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COMMENTARY: RACIAL DISPARITIES IN HEALTH CARE

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Professor Watson has presented us with a provocative paper on the problem of racial disparities in health care. Professor Watson notes that we seem to have reached a dead end in dealing with race discrimination in health care through the civil rights laws. Those laws seem to be incapable of dealing with disparate impact–which is manifestly evident in health care–and focus rather on discriminatory intent, which is usually impossible to prove in particular cases. On the other hand, I view her paper as basically hopeful, pointing to a growing interest in addressing the problem of disparate impact through the emerging concept of cultural competency.

I would like to reflect on Ms. Watson's contribution from the perspective of a particular dilemma facing our country–the problem of the uninsured. Access to health care in the United States depends on a mixture of voluntary (though heavily government subsidized) employment-based insurance and on public programs. This system of coverage is far from complete, however, and about forty million people fall through the cracks.[1] The number of uninsured has been growing steadily for the past decade, and though it dropped briefly in the late 1990s because of the booming economy, it seems to be again on the upswing again as the economy has declined.[2] Though Americans do not necessarily totally lack access to health care because they are uninsured, they do get health care later and less frequently than those who are insured, and suffer much greater mortality and morbidity.[3] Uninsured women with breast cancer, for example, are thirty to fifty percent more likely to die than women with private health insurance, while uninsured patients with colorectal cancer face a fifty percent greater risk of death than insured patients.[4]

The uninsured tend disproportionately to be minorities. While about 12.4 percent of the entire population under 65 is uninsured, 17.9 percent of African-Americans are.[5] Only Hispanics, who experience uninsurance rates of 31.9 percent, are more likely to be uninsured.[6] Rates of uninsured status

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[1] *See* INSTITUTE OF MEDICINE, COVERAGE MATTERS: INSURANCE AND HEALTH CARE 3 (2001).

[2] *See* NATIONAL CENTER FOR HEALTH STATISTICS, EARLY RELEASE OF SELECTED ESTIMATES BASICS ON DATA FROM THE JANUARY-JUNE 2002 NHIS tbl. 1-2 (2002), *available at* http://www.cdc.gov/nchs/about/major/nhis/released200212/table01_2.htm.

[3] *See generally* INSTITUTE OF MEDICINE, CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE (2002).

[4] *Id.* at 9.

[5] *See* NATIONAL CENTER FOR HEALTH STATISTICS, NATIONAL HEALTH INTERVIEW SURVEY fig. 1.3 (2002), *available at* http://www.cdc.gov/nchs/about/major/nhis/released200212/figures01_1-1_3.htm.

[6] *Id.*

are particularly high among low income women of color. Thirty-two percent of African-American women who earn less than two hundred percent of the poverty level are uninsured.[7] African-American women who are insured are more likely than white women to be insured through Medicaid (eighteen percent versus five percent) and less likely to receive employment-based coverage (fifty-four percent versus seventy-three percent).[8]

Dependence on Medicaid has been particularly problematic because of declining Medicaid coverage for adults since the abolition of Aid to Families with Dependent Children in 1996. Between 1994 and 1998, the percentage of African-American women with income below the poverty level who received Medicaid dropped from fifty-five percent to forty-five percent.[9] With recent dramatic increases in Medicaid costs and declines in state revenues, this trend may continue. Most uninsured low-income women, about fifty-eight percent, are employed, but fewer than half of these (forty-nine percent) receive health insurance through their employment.[10] About two thirds work in three occupational categories, services, administrative support, and sales.[11] But these categories, particularly retail trade, have much lower levels of insurance coverage than other categories of employment.[12] African-American women are also, incidentally, far less likely to be covered as dependents than are white women: twelve percent versus thirty-two percent for women between eighteen and sixty-four years of age.[13]

I would make two observations based on this data. First, our employment-based insurance system works best for those who are well educated and who can get good jobs with good benefits. To the extent that people of color, and in particular women of color, have historically and in the present lacked access to equal education and equal employment, they continue to be also denied access to health care coverage, and thus to health care.

Second, even if health care providers and insurers can become more culturally sensitive, this will only help people of color if they can get in the door. Though culturally competent health care providers are a good first step, what we really need is a culturally sensitive agenda for spreading the

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[7] ROBERTA WYN ET AL., FALLING THROUGH THE CRACKS: HEALTH INSURANCE COVERAGE OF LOW-INCOME WOMEN 32 (2001)
[8] *Id.* at 66.
[9] *Id.* at 36.
[10] *Id.* at 48-49.
[11] *Id.* at 53.
[12] *Id.*
[13] NATIONAL WOMEN'S HEALTH INFORMATION CENTER, WOMEN OF COLOR HEALTH DATA BOOK, *at* http://www.4women.gov/owh/pub/woc/figure28.htm (last visited Sept. 7, 2003).

benefits of what is generally regarded to be one of the best health care systems in the world to all who reside in this country, regardless of race or sex.