NOTE

Remedying the Health Implications of Structural Racism Through Reparations

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ABSTRACT

From the early introduction of slavery to the United States, not only did the economic prosperity of slavery depend on extracting reproductive labor from Black birthing people, but so did the field of medicine. Enslaved Black people were experimented on and forced to undergo inhumane procedures in the name of science, yet as the medical profession grew Black people were then denied the benefit of the same medical services that were available to white people in the United States.

In recent years it has become more apparent that structural racism in health care is a public health crisis. Yet often there is less focus on how the legal community and the federal government have contributed to upholding structural racism and what legal and moral obligation these institutional actors have to make amends for the harm it has caused. The injustice of structural racism in health care is not only the effect it has on public health, but also the reality that those who are most directly harmed also bear the cost of this injustice with no legal remedy to challenge it. The law is not designed to protect against structural racism, and as a result those who continue to be oppressed

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and marginalized on a systemic level bear the cost. Too often this cost falls more directly on Black people in the United States. Nowhere is this more evident than in looking at racial disparity in Black maternal and infant mortality that persists regardless of wealth or other socio-economic indicators.

This Note argues that the federal government has both a legal obligation and a moral obligation to provide reparations to Black birthing people who continue to experience racial disparities in pregnancy outcomes due in part to structural racism. The legal system is not currently designed to provide remedies for the harms that structural racism has created and continues to perpetuate for Black birthing people. However, this Note explores the ways that the legal system's design could in fact allow for such remedies using a reparations model that is based on similar examples of reparations-type programs the federal government has previously created.

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INTRODUCTION

On a slave farm in Alabama in 1844, James Marion Sims founded a small hospital where he conducted experimental procedures[1] and established his legacy as the "Father of Gynecology."[2] A statue dedicated to Sims's legacy stood on a pedestal outside of the New York Academy of Medicine to honor his work—that is until 2018, when the New York City mayoral commission recommended its removal in an attempt to "reckon[] with history."[3] The history at issue was the torture and experimentation on enslaved Black women—including Anarcha, Betsey, and Lucy—whose forced contributions to the fields of obstetrics and gynecology were discarded and erased while Sims's contributions were glorified.[4]

As the historian Deirdre Cooper Owens describes, the medical research that developed from Sims's work, and the work of other white surgeons who experimented on enslaved Black people in pursuit of scientific discovery, was fundamentally flawed.[5] This experimentation was fueled by assumptions about the biological inferiority and higher pain tolerance of Black women.[6] These women were either owned or contracted, and the experiments focused on developing techniques that could be used to treat white patients.[7] The experimenters then returned "treated" Black women to their owners to continue to provide reproductive labor.[8] The medical racism, abuse, and neglect that forged the field of obstetrics and gynecology require not only a reckoning with historical harms, but also with their modern implications for Black birthing people.

The Centers for Disease Control and Prevention ("CDC") released data in 2019 showing Black women are three times more likely

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1 DEIRDRE COOPER OWENS, MEDICAL BONDAGE: RACE, GENDER, AND THE ORIGINS OF AMERICAN GYNECOLOGY 36 (2017).

2 *See* Camila Domonoske, *'Father of Gynecology,' Who Experimented on Slaves, No Longer on Pedestal in NYC*, NAT'L PUB. RADIO (Apr. 17, 2018, 1:39 PM), https://www.npr.org/sections/thetwo-way/2018/04/17/603163394/-father-of-gynecology-who-experimented-on-slaves-no-longer-on-pedestal-in-nyc [https://perma.cc/6VQU-6V7P].

3 *Id.*

4 *Id.*

5 *See* COOPER OWENS, *supra* note 1, at 23.

6 *See id.*

7 *See* Domonoske, *supra* note 2; COOPER OWENS, *supra* note 1, at 28.

8 *See* COOPER OWENS, *supra* note 1, at 38.

to die from pregnancy-related causes than white women, regardless of education level or economic status.[9] The history of medical abuse cannot be separated from the political and legal pressures that initially exacerbated the demand for Black women's reproductive labor in order to support the growth of the slave population in the United States.[10] The historical demands of reproductive labor, the abuse of enslaved Black women to achieve such demands, and the perpetuation of flawed scientific and medical practices as a result contribute to the ongoing maternal health crisis for Black birthing people.

The CDC has acknowledged that a racial disparity in pregnancy-related deaths exists and attributes the disparity, in part, to "variation in quality healthcare, underlying chronic conditions, structural racism, and implicit bias."[11] These factors—especially structural racism and implicit bias—are particularly challenging to address due to the long and complicated history of racial oppression that has blurred the causal thread of harms and effects. Black birthing people continue to face disproportionately high adverse birthing outcomes without either (1) a right to maternal health care or (2) an ability to bring a successful legal challenge to obtain relief for harms due to this racial disparity.

The United States legal system is not designed to provide relief for the harms caused by structural racism or racial bias, except in circumstances where discrimination is abundantly clear and intentional.[12] This Note focuses specifically on the relief due to Black birthing people who continue to experience the harms perpetuated by the United States health care system. These harms are preventable, fueled by federal and state action and inaction, and have not been redressed by courts.

Reparations on the part of the federal government are necessary to address the modern racial disparity in health care services that Black birthing people continue to experience. Reparations have an important role in the broader conversation about improving Black

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9 Press Release, Ctrs. Disease Control and Prevention, Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths (Sept. 5, 2019 1:00 PM), https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html [https://perma.cc/J8LQ-TL7P]. The Centers for Disease Control and Prevention ("CDC") press release also noted "[d]isparities were persistent and did not change significantly between 2007-2008 and 2015-2016." *Id.*

10 *See infra* Part I.

11 *Working Together to Reduce Black Maternal Mortality*, Ctrs. Disease Control and Prevention (Apr. 6, 2022), https://www.cdc.gov/healthequity/features/maternal-mortality/index.html [https://perma.cc/KC37-KD6W].

12 *See infra* Part II.

maternal and infant health outcomes because of both the legal and moral obligations the federal government owes to Black birthing people. Racism and its attendant harms have been perpetuated at a systemic level and therefore require systemic solutions. These solutions must be levied both independent of and in addition to efforts within the health system to combat racism in science and medicine. This Note analyzes the parameters of the federal government's legal and moral obligations to Black birthing people.

Part I of this Note explores the systemic oppression of Black people in the United States through laws and policies that favored slavery, segregation, and discrimination. This Part also explores how the systemic racial oppression of Black people has shaped the United States health care system.[13] Part II demonstrates that, despite the harms created and perpetuated by government-sanctioned oppression of Black people, the legal system provides no remedy. Part III argues that reparations are the appropriate remedy for the racial disparity in maternal and infant health outcomes.

I. The Systemic Oppression of Black People in the United States Through Law, Policy, and Social Practices Has Been a Driver of Poor Health Outcomes

Racism, solidified by law and policy, continues to drive health inequality. It is a public health crisis that demands intervention. The key questions are whether this intervention is entirely dependent on policy change, and what underlying legal frameworks may support action on the part of the federal government. It is crucial to begin by considering how the law created these harms and subsequently denied the possibility of relief from these harms. Failing to place the law in its

13 Although slavery in the United States has had a disparate impact on African American people and their ancestors, the segregation, racism, and discrimination that informed structural inequality in this country continues to be experienced by all Black people who come to the United States. This Note does not address the intricate socioeconomic frameworks that exist within the African diaspora and the wide variance in the lived experiences of Black people in this country. The main operating framework put forward here is that anti-Blackness is structural, and stems from the notion that African slaves who were brought to America were inferior, and because of the codification of this inferiority through federal and state laws, these inequities continue to be felt broadly by all people who present or identify as Black in America. *See* Camara Phyllis Jones, Benedict I. Truman, Laurie D. Elam-Evans, Camille A. Jones, Clara Y. Jones, Ruth Jiles, Susan F. Rumisha & Geraldine S. Perry, *Using "Socially Assigned Race" to Probe* White *Advantages in Health Status*, 18 Ethnicity & Disease 496 (2008) (concluding that "[b]eing classified by others as *White* is associated with large and statistically significant advantages in health status, no matter how one self-identifies").

historical context would ignore the reality that the law is not an entity, but rather a series of written reflections of the people—most often wealthy, white men—who forged its meaning.[14] The historical use of law and policy as tools of racial oppression are relevant to forging legal accountability for the harm this has caused for Black communities, and specifically the ongoing harm to Black birthing people.

A. The Transatlantic Slave Trade and The Early Stages of Medical Racism

The enslavement of Black people in America was documented as early as 1619 through the transatlantic slave trade and continued until at least 1808 when it was formally outlawed by the Constitution.[15] The forcible removal of millions of African people to the United States was a treacherous and deadly journey that included forced marches to coastal ports, captive status, Middle Passage deaths during sea transport, and rampant exposure to disease and mistreatment.[16] Survivors suffered exposure to an array of new diseases within the United States, vulnerability to which further exacerbated the trauma of the slave trade.[17] The resulting poor health outcomes of African-born people—who were forced into the slave trade and transported to the

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14 This Note utilizes a Critical Race Theory approach to analyze the connection between differential care in the American health system and this country's history of government-sanctioned slavery, segregation, and racism. The framework of Critical Race Theory has been advanced as a way for legal professionals to conceptualize how the law intersects and interacts with the perpetuation of disadvantage and harm to nonwhite people, and specifically in this context, to Black birthing people. The Critical Race Theory model aims to examine how white supremacy is maintained through social structures—particularly the structures of law and equal protection. *See* Robin D. Barnes, *Race Consciousness: The Thematic Content of Racial Distinctiveness in Critical Race Scholarship*, 103 HARV. L. REV. 1864, 1864–65, 1870 (1990); *see also* Kimberlé Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, 1989 U. CHI. L. FORUM 139, 139–40 (introducing intersectionality as an analytical method); Mari J. Matsuda, *Looking to the Bottom: Critical Legal Studies and Reparations*, 22 HARV. C.R.-C.L. L. REV. 323, 324–26 (1987) (describing the potential use of Critical Legal Studies by minority scholars); Milner S. Ball, *The Legal Academy and Minority Scholars*, 103 HARV. L. REV. 1855, 1859 (1990) (discussing the contributions of minority scholars to discussion of race in legal academia). For a comprehensive list of Critical Legal Theory readings, see Duncan Kennedy & Karl E. Klare, *A Bibliography of Critical Legal Studies*, 94 YALE L.J. 461 (1984).

