ACTIVITIES

Public health activities that have a disparate impact on one racial group may also run afoul of the law. Enforcement of an ordinance may adversely affect one racial group more than another. In *Jew Ho v. Williamson*,<sup>123</sup> the Court invalidated a San Francisco city ordinance that quarantined a twelve block area of Chinatown purportedly to control bubonic plague.<sup>124</sup> The Court held that a municipal regulation establishing a quarantine district is void and violates the constitutional guaranty of Equal Protection of the laws where it is shown that it is enforced against all Chinese persons within the district and against the buildings occupied by them, while it is not enforced against persons of other races, or against their residences, although situated within the limits of the district as defined in the regulation.<sup>125</sup> The resolution was passed after two public health officials reported cases of bubonic plague which occurred within a section of the city populated with Chinese immigrants.<sup>126</sup> Nine cases were reported, and as a result, the health officials were given the authority to establish quarantine within the district of the city where the plague had been discovered.<sup>127</sup> Jew Ho, who owned a grocery store, argued that his business was negatively impacted by the quarantine measures since customers were no longer able to carry on business with those outside of the quarantined district.<sup>128</sup> Additionally, he argued that the ordinance was anti-Chinese in that it was “enforced against persons of the Chinese race and nationality only, and not against persons of other races.”<sup>129</sup> The Court agreed, reasoning that since the board had left out members of races other than the Chinese in its quarantine order, this was tantamount to the administration of a law “with an evil eye and an unequal hand.”<sup>130</sup>

Similarly, Justice Harlan noted that the courts may strike down legislation designed to protect the general welfare when it has no real or substantial relation to the public health, morals, or safety, or if the legislation is a plain palpable invasion of rights secured by the consti-

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123. *Jew Ho*, 103 F. at 10.

124. *Id.* at 26.

125. *Id.*

126. *Id.* at 12.

127. *Id.* at 11.

128. *Id.* at 12.

129. *Id.* at 12-13.

130. *Id.* at 24.

tution in *Jacobson v. Massachusetts*.<sup>131</sup> In his view, “the police power of a state, whether exercised directly by the legislature, or by a local body acting under its authority, may be exerted in such circumstances, or by regulations so arbitrary and oppressive in particular cases, as to justify interference by the courts to prevent wrong and oppression.”<sup>132</sup> Thus, using racial statistics that are unreasonable or oppressive to one group is unconstitutional.

Additionally, there are statutory limitations to the use of racial classifications in health interventions. Title VI of the Act prohibits race discrimination in federally funded programs regardless of whether the recipient is a public or private institution.<sup>133</sup> Sources of public health surveillance information regarding the health status of the population and racial groups include state agencies and multiple federal agencies, such as CDC, Indian Health Service, and the National Cancer Institute.<sup>134</sup> Thus, most public health surveillance initiatives are impacted by Title VI of the Act. However, Title VI creates no legal liability for healthcare providers who collect and report healthcare quality data by race and ethnicity, when such an effort is undertaken as part of an overall program of quality improvement.<sup>135</sup> In medicine, for example, treating individuals differently on account of race might be permissible so long as the evidence of racial differences are sufficiently strong and the differences in treatment are properly tailored to that evidence.<sup>136</sup>

At the state level, there are laws that allow or prohibit the collection of race and ethnicity data in public health and healthcare. In 2003, the Institute of Medicine’s report noted that while the vast majority of states do not prohibit collection of patients’ race and ethnicity data, some may impose restraints on when and how such data may be collected.<sup>137</sup> For example, California, Maryland, New Hampshire, and New Jersey, by statute or regulation, prohibit the collection of racial and ethnic data in certain contexts.<sup>138</sup> California’s insurance code prohibits health insurers from identifying or requesting the applicant’s race, color, religion, ancestry, or national origin on an insurance appli-

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131. *Jacobson v. Mass.*, 197 U.S. 11, 31 (1905).

132. *Id.* at 38.

133. Lilquist and Sullivan, *supra* note 7, at 445.

134. CDC, *supra* note 1.

135. SARAH ROSENBAUM ET AL., POLICY BRIEF, THE LEGALITY OF COLLECTING AND DISCLOSING PATIENT RACE AND ETHNICITY DATA (2006), <http://www.rwjf.org/files/publications/other/RaceEthnicDisparitiesData06222006.pdf>.

136. Lilquist and Sullivan, *supra*, note 7, at 445.

137. Institute of Medicine, *supra*, note 3, at 217.

138. NATIONAL HEALTH LAW PROGRAM AND OFFICE OF MINORITY HEALTH, ASSESSMENT OF STATE LAWS, REGULATIONS AND PRACTICES AFFECTING THE COLLECTION AND REPORTING OF RACIAL ETHNIC DATA BY HEALTH INSURERS AND MANAGED CARE PLANS (2001).

cation.<sup>139</sup> The New Jersey managed care contract provides for racial and ethnic data collection only in the case of an enrollee's consent to sterilization.<sup>140</sup> Furthermore, past voter initiatives in California,<sup>141</sup> Michigan,<sup>142</sup> and Washington<sup>143</sup> permitted amendments to their state constitutions to ban the use of preferential treatment to persons or groups based on race, gender, color, ethnicity, or national origin in public education, employment, and contracting. The Michigan Civil Rights Initiative, for example, amended the Michigan Constitution to prohibit the:

