
November 2015

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Recommended Citation

Michele Goodwin, *Race & Urban Health: Confronting a New Frontier*, 5 DePaul J. Health Care L. 181 (2002)
Available at: <https://via.library.depaul.edu/jhcl/vol5/iss2/2>

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RACE & URBAN HEALTH: CONFRONTING A NEW FRONTIER*

*Michele Goodwin***

Scholars from across the country have recently been involved with the Health Law Institute at the DePaul University College of Law as we begin to critically study the implications of urban health care issues in America. We recognize that those who live and work in urban environments face an array of unique health and access problems and that those issues are too often ignored. However, recent studies documenting the health disparities among the poor and people of color in urban environments underscore the importance of critically examining urban health. The Health Law Institute's annual symposia and workshops will include a focus on the various aspects of urban health. We encourage your participation as discussants, panelists, and audience contributors.

In April, the DePaul Health Law Institute convened a national conference to explore contemporary challenges in urban health and race law affecting those who seem most politically, economically and legally disenfranchised. Law professors, practitioners, epidemiologists, social workers, nurses, community participants, and students from across the country gathered to discuss how race, poverty, age, gender

* The DePaul Health Law Institute is grateful for the contributions from the Center for the Study of the History of Black Cultural Diaspora, the collaboration of the Midwest People of Color Legal Scholarship Conference, and the generous support from DePaul University College of Law Deans Wayne Lewis and Margit Livingston.

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and sexuality may influence health care access and quality care issues. These provocative presentations helped to lay a foundation for future dialogues on urban health. Papers were presented on racial disparities in medicine, urban poor women, sexuality, access to treatment, domestic violence, and health care in the criminal justice system.

Their papers illuminated troubling trends that Dr. George Woods argues characterize a chasm, and not a disparity, suggesting that disparity is too mild of a word and does not fully capture the status of urban health, particularly for people of color. Indeed, doctors themselves have acknowledged racial disparities in the treatment of heart disease and HIV/AIDS, two diseases that disproportionately affect African American patients.

Urban health is an American health care dilemma. Recent studies conducted by the Institute of Medicine, the Kaiser Family Foundation, and by independent scholars reveal troubling trends in health care; health disparities persist and in some cases are worse than ever, even when adjusted for income. In urban communities, access to care is not simply a matter of whether one has health insurance. Although health insurance may be the most important factor in whether or not one may have genuine access to care, a broader understanding of urban health should lead us to consider other factors that contribute to true access or lack thereof. For example, access to care may also be affected by what neighborhood a patient resides in. In certain communities public transportation is unreliable and not always safe. In those same communities private transportation may also be challenging, particularly for the poor. However, these issues are only a small fraction of the considerations contributing to health care disparities in the United States.

Victims of health disparities, particularly in urban communities, tend to have more brown and black faces. Although poverty itself is a significant issue, many of the urban poor happen to be people of color, many of whom have no health insurance at all. For many of the urban poor, access to care is being seen in the emergency wait room at hospitals. Drs. W. Michael Byred and Linda Clayton report in the second volume of their very timely book, *An American Health Care Dilemma*, that historically African Americans have systemically

suffered inferior and inadequate health service.¹ Their well-documented study suggests that America's current health care challenges are linked to past inequities that for African Americans are centuries old. They also suggest that whatever gains were made during America's civil rights movement, have slowly been lost, in part due to decreased funding for medical aid programs and community health centers. Other scholars suggest that welfare reform has dramatically impacted children's health.

Also, as the technology of medical care improves, we would hope to broaden access among different population. However, access for the urban poor has fallen short of expectations. In particular, African Americans are less likely to receive "many types of medical services and procedures."² For example, according to a study on racial disparities in the quality of care for Medicare managed care, "[B]lack bear a disproportionate share of suffering related to a variety of chronic diseases."³ The study also suggests that African American patients are at risk for complicated diseases that otherwise could have been "ameliorated or prevented altogether."⁴

Even for those inner-city people of color with employer-provided insurance, the promise of health insurance is often illusory because of limitations on coverage for pre-existing conditions. Low-income Blacks suffer a disproportionate rate of chronic illnesses such as heart disease and high blood pressure. According to the Centers for Disease Control (CDC) in 1997, 77,174, African Americans died from heart disease, the leading cause of death for Blacks.⁵ About 61,333 died from various cancers.⁶ Exclusion of private health insurance coverage for pre-existing illnesses means that even Blacks who have private insurance may not have coverage for the very condition that most demands treatment.

¹See W. MICHAEL BYRED & LINDA CLAYTON, *AN AMERICAN HEALTH CARE DILEMMA* (2002).

²See e.g., Eric C. Schneider, Alan M. Zaslavsky, and Arnold M. Epstein, *Racial Disparities in the Quality of Care for Enrollees in Medicare Managed Care*, 287 JAMA 1288 (Mar. 13, 2002).

³*Id.* at 1288.