15 *See* W. MICHAEL BYRD & LINDA A. CLAYTON, AN AMERICAN HEALTH DILEMMA: A MEDICAL HISTORY OF AFRICAN AMERICANS AND THE PROBLEM OF RACE: BEGINNINGS TO 1900, at 191, 208 (2000).

16 *See id.* at 194.

17 *Id.*

United States—added fuel to the false construct that Black people were inherently sicker than white people.[18]

The combination of health disadvantage and differential treatment along racial lines became embedded in the social and legal structure of chattel slavery.[19] For example, as early as 1705 the House of Burgesses, the legislative body of the Colony of Virginia, created provisions for the treatment of white servants, requiring proper diet, clothing, and lodging.[20] No such health provisions were made for enslaved Black people.[21] An early failure of the legal system to create equal obligations for the health of white and Black people repeated, and this blueprint has become an underlying societal norm. By 1717, a white servant in South Carolina could complain to a justice of the peace if they were denied proper clothing, diet, or lodging, whereas enslaved Black people had no recourse for poor treatment.[22]

The widespread mistreatment and disregard enslaved Black people experienced led to the evolution of a slave health subsystem of self-reliance.[23] Enslaved Black people would provide for their own care through African healing traditions, including midwifery, root doctors, and spiritual healers.[24] The retention of traditional African medicine as an alternative to the "master's medicine" reflected both a mistrust of and exclusion from other medical services.[25]

The portrayal of Black people as biologically inferior and in need of the protection of slave owners was used as a paternalistic defense of slavery as a social good.[26] However, to portray these efforts as a social good would ignore the economic interests that were at stake in such a system.[27] Disregard for the health of enslaved Black people was prof-

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18 *Id.* at 204.

19 *Id.* at 198.

20 *Id.* at 192.

21 *Id.*

22 *Id.* at 199.

23 *See id.* at 202.

24 *Id.*

25 Kevin Outterson, *Tragedy and Remedy: Reparations for Disparities in Black Health*, 9 DEPAUL J. HEALTH CARE L. 735, 750 (2005).

26 *See*, *e.g.*, BYRD & CLAYTON, *supra* note 15, at 207–08; GEORGE FITZHUGH, SOCIOLOGY FOR THE SOUTH, OR THE FAILURE OF FREE SOCIETY 83–95 (1854) (evoking imagery of charity, family, and friendship to support the continued enslavement of Black people for their own good and in their own best interest).

27 As William Darity and Kirsten Mullen highlight in their review of the economic benefits of the institution of slavery, the United States—and specifically White Americans—gained both the monetary and positional power of slavery at the cost of the enslaved Black people who built that opportunity with their unpaid forced labor. *See* WILLIAM A. DARITY & A. KIRSTEN MULLEN, FROM HERE TO EQUALITY 51–68 (2020) ("The sale and forced labor of [B]lack bodies

itable only to the extent that slaveholders still had a ready source of unpaid labor. The economic interests inherent in viewing enslaved people as livestock also created the need for slave owners to provide certain basic health care.[28] The primary purpose of chattel slavery was the procurement of free labor, and, because enslaved Black people were considered human chattel property, slave owners sought to provide basic health accommodations as a means of preserving the economic value of the enslaved people they relied on for this labor.[29] The laws of this country have consistently operated to protect the property interest of the slave owner over the freedom and liberty of the enslaved Black person.

B. The Law's Embrace of Slavery, Segregation, and Discrimination in Medicine and Beyond

The Constitution, a document that created the structural underpinnings of the modern United States legal system, also formalized the inferior position of enslaved Black people within that system. The Constitution's wording made plain that its protections would not provide any shelter to an enslaved person who sought to escape forced servitude.[30] As originally drafted, the Constitution relegated enslaved Black people—who were referred to as "other persons"—to three-fifths of a "free person" for the purpose of apportioning Congressional seats.[31] This inclusion incentivized the growth of slavery by affording slave states greater congressional representation without acknowledging enslaved people as full citizens, or even full people, with the right of a vote.[32] Although the Constitution put an end to the

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drove the commerce of the United States from the earliest days of the nation and made possible the world we inhabit today.").

28 Outterson, *supra* note 25, at 749–50.

29 Outterson, *supra* note 25 at 748–50.

30 U.S. CONST. art. IV, § 2, cl. 3 ("No Person held to Service or Labour in one State, under the Laws thereof, escaping into another, shall, in Consequence of any Law or Regulation therein, be discharged from such Service or Labour, but shall be delivered up on Claim of the Party to whom such Service or Labour may be due.").

31 U.S. CONST. art. I, § 2, cl. 3 ("Representatives and direct Taxes shall be apportioned among the several States which may be included within this Union, according to their respective Numbers, which shall be determined by adding to the whole Number of free Persons, including those bound to Service for a Term of Years, and excluding Indians not taxed, three fifths of all other Persons."); *see also* Brooke E. Newborn, *Correcting the Common Misreading of the "Three-Fifths" Clause of the U.S. Constitution: Clarifying the "Hostile Fraction,"* 80 PA. BAR ASS'N Q. 93, 94 (2009) (explaining that the Three-Fifths Clause was intended to increase political representation of Southern states in Congress).

32 *See* Newborn, *supra* note 31, at 94.

slave trade, it created a two-year window during which southern states could continue to import enslaved Black people in the short term.[33]

From 1790 to 1808, there was a huge uptick in the number of enslaved people in the United States—from 697,624 in 1790 to about 3,953,760 in 1860.[34] This increase has been tied to both increased importation and "natural population growth."[35] From 1830 to 1865, 5.6 million children were born into slavery.[36] Following the Constitution's ban on the importation of African-born slaves in 1808, slave owners were increasingly dependent on the reproductive health and labor of enslaved Black women.[37] As a result, more white men started to enter the field of midwifery—previously a field predominantly occupied by women.[38] The burgeoning field of gynecology and the understanding of reproductive health was advanced by white male doctors conducting medical research on enslaved Black women.[39] Growing volumes of medical literature referred to these Black women as "breeder[s]."[40] Enslaved Black people were not only the recipients of poor health care, but also the "training material" for the developing field of medicine.[41] The dehumanization enslaved Black people experienced was legitimized by the Constitution, as well as by the Supreme Court in its interpretation of the Constitution, creating and perpetuating systemic racial oppression.

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33 The Constitution guaranteed a two-year period in which the importation of slavery would be allowed to continue, although a tax or duty of no more than ten dollars would be collected for each person imported by the States and subjected to forced servitude. U.S. CONST. art. I, § 9, cl. 1 ("The Migration or Importation of such Persons as any of the States now existing shall think proper to admit, shall not be prohibited by the Congress prior to the Year one thousand eight hundred and eight, but a Tax or duty may be imposed on such Importation, not exceeding ten dollars for each Person."). The Constitutional provisions set forth to protect slavery were preserved under Article V of the Constitution, which prohibited any amendment to the Constitution that would put an end to the slave trade before 1808. U.S. CONST. art. V; *see generally* James Oakes, *"The Compromising Expedient": Justifying a Proslavery Constitution*, 17 CARDOZO L. REV. 2023 (1996).

34 J. David Hacker, *From '20. and Odd' to 10 Million: The Growth of the Slave Population in the United States*, 41 SLAVERY & ABOLITION 840, 840 (2020).

35 *Id.* at 840–41, 843–44.

36 Between 1830 and 1865, 5.6 million children were born into slavery, making up about 60 percent of the over 9.3 million children born into slavery between 1620 and 1865. *Id.* at 846.

37 COOPER OWENS, *supra* note 1, at 15–17.

38 *Id.*

39 *See id.* at 17.

40 *Id.* at 19.

41 BYRD & CLAYTON, *supra* note 15, at 212.

In *Dred Scott v. Sandford*,[42] the Supreme Court affirmed what the Constitution implied: that the "negro race" were a "separate class of persons"[43]—not citizens but a "subordinate and inferior class of beings."[44] The Supreme Court's holding in *Dred Scott* cited to art. I, § 9, cl. 1 and art. IV, § 2, cl. 3 of the Constitution as "conclusively" showing that no formerly enslaved person or their descendants were intended to be embraced by any of the provisions of the Constitution.[45] *Dred Scott* was handed down nearly seventy years after the ratification of the Constitution and forty-nine years after the formal end of the transatlantic slave trade. In this decision, the Supreme Court made clear that the Constitution protected the property rights of slave owners over the basic dignities of enslaved Black people and their descendants.[46]

Some commentators have argued that the historical abuses of slavery have already been remedied. As then-Senate Majority Leader Mitch McConnell stated in 2018, "We've tried to deal with our original sin of slavery by fighting a civil war, by passing landmark civil rights legislation. We elected an African American president."[47] Despite subsequent attempts to amend the Constitution and recognize the equal status of formerly enslaved Black people, however, the period of segregation in public accommodations and narrow readings of the private right to challenge discrimination on a systemic level has preserved the inequities that slavery forged.[48]

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42 60 U.S. (19 How.) 393 (1857), *superseded by constitutional amendment*, U.S. CONST. amend. XIV.

