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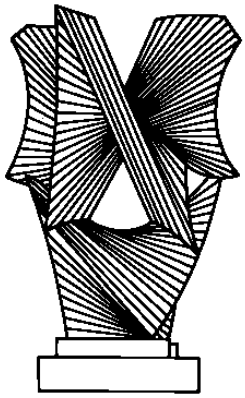

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by Richard A. Epstein

James Parker Hall Distinguished Service Professor of Law
The University of Chicago
1111 E. 60th Street
Chicago, IL 60637

Peter and Kirsten Bedford Senior Fellow
The Hoover Institution

Equal access to health care has become one of the fundamental public policy flashpoints of our time. One basic challenge in this area is to find explanations for the decline in access across the general population. There is a broad level of popular dissatisfaction with the provision of health care in this county, as the number uninsured individuals continues to rise apace no matter what stopgap measures are applied to stem the flow. On this point, I have no reason or desire to defend the current system of health care delivery in the United States against all its critics, insofar as regulations now in place create a bewildering set of subsidies and sanctions that reduce the ability of voluntary market transactions to respond to health care needs of both consumers and health care providers. Here is one short explanation. The level of access depends on the type of coverage that is offered. In recent years, states have imposed mandates on the sorts of conditions that

must be covered. These mandates often require individuals to pay more for particular coverages (e.g., alcoholism, certain forms of psychiatric care) than they are worth to them. The mandate thus operates as an implicit tax that reduces the number of market transactions. On this view, deregulation should increase access by lowering price.

That approach of deregulation is, I think, appropriate as well on a related inquiry of direct relevance to this Conference volume—the perceived differential access and quality of care by racial group. On this question, it is possible to collect a veritable mountain of empirical studies that identifies disparities in the provision of health care. Thereafter, it is often hinted darkly that some large but indeterminate fraction of that difference is attributable to discrimination by health care providers, occasionally overt, but usually unconscious and indirect. The usual responses include stricter enforcement of the antidiscrimination laws, to which I shall demur in this paper. Even though it is not possible to review today's vast literature on the interaction of disparities and discrimination in health care, it is useful to focus attention on one recent, careful, and comprehensive study that summarizes much of the existing literature and lends its support to the proposition that discrimination on grounds of race and ethnicity constitutes a large portion of the problem.[1] I refer here to the findings and conclusions that are contained in the massive report prepared by the Institute of Medicine (IOM): *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.*

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[1]There is, it should be noted, no particular claim of discrimination on grounds of sex, perhaps because the data reveals a consistent pattern in which a higher fraction of women have medical insurance than men (Bureau of the Census 2002, figure 2). Under the entry "People without Health Insurance for the Entire Year by Selected Characteristics: 2002," 16.7 percent of all males, relative to 13.9 percent for all females were without health insurance. For those individuals under the poverty line, the figures were 33.3 percent male uninsured versus 28.1 percent female uninsured. That difference of nearly 20 percent would surely draw extensive commentary if it were in the other direction. I shall ignore it here.

By way of background, the IOM study is unequivocal in its condemnation of the disparities that it does observe. At the outset "[t]he study committee defines *disparities* in health care as racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, or appropriateness of intervention" (IOM 2003, pp. 3–4). In this context, the IOM study gives the term "preferences" a narrow construction so as to exclude any preferences that are influenced by knowledge that members of minority groups, especially African-American, have of past institutionalized injustices in the United States. These injustices (for such they are) include both the general history of segregation, and specific instances of medical malfeasances of which the notorious Tuskegee experiment counts as the leading illustration (IOM 2003, pp. 4, 131–32). The IOM report then notes that some fraction of the disparity could be attributable to "[d]iscrimination that results from biases, prejudices, stereotyping, and uncertainty in clinical communication and decision-making" (IOM 2003, p. 4). It then promptly injects a note of caution by observing that its definitions are used for the purposes of this report only, and do not count as "legal definitions" (IOM 2003, p. 4), while stopping short of indicating what those legal definitions might require, and how they might differ from other definitions that could be offered. Elsewhere, it defines discrimination as "the differential and negative treatment of individuals on the basis of their race, ethnicity, gender, or other group membership" (IOM 2003, p. 95), without exploring how those differences arise or why they might in some cases be justified. The conclusions in the report are summarized in its basic recommendations. These include an increased awareness of the scope and sources of discrimination in health care by health care providers and the general public (IOM 2003, p. 6); increased

representation of minority health care providers among health care professionals; improved language communication, especially for individuals whose first language is not English, and increased resources for funding the enforcement of the civil rights law in this area.

The IOM report then exhaustively reviews large numbers of individual surveys that find differential access to certain medical procedures that are correlated with race or ethnic status, even after various confounding variables (age, income, location, education etc) are taken into account. It recognizes that some portion of this difference could be explained by differential patient responses to proposed treatments, but nonetheless concludes that this phenomenon is not likely to amount to a large effect in most settings. It does not refer to any of the work that points out the difficulties in dealing with the measurement of discrimination or argues that market forces go a long way to ameliorate its effects (Becker 1971; and Heckman 1998. For my endorsement of the position, see Epstein, 1992).