University of Michigan, Michigan State University, Wayne State University, and any other public college or university, community college, or 'school district [in Michigan from discriminating] against, or grant[ing] preferential treatment to, any individual or group on the basis of race, sex, color, ethnicity, or national origin in the operation of public employment, public education, or public contracting.<sup>144</sup>

The relevance of these state voter initiatives to public health is that certain public health agencies, particularly those offering services to the underprivileged or victims of poverty, may be barred from giving preferential treatment in services to groups based on ethnicity, even if those groups may be in dire need of those services. Furthermore, cultural competency studies demonstrate that patients tend to relate better to healthcare workers who speak their language.<sup>145</sup> In this sense, some public hospitals, for example, may be prohibited from hiring persons from certain ethnic groups over others, even if doing so would improve the health outcome of the population served.

At the local level, the New York City Department of Health and Mental Hygiene, in January 2006, passed a law that required that most

139. Cal. Ins. Code § 10141 (2008) (stating, "No application for insurance or insurance investigation report furnished by . . . [an insurer] to its agents or employees for use in determining the insurability of the applicant shall carry any identification, or any requirement therefore, of the applicant's race, color, religion, ancestry, or national origin.").

140. NEW JERSEY NAT'L HEALTH LAW PROGRAM AND OFFICE OF MINORITY HEALTH, ASSESSMENT OF STATE LAWS, REGULATIONS AND PRACTICES AFFECTING THE COLLECTION AND REPORTING OF RACIAL AND ETHNIC DATA BY HEALTH INSURERS AND MANAGED CARE PLANS (2001), <http://www.spannj.org/Family2Family/NJhealthdiscriminationlaws.pdf>.

141. See CAL. CONST. art. I, § 31 (stating that the "state shall not discriminate against, or grant preferential treatment to, any individual or group on the basis of race, sex, color, ethnicity, or national origin in the operation of public employment, public education or public contracting.").

142. See MICH. CONST. art. I, § 26.

143. See WASH. REV. CODE § 49.60.400 (1) (2006) (similarly stating that the "state shall not discriminate against, or grant preferential treatment to, any individual or group on the basis of race, sex, color, ethnicity, or national origin in the operation of public employment, public education or public contracting.").

144. MICH. CONST. art. I, § 26.

145. OFFICE OF MINORITY HEALTH, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, TEACHING CULTURAL COMPETENCE IN HEALTH CARE: A REVIEW OF CURRENT CONCEPTS, POLICIES AND PRACTICES (2002), <http://www.omhrc.gov/assets/pdf/checked/em01garcia1.pdf>.

laboratories report the results of a blood test called “A1C” to the Department.<sup>146</sup> “A1C” is a blood test that measures average sugar level in the blood over three months for people with diabetes.<sup>147</sup> Although the collection of data on diabetes may not necessarily require the inclusion of the race of the patient, the plan to make diabetes a reported disease, similar to HIV/AIDS and Tuberculosis, may touch on privacy issues unless the department can show that there is a compelling interest in the health of the individual that overrides his privacy.<sup>148</sup> Additionally, racial differences in disease prevalence do exist, and collection of disease specific racial data may impact different ethnic groups differently. For example, between 2001 and 2003, the multivariate-adjusted incidence of diabetes was lowest among non-Hispanic whites (6.3 per 1000) and highest among non-Hispanic blacks (8.2 per 1000).<sup>149</sup> Other data indicate a Hispanic incidence of diabetes that is three to five times higher than non-Hispanic whites.<sup>150</sup> This could have implications on the employment status of those diagnosed with diabetes. In *Darnell v. Thermafiber*,<sup>151</sup> Darnell, an insulin-dependent Type I diabetic, sued Thermafiber, a manufacturer of mineral wool insulation, alleging disability discrimination in violation of Americans with Disabilities Act (ADA) when it rescinded an offer of employment based on the results of his urine glucose test and interview.<sup>152</sup> The district court granted Thermafiber’s motion for summary judgment.<sup>153</sup> On appeal, the United States Court of Appeals for the Seventh Circuit held that Thermafiber reasonably relied on the opinion of the physician conducting the physical examination.<sup>154</sup> Although Darnell alleged the physician failed to perform an adequate, individualized assessment of his ability to perform the job, the Seventh Circuit found that the evidence supported the district court’s conclusion that Darnell’s uncontrolled diabetes made him a direct threat to workplace safety.<sup>155</sup> One would not be too far off the mark to imagine a scenario

146. New York City Department of Health and Mental Hygiene, The New York City A1C Registry, <http://www.nyc.gov/html/doh/html/diabetes/diabetes-nycar.shtml> (last visited Jan. 3, 2008).

147. *Id.*

148. Neil Osterweil, *New York City Plans Diabetes Patient Tracking*, MEDPAGE TODAY, July 26, 2005, <http://www.medpagetoday.com/Endocrinology/Diabetes/tb1/1422> (citing James Pyles, an attorney and medical privacy advocate, regarding the New York City Department of Health and Mental Hygiene’s A1C registry.).

149. Linda Geis et al., *Changes in Incidence of Diabetes in U.S. Adults, 1997-2003*, 30 AM. J. PREV. MED. 371, 373 (2006).