43 *Id.* at 410–12.

44 *Id.* at 404–05. The Court distinguished Black people from Native Americans and emigrants, both of whom were eligible for citizenship based on their status as "free and independent people," unlike current and formerly enslaved Black people. *See id.* at 403–04, 411 ("No one of that race had ever migrated to the United States voluntarily; all of them had been brought here as articles of merchandise.").

45 *Id.* at 411. The Court's holding affirmed what the practice of chattel slavery laid bare—Black people were so mistreated that were their status as fellow-citizens recognized, it would undermine all that democracy stood for. *See id.* at 416 ("[I]t is hardly consistent with the respect due to these States, to suppose that they regarded at that time, as fellow-citizens and members of the sovereignty, a class of beings whom they had thus stigmatized . . . .").

46 *See id.* at 447–52.

47 Ted Barrett, *McConnell Opposes Paying Reparations: 'None of Us Currently Living Are Responsible' for Slavery*, CNN (June 19, 2019, 10:39 PM), https://www.cnn.com/2019/06/18/politics/mitch-mcconnell-opposes-reparations-slavery [https://perma.cc/AT6T-F7VF]. McConnell also noted that because no one currently alive was responsible, and the process of figuring out who to compensate would be too difficult because subsequent waves of immigrants have also faced discrimination, reparations are not a good idea. *Id.*

48 The COVID-19 pandemic highlighted the extent of racial disparities in health that continue today. *See, e.g.*, James Louis-Jean, Kenney Cenat, Chidinma V. Njoku, James Angelo &

The disregard for the humanity of enslaved Black people did not cease when slavery was abolished. Although the abolition of slavery uplifted enslaved Black people to the status of free citizens of the United States, the plan for delivering on this freedom was not properly prioritized. In a letter Abraham Lincoln wrote to Horace Greeley on August 22, 1862, he stated:

> If there be those who would not save the Union unless they could at the same time *save* slavery, I do not agree with them. If there be those who would not save the Union unless they could at the same time *destroy* slavery, I do not agree with them. My paramount object in this struggle *is* to save the Union, and is *not* either to save or to destroy slavery. If I could save the Union without freeing *any* slave I would do it, and if I could save it by freeing *all* the slaves I would do it; and if I could save it by freeing some and leaving others alone, I would also do that. What I do about slavery and the colored race, I do because I believe it helps to save this [sic] Union; and what I forbear, I forbear because I do *not* believe it would help to save the Union. I shall do *less* whenever I shall believe what I am doing hurts the cause, and I shall do *more* whenever I shall believe doing more will help the cause.[49]

Lincoln's words rang true, and at every turn the federal government chose to do less. The cause was never freedom for enslaved persons; it was saving the Union.

C. The Federal Government's Short-Lived Attempt to Provide Health Care to Formerly Enslaved Black People

Following the Civil War, the federal government failed to deliver on many promises it made to freedmen who had been formerly enslaved. The lack of resources the government expended had a direct impact on the quality of health care available to freedmen. Freedmen were promised land redistribution and wages for backpay following the Emancipation Proclamation.[50] These promises largely failed to

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Debbie Sanon, *Coronavirus (COVID-19) and Racial Disparities: A Perspective Analysis*, J. Racial & Ethnic Health Disparities 1039, 1043 (2020).

49 Letter from Abraham Lincoln to Horace Greeley (Aug. 22, 1862), *published in* Abraham Lincoln, *A Letter from the President*, Daily Nat'l Intelligencer, Aug. 23, 1862, https://www.loc.gov/item/mal4233400/ [https://perma.cc/9LDH-TDUL].

50 In the wake of the Civil War, the Reconstruction Era briefly seemed as if it might deliver a dismantling of plantations, redistributing slave owners' wealth to the newly freed Black people who were landless and without any resources. *See* Rhonda V. Magee, Note, *The Master's*

materialize, which left freedmen with limited resources.[51] Prior to the Civil War, the slave health care system had provided limited access to medical services; following the Civil War, former slave owners had no incentive to provide any health services.[52]

The federal government made a brief effort to ease the transition through the creation of the Bureau of Refugees, Freedmen, and Abandoned Lands ("Freedmen's Bureau").[53] However, the Freedmen's Bureau ultimately failed to provide adequate relief. In Georgia, for example, the Freedmen's Bureau established five hospitals,[54] but medical services soon ground to a halt because of local resistance to the program, poor organization, and inadequate funding.[55] One of the pitfalls of the program was that, by design, the Freedmen's Bureau was created to provide medical services as a temporary program to ease the period of adjustment rather than a more long-term care option.[56] However, the influx of freedmen to cities in Georgia, coupled with an outbreak of smallpox in 1865, caused overcrowding of already limited resources.[57] The Freedmen's Bureau continued to pressure rural public officials to care for freedmen with little success, and as a result access to care was more inconsistent in rural areas compared with urban areas.[58] When the Freedmen's Bureau shuttered its medical services in Georgia in 1868, it left no health care system in its place.[59] Freedmen were once again dependent on hospitals and white officials despite limited assurances that providers and officials intended to step in and provide care to Black people.[60]

The Freedmen's Bureau's efforts in Georgia and elsewhere reflect the failures of federal Reconstruction to provide for formerly enslaved persons, a failing which led to a segregated society. In this new post-slavery system, Black people were left to navigate a segregated

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Tools, From the Bottom Up: Responses to African-American Reparations Theory in Mainstream and Outsider Remedies Discourse, 79 VA. L. REV. 863, 886–88 (1993).

51 President Andrew Johnson had other plans and moved to rescind the lands that were promised through an amnesty proclamation that forced the restoration of confiscated plantation land to its former owners by defining the property rights as superior to the remedial rights of formerly enslaved people. *Id.* at 888–89.

52 *See* Outterson, *supra* note 25, at 751–52.

53 *See* Todd L. Savitt, *Politics in Medicine: The Georgia Freedmen's Bureau and the Organization of Health Care, 1865-1866*, 28 CIVIL WAR HIST. 45, 45–46 (1982).

54 *Id.* at 55–59.

55 *See id.* at 46–47.

56 *See id.* at 59.

57 *See id.* at 59–60.

58 *Id.* at 62–64.

59 *Id.* at 61.

60 *Id.* at 64.

medical system which discriminated against them, excluded them from hospitals,[61] and performed substandard care.[62] After the Civil War, state and local Jim Crow laws were enacted to replace slavery with a "caste system" that maintained the status quo of white supremacy.[63] This segregated system—which extended into the provision of health care services—was built with the support of federal tax dollars and federal policy and was upheld by the courts.[64] As the Court reasoned in *Plessy v. Ferguson*,[65] segregation was an appropriate state policy because states possessed the "liberty to act with reference to the established usages, customs and traditions of the people, and with a view to the promotion of their comfort, and the preservation of the public peace and good order."[66] If a state statute authorized or required the separation of two races, it was not considered a violation of the Fourteenth Amendment.[67]

D. The Dual Hospital System and The Government's Racially Unequal Funding of Health Care Services

The *Plessy* holding set the precedent for "separate but equal" accommodations, providing legal support for a dual system of health care on the basis of race. During this period, Black people developed their own system of health care services, continuing a history of self-reliance. The rise in Black hospitals— from 63 hospitals in 1912 to 118 hospitals in 1918—represented an effort to combat the inadequate care otherwise available to Black patients in white-led and white-run hospitals, and was made possible by the rise in Black physicians and nurses.[68] Although Black hospitals, operated by and for Black individuals, provided necessary services to Black communities, inadequate funding left many Black hospitals struggling to remain operational.[69]

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61 Outterson, *supra* note 25, at 757–58.

62 Rodney G. Hood, *The "Slave Health Deficit:" The Case for Reparations to Bring Health Parity to African Americans*, 93 J. NAT'L MED. ASS'N 1, 2–3 (2001).

63 Vincene Verdun, *If the Shoe Fits, Wear It: An Analysis of Reparations to African Americans*, 67 TUL. L. REV. 597, 640 (1993) (referring to the caste system that formed as the underlying framework of systemic discrimination).

64 *See id.*

65 163 U.S. 537 (1896), *abrogated by* Brown v. Board of Education, 347 U.S. 483 (1954).

66 163 U.S. at 550.

67 *Id.* at 550–51.

68 *See* VANESSA NORTHINGTON GAMBLE, MAKING A PLACE FOR OURSELVES: THE BLACK HOSPITAL MOVEMENT, 1920-1945 3–13 (1995); *see also* David Barton Smith, *Healthcare's Hidden Civil Rights Legacy*, 48 ST. LOUIS U. L.J. 37, 38–43 (2003) (presenting an overview of the dual systems of health that resulted from segregation in the health care system in which Black physicians and dentists treated Black patients in Black hospitals).