So the question then arises, just what explanations offer the best account of any observed disparity. The answer, which seems ominous, is that much of that persistent difference is likely to be explained by residual forms of invidious discrimination that operate, as it were, on the subconscious level. The IOM study infers the persistence of discrimination in health care by noting the legion of other studies that have found unconscious discrimination, if not pervasive prejudice (Ayres 2001), to persist in other areas of life, such as employment, mortgage lending, and housing, which is said to be documented by the use of testers who are able to elicit differential responses, or which may be detected by closely examining market data involving consummated transactions.

The thesis of this short article is that the leap from disparity to discrimination is not on balance established, even by a preponderance of the evidence. It is, of course the case, that some individual health care provider could have some bias against members of different racial or ethnic groups. But, if so, there is no particular direction to any such individual biases, and no evidence of any institutional forms of bias that require some systematic institutional response. Rather, the path to inference is rendered more uncertain by a variety of definitional, methodological and empirical issues that beset any systematic effort to identify the levels of discrimination in the provision of health care, or for that matter other types of services today. In particular, the IOM study devotes insufficient effort to give a consistent and coherent definition of discrimination. In addition, it tends to downplay the serious difficulties that arise from seeking to prove some form of discrimination either by the use of testers or the evaluation of field data, both beyond and within the health care area.

Definitional Questions of Discrimination

There are a number of important issues that bear in determining on what counts as discrimination. The point here is not simply one of the choice of stipulative definitions. The word "discrimination" carries strong negative connotations, and any individual or group that is found to have practiced overt and conscious discrimination is, without question, subject to serious legal, social, and business sanctions. These sanctions would remain even if the antidiscrimination laws were repealed tomorrow, which, for the sake of the record, is something that I have long urged, and continue to urge today (Epstein 1992 and 1997). But no matter what the legal framework, the social importance that is attached to the antidiscrimination norm makes it absolutely vital that this term, and the

opprobrium it carries, is not falsely attached to any individual or institution. The concern goes not only to the inherent injustice of making false charges against the innocent, but also to the waste of social resources, economic and moral, that are spent in denouncing or correcting some nonexistent wrong. Misinformation always leads to bad decisions by individuals and groups, and false claims of discrimination are no exception to that general rule. That particular risk is increased in light of the four factors that the IOM study lists together under the head of discrimination. The last two heads of analysis, uncertainty in clinical judgment and difficulties in communication, do not themselves seem to be forms of discrimination. All communications issues involve two or more persons, and the effort is to minimize the slips that occur in the effort to transmit information in difficult settings. Matters of clinical judgment often depend on good communication, so again, any disparity that is attributable to this factor also counts as an issue of concern, but not as a form of discrimination.

At this point, the key elements of discrimination are bias or prejudice. Both of these are difficult to defend since *by definition* they preclude the possibility of any justification or excuse. The case for the IOM study would be far stronger if it could offer documented instances of systematic overt bias and prejudice. These are rarities, in sharp contrast to the overt promotion of affirmative action, which is never treated as a form of discrimination, but as its antidote. The point here is not to attack affirmative action programs, especially if voluntary, but to point out that there are forms of discrimination that are easy to detect, even if fully justified. But invidious forms of discrimination are hard to find because they occur only infrequently given the costs that attach to them. All

sorts of horrific practices that were painfully evident fifty years ago have almost entirely disappeared today.

The most elusive term in the analysis, therefore, is the bridge notion of "stereotyping." In one sense, *stereotype* is simply one term to describe prejudice or bias that operates at the group or the individual level, which, once proved, allows for no defense. But here the definitional issues matter: do *true* generalizations count as stereotypes, even if they convey a negative impression about the group to which they apply? If someone says that members of group X are likely to have a higher crime rate than members of group Y, that statement is true even if individual *x* in group X has never committed a crime while individual *y* in group Y has committed a crime. It is of course wholly improper to use any statement about groups when it is *certain* that the generalized description in question does or does not apply to a given individual. More generally, the claim about bias and prejudice is that these forms of behavior are at their strongest when decision-makers rely on *false* generalizations to base future behavior, a wrong that is compounded when they do so with knowledge of the error. But it is much more difficult to attach equal, or even any, condemnation to the *correct* use of statistical generalizations in the absence of such certain information, especially when it is widely known that background probabilities count for a great deal in making any accurate estimation of risk (Tversky and Kahneman 1973 and 1974), and that some sensible heuristics might work well to combine background with case information (Gigerenzer et al. 1999).

