How Can We Accelerate Progress Toward Healthcare Equity?

Brian D. Smedley, Ph.D.

The Urban Institute


RACIAL JUSTICE = HEALTH CARE JUSTICE
I CAN'T BREATHE
NURSES FOR BLACK LIVES MATTER


BLM
RACISM IS A PANDEMIC
RESPECT EXISTENCE EXPECT RESISTENCE


RACISM IS A PUBLIC HEALTH CRISIS


RACISM IS A PUBLIC HEALTH CRISIS


White Coats for BLACK LIVES
#RESIST
Racism is a Public Health issue
PUBLIC HEALTH CRISIS
RACISM MAKES OUR PATIENTS SICK
Black Lives Matter


RACISM
is a Public Health CRISIS
National Nurses United

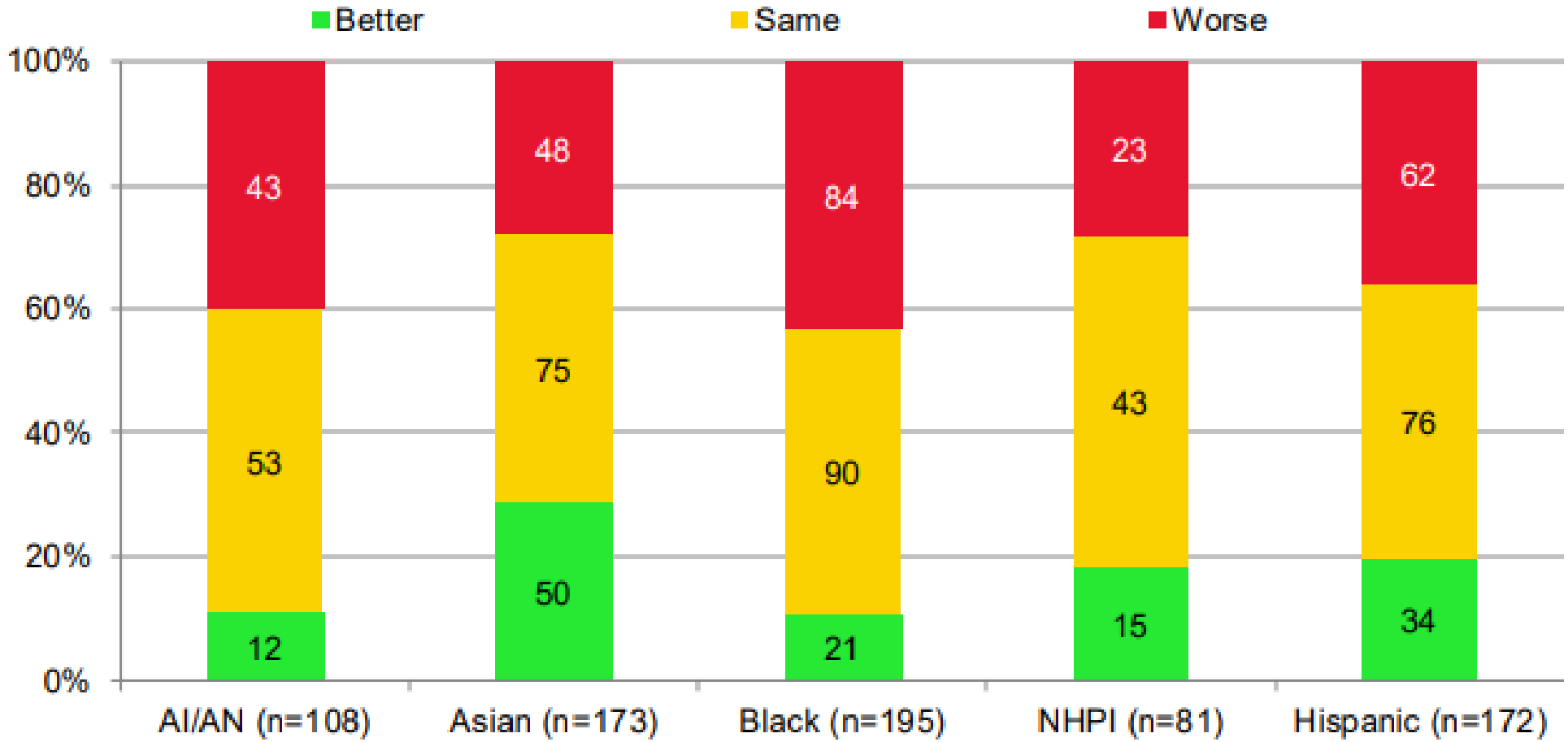

BLACK LIVES MATTER
RACISM KILLS

Are We Making Progress Toward Eliminating Healthcare Disparities?