69 *See, e.g.*, Moyra Schauffler, *The Rise and Decline of African-American Hospitals in Phil-*

Much like with the federal government's short-lived effort to provide medical services through the Freedmen's Bureau, funding remained the biggest barrier to the successful creation of a system of Black health care.[70] Cost concerns and challenging operational demands were not unique to Black hospitals, and it became increasingly clear that federal funding was necessary to spur the construction of more hospital facilities nationwide.[71] However, the federal government's unequal funding of health care services disproportionately benefitted white communities and white patients, leaving Black hospitals and Black communities behind.[72]

Prior to the twentieth century, physicians provided in-home services to those who could afford it, and hospitals were primarily religious organizations providing charitable services.[73] The rise of hospital-based healthcare was supported by the passage of the Hospital Survey and Construction Act of 1946 ("Hill-Burton Act"),[74] the enactment of Medicare and Medicaid in the 1965 Amendments to the Social Security Act under Title XVIII,[75] and the Emergency Medical Treatment and Active Labor Act ("EMTALA") of 1986.[76]

Each of these federal intrusions into the health care system demonstrated the federal government's willingness to use tax dollars to expand access to health care. Congress created a statutory right to federally funded health care for qualifying individuals with the estab-

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adelphia, HIDDEN CITY (Oct. 2, 2020), https://hiddencityphila.org/2020/10/the-rise-and-decline-of-african-american-hospitals-in-philadelphia/ [https://perma.cc/RQR4-VV4H] (charting the history of Black hospitals in Philadelphia); Jamon Jordan, *Detroit Had 18 Black-Owned and Operated Hospitals: Why They Vanished*, DETROIT FREE PRESS (Feb. 27, 2022, 2:56 PM), https://www.freep.com/story/opinion/contributors/2022/02/27/detroit-hospitals-black-history-month/6925953001/ [https://perma.cc/CL9V-VBZU].

70 GAMBLE, *supra* note 68 at 6–10 (noting how the growth of Black hospitals was in large part the result of hard-fought efforts on the part of the Black community to finance medical facilities that would provide care to indigent Black patients who lacked access to adequate care). The reliance on raising such funds from the community, particularly from white philanthropists, posed its own challenges and gave white philanthropists an outsized influence over Black health. *Id.* at 105–06, 128–30.

71 *See infra* note 79 and accompanying text.

72 GAMBLE, *supra* note 68 at 45–49 (comparing the overall inadequacy of medical care in the early 20th century to the specific inadequacy of health care—even in emergencies—for Black patients who suffered higher morbidity and mortality rates than white patients).

73 *See* Mark J. Garwin, *Immunity in the Absence of Charity: EMTALA and the Eleventh Amendment*, 23 S. ILL. U. L.J. 1, 1 (1998).

74 Hospital Survey and Construction (Hill-Burton) Act, Pub. L. No 79-725, 60 Stat. 1040 (1946).

75 Social Security Amendments of 1965, Pub. L. No 85-97, 79 Stat. 286.

76 Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, Pub. L. No. 99-272, § 9121, 100 Stat. 82, 164-67.

lishment of Medicaid and Medicare.[77] Congress also created a minimum treatment standard for patients who are in active labor and arrive at a Medicare-participating hospital with the establishment of EMTALA.[78] Congress took steps to elevate health care to the status of a pseudo-fundamental right, but ultimately fell short of providing sufficient legal protections to ensure equal access to quality care for Black patients. The federal government's shortcomings were particularly significant in the case of the Hill-Burton Act, which fueled racial disparities in health care by permitting federal funds to be directed toward building segregated hospitals.[79]

The Hill-Burton Act was signed by President Harry Truman, who remarked at the time of signing that "This bill . . . lays a groundwork for providing more and better medical care for the people of our country. Its aim is to assist States in the construction of necessary physical facilities for furnishing adequate hospital, clinical and similar services to all their people."[80] Despite the promise of adequate services for all people, the Hill-Burton program embraced the funding of segregated hospital facilities, designating funds for 104 facilities that engaged in "complete racial exclusion" and 7000 facilities that were "segregate[d] by ward, room[,] or floor."[81] This decision spurred the continued segregation of hospitals, using taxpayer money, yet deferred to the states to determine how health facility funds would be spent.[82] Reporting at the time showed facilities were not built in the poorest areas of Southern states, citing "the fact that these poor areas lack the funds to build or maintain a hospital,"[83] and were concentrated in small towns rather than urban areas.[84]

The practice of providing federal funding to the construction of segregated hospitals went unabated for twenty years,[85] until the 1963

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77 Social Security Amendments of 1965, Pub. L. No 85-97, 79 Stat. 286.

78 Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, Pub. L. No. 99-272, § 9121, 100 Stat. 82, 164-67.

79 Emily A. Largent, *Public Health, Racism, and the Lasting Impact of Hospital Segregation*, 133 PUB. HEALTH REPS. 715, 715 (2018).

80 Statement by the President Upon Signing the Hospital Survey and Construction Act, PUB. PAPERS 413 (Aug. 13, 1946).

81 Outterson, *supra* note 25, at 768–70.

82 *See id.* at 767–68.

83 *See* John W. Cronin, Louis S. Reed & Helen Hollingsworth, *Hospital Construction Under the Hill-Burton Program: Analysis of the Type, Size, and Location of Projects Being Built with Federal Aid*, 65 PUB. HEALTH REPS. 743, 746–52 (1950).

84 *Id.* at 747.

85 *See generally* Largent, *supra* note 79, at 715–16 (discussing the problem of segregation in hospitals prior to *Simkins* and the medical community's response to the decision).

decision in *Simkins v. Moses H. Cone Memorial Hospital*.[86] The Fourth Circuit's decision meant hospitals receiving federal funds could not deny Black medical professionals use of these facilities.[87] However, this remedy did not recoup funds that had already been directed to segregated facilities, nor did it alter the fact that many hospitals were placed in geographic locations that Black patients had more trouble accessing.[88]

Under Hill-Burton, taxpayer money funded construction of segregated hospitals for nearly twenty years. Despite paying taxes under the same tax laws, Black taxpayers were denied the same benefits and quality of healthcare services as white taxpayers.[89] In 1964, the Public Health Service issued regulations that prohibited discrimination in facilities receiving Hill-Burton funds.[90] As with the effort to abolish slavery, the effort to prohibit segregation and discrimination in public accommodations receiving federal funds was too little too late. The racial disparity in health care was intrinsically woven into these facilities from their creation.

Part I of this Note presented a wide-ranging review of the ways slavery, segregation, and racism have shaped the United States health care system, in the context of the legal and political forces that provided support and funding for racial inequality in health care. The next Part of this Note explores possible legal remedies available to those who experience harm within the health care system on the basis of race. This Note concludes that the current legal remedies are inadequate and must be re-envisioned.

II. The Limitations of Legal Remedies to Structural Racism in Health Care

The right to health care has historically been recognized as a fundamental right in international settings.[91] However, the right to health

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86 323 F.2d 959, 969–70 (4th Cir. 1963), *cert denied*, 376 U.S. 938 (1964), *abrogated by* Modaber v. Culpeper Memorial Hospital, Inc., 674 F.2d 1023, 1026 (4th Cir. 1982) (holding that the portion of the Hill-Burton Act that allowed "separate but equal" facilities was unconstitutional under the Due Process Clause of the Fifth Amendment and the Equal Protection Clause of the Fourteenth Amendment).

87 *Id.*

88 *Id.*

89 *See id.*

90 *See* Largent, *supra* note 79, at 718.

91 *See* Const. of the World Health Org. 1 (1946) ("The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."); *see also* G.A. Res. 217 (III) A, Universal Declaration of Human Rights, art. 25 (Dec. 10, 1948) ("Everyone has the

care has not been recognized as a constitutionally protected fundamental right within the United States legal system. Statutes such as Medicare and Medicaid make up the bulk of the federal government's effort to support accessible health care.[92] The Supreme Court has held that only fundamental rights that are explicitly or implicitly guaranteed in the Constitution are considered substantive constitutional rights.[93] Despite the social value of safe housing and quality education, the Supreme Court has not recognized them as fundamental rights, and "the Constitution does not provide judicial remedies for every social and economic ill."[94] This distinction limits the availability of judicial remedies to protect social and economic ills—like the preventable racial disparity in maternal and infant health outcomes for Black birthing people—because health is not a constitutional right.

Yet, another constitutional interpretation is possible. As Justice Kennedy wrote in *Obergefell v. Hodges*,

> The nature of injustice is that we may not always see it in our own times. The generations that wrote and ratified the Bill of Rights and the Fourteenth Amendment did not presume to know the extent of freedom in all of its dimensions, and so they entrusted to future generations a charter protecting the right of all persons to enjoy liberty as we learn its meaning. When new insight reveals discord between the Constitution's central protections and a received legal stricture, a claim to liberty must be addressed.[95]

It was this evolving idea of liberty that the Court in *Obergefell* embraced when it held the fundamental right to marry included the right for same-sex couples to marry.[96] Were health care a fundamental right, a challenge to a federal or state law that abridged this right would be subject to strict scrutiny judicial review rather than a less

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right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."); G.A. Res. 2200A (XXI), art. 12 (Dec. 16, 1966) ("The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.").

92 *See* David Orentlicher, *Rights to Healthcare in the United States: Inherently Unstable*, 38 AM. J.L. & MED. 326, 327 (2012).

93 *See* San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 31–37 (1973).

94 *Id.* at 32 (quoting Lindsey v. Normet, 405 U.S. 56, 74 (1972)).

95 576 U.S. 644, 644–45 (2015) (recognizing the right to marry is a fundamental right under the Due Process and Equal Protection Clauses of the Fourteenth Amendment and this right applies equally to same-sex couples).

96 *Id.*

searching rational basis review.[97] While some laws do survive strict scrutiny, a majority do not.[98] Yet, even if health were a fundamental right that was afforded constitutional protection, this protection would not guarantee access for those without the financial ability to access the right.