150. HENRY G. CISNEROS, COOPERATIVE ACTION FOR MINORITY HEALTH POLICY: HEALTH POLICY AND THE HISPANIC 12, 14 (Antonio Furino ed., 1992).

151. *Darnell v. Thermafiber*, 417 F.3d 657 (7th Cir. 2005).

152. *Id.* at 659.

153. *Id.*

154. *Id.* at 660.

155. *Id.* at 662.

where some employers may use race based public health statistics to pin point certain racial groups susceptible to particular diseases. Although Title VII of the Act<sup>156</sup> prohibits employment discrimination on the basis of race, color, religion, sex, or national origin, circumventing the Act is always a glaring possibility. For example, in 1981, the Air Force Academy dropped its eight-year ban on applicants who possessed a single gene for sickle-cell anemia (also referred to as the “sickle trait”).<sup>157</sup> At that time, the trait was estimated to be present among two million American blacks.<sup>158</sup> The trait was used to exclude blacks from the Air Force Academy and was also cited by the Navy, in keeping blacks out of submarine service.<sup>159</sup> The Air Force Academy admitted that the decision to drop the ban was made after more medical knowledge, which indicated that the policy was not justified by scientific facts, became available.<sup>160</sup>

In summary, legal pitfalls to the use of racial statistics exist at the federal, state, and local levels. At the federal level, the use of racial statistics may implicate Titles VI and VII of the 1964 Civil Rights Act. At the state level, the Fourteenth Amendment’s Equal Protection Clause may be at issue. And, at the local level, laws designed to collect racial data may implicate issues of personal privacy as well as employment. How the use of racial data in public health surveillance impacts public policy is more important to this discussion.

### VIII. PUBLIC HEALTH SURVEILLANCE AND PUBLIC POLICY

Public health is a social enterprise that is extremely sensitive to public policy. By definition, public health is “what we, as a society, do collectively to assure the conditions for people to be healthy.”<sup>161</sup> Law is the traditional way in which governments seek to protect the public good by changing the behavior of individuals.<sup>162</sup> As a matter of public policy, governments have the authority to coerce people to do what is safe for others and for themselves.<sup>163</sup> For example, in *Michigan Dept. of State Police v. Sitz*, the Court held that the use of sobriety check-

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156. 42 U.S.C. § 2000e (2000).

157. Richard Severo, *Air Force Academy to Drop its Ban on Applicants with Sickle-Cell Gene*, N.Y. TIMES, Feb. 4, 1981, <http://query.nytimes.com/gst/fullpage.html?sec=health&res=9B06E5DE133BF937A35751C0A967948260>.

158. *Id.*

159. *Id.*

160. *Id.*

161. COMM. FOR THE STUDY OF THE FUTURE OF PUB. HEALTH, INST. OF MED., *THE FUTURE OF PUBLIC HEALTH* (National Academy Press 1988).

162. Frederic E. Shaw & Christopher P. Ogolla, *Law, Behavior, and Injury Prevention, in INJURY AND VIOLENCE PREVENTION: BEHAVIORAL SCIENCE THEORIES, METHODS, AND APPLICATIONS*, 442, 452 (Andrea Carlson Gielen et al. eds., 2006).

163. *Id.*

points did not violate the Fourth Amendment of the U.S. Constitution.<sup>164</sup> The Court's rationale was that such stops were a reasonable means of preventing drunken driving.<sup>165</sup>

Health policy is driven by health data that indicate the risks or impacts of certain public health activities.<sup>166</sup> Health data is collected by way of public health surveillance.<sup>167</sup> When these statistics are collected by racial categories, a fundamental right may be affected. For example, researchers with the Health Research and Educational Trust conducted a survey among one thousand hospitals nationwide to address questions about their data collection.<sup>168</sup> Thirty percent reported drawbacks to collecting race and ethnicity data.<sup>169</sup> These drawbacks included the possibility that collecting data on race and ethnicity might be used to profile patients and discriminate in the provision of care.<sup>170</sup> This indicates that the collection of racial statistics has major implications for public health policy.

As mentioned earlier in this discussion, data on race and ethnicity are used by epidemiologists and policy makers to monitor trends over time at the national, state, and local levels; to evaluate programs; to understand the etiologic process and identify points of intervention; and to monitor and enforce laws against discrimination.<sup>171</sup> Therefore, it is critical that public health practitioners understand the impact of surveillance on policy. Nowhere is this understanding more critical than among the public health workforce charged with the collection of this data.

Most public health surveillance is done by epidemiologists, who study the frequency and distribution of human diseases.<sup>172</sup> One school of thought holds that many epidemiologists lack policy expertise.<sup>173</sup> Proponents of this school of thought contend that science is an

164. *Michigan Dept. of State Police v. Sitz*, 496 U.S. 444, 455 (1990).

165. *Id.* at 455-56 (Blackmun, J., concurring in judgment) (stating, "I fully agree with the Court's lamentations about the slaughter on our highways, and about the dangers posed to almost everyone by the driver who is under the influence of alcohol or other drug.").

166. See GUIDELINES WORKING GROUP, CTRS. FOR DISEASE CONTROL, UPDATED GUIDELINES FOR EVALUATING PUBLIC HEALTH SURVEILLANCE SYSTEMS: RECOMMENDATIONS FROM THE GUIDELINES WORKING GROUP (2001), <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5013a1.htm>.