There is a great willingness to combine background information (about the frequency of blue and yellow buses on a particular route) with specific information (what someone recalls to be the color of this bus) in dealing with ordinary questions of

evidence. It therefore requires at least some pause before that strategy of compound identification is condemned when the background information contains a race variable. When Jesse Jackson states that he is more worried when tailed by a black man than a white man at night, he is making *rational* statements about risk, and about the benefits of taking evasive action. The same is true of a cab driver of whatever race who is uneasy about taking a wholly respectable passenger into a dangerous black neighborhood: the risks of adverse consequences are not wholly dependent on what the passenger does, but on the conduct of potential criminals who cannot be observed at the outset of the transaction, or even the inability to get a return fare to offset some portion of the cost count as reasons to discriminate that no market will dissipate. It may be regrettable that Jesse Jackson or the ordinary cab driver (has to) feel that way, but it hardly counts as an unjustified prejudice for this negative treatment if it responds to economic costs that are real. No one would question the use of that information to choose between individuals of the same race; why then, if the information is reliable, does it become morally necessary (without the benefit of argument) to rule these behaviors out of bounds? The IOM study thus cuts too broadly in its definition of discrimination because it forecloses any debate over possible justifications for any observed negative treatment. The easy elision of prejudice and stereotyping skews the fundamental inquiry.

In order to see the full complexity of this definitional issue, it is useful to note that the original purpose of the civil rights laws was to remove what their supporters counted as the *irrational* use of race in making decisions. The basic expectation was that the elimination of discrimination would result in *more* efficient markets because of the removal of extraneous factors. Typical of the general observations is this: "Under Title

VII, employment will be on the basis of merit, not race" (*Cong. Rec.* p. 1600, statement of Congressman Joseph Minish). The last objective that anyone defended early on was that the introduction of an antidiscrimination law would introduce any element of *subsidy* in favor of members of any group. Yet just that can happen by using definitions that knock out statistical information because of its disparate impact on grounds of race.

The point here—that discrimination laws can create implicit cross-subsidies—is of major significance, for all forms of insurance necessarily rely on group characteristics as signals for the occurrence of some future, uncertain, and insurable event. It is of course possible by law to ban the use of explicit racial classifications in dealing with insurance, and I know of no major corporation that would ever risk the incorporation of an explicit race variable into its rate structure no matter what the legal rules provided: the public ill will would be too difficult to withstand. But risk classifications have to depend on some variables, and it is hard to justify any conclusion that an insurer has behaved out of bias and prejudice when it allows rates to vary on these factors. The willingness to condemn *accurate* statistical behavior as a form of stereotyping impinges on the ability to use reliable race-neutral proxies (e.g., home address or college boards) that are in fact correlated with race because of their disparate impact. More concretely, the sketchy IOM study treatment of discrimination perpetuates a major ambiguity into equation, because there are in fact two quite distinct treatments of discrimination—one economic and the other legal—that have been at work in this area.

The standard economic treatment of discrimination starts with the notion that there are different prices that are charged for (what appears to be) the same product. In general, economic theory predicts a convergence toward a single price for one product, so

that some explanation has to be offered to account for the observed disparities. The first explanation is that what appears to be discrimination is in fact not, for the two items differ in some relevant particular that affects the cost of its provision. The most common example is the provision of kilowatt electricity at off-peak and peak periods. Off-peak electricity is far cheaper to supply because the equipment can be run cheaply and efficiently. Once the output demanded starts to expand, the additional costs per unit increase, which is why peak-load pricing is a staple of rate regulation. But even in a pure competitive industry, the differences in the cost of production will always translate into a difference in price. New entrants will bid down the price of the cheap electricity, and exit from the market will lead to a rise in the price of expensive electricity. Any differences in price that track differences in cost do not give rise to any potential economic misallocation.

The analysis gets more difficult when the discrimination in the observed prices is not tied to underlying costs, but is a function of the differential demand of various buyers. This demand-driven discrimination cannot arise in a competitive market, for the moment any seller tries to raise his price, someone else will either enter the market or expand output to bring the price back down again. It is only in a system where a seller has monopoly prices (and the first buyer cannot resell to the second) that demand-side price discrimination is possible. In essence, the clever monopolist who knows about differential demand will charge the higher demanders more than the lower ones. It is, however, far from clear whether this differential pricing should be regarded as a good or bad thing. Without the discrimination, the low demanders would be forced to abandon the market if they could not pay the (single) monopoly price; in practice this form of price

discrimination allows more buyers to remain in the market. In the limit, where perfect price discrimination is possible, we have the exact same output that we have under perfect competition, because every buyer in the competitive market still remains. But there is this one key difference: all the net social gains from production go to the monopolist while under competition they all go to the buyers of the goods.

