

Healthcare

From Uprooting Racism by Paul Kivel

The US healthcare system is so riddled with racism that tens of thousands of people of color die needlessly every year because of its inadequacies. Others are permanently disabled, live with remediable conditions, or suffer seriously inferior quality of life. The impact of race is felt in every area from basic accessibility to healthcare, through adequacy of coverage, treatments prescribed, prenatal care, cultural sensitivity of care, availability of specialized treatments and physical proximity to hospitals, to under-prescription of routine diagnostic tests and painkillers and over-prescription of amputations and sterilization. Former US Surgeon General David Satcher has labeled these disparities “institutionalized racism.”¹

The cumulative impact is devastating to people of color. To give just one example for the African American community, which is the best documented, it is estimated that blacks suffer over 91,000 *excess deaths* a year - that is 37% of all black deaths.² Excess deaths are deaths from health conditions that are preventable or treatable and are therefore unnecessary or avoidable.³ In other words, all other factors being equal, 91,000 black people die each year because of racism. Because of this, African Americans have a life expectancy a four and a half years less than white Americans.⁴ For parts of the Latino/a and Southeast Asian communities, life expectancy and healthcare status are equally low, and in many Native American communities they are even lower. Obviously not all the

deaths of people of color are attributable to racism, but it is well documented that tens of thousands are.

Race and gender clearly make a difference in how patients are diagnosed and treated. In one study, medical residents viewed a video showing a white male and a black female patient (the students did not know they were actors), who described identical systems of chest pain indicative of heart disease. Seventy-four percent of the students believed the white male had heart disease, but only 46% believed the black female.

Another study of Medicare patients found that only 64% of black patients receive potentially curative treatment for early stage lung cancer, while 77% of white patients receive it, leading to survival rates of 34% for whites and just 26% for blacks after five years. A UCLA study found that Hispanics in emergency rooms in Los Angeles are twice as likely as white people in comparable circumstances to end up with no pain medication - not even a Tylenol. Over 30 years' worth of studies show that people of color who arrive at a hospital while having a heart attack are significantly less likely to receive aspirin, beta-blocking drugs, clot-dissolving drugs, acute cardiac catheterization, angioplasty or bypass surgery.⁵

Racism in the healthcare system is also an international problem. The example of the drug development, pricing and delivery systems shows how people of color in economically exploited countries suffer needlessly from policies that ultimately benefit

white people in developed countries, and financially benefit an even smaller number of the white Western elite.⁶

Pharmaceutical companies do not develop many treatments to cure diseases that primarily affect people in economically exploited countries (and kill millions of people annually). Of the 1556 new drugs marketed between 1975 and 2004, only 21 were indicated for neglected diseases (including malaria and tuberculosis, but not HIV), and a mere 10 were directed at neglected tropical diseases which affect over a billion people annually.⁷ The main emphasis of drug company research programs is “lifestyle drugs” for conditions like obesity, baldness, face wrinkles and impotence. Although the companies complain that otherwise research would be unprofitable, the worth of the five largest pharmaceuticals is twice the combined GDP of all sub-Saharan Africa.

Drug companies defend their profits at the cost of millions of lives in Africa, South America and Asia. For example, GlaxoWellcome threatened legal action against the Indian company Cipla for trying to provide Ghana and Uganda with a cheap version of Combivir, two drugs developed in the US with public funding. Nearly 40 companies took the South African government to court to prevent its making low-cost generic equivalents of certain AIDS drugs available to people who could not otherwise afford to be treated for AIDS. This lawsuit was dropped only after there was a large international outcry in response to the fact that about 5.7 million South Africans are HIV-positive, and most will die much sooner without access to low-cost drug treatments.⁸

Brazil is a country that shows a significant saving of life is possible with more humane drug availability policies. In the early 1990s the country had the fourth-largest number of reported cases of HIV/AIDS in the world. The government began to import, produce and distribute large quantities of anti-retroviral drugs, which lowered the price for a year's treatment to \$600, compared with \$10,000 for the drug company's version of the drugs. This policy has reduced the number of AIDS-related deaths by 38%. However, the United States government, at the urging of pharmaceutical companies, threatened retaliatory measures if the policies were not discontinued.⁹

All people should have a basic right to adequate healthcare. Of course economic factors also play a role in who has access to healthcare in the US, and we need to address the concerns of many white people who suffer from inadequate care. But we have seen that race is an independent variable, and we need to develop race-specific remedies that address the systemic ways that people of color are denied, have limited access to, or experience inadequate medical care, leading to needless suffering and death.

1. Much of the following information is summarized in an article by Neil Rosenberg.

“Separate and Unequal: U.S. Practices a System of Medicine that Shortchanges Minorities and Women.” *Milwaukee Journal Sentinel*, April 16, 2001.

2. W. Michael Byrd and Linda A. Clayton. *An American Health Dilemma: A Medical History of African Americans and the Problem of Race, Beginnings to 1900*. Routledge, 2000, p. 29.

3. Abstract of : James Macinko and Irma T. Elo. "Black-White Differences in Avoidable Mortality in the United States, 1980-2005." *Journal of Epidemiology and Community Health*, April, 2009. [online]. [cited February 27, 2011].

jech.bmj.com/content/early/2009/04/12/jech.2008.081141.abstract.

4. US Centers for Disease Control and Prevention. *Health, United States, 2009*.

Publication #DHHS 2010-1232, January 2010. [online]. [cited February 27, 2011].

cdc.gov/nchs/data/hus/hus09.pdf.

5. For an in-depth look at racial disparities in healthcare see Brian D. Smedley et al.

Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. National Academies, 2003. [online]. [cited February 27, 2011].

books.nap.edu/openbook.php?record_id=10260&page=R1.

6. The examples in this chapter are taken from Jordi Martorell. "Drug Companies Putting Profits Before Millions of People's Lives." March 9, 2001. [online]. [cited February 27, 2011]. marxist.com/drugs-companies-profits090301.htm.

7. P. Chirac and E. Torrele. "Global framework on essential health R&D." *Lancet* Vol. 367 (May 13, 2006), pp.1560–1561. [online]. [cited February 28, 2011].

ndi.org/images/stories/pdf_scientific_pub/2006/chirac_lancet05132006.pdf.

8. Martorell, "Drug Companies Putting Profits Before Millions of People's Lives."

9. Indira A.R. Lakshmanan. "The rising cost of AIDS drugs threatens Brazil's free treatment program." *New York Times*, January 3, 2007. [online]. [cited February 27, 2011]. nytimes.com/2007/01/03/world/americas/03iht-aids.4090052.html.