167. See *id.*

168. Romana Hasnain-Wynia, et al., *Who, When, and How: The Current State of Race, Ethnicity and Primary Language Data Collection in Hospitals* (The Commonwealth Fund 2004), [http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=225959](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=225959).

169. *Id.*

170. *Id.*

171. Carter-Pokras et al., *supra* note 11, at 403.

172. See Charles Poole & Kenneth J. Rothman, Letter to the Editor, *Epidemiologic Science and Public Health Policy*, 43 J. CLINICAL EPIDEMIOLOGY 1270 (1990); David A. Savitz et al., *Reassessing the Role of Epidemiology in Public Health*, 89 AM. J. PUB. HEALTH 1158-61 (1999).

173. See Savitz, *supra* note 171, at 1159.

attempt to achieve a deeper level of understanding, not an attempt to establish public policies.<sup>174</sup> The job of scientists should be to formulate and evaluate scientific hypotheses, rather than to muster support for or marshal evidence against specific policies.<sup>175</sup> Interestingly, this was the same argument used in the infamous Tuskegee Syphilis study.<sup>176</sup>

The second school of thought contends that the claim that epidemiologists lack policy expertise is generally weak since epidemiologists practice in many forms of legal and policy-making areas.<sup>177</sup> The American College of Epidemiology guidelines state, “epidemiology has as its primary roles the design and conduct of scientific research and the public health application of scientific knowledge.”<sup>178</sup> Furthermore, many public health professionals (including epidemiologists) are accustomed to a rational course of preventive public health action, from medical reports, epidemiologic findings, analysis, and finally well-considered policy.<sup>179</sup>

Regarding racial surveillance, there have been important changes in science and policy that impact the use of race and ethnicity in epidemiologic and public health research.<sup>180</sup> For example, Medicaid managed care and State Children’s Health Insurance are programs whose regulations both require the collection and reporting of race or ethnicity data.<sup>181</sup> Policy experience for epidemiologists could prove to be critical.

Epidemiologists are not lawyers; therefore, they are likely to be walking on a slippery slope when they collect racial data for public health surveillance. However, epidemiology can and indeed has been involved in solving and deciding many cases where the disposition hinged on scientific evidence.<sup>182</sup>

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174. Kenneth J. Rothman & Charles Poole, Editorial, *Science and Policy Making*, 75 AM. J. PUB. HEALTH 340, 341 (1985), available at <http://www.ajph.org/cgi/reprint/75/4/340>.

175. *Id.* at 341.

176. For a detailed analysis of Tuskegee Syphilis study, see Stephen B. Thomas & Sandra Crouse Quinn, THE TUSKEGEE SYPHILIS STUDY, 1932 TO 1972: IMPLICATIONS FOR HIV EDUCATION AND AIDS RISK EDUCATION PROGRAMS IN THE BLACK COMMUNITY, 81 AM. J. PUB. HEALTH 1498 (1991), available at <http://www.ajph.org/cgi/reprint/81/11/1498>.

177. Douglas L. Weed & Pamela J. Mink, *Roles and Responsibilities of Epidemiologists*, 12 ANNALS OF EPIDEMIOLOGY 67, 67-72 (2002).

178. ETHICS GUIDELINES § 2.1 (Am. Coll. of Epidemiology 2000).

179. Shaw & Ogolla, *supra* note 161, at 459.

180. Carter-Pokras et al., *supra* note 11, at 403.

181. *Id.* at 403.

182. See *Norris v. Baxter Healthcare Corp.*, 397 F.3d 878 (10th Cir. 2005); *Ealy v. Richardson-Merrell, Inc.*, 897 F.2d 1159 (D.C. Cir. 1990); *Brock v. Merrell Dow Pharmaceuticals, Inc.*, 874 F.2d 307 (5th Cir. 1989).



## IX. EPIDEMIOLOGY AND LITIGATION

The role of epidemiology in litigation can not be understated. Epidemiological evidence is often used by courts to decide cases where the plaintiff seeks to establish a causal connection between the exposure and the outcome.<sup>183</sup> Some commentators have observed that “the main force driving the increased use of epidemiology in the courtroom has been tort litigation.”<sup>184</sup> Tort law “has been used to seek compensation for injuries in which causation is not provable by mere eyewitness testimony regarding a specific causal event.”<sup>185</sup> For example, in *Norris v. Baxter Healthcare Corp.*,<sup>186</sup> plaintiff claimed systemic and local injuries from a silicone breast implant and sought review of a summary judgment from the United States District Court for the District of Colorado granted in favor of defendant, the successor of the breast implant manufacturer.<sup>187</sup> The appellate court affirmed the district court’s finding that plaintiff’s experts did not offer valid testimony to support either general or specific causation.<sup>188</sup> Plaintiff’s experts “completely ignored or discounted without explanation the many epidemiological studies which found no medically reliable link between silicone breast implants and systemic disease.”<sup>189</sup> The court reasoned that epidemiology is the best evidence of general causation in a toxic tort case.<sup>190</sup> According to the court, “while the presence of epidemiology does not necessarily end the inquiry, where epidemiology is available, it cannot be ignored. As the best evidence of general causation, it must be addressed.”<sup>191</sup>

On the other hand, in *Sulesky v. United States*,<sup>192</sup> the court found that defendant’s flu shot was the proximate cause of plaintiff contracting a disease and that plaintiff was entitled to recover damages for physical injuries, physical pain and suffering, mental anguish, and reasonable and necessary medical expenses, even though epidemiological evidence showed that there was no causal link between the flu vaccination and the disease contracted by the plaintiff. In that case, plaintiff, Kathryn Sulesky contracted Gullain-Barre Syndrome after

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183. *Daubert v. Merrell Dow Pharmaceuticals Inc.*, 509 U.S. 579 (1993).

