A Pandemic Recovery for Health Care Means Addressing Racial Inequities

written by Theresa Hush | June 4, 2020



Health systems, eager to bring patients back, are using new methods to reach out—mass emails to reassure patients of clean and safe facilities, targeted phone calls to reschedule cancelled appointments and procedures, broadcast television announcements and social media ads that strive to convince patients not to defer care any longer.

Providers hope they can recover by encouraging their patients to return. But the pandemic has changed the landscape in health care, in ways that health systems didn't expect. Significantly, it has laid bare the fact that Black Americans are dying in far larger numbers from COVID-19, driven by more severe risk factors.

The current moment demands that we reflect on this evidence about disparate health care outcomes, and solutions for it. We know that racial biases are present in all aspects of our

culture, not just policing. Now is an opportunity to honestly look into health care and determine how we can rid the system of these biases to provide better health to Black Americans, and to alleviate pain.

In the near and far future, bringing down the costs of health care will require reducing risk factors for Black Americans, both because it is the ethical thing to do and also because doing so will lower patient costs and pandemic spikes. That financial reality will become clear to providers as well as payers, employers, and consumers as health care losses mount under the pandemic.

There is overwhelming data that shows that people of color, especially Black Americans, suffer poorer outcomes, including death, across all conditions. And all too often, those outcomes are blamed on the patient. Health care is full of language that implies that Black women or Black men, depending on the medical condition, are not able to “manage” their conditions. In other words, we are blaming these patients for getting worse, for their diabetes progressing to kidney failure and amputated feet. We blame Black women for their higher maternal mortality by implying that they didn’t take care of themselves. We blame Black women for higher deaths by heart attacks by assuming they didn’t do anything to address health risks. The truth is that we don’t always know the reasons for poorer health outcomes, or how genetic and biological factors create more serious risks.

Differential Risks and Inequities in Health Care Have Come Under Strong Light

COVID-19 created the first widespread realization, finally, about how inequities in health care contribute to a tragic

death rate for Black Americans, well beyond their proportion in the population. Despite also having significantly higher medical risks, black and brown workers provide many of the essential services that are keeping the rest of the economy and country going, and are paying for it by getting sick. Those of us who are fortunate enough to work from home and continue to get groceries delivered and garbage removed are enabled by the mostly Black and Latinx workers who put themselves at risk. The heartless murder of George Floyd by police last week is not just the most recent, flagrant example of racism against black men, but an atrocity that is the culmination of months of pandemic deaths of Black Americans, with roots in the same racial discrimination. And it should incite a change in health care as well.

The data on COVID-19 deaths clarifies who has not been helped by our health care system. Vulnerabilities to the virus are supported by a strong body of data about chronic health risks for people of color: higher rates of heart attacks, deaths by metastatic breast and other cancers, maternal mortality and reproductive system disease and cancers, autoimmune disease and chronic stress. Likewise, risk factors like diabetes, hypertension, and obesity are significantly higher in black communities.

Racial disparities in health outcomes may be a frequent subject of studies and many health initiatives, but there has yet to emerge an urgent commitment to real change that addresses systemic racial bias as a root cause. Health care providers must confront attitudes that blame Black Americans for their own conditions and risk factors, while failing to address lack of insurance, income, access to healthy food and primary health

care, and educational opportunities. In the last decade, evidence emerged that a genetic hypersensitivity to salt may be influencing outcomes specifically for Black Americans with hypertension. Yet there is a tendency to assume that unhealthy habits and noncompliance lie at the root of poor outcomes, rather than our system's failure to tailor clinical and administrative strategies. Black Americans are set up to fail in health care, and then redlined when they need care—either by coverage that is not accepted or lack of community facilities.

The Reopening of Health Systems Could Lead to Further Inequities

As health systems balance risk and patient flow while they reopen services, they continue to look to telehealth to fill the gap in care. Many consider telehealth to be a permanent fixture in health care and want to vastly expand it.