Nonetheless, there are difficulties with the price discrimination practiced by monopolists. First, the ability to estimate demand for individual consumers or groups of consumers is far from perfect. Price discrimination, therefore, absorbs higher transaction costs than pure competition, which in turn drives down consumer welfare. In addition, any imperfect form of price discrimination still excludes some buyers from the market. These considerations are sufficient to explain the general preference for competition over monopoly, but do not resolve the harder question whether monopoly with price discrimination is better, or worse, than without it. For these purposes it is sufficient to note that various forms of discrimination that rely on arbitrary qualities, such as race, sex, or age, are generally frowned upon: the sentiment is that two people with the same reservation price (i.e., maximum willingness to pay) should pay the same actual price. That judgment is not iron-clad, but for these purposes, we can accept this point: under the current law, any form of demand-driven discrimination based on race should be regarded as illegal.

These two forms of discrimination present serious problems for any rate-making process. One objective is to make sure that differences in cost are respected in setting the rates, so as to avoid the creation of any cross subsidies between different classes of consumers. In accordance with that view, price differences should be keyed to the cost of

providing services to particular groups. Improper price discrimination occurs when the members of one group are forced to bear the costs associated with the provision of service to the other. In this context, any formula or test is nondiscriminatory if it offers all individuals in either group an equal rate of return on any investment that they make. One consequence of this definition is that the rates charged for any given person do not depend on the existence or nonexistence of that second group.

For example, in the insurance market, if the only covered individuals were members of group A with a premium that averages $100 per person, then that average rate should not go up or down because of the introduction into the mix of group B with an average premium of $150 (or $50) per person. The median rates in both settings should remain the same, as should the variation across members in the group, as determined by any nonracial variables that might have predictive value. The basic rate structure allows the firm to obtain a normal rate of return from its investment from the customers in group A, and gives all individual members the same expected return on their premium. In a market economy, the arrival of a second group does not lead to any change in the premium structure for the members of the first one.[2] Stated generally, the rates that should be charged to white and black persons should not vary with the arrival or disappearance with the other group. Given these stabilizing tendencies, any legal requirement to charge a blended rate of $125 (or $75) creates an implicit subsidy for members of one group or the other. Those individuals who are subsidized will engage in too much dangerous activity. Those who pay the subsidy will engage in too little. Either

[2]Here I ignore the complications that arise if there are any economies of scale that allow for a reduction in the amount of fixed costs that would be allocable to any individual customer.

way there is a resource distortion that more accurate pricing could avoid. It follows that when the cost of service is different, charging identical rates is an economic form of price discrimination that leads to resource misallocation: too many high risk people are in the market, and some low-risk people are driven out.

The common legal definition of discrimination unfortunately works at cross-purposes with this economic account. Here the argument is one that stresses *formal* equality between members of two different groups, regardless of the incidence and distribution of actual losses. Some years ago I worked on a case in which the charge of discrimination was that the insurance rates in predominantly black neighborhoods were discriminatorily high because the identical coverage (expressed in terms of property value, limits, deductibles, period of coverage, etc.) was higher than it was in a nearby white neighborhood. The factual basis of this charge is easy to make out, because one need only compare the rates in the two areas. But the economic definition of discrimination requires that one examine the relationship between loss experience and rates, which is also easy to do at the end of the policy periods. In the cases at hand, the premiums charged in the predominantly black neighborhood were not sufficient to cover the losses in question, while those charged in the predominantly white neighborhood were more than sufficient to cover the losses in question. Stated otherwise, the insurance market was not stable in the predominantly black areas owing to the net losses, which in turn suggested exit from the area, which would be accompanied by an inflow of capital into the white neighborhoods. The contrast could not be starker. This one set of facts provides conclusive proof of two antithetical forms of discrimination: the economic account finds discrimination in favor of residents in the predominantly black

neighborhood, and the legal account finds against it. When it is said that markets will not stop discrimination (Sunstein 1991), the charge is manifestly true if the so-called legal definition of discrimination is used, but in all likelihood false if the economic definition is used. The persistence of real cost differences between groups will keep unregulated firms from charging identical rates no matter whether market is competitive or monopolist in structure. In the insurance case mentioned, the reason why the market did not equilibrate in accordance with the underlying losses was doubtless because of the fear of severe legal response through regulation or litigation if the economic differences were not muted. There is no question that various types of measures (e.g., assigned risk pools) can introduce a major extent of cross-subsidy in insurance markets if allowed to operate. They can also lead to major bankruptcies is allowed to run on indefinitely (Epstein 1991).

Some Empirical Evidence

This choice between competing definitions helps explains much of the data found in dealing with these issues in multiple contexts. Here I shall briefly discuss some of the arguments that have been used to identify pervasive levels of discrimination in various nonhealth care markets.