184. Tom Christoffel & Stephen P. Teret, *Epidemiology and the Law: Courts and Confidence Intervals*, 81 AM. J. PUB. HEALTH 1557, 1661 (1991)

185. *Id.* at 1662 (commenting on a “rapidly growing area of tort law usually labeled ‘toxic torts’ or ‘environmental injury litigation’”).

186. *Norris v. Baxter Healthcare Corp.*, 397 F.3d 878.

187. *Id.* at 880.

188. *Id.* at 886-87.

189. *Id.* at 884.

190. *Id.* at 882.

191. *Id.*

192. *Sulesky v. United States*, 545 F. Supp. 426 (W.Va. 1982).

she received a swine flu shot in 1976.<sup>193</sup> The shot was received during the course of the mass immunization program instituted and conducted by the government.<sup>194</sup> The judge relied on the testimony of the treating physicians and wrote that the epidemiological evidence offered by the government was not determinative on the issue of causation.<sup>195</sup>

The relevance of these two cases is not only to show the role of epidemiology in litigation but also to underscore the larger point that law, unlike public health, has different standards and levels of proof. These standards of proof might be higher and/or stricter in racial surveillance than in other forms of surveillance. Additionally, public health surveillance often involves the collection of epidemiological data, which is widely accepted into evidence under Federal Rule of Evidence 702.<sup>196</sup> Examples of other federal cases in which epidemiological evidence was heavily relied upon include *Brock v. Merrell Dow Pharmaceuticals Inc.*,<sup>197</sup> *Ealy v. Richardson-Merrell, Inc.*,<sup>198</sup> and *Daubert v. Merrell Dow Pharmaceuticals Inc.*<sup>199</sup> In *Brock*, plaintiffs brought suit claiming injury from ingesting a drug manufactured by defendant, Merrell Dow Pharmaceuticals.<sup>200</sup> Regarding the sufficiency of the evidence presented, the court stated:

[U]ndoubtedly the most useful and conclusive type of evidence in a case such as this is epidemiological studies. Epidemiology attempts to define a relationship between a disease and a factor suspected of causing it—in this case ingestion of Bendectin during pregnancy. To define that relationship, the epidemiologist examines the general population, comparing the incidence of the disease among those people exposed to the factor in question to those not exposed. The epidemiologist then uses statistical methods and reasoning to allow her to draw a biological inference between the factor being studied and the disease etiology.<sup>201</sup>

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193. *Id.* at 428.

194. *Id.* at 427.

195. *Id.* at 430.

196. FED. R. EVID. 702.

Testimony by Experts. If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise, if (1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case. *Id.*

197. *Brock v. Merrell Dow Pharmaceuticals, Inc.*, 874 F.2d 307 (5th Cir. 1989).

198. *Ealy v. Richardson-Merrell, Inc.*, 897 F.2d 1159 (D.C. Cir. 1990).

199. *Daubert*, 509 U.S. 579.

200. *Brock*, 874 F.2d at 308.

201. *Id.* at 311 (citing A. Lilienfeld & D. Lilienfeld, FOUNDATIONS OF EPIDEMIOLOGY 3 (2d ed. 1989)).

In *Ealy v. Richardson-Merrell, Inc.*,<sup>202</sup> defendant Merrell Dow appealed a jury award of compensatory damages to plaintiff Ealy due to injury resulting from plaintiff's use of defendant's product, Bendectin.<sup>203</sup> In reversing the lower court, the appellate court reasoned that the then existing body of published epidemiological studies found "no significant statistical association between the ingestion of Bendectin and birth defects."<sup>204</sup>

On the other hand, in *Daubert*,<sup>205</sup> the Supreme Court established the general applicable standard for admission of expert testimony.<sup>206</sup> In that case, petitioners' parents alleged that the mothers' ingestion of Bendectin resulted in the children's birth defects.<sup>207</sup> The district court granted summary judgment to respondent based on the ground that published scientific evidence did not show a statistical link between the use of Bendectin and birth defects.<sup>208</sup> The appellate court affirmed, but the Supreme Court reversed holding that "'general acceptance' is not a necessary precondition to the admissibility of scientific evidence under the Federal Rules of Evidence."<sup>209</sup>

The outcome of these cases ultimately depended on epidemiological studies and statistical correlations. It is likely that epidemiological data will become an increasingly standard part of litigation. When it comes to racial data, however, the standard is likely to be higher. For racial data to pass legal muster, it must meet both the strict scrutiny standard and the expert scientific standard required by Federal Rule of Evidence 702.<sup>210</sup>

#### X. RACIAL CLASSIFICATION IN PUBLIC HEALTH: STRENGTHS AND WEAKNESSES

In 2003, the influential Institute of Medicine released a report on healthcare disparities in the United States.<sup>211</sup> The writers observed that "standardized data collection . . . is critically important in the effort to understand and eliminate racial and ethnic disparities in healthcare."<sup>212</sup> The researchers conceded that the "collection of racial

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202. *Ealy*, 897 F.2d 1159.

