

Chapter Sixteen

Minorities

MYTH NO. 16: SINGLE-PAYER NATIONAL HEALTH INSURANCE WOULD BENEFIT RACIAL MINORITIES

Critics of the U.S. health care system often point to the disadvantages faced by minorities. On the average, African Americans and Hispanic Americans are less likely than whites to have health insurance, see a physician or enter a hospital. But is single-payer health insurance the answer? Empirical studies show that minorities also face medical discrimination under systems of national health insurance.¹ In fact, they often fare worse.

In a market where prices are used to allocate resources, goods and services are rationed by price. Willingness to pay, rather than race or political connections, determines which individuals utilize resources. In a nonmarket system, things are very different. Unable to discriminate on the basis of price, suppliers of services must discriminate among potential customers based on other factors. Race and ethnic background are invariably among those factors.²

RACIAL DISCRIMINATION IN THE UNITED STATES

Take the (nonprice) rationing of organ transplants, for example. Currently, in the United States no “market” exists for transplant organs. Donated organs are supposedly available on the basis of need. Yet, despite the existence of a nonprofit organ donor system that supposedly does not discriminate on ability to pay, the rate of organ transplantation among minorities is proportionally lower than for whites. According to the United Network for Organ Sharing, African Americans received only 3.7 percent of pancreases despite comprising 8 percent of those

waiting. Blacks received only 14.9 percent of living donor kidneys and 27 percent of cadaveric kidneys despite comprising 34.8 percent of the people on the waiting list.³

Other evidence points to discrimination in the U.S. health care system. Many studies have found that ethnic minorities receive fewer routine services and lower-quality medical care than whites. The reasons include lower rates of health insurance coverage and the fact that minority patients sometimes wait longer to seek care. However, the disparities tend to narrow significantly—if not disappear altogether—when adjusted for income and other socioeconomic differences.⁴

By contrast, few studies of how racial minorities fare under national health insurance in other countries have been published. The few studies that exist, together with surveys and anecdotal evidence, are consistent with what economic theory would predict: minority patients do not fare well under nonprice rationing of health care.

RACIAL DISCRIMINATION IN BRITAIN

In Britain, uneven levels of access and treatment for the country's growing minority population (mostly South Asian) have fueled claims of racism within the NHS. For example, according to the British newspaper *The Guardian*, a confidential government report as well as an independent think tank report found racism flourishing in the NHS.⁵ In one case, the NHS had accepted an organ donation for white-only patients.⁶

A survey of GPs in England found diabetes and asthma programs were more common in affluent, mostly white areas than in inner-city London, which has a high minority population. The NHS also was less likely to equip hospitals in London's minority areas for cervical cancer testing and childhood immunization.⁷

RACIAL DISCRIMINATION IN CANADA

Similar problems have been identified with respect to indigenous minorities in Canada.⁸ In a recent study of Canadian Indian groups, researchers found that all of the groups sampled had much less access to health care than Caucasians, despite their greater health needs. For example, the infant death rate during the study period was 13.8 per 1,000 live births for Indian infants and 16.3 per 1,000 for Inuit infants, approximately twice the rate (7.3 per 1,000) for all Canadian infants during the same period. Overall, Canadian aboriginal

people “die earlier than their fellow Canadians and sustain a disproportionate share of the burden of physical disease and mental illness.”⁹

RACIAL DISCRIMINATION IN NEW ZEALAND

In New Zealand, the average life expectancy for Maori men (sixty-eight years) is 5.5 years less than for non-Maori men, and six years less for Maori women (seventy-three years) than for non-Maori women.¹⁰ Furthermore, those Maori who live in the least deprived areas live seven years longer than those in the most deprived areas. The corresponding figure for women is eight years. The disparities do not stop with life expectancy. Most diabetes is preventable (or manageable) through early diagnosis and intervention. However, its incidence among forty-five- to sixty-four-year-old Maori is four times that of comparable non-Maori. The incidence of high blood pressure among young (25–44) Maori men and women, respectively, is almost twice the rate of non-Maori New Zealand men and women of European ancestry.¹¹

RACIAL DISCRIMINATION IN AUSTRALIA

Australia also has both a significant minority population (the Aborigines). Various studies have reported that¹²

- Aborigines are three times more likely to die in infancy than white Australians and about half of the survivors will die before they reach age fifty.
- Of all Aborigines who died between 1995 and 1997, 53 percent of men and 41 percent of women were under age fifty; by comparison, 13 percent of all other Australian men and 7 percent of all other Australian women who died were under age fifty. The disparities appear to be a result of health care access inequalities.
- Death rates are higher for Aborigines in all age groups. In infancy, Aborigines are 3.1 to 3.5 times more likely to die than other Australians. In the thirty-five to fifty-four age group, they are six to seven times more likely to die than other Australians.