A. No Government Obligation to Provide Health Care

The notion of a government obligation to provide medical care arises in certain distinct circumstances where a person under government control is dependent on the government for basic needs.[99] For example, the Supreme Court has recognized that under the Eighth Amendment, which prohibits "cruel and unusual punishments,"[100] the government has an obligation to provide medical care for the people the government incarcerates because the individual's needs cannot be met through other means.[101] This reasoning has been extended to include individuals who have been institutionalized and thus are dependent on the State.[102]

Additionally, the Supreme Court has found that the Constitution sets forth certain implicit privacy rights that are absolute and fundamental to the concept of liberty, even where the Constitution does not explicitly mention a right to privacy.[103] Under the Fourteenth Amendment's Due Process Clause, fundamental rights are protected under the Constitution from state infringement.[104] In *Roe v. Wade*,[105] the Supreme Court held that the right of personal privacy includes the decision over whether to obtain an abortion, and that, where "fundamental rights" are involved, any regulation of such rights must be justified by a compelling state interest.[106] However, in *Maher v. Roe*,[107] the Supreme Court shied away from identifying a constitu-

97 *See, e.g.*, *Rodriguez*, 411 U.S. at 40 (applying rational basis review where the challenged Texas law did not "impinge upon constitutionally protected rights" by using local property taxes to fund schools).

98 Adam Winkler, *Fatal in Theory and Strict in Fact: An Empirical Analysis of Strict Scrutiny in the Federal Courts*, 59 VAND. L. REV. 793, 796 (2006) (finding that from 1990 to 2003 only 30 percent of laws reviewed under strict scrutiny were upheld).

99 KATHLEEN S. SWENDIMAN, CONG. RSCH. SERV., R40846, HEALTH CARE: CONSTITUTIONAL RIGHTS AND LEGISLATIVE POWERS 5 (2010).

100 U.S. CONST. amend. VIII.

101 Estelle v. Gamble, 429 U.S. 97, 103 (1976).

102 Youngberg v. Romeo, 457 U.S. 307, 317 (1982).

103 Roe v. Wade, 410 U.S. 113, 152–53 (1973).

104 *Id.* at 167–68.

105 410 U.S. 113 (1973).

106 *Id.* at 154–55.

107 432 U.S. 464 (1977).

tional right to health care at the government's expense for pregnancy-related medical expenses.[108] In doing so, the Court reasoned that "when a State decides to alleviate some of the hardships of poverty by providing medical care, the manner in which it dispenses benefits is subject to constitutional limitations."[109]

The Supreme Court has determined that financial need alone does not constitute "a suspect class for purposes of equal protection analysis."[110] *Maher* allowed Congress to withhold subsidies for medically necessary abortion care under the Hyde Amendment.[111] The Court reasoned that the Due Process Clause of the Fourteenth Amendment may protect against unwarranted government interference in individual privacy rights, but does not entitle individuals to "such funds as may be necessary to realize all the advantages of that freedom."[112]

In *San Antonio Independent School District v. Rodriguez*,[113] the Court held the Equal Protection Clause does not require absolute equality or equal advantage when a service, like education, is unequal as the result of wealth disparity.[114] The Court's refusal to recognize a judicial remedy reflected the Court's general refusal to create additional substantive constitutional rights that are not explicitly or implicitly guaranteed by the Constitution.[115]

The Constitution and Supreme Court precedents demonstrate that there is no constitutional right to health care at the government's expense. Nor are there sufficient grounds to challenge unequal access to certain services, even where those services are either protected by the Constitution or fundamental to society, when the underlying disparity is driven by wealth inequality. However, the Constitution and the courts have recognized that there are certain statutory rights that protect individuals from discrimination in accessing medical services. The following Section provides a brief overview of this statutory framework.

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108 *Id*. at 469.

109 *Id.* at 469–70.

110 *Id.* at 471.

111 Harris v. McRae, 448 U.S. 297, 316–17 (1980).

112 *Id.* at 318.

113 411 U.S. 1 (1973).

114 *See id.* at 28–29.

115 *Id.* at 33–36.

B. Equal Protection Claims Are Difficult to Win and the Available Relief Is Limited

Under the Fourteenth Amendment's Equal Protection Clause, the State cannot "deny to any person within its jurisdiction the equal protection of the laws."[116] Although the Equal Protection Clause does not apply to activities of private persons, and possibly private hospitals, federal courts have applied the Equal Protection Clause to hospitals where the State is significantly involved in their regulation or operation.[117] This was the case in *Simkins*,[118] which established the basis for overturning segregation practices in hospitals receiving federal funding.[119]

In addition to the Equal Protection Clause, Title VI of the Civil Rights Act[120] has similarly been utilized by the federal government to enforce compliance with antidiscrimination principles.[121] Under Title VI of the Civil Rights Act, a private individual may sue to enforce Section 601 of Title VI,[122] which prohibits discrimination in programs receiving federal financial assistance on the basis of race, color, or national origin, and obtain injunctive relief and damages.[123] Racial discrimination in hospitals and other health care services that receive federal financial assistance is remediable under Title VI.[124] Both Congress and the courts, however, have acted to limit the remedial effect of Title VI in the provision of health services.

The ability to enforce Title VI was significantly limited by *Alexander v. Sandoval*,[125] in which the Supreme Court held that there is no private right of action to enforce disparate impact regulations under Title VI and that § 601 prohibits only intentional discrimination.[126] The Court held that the only recourse to enforce disparate impact regulations was available under the independent application of § 602, au-

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116 U.S. CONST. amend. XIV.

117 *See*, *e.g.*, Simkins v. Moses H. Cone Mem'l Hosp., 323 F.2d 959, 969–70 (4th Cir. 1963), *cert denied*, 376 U.S. 938 (1964).

118 *See supra* notes 80–90 and accompanying text.

119 *See* Sarah C. Carey, *A Constitutional Right to Health Care: An Unlikely Development*, 23 CATH. U. L. REV. 492, 495–501 (1974).

120 Civil Rights Act of 1964 tit. VI, 42 U.S.C. § 2000d.

121 *See* Charles F. Abernathy, *Title VI and the Constitution: A Regulatory Model for Defining "Discrimination,"* 70 GEO. L.J. 1, 6–8 (1981).

122 Civil Rights Act of 1964 § 603, 42 U.S.C. § 2000d-2.

123 Civil Rights Act of 1964 § 601, 42 U.S.C. § 2000d.

124 *See* Adrian D. Samuels & Mariah J. Cole, *Utilizing Title VI As a Means to Eradicate Health Discrimination*, 10 J. HEALTH DISPARITIES RSCH. & PRAC. 30, 30, 34 (2017).

125 532 U.S. 275 (2001).

126 *See id.* at 281, 293.

thorizing a federal agency to issue a regulation to proscribe activities creating a disparate impact on racial groups.[127] The ability to enforce regulations that have a disparate impact on Black communities and individuals has thus been reserved for federal agencies rather than private individuals.

Individuals may still challenge discriminatory health services under EMTALA[128] through a private action claim based on disparate treatment.[129] EMTALA requires hospitals participating in Medicare to provide screening and stabilization of individuals who present with an emergency condition if an emergency condition is detected.[130] EMTALA requires only an "appropriate medical screening" that is "within the capability of the hospital's emergency department."[131] A lack of uniformity in defining this standard creates significant challenges for a private individual.[132] EMTALA grants an individual a private right of action to challenge a hospital where the individual suffers personal harm as a result of the hospital's violation of EMTALA.[133] However, courts have read in Eleventh Amendment immunity for state institutions like state university teaching hospitals, leaving protections only for individuals who seek treatment in private hospitals.[134]

Discrimination on the basis of race is exceedingly hard to challenge through legal remedies, because the roots of the harm often go beyond a single actor and the institutionalization of harm persists.[135] This phenomenon is a result of legal and political forces that infused racialized practices in this country's core institutions when they were

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127 *See id.* at 281.

128 Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd.

129 *Id.* § 1395dd(d)(2)(A).

130 *Id.* § 1395dd(a)-(b).

131 *Id.* § 1395dd(a).

132 Several circuits have held that violations should not be determined against a national standard of care, but rather against the screening hospital's regular practice. For example, the Fourth Circuit has held the determination of whether a medical screening is appropriate—given the capabilities of the hospital—should be left to the finder of fact. *See* Power v. Arlington Hosp. Ass'n, 42 F.3d 851, 859 (4th Cir. 1994). The plaintiff must make a threshold showing of differential treatment which is rebuttable by a hospital's showing that the patient was given the same level of treatment other patients receive or that the physician did not believe the screening was necessary, and the plaintiff may then challenge this medical judgment by putting forward their own expert. *Id.* at 585; *see also* Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 268 (6th Cir. 1990) (interpreting the "vague phrase 'appropriate medical screening' to mean a screening that the hospital would have offered to any paying patient").

133 42 U.S.C. § 1395dd(d)(2)(A).

134 *See* Garwin, *supra* note 73, at 38–39.

135 *See*, *e.g.*, Shreya Atrey, *Structural Racism and Race Discrimination*, 74 CURRENT LEGAL PROBS. 1, 3–4 (2021).

created.[136] Both Title VI and EMTALA fall short of establishing a standard of care that protects Black people who encounter racism in the health care system.