203. *Id.* at 1159.

204. *Id.* at 1164.

205. *Daubert*, 509 U.S. 579.

206. *Id.*

207. *Id.* at 579.

208. *Daubert*, 509 U.S. at 585.

209. *Id.* at 597.

210. FED. R. EVID. 702.

211. INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE, *supra* note 3. See Chapter Seven's discussion on data collection and monitoring.

212. *Id.* at 215.

and ethnic data in health systems poses special challenges,” including what types of data to collect and how often.<sup>213</sup> The report recommended that information should be recorded as part of the patient’s record and stratified by race, socioeconomic status and primary language, where possible.<sup>214</sup> A decade and a half ago, the CDC’s working group on the use of Race and Ethnicity<sup>215</sup> in Public Health Surveillance recommended, among other things, that:

- 1) for effective public health surveillance, scientific criteria must be used to define concepts and measurement procedures for categories such as race and ethnicity,
- 2) valid and reliable concepts of race, ethnicity and related notions such as ancestry or national origin should be explored,
- 3) social, economic and political forces underlying differences in health status among racial and ethnic populations should be investigated and reported population studies of health status and,
- 4) when the information on health status of racial and ethnic populations is reported, the explanation should address: (a) why the information is collected (b) how the information is collected and (c) what the findings mean.<sup>216</sup>

These would appear to be strong and rational recommendations; moreover, they are designed to draw attention to the problems associated with racial surveillance. On the other hand, the recommendations can be criticized on the grounds that they are weak because most local health departments that conduct public health surveillance neither have the staff nor the resources to engage in the intellectual rigors of refining terminologies as called for by the workgroup.<sup>217</sup> Additionally, as previously mentioned, much of the data collected by these agencies conform to the Revised Minimum Standards for the Classification of Federal Data on Race and Ethnicity issued by the OMB in 1997.<sup>218</sup> Since the categories developed by OMB were not anthropologic or scientifically based designations but categories that described the socio-cultural construct of our society, it seems like the recommendation that “scientific criteria must be used to define con-

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213. *Id.* at 216.

214. *Id.*

215. Rueben C. Warren et al., *The Use of Race and Ethnicity in Public Health Surveillance*, 109 Pub. Health Reports 4-6 (1994) (discussing racial and ethnic variables used with health information).

216. *Id.* at 5.

217. TRUST FOR AMERICA’S HEALTH, NATIONWIDE HEALTH TRACKING: INVESTIGATING LIFE-SAVING DISCOVERIES 8 (2004), available at <http://healthyamericans.org/reports/files/HealthTrackingBackground.pdf>.

218. Recommendations from the Interagency Committee for the Review of the Racial and Ethnic Standards to the Office of Management and Budget, 62 Fed. Reg. 36,874, 36,943 (July 9, 1997). See also Office of Management and Budget, *Guidance on Aggregation and Allocation of Data on Race for Use in Civil Rights Monitoring and Enforcement* (2000), available at <http://www.whitehouse.gov/omb/bulletins/b00-02.html>.

cepts and measurement procedures for categories such as race and ethnicity” was never taken into consideration by OMB staffers.<sup>219</sup>

From a judicial perspective, courts have not been helpful in issuing guidelines and recommendations on the use of racial data in public health activities. In *Madison-Hughes v. Shalala*,<sup>220</sup> for example, plaintiffs alleged that health care providers, who were recipients of DHHS funds discriminated against them. “Plaintiffs challenged the failure of [the DHHS] to comply with [federal regulations] governing Title VI of [the Act], 42 U.S.C.S. § 2000d, which provide for [the DHHS] to collect data and information from recipients of federal assistance sufficient to permit effective enforcement of Title VI.”<sup>221</sup> The court held that no statutory mandate existed requiring the DHHS to collect data.<sup>222</sup> “Title VI’s only substantive provision,” explained the court, “simply prohibited discrimination on the grounds of race, color, or national origin.”<sup>223</sup> “The language of the statute [did] not provide for mandatory collection of such racial data.”<sup>224</sup> The DHHS’s collection of racial data from recipients under 45 C.F.R., section 80.6(b)<sup>225</sup> was discretionary and not mandatory. The court reasoned that the DHHS “has been granted the discretion to balance the factors involved in selecting the data it needs to carry out this responsibility,” because the DHHS is charged with enforcing Title VI compliance.<sup>226</sup> However, this holding may be problematic. Health is an important area where collection of data by race is clearly needed. This may entail making the collection of racial data mandatory in some cases. As discussed earlier in this paper, diseases such as HIV/AIDS and Diabetes significantly impact some racial groups more than others. For public health to effectively address these diseases, the collection of racial data should be regulated.