But there are dangers to a telehealth expansion strategy. We haven't yet calculated who has benefited from telehealth during the shutdowns and related outcomes across race, ethnicities, and language. If we are committed to reducing disparities in health care, we can't target delivery strategies that work for some groups—e.g., people with high speed internet—and not others, like people less likely to have computers or who have inadequate internet service. We need to measure outcomes to ensure that we are not reducing access and worsening health conditions. We simply cannot afford risking further restriction of access to care for Black and Latinx Americans, without first assessing and resolving these issues.

Use of Social Determinants and Risk Stratification Can Be Helpful or Negative

Understanding that there are health risks as well as obstacles to treatments is a positive step that helps connect patients with needed behavioral health and community services. But collecting and building population health strategies using Social Determinants of Health (SDOH) is not enough to make health care equitable. Nor is it always used for good.

In fact, SDOH can also be used negatively to tag patients as noncompliant or brand them as high risk. Similar labels were used to dismiss patients from practices under financial risk in HMOs. The collection and use of SDOH data must be guided by ethics and accountability in health care, and closely monitored to ensure that discriminatory systems are not set up to eliminate patients.

Likewise, risk stratification and risk factors themselves are double-edged. Not understanding the underlying genetics or biology leads to assumptions about consumers' choice of maintaining risk over health—particularly for women of color. Obesity, for example, is commonly attributed to choices in diet and exercise, when the reality is much more complex and medical knowledge is still at an early stage.

The current state of medical science does not have all the answers to why certain risk factors exist, why patients simply cannot reduce their risks. But we do know that there is more than choice at play.

The Opportunity for Health Systems to Address Racism and Inequities Is Now

If the pandemic created an opportunity to revisit how health care is provided to communities of color, this past week kicked that door wide open to reveal how racial biases influence health care. But there is also no environment better equipped to address these issues of quality and equity than health care. Doing so builds on systems that articulate values and measurement of results, where values are explicitly articulated and measures of quality are woven into the culture.

Doing so is also necessary. Providing better health outcomes does not happen if we don’t listen to people and tailor solutions to their circumstances. There is overwhelming data that shows that Black Americans experience some diseases differently, and that they are dying in greater numbers than white Americans. Those numbers can no longer be ignored.

Responsibility for outcomes is beyond what physicians and health systems once believed their “job” to be: provision of strictly medical care. The accountable care movement and Value-Based Health Care have specifically focused on a much larger context for health care outcomes. The time to fully embrace that new accountability is now.

Where to begin? Let’s take a lesson from all the voices on the streets and start listening. There are stark messages that speak to health care as much as to any circumstance where human dignity and pain are at stake:

“Can you hear us now?”

“My color does not make me a risk.”

“Privilege is when you call it untrue because you don’t experience it personally.”

“Black lives matter.”

We can see patients for who they are and what they are telling us. We can quit assuming that uncontrolled chronic disease is their fault, and that they are not complying with treatment. We can perceive the pain expressed by Black women as a real symptom, and accept that something is wrong. Failure to listen or understand patients leads to misdiagnoses and inappropriate treatments that can prove fatal.

Rooting out racism and inequities requires conversations within organizations that are stark, emotional, and far-reaching. That discussion needs to happen in health care, with both health care professionals and patients involved in the dialogue.

There are more than enough clinical and administrative areas with glaring disparities in outcomes to choose from in order to concentrate efforts to reduce inequities. We just need to follow the ample data. The familiar process of using data, analytics, and measures of quality to evaluate health care processes and outcomes sorely needs to include race, ethnicity, and gender.

The real guts of this effort involves refining approaches and interventions to change outcomes. Science and health systems cannot determine or impose these; there is too much history behind experiments based on race that has wreaked harm on many

racial groups, including Black Americans.

Instead, transparency and inclusion of people of color—patients, communities, researchers, and physicians—are essential to bringing about change. And they must comprise the leadership of such efforts.

Change is hard and has come slowly to health care. This is the moment to catalyze profound transformation of health outcomes for people of color in the United States. Our health care system won't recover unless we work it out.

Founded in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk.

Image: Julian Wan