An example of this shortfall is the Tuskegee Syphilis Study. The Tuskegee Syphilis Study, which lasted from 1932 through 1972, was led by the U.S. Public Health Service ("PHS").[137] The PHS worked with local health agencies to recruit Black men from Macon County, Alabama to be part of an observational experiment on the long-term effects of untreated syphilis.[138] The PHS relied on deceptive practices to engage participants, advertising free health services without disclosing the nature of the study.[139]

In 1974, a settlement of $10 million was made to the 601 men who were the subjects of the Tuskegee Syphilis Study.[140] Additionally, the study participants' wives, ex-wives, widows, and offspring each received lifetime medical and health benefits.[141] However, no monetary award was given to any of the subjects' sexual partners or their families, nor the community in Macon County, Alabama, which was rocked by the revelation that forty years of experimentation had been conducted on members of their community without the subjects' knowledge.[142]

Although the legal system was able to account for the direct harms of the Tuskegee Syphilis Study, the broader implications of the mistrust it evoked in the Black community towards the health care system were equally damaging and went largely unaddressed. The

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136 *Id.*

137 *See* FRED D. GRAY, THE TUSKEGEE SYPHILIS STUDY 48 (1998).

138 *See id.* at 48–73.

139 *See id.* at 49–51. Researchers misled the men who were recruited, leading the men to believe the medical complications they were experiencing was a result of "bad blood," and withheld penicillin treatment from infected participants. April Dembosky, *Stop Blaming Tuskegee, Critics Say. It's Not An 'Excuse' For Current Medical Racism*, NAT'L PUB. RADIO (Mar. 23, 2021, 11:05 AM), https://www.npr.org/sections/health-shots/2021/03/23/974059870/stop-blaming-tuskegee-critics-say-its-not-an-excuse-for-current-medical-racism [https://perma.cc/JT67-XUJC].

140 The settlement was divided into four categories: 1) $37,500 to "[l]iving syphilitic group participants;" 2) $15,000 to "[h]eirs of deceased syphilitic group participants;" 3) $16,000 allocated to "[l]iving control group participants;" and 4) $5,000 allocated to "heirs of deceased control group participants." *The U.S. Public Health Service Syphilis Study at Tuskegee: Frequently Asked Questions*, CTRS. FOR DISEASE CONTROL & PREVENTION (Apr. 22, 2021), https://www.cdc.gov/tuskegee/faq.htm [https://perma.cc/8AYN-WPA4].

141 *See U.S. Public Health Service Syphilis Study at Tuskegee: The Tuskegee Timeline*, CTRS. FOR DISEASE CONTROL & PREVENTION (Apr. 22, 2021), https://www.cdc.gov/tuskegee/timeline.htm [https://perma.cc/XD56-6XZL].

142 *See U.S. Public Health Service Syphilis Study at Tuskegee: Frequently Asked Questions*, CTRS. FOR DISEASE CONTROL & PREVENTION (Apr. 22, 2021), https://www.cdc.gov/tuskegee/faq.htm [https://perma.cc/5FFK-KYS9].

medical mistrust resulting from the Tuskegee revelation has been correlated with a 1.5-year decline in the life expectancy for forty-five-year-old Black men.[143] The Tuskegee settlement did little to repair this harm, and the federal government made little effort to begin to regain the trust of Black people in the wake of revelations about the study.

III. Tying Structural Racism in the Health Care System to the Case for Health Reparations

The previous Sections of this Note have identified how slavery, segregation, and racism have interacted to create a dual system of health care—stratified along racial lines—in the United States.[144] The ratification of the Thirteenth Amendment on December 6, 1865,[145] the Fourteenth Amendment on July 9, 1868,[146] and Fifteenth Amendment on February 3, 1870,[147] spurred the slow unraveling of the South's hold on slavery. Although these amendments abolished slavery, the nation's underlying interest was in saving the Union by appeasing slaveholders.[148] This interest influenced the federal government to expend few resources to realize the Thirteenth, Fourteenth, and Fifteenth Amendments' equal rights guarantees.[149]

The United States federal government has failed to adequately enforce these protections, and the courts have determined there is virtually no legal recourse for the harms that this failure has perpetuated. This Part considers how the failure to deliver on the promise of freedom to formerly enslaved Black people and the ancestors of formerly enslaved Black people in the United States is not only a moral failure, but a breach of implied duty. The federal government owes this duty until the promise of equality is upheld and Black people receive the unfettered enjoyment of citizenship without the infringement of systemic racial oppression. Structural racism undermines the promise of freedom that was guaranteed by the Thirteenth, Fourteenth, and Fifteenth Amendments.

The Tuskegee Syphilis Study settlement has laid the groundwork for a reparations model incorporating direct payments and provision of federal health services to remedy past wrongs. The model is insuffi-

143 Marcella Alsan & Marianne Wanamaker, *Tuskegee and the Health of Black Men*, 133 Q.J. Econ. 407, 408 (2018).

144 *See supra* Part I.

145 U.S. Const. amend. XIII.

146 U.S. Const. amend. XIV.

147 U.S. Const. amend. XV.

148 *Cf.* Lincoln, *supra* note 49 and accompanying text.

149 *See supra* text accompanying notes 49–60.

cient to address the broader impact of the study on the Black community as a whole, however, as it focuses on individual study participants without addressing the underlying distrust and harm that the study sowed. For reparations to be an effective model, they must be enacted on a broader basis and must be fundamentally structured toward a functioning health system rather than individual health outcomes.

A growing number of commentators have embraced the idea that racism is not simply an ideology, but a social system.[150] As former President of the American Public Health Association Camara Phyllis Jones argues, understanding the causes of racial health disparities should focus on analyzing the structures, policies, practices, and norms that impact who is advantaged and who is disadvantaged.[151] Jones identifies three levels in which "racial" health disparities are produced: (1) differential care within the health care system, (2) differential access to health care, and (3) differences in exposure and life opportunities that create different levels of health and disease.[152] The current legal framework may account for some of the harms that fall into this first level of health disparities, but is woefully deficient in addressing the second two levels.

Courts are willing to recognize proximate cause between a wrongful act and the purported injury suffered and provide a remedy, but they typically limit relief to "well-identified victims against well-identified wrongdoers."[153] The Supreme Court has held that the question of recognizing broader remedies for harms related to slavery and discrimination should be left to Congress to determine the extent of government liability,[154] effectively forestalling the ability to litigate harms perpetuated by systemic racism without a congressional statutory right. As Mari J. Matsuda argues, this approach ignores the reality that victims and perpetrators often belong to groups that

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150 *See, e.g.*, Eduardo Bonilla-Silva, *Rethinking Racism: Toward a Structural Interpretation*, 62 AM. SOCIO. REV. 465, 466–67 (1997) (arguing the term "racism" should be viewed as describing "the racial ideology of a racialized social system"); Camara Phyllis Jones, *Confronting Institutionalized Racism*, 50 PHYLON 7, 7, 9–10 (2002) (defining racism as a system where opportunity is structured based on the way a person looks, resulting in the unfair disadvantage of some individuals and groups and the unfair advantage of others).

151 *See* Jones, *supra* note 150, at 9–10.

152 Jones, *supra* note 150, at 8.

153 Alfred L. Brophy, *Some Conceptual and Legal Problems in Reparations for Slavery*, 58 N.Y.U. ANN. SURV. AM. L. 497, 502 (2001).

154 *See* FDIC v. Meyer, 510 U.S. 471, 486 (1994) (rejecting plaintiff's constitutional claim against a federal agency, arguing that allowing individuals to seek damages against federal agencies rather than against individuals could create a significant financial burden for the federal government—a scope of liability that Congress is best positioned to determine).

historically have received collective treatment, and the issue of proximate cause is as much about the politics of line-drawing as it is about causal connection.[155] The courts have demonstrated an unwillingness to draw the line of culpability in a way that would provide remedies for implicit discrimination.

As Kimberlé Williams Crenshaw argues, the focus on civil rights legislation as the end of Black oppression has led society to "embrace[] the rhetoric of equal opportunity without fulfilling its promise."[156] As Crenshaw points out, racial hierarchy was not resolved by facially race-neutral laws because racism remained part of the popular consciousness, underpinning the historical dominance of white superiority and legitimizing racial subordination of Black people.[157]

As long as the stain of structural racism continues to contribute to the racial disparity in maternal and infant health outcomes, Black birthing people are experiencing a harm that is the federal government's obligation to correct. Structural reform is necessary, and, as this Note has demonstrated, structural reform requires adequate funding. This Part focuses on the federal government's obligation, how a similar obligation to Native American and Federal Indian Tribes has been fulfilled, and why a federally funded health program for Black birthing people is an appropriate structural reform.

A. The Right and Privilege to Be Free from the Vestiges of Slavery

The imagining of Black liberation through the Thirteenth Amendment was ultimately a half promise that the federal government has continuously failed to deliver on. In the absence of federal action, racism and racial hostility continue to relegate Black people in the United States to a position as lesser citizens. The impact of such racism on health care continues to devastate the Black community.

In *Hodges v. United States*,[158] Justice Brewer narrowly interpreted Congress's authority to use the Thirteenth Amendment to regulate the private denial of individual rights.[159] The Court found that Congress could not intervene to address racial hostility toward African American manufacturers in their right to contract.[160] The Court held

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155 *See* Matsuda, *supra* note 13, at 380–85.

156 Kimberlé Williams Crenshaw, *Race, Reform, and Retrenchment: Transformation and Legitimation in Antidiscrimination Law*, 101 HARV. L. REV. 1331, 1347 (1988).

157 *Id.* at 1378–79.

158 203 U.S. 1 (1906), *overruled in part by* Jones v. Alfred H. Mayer Co., 392 U.S. 409 (1968).

159 *See id.* at 19–20.