Unlike *Madison-Hughes* however, in *Linton v. Carney*,<sup>227</sup> the court found that a Tennessee policy limiting the number of nursing home beds available to Medicaid patients disproportionately affected blacks.<sup>228</sup> Plaintiffs, a group of indigent patients, in their action under Title VI of the Act, filed suit against defendant, the Tennessee Com-

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219. Recommendations from the Interagency Committee for the Review of the Racial and Ethnic Standards to the Office of Management and Budget, 62 Fed. Reg. 36,874, 36,943 (July 9, 1997).

220. *Madison-Hughes v. Shalala*, 80 F.3d 1121 (6th Cir. 1996).

221. *Id.* at 1123.

222. *Id.* at 1125.

223. *Id.*

224. *Id.*

225. 45 C.F.R. § 80.6(b) (2007).

226. *Madison-Hughes*, 80 F.3d at 1126.

227. *Linton v. Carney*, 779 F. Supp. 925 (M.D. Tenn. 1990).

228. *Id.* at 932.

missioner of Health and Environment.<sup>229</sup> Plaintiffs sought to enjoin a state policy through which only a portion of the beds in Medicaid-participating nursing homes were certified to be available for Medicaid patients.<sup>230</sup> The plaintiffs contended that “the policy artificially limit[ed] the accessibility of nursing home care to indigent Medicaid patients and foster[ed] discrimination against [them] by nursing homes.”<sup>231</sup> The court held that the policy violated federal Medicaid statutes and various regulations relating to the nursing home survey and certification process.<sup>232</sup> The court reasoned that “Tennessee’s limited bed certification policy . . . transform[ed] the survey and certification process into an instrument for denying patients’ access to the medically necessary care to which they [were] entitled.”<sup>233</sup> Here, the court took the position that “statistical evidence of disparate racial impact of state policies and federally fund[ed] programs can establish liability under Title VI.”<sup>234</sup>

The court in *Madison-Hughes*<sup>235</sup> found no violation of Title VI of the Act stating that the DHHS’ collection of racial data was discretionary.<sup>236</sup> In *Linton*, however, the court found a violation of Title VI of the Act based on statistical evidence of disparate racial impact of state policies.<sup>237</sup> The court reasoned that, because of the higher incidence of poverty in the black population and the concomitant increased dependence on Medicaid, a policy limiting the amount of nursing home beds available to Medicaid patients will disproportionately affect blacks.<sup>238</sup> This holding is more in line with the public health goal of eliminating health disparities. This court was cognizant that race sometimes determines access to healthcare; and therefore, the collection of data would be necessary where failure to do so would have unjustifiable impact on minorities.<sup>239</sup>

## XI. SO, WHAT DOES THE FUTURE HOLD FOR RACE BASED STATISTICS IN PUBLIC HEALTH?

The use of racial statistics in public health surveillance can be viewed under two prongs. First, the collection of racial data per se is

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229. *Id.* at 927.

230. *Id.*

231. *Id.*

232. *Id.* at 935-36.

233. *Id.* at 933.

234. *Id.* at 935.

235. *Madison-Hughes*, 80 F.3d at 1126.

236. *Id.* at 1125.

237. *Linton*, 779 F. Supp. at 932.

238. *Id.*

239. *Id.* at 935.

not likely to violate the Constitution.<sup>240</sup> Second, very few governmental interests have been found by the Supreme Court to be compelling enough to validate racial classification.<sup>241</sup> It is hard to predict whether the Supreme Court will ever take a case that challenges the use of race in public health activities. In an oft quoted line in *Grutter*,<sup>242</sup> Justice Sandra Day O'Connor wrote that the Court expects that twenty five years from now (i.e., twenty five years from 2003), the use of racial preferences will no longer be necessary to further the interest approved (i.e., creating a critical mass of minority students and providing a diverse student body).<sup>243</sup> By the same token, is it logical to argue that in 2028 it will no longer be necessary to use racial statistics in public health surveillance? Commentators evaluated Justice O'Connor's conjecture and concluded that this is unlikely to come to pass.<sup>244</sup> Now that Justice O'Connor has been replaced by Justice Samuel Alito, it is likely that the Court will take a more conservative and stricter look at the use of racial statistics in public health surveillance. This, of course, will depend on how statistics are used.

Historically, the Supreme Court has allowed the use of race in public programs when it is used to redress actions having an unjustifiable disparate impact on minorities. For instance, in *Swann v. Charlotte-Mecklenburg Board of Education*,<sup>245</sup> and *Cooper v. Aaron*,<sup>246</sup> the Court seemed to support use of race-conscious programs to achieve public school diversity. In *Swann*, the Court observed that

[s]chool authorities are traditionally charged with broad power to formulate and implement educational policy and might well conclude, for example, that, in order to prepare students to live in a pluralistic society each school should have a prescribed ratio of Negro [sic] to white students reflecting the proportion for the district as a whole. To do this. . . an educational policy is within the broad discretionary powers of school authorities; absent a finding of constitutional violation, however, that would not be within the authority of a federal court. . . .<sup>247</sup>

In the recent Supreme Court case, *Parents Involved in Community Schools v. Seattle School District No. 1*, Chief Justice John Roberts referred to the argument in *Swann* as dicta and wrote that *Swann*

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240. Lilquist and Sullivan, *supra* note 7, at 443.