Employment markets are one such area, and there have been studies that have claimed extensive prejudice in their operation. One study by Claudia Goldin and Cecilia Rouse (2000) reported that women in highly competitive auditions for orchestral positions improved their success rate relative to men once the standard viewed auditions were replaced by blind auditions, which required all applicants to perform from behind a curtain. I have no reason to quarrel with the data, but question the implications. This change in procedure was adopted by the orchestra itself, which offers some evidence that

markets are capable of self-correction once some unfairness is pointed out. Second, the blind audition process (in unionized orchestras) covers initial stages, and not the final round before the conductor and the final selection committee. And for good reason: something is lost about the dynamics of an orchestra, which depends in part on interactions and appearance. Third, the study does give a full account of the entire range of hiring practices. Blind auditions are consistent with affirmative action programs that recruit women candidates for auditions in the first place. Do those who believe that there is pervasive discrimination against women deny the power of affirmative action programs in virtually all aspects of higher education? Or assume that the scores in science and math for women at select institutions are indistinguishable from those of men? To admit the truth of these statements is not to condemn the practices in question, for even if some conscious discrimination is present, the issue of whether it is justified (on the grounds of a superior student or workplace mix) is still open. Contrary to what the defenders of the civil rights laws thought, "merit" is not exclusively an individual concept, but one that rests in large measure on the "fit" that individual workers have with the team of which they are a part (Collins 2001, pp. XXX). But no matter how one comes out on this, any overall assessment of this issue cannot treat the affirmative action question as though it were wholly separate from the discrimination issue, when in fact they are opposite sides of the same coin.

Further evidence of "pervasive prejudice has been advanced chiefly by Ian Ayres, on the proof of "pervasive prejudice" in various automobile selling and lending markets (Ayres 1991). Some years ago Ayres published a number of highly visible studies that purported to document through the use of testers persistent discrimination in the level of

markup that dealers charged customers for new automobiles,[3] concluding that there is, to use his phrase, *pervasive prejudice* in a wide range of important markets, such as automobiles and housing, that allow for any variation in price. Since that time he has done further work with actual sales data in order to prove the identical point. His numbers, which I will take as wholly accurate, indicate that black drivers of both sexes pay somewhat higher rates than white drivers for the same kind of automobile. The implicit subtext of his argument is that there are no cost differences to the provision of the automobiles in the two areas, so that any price differential is attributable as a form of pervasive prejudice. The source and depth of this prejudice is somewhat obscure, and may not rest on associational dislikes, i.e., by people who don't like to be around black persons. "For example, if sellers enjoy extracting an extra dollar of profit from people of color more than from whites, we might expect to see disparate racial treatment in pricing or quality of service" (Ayres 2001, p. 4). One could question which "sellers" fit this description, or why there are no sellers who find similar pleasure in milking their white customers. Even so, this form of prejudice is treated as extraordinarily tenacious. In contrast to the standard economic accounts of discrimination, these differences persist strongly over time in highly competitive markets, and are not eroded by new entry or customer strategies of shifting from less to more desirable dealerships. In his view, these differentials represent a general pattern of unconscious stereotyping similar to that which the IOM study found in connection with the provision of health care.

Ayres's conclusions are at war with the standard economic account of discrimination. This account does not assume that all individuals are interested only in

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[3]Harv. L. Rev. (1988); Mich. L. Rev. [author, article?]

money. Rather, it assumes that if the real costs are identical, as Ayres postulates them to be, then *some* sellers will be prepared to undercut the market because all dealers do not suffer from the uniform degrees of latent or sadistic prejudice. The behavior of the market is not defined by how the majority of dealers respond to racial differences in their customers. It responds to how those individual dealers who are *most* sympathetic to black customers view the situation. If Ayres's assumptions and data are both correct, then the traditional theory has suffered a decisive refutation, with no replacement in sight.

In principle, we should be very reluctant to abandon theories that seem to fall within the orthodox assumptions of economic theory. Instead we should test whether the initial set of assumptions, relating to constant cost of services and product are in fact accurate. On this point, Ayres is correct to note that the sale of an automobile is in part a "relational contract," which means that the relationship between the parties continues after the time of sale (Ayres 2001, p. 4). He uses this information to note that the variations that are introduced could allow the sales representative the opportunity to extract some additional unit of profit from black customers (Ayres 2001, p. 21). But the relational aspects of the transaction have other consequences as well, namely, introducing a possible variation in the *cost* structure of dealing with different customer groups, that is, a set of unobserved variables that escape the analyst, but influence the behavior of the decisionmaker.[4] At this point, it is no longer necessary to postulate massive levels of undetected prejudice, for sales transactions, as Ayres recognizes (Ayres 2001, p. 4) are not simple one shot deals, but the opening chapter in ongoing relationships between

[4]On the difficulty of dealing with these in connection with audit tests, see Heckman 1998, pp. 107–11.

dealers and customers. If these relationships are more costly to continue with black customers than with white customers (because delivery is more costly, or service calls are more frequent, or if higher default rates require dealer time), then we should expect to see some price differential to persist for the reason noted above: cost-based forms of discrimination are *never* eliminated by market pressures no matter how free new entry. I have not done any detailed study on how these automobile markets work, but at the very least the situation seems to be this: we could either have some unidentified cost difference or some unidentified form of prejudice that drives the model. The former of these is perfectly consistent with basic economic theory. The latter reminds us of the unobservable ether that was unable to save Newtonian mechanics.