- The Agency for Healthcare Research and Quality's (AHRQ) 2021 *National Healthcare Disparities and Quality Report* finds that since 2000, disparities "have narrowed for only about 8% of measures of American Indian and Alaska Native populations, 2% of measures for Asian populations, 3% of measures for Black populations, 4% of measures for Hispanic populations, and 10% of measures of Native Hawaiian/Pacific Islander populations."

AHRQ National Healthcare Quality and Disparities Report, 2021

Figure 1. Number and percentage of quality measures for which members of selected groups experienced better, same, or worse quality of care compared with White people for the most recent data year, 2015, 2017, 2018, or 2019



What Factors are Associated with Healthcare Inequity?

- Separate and inequitable healthcare systems – due to residential segregation, the maldistribution of healthcare resources, health system policies (e.g., limited provider networks)
- “Tiered” health insurance and differences in provider reimbursement
- Clinician biases, stereotypes, and prejudice
- Race-based clinical decision support and algorithms
- A persistent lack of diversity among healthcare professionals

“Medical Apartheid” – Separate and Inequitable Care for Patients of Color

(Gangopadhyaya, 2021)

- Study investigated differences in Black and White patient safety measures using hospital discharge records from 27 states
- Black patients experienced higher rates of adverse patient safety events on 55% of patient safety measures
- For 82% of patient safety indicators, **Black patients were significantly less likely to be admitted into hospitals classified as “high quality”** (i.e., hospitals best at minimizing patient safety risks based on the median value of each patient safety indicator)
- This same research team found Black patients experience higher rates of hospital-acquired illnesses or injuries related to surgical procedures relative to white patients **treated in the same hospital**.
- Within-hospital differences in Black-white adverse patient safety rates remain when comparing Black and white patients with **similar coverage types**.

“Tiered” Health Insurance

- People of color remain disproportionately un- and under-insured, despite the ACA

- *Unequal Treatment*: “Medical care financing arrangements should **discourage fragmentation** of healthcare provision into **separate tiers of providers who adhere to different standards of care** and disproportionately serve separate racial and ethnic minority segments of American society. Medicaid and other government programs that mandate enrollment of beneficiaries in managed care should be prepared to pay plans at rates that give Medicaid enrollees access to the same health plan products serving substantial proportions of privately insured patients.”

Racial Bias Among Healthcare Providers

- A systematic review of 15 studies measuring implicit bias and health outcomes confirmed that **healthcare professionals hold the same level of implicit bias** against Black, Latinx, and dark-skinned people as the general population, and that “implicit bias was significantly related to patient–provider interactions, treatment decisions, treatment adherence, and patient health outcomes” (Hall et al., 2015)

- A systematic review of 37 studies confirmed the substantial evidence of “pro-White or light-skin/anti-Black, Hispanic, American Indian or dark-skin bias” among a variety of healthcare professionals across multiple levels of training and disciplines (Maina et al. 2017)

Physician Biases are Associated with Poorer Treatment

- Over 70% of white medical students and residents believe that there are biological differences in pain perception between blacks and whites (Hoffman et al., 2017)

- Physicians' implicit biases contributed to racial and ethnic disparities in the use of medical procedures such as thrombolysis for myocardial infarction. The study also showed that as physicians' IAT (implicit bias) scores increased, their likelihood of treating Black patients with thrombolysis decreased (Green et al., 2007).

Negative Patient Descriptors: Documenting Racial Bias in the Electronic Health Record

(Sun et al., 2022)

- Researchers analyzed a sample of 40,113 history and physical notes (January 2019–October 2020) from 18,459 patients for sentences containing a negative descriptor (for example, resistant or noncompliant) of the patient or the patient's behavior.