Despite the greater overall health needs of these populations, minorities in countries with single-payer systems are routinely marginalized by systems that direct resources and services toward the more affluent, white, urban majority.

NOTES

1. For a discussion, see Michael Lowe, Ian H. Kerridge and Kenneth R Mitchell, “‘These Sorts of People Don’t Do Very Well’: Race and Allocation of Health Care Resources,” *Journal of Medical Ethics* 21, no. 6 (December 1995).

2. See Gary S. Becker, *The Economics of Discrimination*, 2nd ed. (Chicago: University of Chicago Press, 1971).

3. *2001 Annual Report of the U.S. Organ Procurement and Transplantation Network and the Scientific Registry for Transplant Recipients: Transplant Data 1991–2000*, U.S. Department of Health and Human Services, 2001, available at www.ustransplant.org. In 2000, blacks comprised 36 percent of those waiting for kidneys, and 8 percent of those waiting for a pancreas. Blacks do receive a proportionate number of donor hearts (13.4 percent) while comprising an identical proportion of those waiting (13.4 percent); see also G. Caleb Alexander and Ashwini R. Sehgal, “Barriers to Cadaveric Renal Transplantation among Blacks, Women and the Poor,” *Journal of the American Medical Association* 280, no. 13 (October 7, 1998): 1148–52; John Z. Ayanian et al., “The Effect of Patients’ Preferences on Racial Differences in Access to Renal Transplantation,” *New England Journal of Medicine* 341, no. 22 (November 25, 1999): 1661–69.

4. Brian D. Smedley, Adrienne Y. Stith and Alan R. Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, D.C.: National Academy Press, Institute of Medicine, March 2002).

5. John Carvel, “Secret Government Report Finds Racism Flourishing in NHS,” *Guardian Unlimited*, June 25, 2001; Carvel, “NHS Staff Tell of Morale-Sapping Racism,” *Guardian Unlimited*, June 25, 2001; Carvel, “Racism Is Rife in NHS, Says Study,” *Guardian Unlimited*, June 19, 2001.

6. The incident took place in July 1998. Sarah Boseley, David Brindle and Vikram Dodd, “NHS Took Organs Donated for Whites Only,” *Guardian Unlimited*, July 7, 1999; and Sarah Boseley, “Transplant Chief Loses Job over Racism Row,” *Guardian Unlimited*, February 23, 2000. For a report on this event and the NHS policy, see “An Investigation into Conditional Organ Donation—The Report of the Panel,” UK Department of Health, February 2000.

7. Brenda Leese and Nick Bosanquet, “Change in General Practice and Its Effects on Service Provision in Areas with Different Socioeconomic Characteristics,” *British Medical Journal* (August 26, 1995): 546–50.

8. Aboriginal people have less access to health care services than other Canadians because of geographic location and a shortage of personnel trained to meet their needs. See Harriet L. MacMillan et al., “Aboriginal Health,” *Canadian Medical Association Journal* 155, no. 11 (December 1, 1996): 1569–78. Also see “CMA’s Submission to the Royal Commission on Aboriginal Peoples,” in *Bridging the Gap: Promoting Health and Healing for Aboriginal Peoples in Canada* (Ottawa: Canadian Medical Association, 1994), 9–17; *Aboriginal Health in Canada* (Ottawa: Medical Services Branch, Health Canada, 1994); and Vincent F. Tookenay, “Improving the Health Status of Aboriginal People in Canada: New Directions, New Responsibilities,” *Canadian Medical Association Journal* 155, no. 11 (December 1, 1996): 1581–83.

9. MacMillan et al., "Aboriginal Health."
10. Lisa Macdonald, "Maori/Non-Maori Lives: The Widening Gap," *Green Left Weekly*, no. 326, (July 29, 1998), available at <http://jinx.sistm.unsw.edu.au/~greenlft/1998/326/326p23b.htm>; and Michele Grigg and Ben Macrae, *Tikanga Oranga Hauora* (Health Trends), Ministry of Maori Development, Wellington, New Zealand, Whakapakari No 4., 2000, available at www.tpk.govt.nz/maori/education/tohtrend.pdf.
11. Grigg and Macrae, *Tikanga Oranga Hauora*.
12. "The Health and Welfare of Australia's Aboriginal and Torres Strait Island Peoples," Australian Bureau of Statistics, 2000. For similar trends in health care for New Zealand's Maori population, see "Our Health, Our Future: The Health of New Zealanders 1999," New Zealand Ministry of Health, 1999, and "Maori Health," *Healthcare Review—Online 2*, no. 4, December 1997.