⁴*Id.*

⁵*Cancer Facts and Figures for African Americans*, AMERICAN CANCER SOCIETY 2 (2000-2001).

⁶*Id.*

Jack Lynch, the Director for Community Affairs at the Regional Organ Bank of Illinois noted at our April Symposium that dramatic racial disparities also exist in the field of organ transplantation.⁷ He suggested that disparities in organ transplantation have two distinct characteristics: a) lack of or poor communication from physicians to patients and their families; and b) poor access to treatment and possible racial profiling in the early referral stage.⁸ Patients echo the concerns raised by Lynch. For example, a 1999 study conducted by the New York Daily News highlighted troubling trends among doctors of patients of color in need of transplantation. The study suggests that doctors may be involved in a type of racial profiling by considering the social value of their patients when deciding whether or not they would be suitable for organ transplantation.⁹

However, New York is not alone in facing an urban health crisis. Laurie Kaye Abraham spent three years chronicling four generations of an urban Black family, living in the Chicago area and their engagement with the American health care system. Their dismal treatment and utter hopelessness is summed in Abraham's revealing title for the book: *Mamma Might Be Better Off Dead*.¹⁰

In an effort to bring "people" into the investigation of health care reporting, Abraham follows the pseudonymously named Banes family, interviewing their doctors, friends, others similarly situated, reviewing medical records, the Chicago Jewish Archives, and speaking with policy makers. As Abraham probed, she "moved in and out of this

⁷See Jack Lynch, *Racial Disparities in Organ Transplantation Access*, Apr. 5, 2002 (notes on file with author).

⁸*Id.*

⁹See e.g., Kevin McCoy, *Deadly Disparity in Transplants: Blacks & Hispanics Deprived*, DAILY NEWS (New York), Aug. 8, 1999, at 6 (commenting that Blacks and Hispanics are not placed on organ waiting lists "because their doctors did not refer them"); Brigid Schulte, *Minorities Face Unequal Health in U.S.: Statistics Show Ethnicities Encounter Higher Illness Rates*, FT. WORTH STAR-TELEGRAM, Aug. 2, 1998, at 1 (commenting that doctors are less likely to perform "high-tech" diagnostic treatments on Blacks, and make extreme efforts to save their lives); *Putting Patients First—Allocation of Transplant Organ: Hearings Before the House Commerce Comm. Subcomm. on Health and The Environment and the Senate Labor and Human Resources Comm. and the Senate Labor and Human Resources Comm.*, 106th Cong., 2nd Sess. (1998) [hereinafter *Callender Testimony*] (testimony of Dr. Clive O. Callender)(commenting on institutional racism being "alive and well and thriving" in American healthcare and "the green screen" which he asserts is the financial barrier to Blacks receiving organ transplantation).

¹⁰See e.g. LAURIE KAYE ABRAHAM, *MAMA MIGHT BE BETTER OFF DEAD* 183 (1993).

family's life in an attempt to discover what health care policies crafted in Washington, D.C., or in the state capitol at Springfield, look like when they hit the street."¹¹ What she found were gross inequities so deeply ensconced in the culture of American health care, that although previously an experienced health care reporter, she truly had not fully understood "lack of access to care."¹²

Abraham's findings, like those of Arthur Caplan, Barbara Noah and other scholars, reveal that lack of access is more subtle than simply a lack of health care insurance. The glaring inequities chronicled by legal and medical scholars point to a history and pattern of inequity, a visible gap manifested in how America values its poor as compared to its wealthier citizens. The gap, unfortunately is not only an economic based construction, but has racial implications as well. From miscegenation laws, to eugenics, Tuskegee experiments, and sterilization of women of color, the law, its makers, and American citizens have been involved with a traumatic tango, evidencing racial, gender and socio-economic discrimination and "body valuing." These disturbing eras likened to a mad political dance, intermingling social policies, cultural presumptions, and the law, is buried beneath denial, and a fleeting sense of hope. Consequently, a rich history of the law's engagement with particular groups and their bodies is overlooked, and virtually dismissed by all involved. While some scholars like Faith Davis, Phillip J. Bowman, Paul Lombardo, and Dorothy Roberts, have informed this scholarship by plowing through untilled fields of massive data, documenting the intersectional history of law, medicine and race, such efforts virtually stand alone.

It is hard to parcel out the reasons why patients of color suffer at rates disproportionate to their fellow white Americans for so many diseases. Blaming race alone does not fully bring us to solutions, although racism seems to be an ever-present and functioning force in health care delivery. However, in addressing the challenges in urban health, we might begin to look at poor physician-to-patient communication, ineffectual outreach and support, and lack of available medical facilities in their neighborhoods, as contributing to the urban access problem. As the Health Law Institute continues to examine the

¹¹*Id.*

¹²*Id.* at 2.

intersections of urban health, poverty, gender, race, and sexuality, we hope that you will join us and contribute to the dialogue and scholarship in this field.