241. *Id.*

242. *Grutter v. Bollinger*, 539 U.S. 306 (2003).

243. *Id.* at 345.

244. ALAN KRUEGER, JESSE ROTHSTEIN, SARAH TURNER, CTR. FOR STUDIES IN HIGHER EDUC., RACE, INCOME, AND COLLEGE IN 25 YEARS: EVALUATING JUSTICE O'CONNOR'S CONJECTURE (2006), available at <http://cshe.berkeley.edu/publications/docs/ROP.+Krueger.19.06.pdf> (last visited Nov. 12, 2008).

245. *Swann v. Charlotte-Mecklenburg Bd. of Educ.*, 402 U.S. 1, 91 S.Ct. 1267 (1971).

246. *Cooper v. Aaron*, 358 U.S. 1, 78 S.Ct. 1401 (1958).

247. *Swann*, 402 U.S. at 16.

evaluated a school district engaged in court ordered segregation.<sup>248</sup> Furthermore, Justice Roberts argued that in *Brown v. Board of Education*<sup>249</sup> that the Court found the assignment of students to different schools on the basis of race, violated equal protection and that programs that use race in school assignments to achieve diversity cannot be distinguished from *Brown*.<sup>250</sup> The Chief Justice added an interesting thought by stating, “[g]overnment action dividing us by race is inherently suspect because such classifications promote ‘notions of racial inferiority and lead to politics of racial hostility.’”<sup>251</sup> Here, the Chief Justice argued against distinctions based on race. He observed that “distinctions between citizens solely because of their ancestry are by their very nature odious to a free people whose institutions are founded upon the doctrine of equality.”<sup>252</sup>

Whether governmental classification by race for public health purposes will lead to notions of racial hostility is hard to tell. Would, for example, use of racial surveillance advance the notions that the Chief Justice talked about? Is it possible to entirely eliminate the use of race from governmental decision making? The answer to these questions is likely “no” because public health still needs the use of race in its programs. What should be at issue is not the collection of racial data per se but what the information is being collected for. Based on the foregoing discussion, the Supreme Court is likely to take the same approach in public health cases as in school diversity cases. Therefore, racial classification, even for public health purposes, is presumptively invalid and can be upheld only if there is a compelling justification. The premise that racial statistics may not be used in public health surveillance in the future is becoming increasingly possible.

As noted earlier in the discussion, the California Civil Rights Initiative passed in 1996 amended the state constitution to prohibit public institutions from discriminating on the basis of race, sex, or ethnicity.<sup>253</sup> In 1998, Washington State voters passed the Washington State Civil Rights Act which called for the state not to discriminate against or grant preferential treatment to any individual or group on the basis of race, sex, color, ethnicity, or national origin in the operation of public employment, public education, or public contracting.<sup>254</sup> Similarly, in 2006, voters in Michigan passed the Michigan Civil Rights Initiative

248. *Parents Involved in Cmty. Sch. v. Seattle Sch. Dist. No. 1*, 127 S.Ct. 2738, 2752 n.10 (2007).

249. *Brown v. Bd. of Educ.*, 347 U.S. 483 (1954).

250. *Parents Involved in Cmty. Sch.*, 127 S.Ct. at 2767-68.

251. *Id.* at 2744.

252. *Id.* (citing *Adarand*, 515 U.S. at 214).

253. See CAL. CONST. art. I, § 31.

254. See WASH. REV. CODE § 49.60.400 (1), *supra* note 143.



which amended the state constitution to prohibit affirmative action programs that gave preferential treatment to persons or groups based on race, gender, color, ethnicity, or national origin in public education, employment, and contracting.<sup>255</sup> Although other states have not followed this trend, the Supreme Court indicated its approval by refusing to overturn the California Civil Rights Initiative.<sup>256</sup> Given the substantial number of government funded epidemiologic studies that use racial statistics, these voter initiatives serve as early warning signs of what may happen if no exemption is provided for race related measures in public health surveillance.

## XII. CONCLUSION

With the current conservative leaning of the Supreme Court, the Court is not likely to look favorably on the use of racial statistics in public health activities. This might mean that public health agencies would have to develop other parameters for collecting health information, such as, socioeconomic status, neighborhood and geographic locations, and disease conditions. Whether the race neutral data collection system will positively or negatively impact the health of minorities is a matter of conjecture. What is apparent is that the use of racial statistics in both medical research and public health surveillance probably will undergo strict scrutiny by the courts. It is of critical importance, therefore, that the public health community includes public health attorneys and other lawyers in the drafting, formulation, testing, and implementation of data collection instruments. Attorneys are familiar with the constitutional principles of equal protection and due process, standards of review, powers and duties of the state, limitations on the power of the state to constrain the autonomy, privacy, liberty, proprietary, and other legally protected interests of individuals in order to assure the health of a population and limitations on the duties of states to assure the health of a population.<sup>257</sup> Furthermore, it is critical that public health practitioners advance the thesis that unlike public education, employment, and contracting, public health is an important area where collection of data by race is needed, especially in an effort to understand and eliminate racial and health disparities.

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255. See MICH. CONST. art. I, § 26, *supra* note 143.

256. *Coal. for Econ. Equality v. Wilson*, 122 F.3d 692 (9th Cir.1997).

257. GOSTIN, *supra* note 10.