- Sought to determine the odds of finding at least one negative descriptor as a function of the patient's race or ethnicity, controlling for sociodemographic and health characteristics [e.g., "refused," "(not) adherent," "(not) compliant," "agitated"].

- Compared with White patients, Black patients had 2.54 times the odds of having at least one negative descriptor in the history and physical notes.

- "Our findings raise concerns about stigmatizing language in the EHR and its potential to exacerbate racial and ethnic health care disparities."

Clinical Decision Support Tools and the (Mis)Use of Race

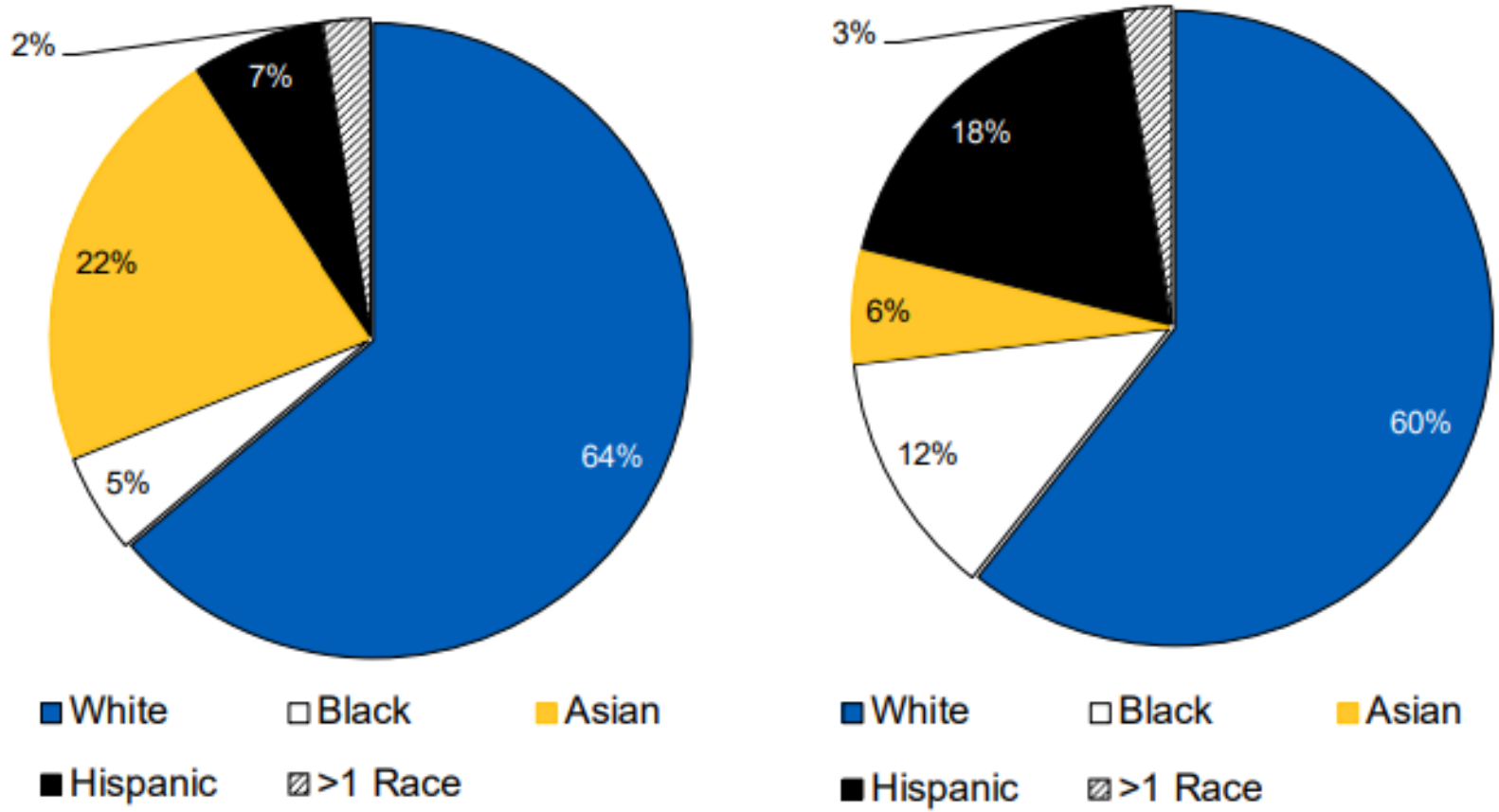
(House Ways and Means Committee, Majority Staff Report, 2020)