The question then arises on how to choose between these two programs. Here are some reasons why we should go with the cost explanation. Audit studies require the investigators to prepare the tests. Often that preparation is done by individuals who have a strong conviction that discrimination will be found. That could easily lead the testers to alter behavior in subtle ways that bring about the desired results. Double blind studies are surely preferable, but exceedingly difficult to do in this area. Second, we have so few instances of overt discrimination in any of these cases. One reason perhaps is that particular evidence of this sort does not prove pervasive discrimination because it is confined to a small number of circumstances. Yet, by the same token, it is exceedingly odd that some form of prejudice could lie just below the surface and never manifest itself in concrete cases. Yet the absence of those instances is consistent with the theory of cost-based discrimination because we should expect all vendors to adapt the same strategy regardless of their own race because they all face the same set of customers. Ironically,

Ayres supplies us with a tidbit of evidence in this direction when he notes that the same pricing practices appear to take place among different customer groups even when all the sales personnel are black (Ayres 2001, p. 107, note 33). At this point we should expect group favoritism to run in the opposite direction to extent that any race-neutral theory of prejudice stresses the in-group, out-group distinction. Yet none occurs, which offers at least some evidence that profit motivations do matter. At this point, it is important to note that under current law, these distinctions may not matter because differential treatment based on differential costs of service, if correlated with race, is regarded as illegal under the so-called disparate impact theories that control in this area. The choice of definitions matter, because the current law treats rational conduct as though it were a form of bigotry.

The efforts to prove discrimination in new car sales have some plausibility because the sales persons have to enter into direct contact with ordinary individuals whose race and sex is evident from the outset. The associational dislike stories cannot be dismissed out of hand. But if statistical analysis is allowed to control the search for discrimination, then the same techniques could be extended to cases where there is no contact whatsoever between the parties. On this point, Ayres and I were expert witnesses on the opposite side of at least one case in which the charge for discrimination arose out of the practices associated with the financing of automobiles (*Cason v. Nissan Motors Acceptance Corp.* F.3d (6th Cir. 200X)). In these cases, brought for violations of the Equal Credit Opportunity Act [citation], the typical transaction arises when the purchaser of an automobile decides to purchase the car on credit from a dealer. The dealer then offers a loan at a set annual percentage rate (APR). The disclosure of relevant loan terms

is regulated by the standard truth-in-lending statute. Once the loan has been negotiated, then the dealer sells the commercial paper to anyone of a number of competing firms who pay it a fee for originating the loan. The "acceptance corporation," such as Nissan Motors Acceptance Corporation (NMAC), makes no direct loans to customers. Before it decides to buy dealer paper, it runs an elaborate program on key demographic data in order to make its decision. For the loans that it wishes to "accept," it offers the dealer a fee, called the "mark-up, so that it receives a lower yield from the transaction, known as the "buy rate." The key relationship between these variables is as follows:

Buy rate + mark up = Annual percentage rate

At no stage in the process is there any personal contact between the acceptance corporation and the dealer's customer; nor can the acceptance corporation infer the race of the customer from the transaction, so much so that there was major difficulty in litigation in trying to sort people (by zip code, for example) into white and black in order to find out who was in the plaintiff class. Any effort to show that these cases involve unconscious prejudice is negated by the institutional safeguards involved. It is also accepted that two identical applicants (and remember here there is no background knowledge to control for) receive the identical mark-ups regardless of race. The built-in institutional arrangements make these financing arrangements the laboratory illustration of a prejudice-free transaction. Yet the law suits in question all allege that all these transactions discriminate against black customers because as a group their loans are subject to higher mark-ups than loans to white customers. That difference is attributable

to the then-standard industry practice of paying higher markups for high-risk loans than for low-risk loans. Since disparate treatment is out of the question, the only question is whether or not that differential has a disparate impact that violates the antidiscrimination law , when it is conceded that all interest rate differentials reflect the difference in credit risks.

In principle, the first concern should be whether to allow disparate impact cases (without any evidence of intention) in cases of race-blind financing. I do not think that this is appropriate, even for those who believe that the antidiscrimination law has a place to play in employment transactions where the (too) stringent rules in effect allow only those employment practices justified by some "business necessity" for which no narrower employment practice is available (Ayres 2004). This test lags because it never makes it clear what kind of necessity has to be shown to justify any particular employment practice. There are empirically an infinite array of variations, so that some practices that have some disparate impact are also somewhat more efficient. Just how these tradeoffs work in litigation is anyone's guess, even today after over thirty years of experience with this or that version of the standard. Unfortunately, the only fixed point in this analysis is that any high level of judicial scrutiny cuts deep into ordinary management prerogatives, even if they reach only practices that pose little risk of social mischief. The original rationale for allowing the use of statistical evidence in employment cases was that the clever employer intent on discrimination (a more plausible construct in 1965 than today) could hide his intentions behind a set of pretexts that only solid statistical evidence could pierce. But here the institutional arrangements preclude the use of pretextual devices, so that there are no cases of submerged, invidious discrimination left to expose. That said,

the chief result of the disparate impact case is to hypothesize pervasive discrimination in what everyone acknowledges to be an intensively competitive environment in which no lender has more than a sliver of the relevant market.