160 *Id.*

the Thirteenth Amendment did not specifically protect the "African race," but instead applied to all races, thus limiting Congress's ability to address individual rights specific to formerly enslaved people.[161] The Court contended that the adoption of the Thirteenth, Fourteenth, and Fifteenth Amendments signified that formerly enslaved people were not wards of the government like Indian tribes, and thus not subject to Congress's jurisdiction.[162]

Justice Harlan challenged this contention in his dissent. He asserted that when Congress chose to eradicate slavery, it "acquired the power not only to legislate for the eradication of slavery, but the power to give full effect to this bestowment of liberty on these millions of people."[163] Justice Harlan emphasized that the Thirteenth Amendment conferred both freedom and "the right and privilege of being free from the badges or incidents of slavery."[164]

The Court implied that, because formerly enslaved Black people were granted citizenship, they were not entitled to specific federal protections beyond the rights encompassed in the Thirteenth, Fourteenth, and Fifteenth Amendments. As the Jim Crow era demonstrated, however, formerly enslaved Black people did not receive equal citizenship. The failures of Congress and federal courts to fully guarantee equal protections of citizenship essentially rendered formerly enslaved Black people wards of the government. Formerly enslaved Black people and their ancestors have been unable to take full advantage of the benefits of citizenship—specifically access to quality health care—and remain dependent on the federal government. Continued health disparities demonstrate that the obligation to free Black people from the vestiges of slavery remains unfulfilled. The federal government must intervene to address racism in the American health system.

B. The Federal Government's Fulfilment of Its Health Services Obligations Under Tribal Law

One example of the federal government fulfilling its obligation to a specific group of oppressed and marginalized people is in federal Indian law and the creation of the Indian Health Service ("IHS"). The IHS provides federally funded health services, including comprehensive primary and preventative care, to members of federally recog-

161 *See id.* at 18.

162 *See id.* at 19–20.

163 *Id.* at 29 (Harlan, J., dissenting).

164 *Id.* at 35.

nized tribes.[165] The relationship between the United States government and Native Americans is one fraught with mistreatment, exploitation, and broken promises; however, the role of Federal Indian law in shaping and reshaping this relationship is the focus of this Section.

Federal Indian law defines the trust responsibility that the federal government holds to Indian tribes and individual Indians through the Constitution, treaties between the United States and various Indian tribes, acts of Congress, and the Supreme Court's jurisprudence.[166] The trust relationship between the United States government and Indian Tribes establishes an obligation on the part of the federal government to provide health care to American Indians and Alaska Natives.[167] This trust relationship reflects the unique legal status of Indian Tribes: the Commerce Clause of the Constitution recognizes Congress's power to regulate Commerce with Indian Tribes,[168] and the Supreme Court has recognized "the plenary power of Congress, based on a history of treaties and the assumption of a 'guardian-ward' status, to legislate on behalf of federally recognized Indian tribes."[169]

The Supreme Court drew on the historical treatment of Indian Tribes to inform their "guardian-ward" status, referencing how the United States took possession of Tribal land and left Indian Tribes "uneducated, helpless and dependent people, needing protection against the selfishness of others and their own improvidence."[170] Additionally, the recognition of tribal sovereignty and classification of Indian tribes as a political community shaped the unique parameters

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165 Reference to the Indian Health Care Improvement Act and provision of health benefits to Indian tribes is not meant to glorify or disregard the continued disparity in Indian health in the United States. This Note does not specifically address Native Americans or Indian tribal health disparities, nor does it explore the ongoing efforts of Black freedmen and their ancestors to obtain tribal recognition from tribes who participated in the practice of chattel slavery. *See generally*, Earchiel Johnson, *Slaves of the Tribe: The Hidden History of the Freedmen*, PEOPLE'S WORLD (Nov. 29, 2017, 11:54 AM), https://www.peoplesworld.org/article/slaves-of-the-tribe-the-hidden-history-of-the-freedmen/ [https://perma.cc/49LE-RS4G]. Reference to the IHCIA is purely intended to demonstrate the framework federal policies towards Indian tribes have utilized, and the fact that the framework is imperfect has been and should continue to be analyzed and challenged.

166 *See* DAVID H. GETCHES, CHARLES F. WILKINSON, ROBERT A. WILLIAMS, JR., MATTHEW L.M. FLETCHER & KRISTEN A. CARPENTER, CASES AND MATERIALS ON FEDERAL INDIAN LAW 2–3 (7th ed. 2017).

167 *See Basis for Health Services*, INDIAN HEALTH SERV. (Jan. 2015), https://www.ihs.gov/newsroom/factsheets/basisforhealthservices/ [https://perma.cc/B6FA-2NT6].

168 U.S. CONST. art. I, § 8, cl. 3.

169 Morton v. Mancari, 417 U.S. 535, 551 (1974).

170 *Id.* at 552 (quoting Board of County Comm'rs v. Seber, 318 U.S. 705, 715 (1943)).

of the federal government's policies and obligations toward Indian tribes.[171] For example, in *Morton v. Mancari*,[172] the Court held that differential treatment of Indian tribal members is a cornerstone of Indian-American relations and does not constitute racial discrimination.[173]

The paternalism, racism, and ignorance that laces through much of the federal government's historical approach to tribal relations cannot be understated and should not be ignored or downplayed. However, the federal government's provision of federal health services to Indian tribal members is a unique framework[174] that helps to advance the conversation about the provision of federal health services to groups that have faced historical harm as a result of federal policies and actions.

The Indian Health Care Improvement Act of 1976 ("IHCIA") authorizes IHS activities[175] and allows the IHS to collect Medicare and Medicaid reimbursements.[176] The IHS is a federal agency within the Department of Health and Human Services that provides health services to members of federally recognized tribes with a mission of "rais[ing] the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level."[177] Unlike a health insurance program, the IHS provides medical services—including outpatient, ambulatory, emergency, dental, public health nursing, and preventative health care—directly through contracts with Indian Tribes or Tribal Organizations, and these services are not limited by a

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171 Worcester v. Georgia, 31 U.S. (6 Pet.) 515, 557 (1832) (holding the Cherokee nation is a distinct political community and that the laws of the state of Georgia have no force over tribal land).

172 417 U.S. 535 (1974).

173 *See id.* at 552–53.

174 Despite the utility of the framework, the implementation of health services primarily on Indian reservations creates challenges for a majority of Native Americans, who reside in urban and non-reservations and as a result must travel long distances for care. INSTITUTE OF MEDICINE, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 85 (Brian D. Smedley, Adrienne Y. Stith & Alan R. Nelson eds., 2003). Additionally, the program receives limited federal support and spending that falls below the per capita spending on other federal health programs. *Id.*

175 25 U.S.C. §§ 1601–1683; *see also* ELAYNE J. HEISLER, CONG. RSCH. SERV., R41630, THE INDIAN HEALTH CARE IMPROVEMENT ACT REAUTHORIZATION AND EXTENSION AS ENACTED BY THE ACA: DETAILED SUMMARY AND TIMELINE 2 (2014).

176 ELAYNE J. HEISLER, CONG. RSCH. SERV., R43330, THE INDIAN HEALTH SERVICE (IHS): AN OVERVIEW 18 (2016).

177 *Agency Overview*, INDIAN HEALTH SERV., https://www.ihs.gov/aboutihs/overview/ [https://perma.cc/9654-FKZ8].

medical benefit package as are health insurance plans.[178] Eligibility for access to benefits is based on recognized tribal membership, which generally is determined by the tribe and may include a descendent from a tribal roll traced by bloodline, minimum percentage of genealogical descent, proof of descent, or in some instances is determined by statute.[179]

The obligation that the federal government owes to the descendants of formerly enslaved Black people is an obligation that stems from the historical treatment of enslaved Black people. The ongoing effects of this historical treatment has fueled the current public health crisis, as well as placed limitations on individual freedom by failing to raise Black people to the status of full citizens that are free from the vestiges of slavery. Racism and the racial inequality that Black people experience in the current health system is a vestige of slavery that renders Black people dependent on the federal government for health services. Reparations, in the context of health care, calls for the federal government to recognize its ongoing obligation to Black people who continue to be harmed by lack of access to health care.

The Constitution, as it was originally drafted, recognized enslaved Black people as a distinct group.[180] It is not enough to simply erase such a distinction through amendments that carry no legal might and fail to guarantee adequate enforcement mechanisms. As the body of federal Indian law reflects, historical wrongs require modern intervention, and as of today the federal government and the courts have failed to apply this set of principles to the experience of formerly enslaved Black people and their descendants. The conversation about

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178 ELAYNE J. HEISLER, CONG. RSCH. SERV., R43330, THE INDIAN HEALTH SERVICE (IHS): AN OVERVIEW 1, 10 (2016). The IHS system is primarily made up of hospitals, health centers, health stations, Alaska village centers, and youth regional treatment centers, which are predominantly located on or near reservations, totaling 118 IHS-operated and 534 tribally operated facilities, with an additional thirty-five urban Indian organizations in fifty-seven locations. *Id.* at 6–7, 9. Because most facilities are limited to outpatient services, specialty care and inpatient services may be accessed through contracted providers using the purchased/referred care program ("PRC") or catastrophic health emergency fund ("CHEF"). *Id.* at 11. Additional telehealth behavioral resources are also available, as are paraprofessional services provided by community members who receive training through IHS. *Id.* at 10–12. The IHS provides specific services that target common health conditions of its beneficiaries, including a diabetes program, and behavioral health services for substance abuse and mental health, and the Maternal Child Health program, which aims to improve maternal outcomes through health promotion, risk reduction, and improvement of quality healthcare. *Id.* at 13–14; *Maternal and Child Health*, INDIAN HEALTH SERV., https://www.ihs.gov/dccs/mch/ [https://perma.cc/HQ9P-9VKH].