- Clinical support tools (CDSTs) can help address racial health disparities, advance health equity, modernize health systems and care delivery, and improve quality of care.
- However, their potential to advance equity while addressing disparities is complicated by the reality that the **methods and assumptions used in the algorithms at the core of CDSTs may themselves import biases** that are detrimental to patients of color.
- New England Journal of Medicine (2020): “Many of these race-adjusted algorithms guide decisions in ways that may direct more attention or resources to White patients than to members of racial and ethnic minorities.”
- While the use of race in clinical algorithms is largely driven by differences in health outcomes that are common to large datasets, **these differences are most likely due to the effects of racism and other determinants of health, not “biological” effects of one race versus another**.

Racial and Ethnic Distribution of Physicians

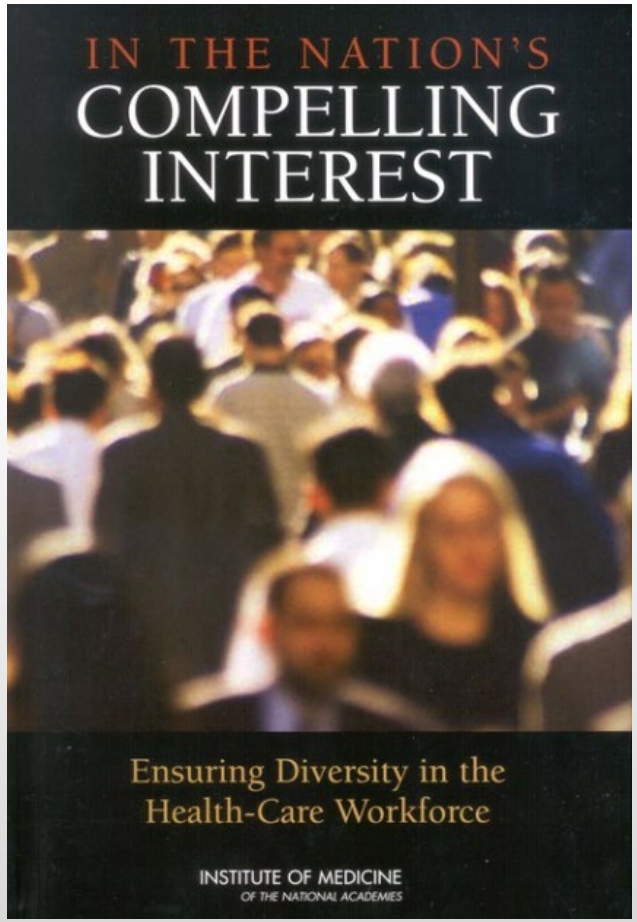
(AHRQ, National Healthcare Quality and Disparities Report, 2021)

Figure 8. Racial and ethnic distribution of all active physicians (left) and U.S. population racial and ethnic distribution (right), 2019



In The Nation's Compelling Interest: Ensuring Diversity in the Healthcare Workforce

National Academies Press, 2005



In The Nation's Compelling Interest: Ensuring Diversity in the Healthcare Workforce

National Academies Press, 2005

- Changes to health professions education admissions – whole file review, de-emphasize standardized tests,
- Attend to the institutional racial climate
- Include diversity efforts in accreditation standards
- Reduce financial barriers for students seeking to work in underserved communities, expand funding for U.S. Public Health Service programs

- Promote educational equity

“Anti-racism is . . . a collective healing, without which our nation will remain painfully and inequitably divided, corroding opportunity, spirits, and bodies alike.”

Dr. Mary Bassett: We Must ‘Name Racism’ As A Cause of Poor Health
Racism is messy. But acknowledging its effects is a key part of improving public health. 02/08/2017