The only way to establish a legal case of discrimination is to assume that the differential markups reflect a practice of discrimination. But immediately the objection arises, why would finance company pay a dealer anything extra for work that was not undertaken? The much more likely explanation is that the charges involved here vary with the costs needed to place more difficult loans. Thus, a dealer might have to place multiple phone calls to different lenders to persuade them to take a risky customer. In addition, the system of payment from dealers only takes place on completed transactions, and thus has to cover the costs of those loan transactions that fail entirely even after dealer efforts. To make this case of discrimination work, it would be necessary to understand in detail the relevant cost functions, but these were never explored in any detail in the case. Rather, it was just postulated that the costs did not follow the markups so that discrimination had to be the cause. In a sense, these finance cases are the reduction ad absurdum of the dealer selling cases: better to postulate some hidden prejudice than treat the observed set of rates as the process of an impersonal set of market transactions, which these cases undoubtedly were.

Application in Medical Areas

I have spent this time examining the use of discrimination in other areas to show that one has to take with a grain of salt the IOM claims that pervasive prejudice should be treated as an established norm in other industries. But it is clear that these techniques to prove discrimination, however shaky, can be used in this context as well. Once again Ayres and

his colleagues have taken the lead in arguing that the traditional guidelines for organ transplantation, with their emphasis on antigen matches, had a disparate impact in practice even though they were neutral in form. The observation that black candidates for kidney transplants, for example, had longer queuing times than white candidates fueled some changes in UNOS protocols for organ allocation.

In one sense this program is unexceptionable. If it turns out that anything less that a perfect antigen match has no predictive value on how long individuals will survive upon receipt of a kidney, then that factor should be disregarded on the simple ground that in an administrative system (which treats voluntary purchase as a criminal act) the only intelligible objective is to maximize the present discounted value of future years of life saved, adjusted for quality of life considerations. At this point, the only question that one has to ask in order to compare two different protocols is which one produces the larger net saving for the organs so distributed. In one sense, this inquiry can be run without regard to race by seeking to identify those neutral variables (including time on a waiting list) that determine the organ allocation. On this view, or rephrase "the distribution of organs between white and black recipients is utterly immaterial on the ground that each counts for one and only one.

The hard question is whether the newer system or older system of allocation better achieves this particular goal. It does not, however, follow that race is irrelevant to the overall inquiry because the relevant question is *not* how long will people survive with a transplant, but how much *longer* they would survive with a transplant than on dialysis. Thus if two persons each could live five years with a transplant, and one could live only one year without it, and the other four years without it, then, all other things being equal,

give the kidney to the former, at least in the absence of any market test. Therefore, if race is, either way, a determinant of receptivity to dialysis, it should be taken into account in service of the neutral end. At most, race (or randomization) would be a decider only when there is *no* difference on the strength of any medical criterion. Whether the new UNOS rules meet this test is for others to determine. What matters for this analysis is the criterion: greatest net lives saved per organ. If, for example, alcoholism was negatively correlated with transplant success, and positively correlated with race, it should be fit into the analysis even under a disparate impact regime.

The question of discrimination also surfaces in connection with standardized provision of health care. In this context, the usual market forces are often consciously overridden, because the extensive set of health care services provided through government agencies is not meant to replicate the market in that it tolerates a good deal of cross subsidy. In dealing with these subsidies, it should be noted that in most relevant classes of medical treatment, the incidence of illnesses within the black population is higher than that found within the white population (IOM 2003, 81–87) There are significant differences in the frequency of diseases of the heart, cerebrovascular diseases, malignant neoplasms, and diabetes, across these groups. The bottom line is this: "The mortality rate for African Americans is approximately 1.6 times higher than that for whites—a ratio that is identical to the black/white mortality ratio in 1950." (IOM, at 82)—which of course implies a greater absolute percentage reduction in black mortality relative to white. A quick look at these figures is against a background in which race is not used as a marker in the provision of health care, such that the present system involves a substantial net wealth transfer from white to black individuals, which undercuts any

claim of global discrimination against blacks who have been the net recipients under current government policy. It is, however, some evidence of the predisposition of the IOM drafters that the neutral racial policies that produce this result are not so much as mentioned, even though the adverse effects that neutral policies on members of various minority groups, as in organ transplantation, is a staple of the modern literature.

The question then is what to make of the persistent findings of differential treatment that are reported in these areas. Here one lesson that could be learned, but is not, is that it is important to understand the detailed industry judgments before making any inferences about discrimination. In medical services, cost is often not the relevant variable, so that the determinants of medical choices are harder to find. As noted, the IOM report lumps together the questions of clinical uncertainty and communication breakdown with bias and prejudice in dealing with discrimination. Yet there is good reason why this should not be so. The failures that occur in these instances are not the result of ill-motive or insensitive behavior. The breakdowns in the system, and these are numerous, are problems of management that everyone should try to eliminate, but not the source of some deep-seated structural failure.

