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. 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.

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.”

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. 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.

RACIAL DISCRIMINATION IN AUSTRALIA

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

- 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).


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.


11. Grigg and Macrae, Tikanga Oranga Hauora.