179 HEISLER, *supra* note 178, at 3.

180 *See supra* notes 30–33 and accompanying text.

reparations is not simply about money, but about systemic failings that require systemic solutions.

C. Envisioning The Creation of a Trust Obligation to Black Birthing People

The vulnerabilities of this country's health care system have been laid bare. The health care system is unequal and in need of reform to address Black health disparities, particularly the disparity in maternal and infant health outcomes. Various models present themselves, though a path forward is far from clear. Despite this challenge, reparations are a viable path forward and potentially one of the only remedies that could address structural racism in a way that would expand health care access for Black birthing people.

Some scholars have noted that reparations to Black people are distinct from the services that have been directed toward fulfilling the trust obligation the federal government has with Indian tribes, because these claims are based on treaties resembling those between separate nations rather than a nation and its own citizens.[181] As discussed previously,[182] however, the Supreme Court has historically not considered formerly enslaved people to be citizens, but instead their own group with distinct rights.[183] This historical treatment was also reflected by the Constitution's classification of formerly enslaved Black people as "other persons."[184]

Throughout history, Black people were regarded as helpless and dependent, and it was this status that was used to justify slavery.[185] Although the federal government's position on slavery shifted, it did so slowly, in flawed and inadequate half-steps that erased the facial "othering" of Black people but left behind the systemic and institutionalized structures of disparity and discrimination.[186] The federal government recognized the need to provide federal health services for formerly enslaved Black people and their descendants when it created the Freedmen's Bureau, and that need continues to exist today.[187]

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181 Verdun, *supra* note 63, at 648.

182 *See supra* Part III.A.

183 *See supra* Part III.A.

184 *See supra* Part I.B.

185 *See* Michael E. Ruane, *A Brief History of the Enduring Phony Science That Perpetuates White Supremacy*, WASH. POST (Apr. 30, 2019), https://www.washingtonpost.com/local/a-brief-history-of-the-enduring-phony-science-that-perpetuates-white-supremacy/2019/04/29/20e6aef0-5aeb-11e9-a00e-050dc7b82693_story.html [https://perma.cc/T2X5-25T2].

186 *See supra* Part II.

187 *See* Georges C. Benjamin, *Health Inequity from the Founding of the Freedmen's Bureau to COVID-19*, 23 AM. MED. ASS'N J. ETHICS 189, 189 (2021).

The federal government failed to recognize the obligation that it owed to formerly enslaved Black people and their descendants, and the temporary nature of the Freedmen's Bureau was inadequate in fulfilling this obligation. This inadequacy continues to result in the perpetuation of harm. The medical services we know today were forged from the abuse and experimentation on enslaved Black people, and the gynecological services women continue to rely on were developed from the abuse endured by enslaved Black women.[188] Yet, Black women continue to experience inadequate access to these services, and to quality health care generally, despite the labor that was extracted from them to create it.[189]

Formerly enslaved Black people and their descendants have not been adequately compensated for the labor they put into the creation of wealth and industry in this country, particularly the reproductive labor discussed in this Note. The federal government's tacit endorsement of chattel slavery legitimized such practices. Ongoing impacts of this disparate treatment have endured as a crisis of differential treatment within health services. The federal government is responsible for addressing these harms. The federal government must recognize that, as with the historical treatment of Indian tribes, the historical enslavement of Black people in the United States has resulted in its obligation to provide for those it left dependent and "othered."

A recent reparations plan put forward in Evanston, Illinois is one of the first programs in the United States to institute payments to Black residents for historical discrimination by providing them with direct payments in recognition of past wrongs.[190] The Evanston, Illinois municipal reparations program seeks to provide $25,000 housing grants to Black residents to support homeownership and renovation.[191] The plan, which is funded by collection of a three percent tax on marijuana, will be made available to ancestors and descendants of African American or Black residents of the city between 1919 and 1969, as well as a third category of people who experienced housing

188 *See* COOPER Owens, *supra* note 1, at 21, 25, 38.

189 *See* Juanita J. Chinn, Iman K. Martin, & Nicole Redmond, *Health Equity Among Black Women in the United States*, 30 J. WOMEN'S HEALTH 212, 213 (2021).

190 *See* Julie Bosman, *Chicago Suburb Shapes Reparations for Black Residents: 'It Is the Start'*, N.Y. TIMES (Mar. 22, 2021), https://www.nytimes.com/2021/03/22/us/reparations-evanston-illinois-housing.html [https://perma.cc/3F2R-UFH4].

191 Memorandum from Kimberly Richardson, Interim Assistant City Manager, to Mayor & Members of Evanston City Council (Mar. 22, 2021), https://cityofevanston.civicweb.net/document/50624/Adoption%20of%20Resolution%2037-R-27,%20Authorizing%20the.pdf?handle=E11C7B73E1B6470DA42362AB80A50C46 [https://perma.cc/289C-THVB].

discrimination as a result of the city's discriminatory housing practices after 1969.[192]

Some critics challenged the "Evanston model" as a housing subsidy dressed up as a reparations program.[193] This program, however, moves the conversation forward and acknowledges that subsidy programs must address disparities created by historical discrimination. Long-term reparations models must provide systemic remedies to address systemic problems.

Reparations must recognize the moral obligation that federal and local governments owe to the descendants of Black people. Federal policies relied on the false notion of Black inferiority. Thus, federal practices must address the inequitable and unequal health care system Black people continue to experience.

As the IHS model has demonstrated, the federal government may not be in the best position to act as a health care provider. The implementation of health services primarily on Indian reservations has led to significant challenges for a majority of Native Americans, who reside in urban and other non-reservation settings and must travel long distances for care.[194] As well, the program receives limited federal support, with spending below the per capita spending on other federal health programs.[195]

Typically, Congress has relied on its Constitutional spending power for health care financing,[196] utilizing its power to collect taxes to provide for the "general Welfare of the United States."[197] The current set of federally funded healthcare programs, including Medicare, Medicaid, and the Children's Health Insurance Program, reflects that the United States is already reliant on a system in which government revenue is a key source for health care expenditures.[198] One of the largest sources of health subsidies are tax preferences for employer-provided health care benefits, followed by the exclusion of Medicare benefits.[199] One possible way to pay for a health care program for the descendants of formerly enslaved Black people who continue to experience significant health burdens would be to expand the estate tax.

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192 *Id.*

193 *See* Bosman, *supra* note 190.

194 *See* SMEDLEY ET AL., *supra* note 174, at 85.

195 *Id.*

196 SWENDIMAN, *supra* note 99, at 7.

197 U.S. CONST. art. I, § 8, cl. 1.

198 *See* SWENDIMAN, *supra* note 99, at 8.

199 STAFF OF J. COMM. ON TAXATION, JCX-66-08, TAX EXPENDITURES FOR HEALTH CARE 3, 20 (2008).

Research demonstrates that raising the estate tax would generate significant revenue,[200] and this revenue stream would target generational wealth transfers among the wealthiest people in the country.

The tax system is an appropriate vehicle to fund a comprehensive health reparations program. The federal government has consistently sought to use taxpayer money to fund health services that supported segregated health facilities and failed to adequately fund hospitals and health care services in predominantly Black communities.[201] Black taxpayers have continued to pay into a system of federal health benefits of which they have not received adequate care. Given the high cost of health care in the United States and the disproportionate cost of health care that is experienced by Black people who are not only more likely to pay more for health insurance, but also less likely to hold insurance at all, the estate tax model would redistribute the benefit of lower overall health costs to those experiencing the most direct impact of our failed health system. This proposal would not simply provide a health benefit to the Black population, but also improve overall public health.

Conclusion

Black people in the United States continue to live with the badges and incidents of slavery—subjected to continued racial discrimination and marginalization as a result of the federal government's failure to adequately dismantle systemic racism. Despite the guarantees that were made by the federal government to formerly enslaved Black people and their ancestors through the Thirteenth, Fourteenth, and Fifteenth Amendments, these Constitutional protections have not been enforced to ensure equality of Black people in the United States. The legal precedent for a reparations program stems from the recognition that the unfulfilled promises of citizenship and equal status have established a unique relationship between the federal government and all Black people who were intended to receive the protection of these amendments. The nature of this relationship also implies the existence of certain legal obligations to Black people who have been denied these protections and thus forced to depend

200 William G. Gale, Christopher Pulliam, John Sabelhaus & Isabel V. Sawhill, Brookings, Taxing Wealth Transfers Through an Expanded Estate Tax (2020), https://www.brookings.edu/research/taxing-wealth-transfers-through-an-expanded-estate-tax/ [https://perma.cc/Q3YE-T3SC].

201 *See generally* Largent, *supra* note 79, at 715–20.

more heavily on the federal government.[202] This obligation is directly related to the harms Black birthing people continue to experience because these harms have been attributed in part to structural racism and by extension the federal government.

In the absence of sufficient legal remedies to address structural racism in the health care system generally and in the disproportionate harms to Black birthing people specifically, structural change is an appropriate remedy to address structural harm. The reproductive labor that was extracted from enslaved Black women to sustain the institution of slavery in the United States has never been properly compensated, and that debt is owed by the federal government for the laws and policies that contributed to this harm. This harm has never been adequately remedied, and the resulting generational trauma that Black birthing people have experienced as a result of this failure is a health crisis that the federal government has a moral obligation to remedy.

202 *See supra* Sections III.B.–C.