The question then arises, just how pervasive these failures could be. Given the observed differences in the treated populations, they could be every bit as pervasive as the alleged discrimination in health care. Here are some possibilities that could be taken into account, but often are not. The conscientious physician does not treat any medical condition in isolation. It is critical to know something of the capabilities of the patient and the surrounding support structure from family and friends. Thus assume that we have a situation in which the choice is between a simple procedure with modest returns and a

complex procedure with higher returns but greater risk. The same physician might be well advised to recommend the former procedure to patients with less sophistication and weak support services, and the latter procedure to individuals with high awareness and strong support procedures. As with general efforts to prove discrimination, the number of variables that can be included in any regression are far fewer than those which can be taken into account in dealing with the case, whether we deal with automobile sales representatives or physicians. In the treatment of any particular case, that judgment will be based on the treating physician's close personal assessment of the individuals in question and will not turn on the only variables that outside analysts can use: age, income, years of education, etc. At this point, it could well be that recommending differential treatments represents the correct clinical judgments. If, as often happens, the coherence of family and support structures do vary by race, then, rightly understood, differences of this sort, if systematically replicated, are evidence of fair treatment across the board. Once again, if these differences do exist, then no amount of sensitivity training would, or should, eliminate them. And any litigation effort to insure uniform treatment would have the perverse effect of making medical care more dangerous to all patients.

The question then is how does one get the relevant information on the variables that count in individual cases. Large utilization studies are not likely to produce the right sort of results because if these variables of self-sufficiency and social support networks are operative in some cases, they could easily be operative in all, which means that supposed evidence of pervasive discrimination is in reality evidence of conscientious efforts to tailor the treatment to the patient, not the statistical category. How then can we tell whether the difference is to be treated as good or bad? Once again it is necessary to

have recourse to another theme from the general discrimination literature. It seems very odd that latent prejudices will simmer just below the surface and never manifest themselves in visible forms of antisocial behavior. The case for pervasive discrimination seems still weaker since virtually every writer on discrimination in health care (Satel 2004) thumpingly deplores the discrimination that they detect in their studies, and that the entire profession has set its public face against any form of discrimination in the provision of health care with a set of social norms that are so thick that you can cut them with a knife. There are, in addition, instructive anecdotes about individual physicians who sense a breakdown in communication and then take proactive steps to correct them. Sally Satel's brief account of how poor patients, often people of color, do not know the difference between a simple swab for bacterial infection from a Pap smear for cancer is but one illustration of the barriers that have to be overcome in the provision of routine clinical care. Greggory Bloche's (2004) study of communication is yet another effort to break down the process in order to isolate the potential sources of failure.

It seems clear that most of the tangible gains that could be achieved in health care under the current system lie in making everyone more sensitive to these communications glitches. But if that is the case, then we should be deeply troubled by the IOM study's eagerness to find (illicit) discrimination as the source of the various difficulties in dealing with today's health care problems. Indeed, the constant criticisms of the current system for its untoward biases have *bad* short-term consequences, when measured in flesh-and-blood terms. One public source of concern is the unwillingness of minority individuals to use the health care system because they think that it is stacked against them. If that charge were indeed true, then the decision by members of disadvantaged groups to keep

out is rational: people will make less use of a system that promises them fewer benefits. But now think of how things look if it turns out that the claims of illicit discrimination are overplayed. At this point, the net effect is to give *false* information to potential users of the legal system, which is likely to keep them out of a health care system that is far more sympathetic to their claims that the received wisdom allows. That reluctance to work within the system in turn translates itself into lower levels of care and high risks of mortality and morbidity. I would not want that sequence of events to rest on my shoulders.

The IOM study adopts exactly the wrong approach when it lends its sympathetic ear to the critics of the current system. I would write the exact opposite report. Instead of dwelling on the Tuskegee experiments as evidence of current biases that linger within the system, I would trumpet the dedicated men and women in the profession who are determined to help people of all backgrounds and races deal with their health problems. I would stress that the attitudes of physicians today have shown a true revolution from those that permeated the generation or two ago; that the influx of physicians from all races and all walks of life has transformed the internal culture, so that wary customers should have confidence in the incredible dedication that young physicians, in particular show, notwithstanding their long hours and low pay. Truth is, this seems like the more accurate summary of the available evidence. It is a shame to attack so many people of good will on evidence that admits a much more benign interpretation. And it would be a shame to lose lives because of a determined effort to make things appear worse than they really are. There are better ways to spend money to improve health. And there are enough

problems in the health care system even without the genteel guilt trip that pervades the IOM study.

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Readers with comments should address them to:

Richard A. Epstein
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