COMMENT

Racism: a fundamental driver of racial disparities in health-care quality

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Racial disparities in health-care access, quality and outcomes are pervasive and persistent. Racism is a fundamental driver of racial disparities. Individuals and institutions in the health-care system must prioritize addressing racism as their professional responsibility through training, support and inclusion.

" … race and racism and their effects are at the core of racial disparities seen in healthcare "

In 2003, the United States (US) National Academy of Medicine published *Unequal Treatment*, highlighting pervasive racial disparities in health-care quality that were not accounted for by differences in access, disease severity or socioeconomic status. These inequities persist, as Black, Indigenous and Hispanic populations received worse care than white populations in 35–40% of US health-care quality measures in 2018 (REF.[1]). Racial disparities exist across specialties. For example, Black and Hispanic children with autism experience delays in diagnosis[2], Black elderly patients have higher readmission rates after a total knee or hip replacement[3], and Black patients have higher rates of mortality after cancer surgery for nine common cancers[4], compared with their white counterparts. These disparities have stayed the same[4] or have increased[3] over time.

The societal constructs of race and racism and their effects are at the core of racial disparities seen in healthcare (BOX 1). Race is not reflective of inherent genetic differences. Nevertheless, there is a long history of health-care systems perpetuating the myth of biological inferiority to rationalize the oppression of communities of colour. Historically, health-care providers and researchers have rationalized the enslavement, genocide and exploitation of different populations[5]. Existing scientific evidence has debunked the myth that race captures genetic difference but the effects of race remain evident. In one survey of 600 US physicians in 2005, 81% believed that race should be used as a biological variable to determine disease and 85% felt that drugs for specific racial and/or ethnic groups provide a therapeutic advantage[6]. These survey answers exemplify how the biomedical community often views race as a proxy for biological difference, rather than reflective of societal categorization. This belief can also lead to differential care, with one study finding that medical trainees who endorsed false beliefs of biological distinction between Black and white individuals were more likely to underrate and undertreat pain in Black patients compared with white patients in identical scenarios[5]. Racism also creates conditions in which historically disadvantaged groups are chronically exposed to adverse psychosocial, economic and environmental stressors that lead to earlier onset, higher rates and greater severity of disease. Understanding these differential exposures and their effects is necessary to contextualize any discussion or investigation of racial disparities in health and healthcare. Inappropriately attributing racial disparities to inherent genetic differences or discussing racial disparities without this important context can perpetuate false beliefs of the past[5–7].

Cultural racism is a driver of bias and discrimination against communities of colour. Racial biases are preconceived assumptions, beliefs, or stereotypes about a racial group that can affect behaviour consciously or unconsciously. There is substantial evidence that these explicit and implicit racial biases are prevalent among health-care providers and contribute to lower quality of care for patients of colour through their negative effect on provider behaviour and communication[5]. For example, literature demonstrates that higher implicit bias in physicians is associated with lower quality of care for marginalized groups[5]. Reports of racial discrimination are common among marginalized racial groups and associated with negative mental health outcomes, preclinical indicators of disease (such as cortisol dysregulation and coronary artery calcification) and physical health outcomes (such as hypertension, diabetes mellitus and obesity)[8]. Discrimination within and outside of health-care settings has also been associated with patients demonstrating reduced adherence to medical recommendations and delaying medical care[8].

Importantly, racism affects an individual's opportunity to receive high-quality care before entering health-care settings. The disproportionate burden of negative social determinants of health among communities of colour must be understood within the historical context that created it[5]. This includes government-sanctioned residential and hospital segregation and chronic under-resourcing of health-care delivery to these communities. Furthermore, hospitals in these communities are more likely to close and providers are less likely to be able to refer their patients to high-quality specialty care[9].

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Box 1 | **Definitions**

Race
A socially constructed categorization that is defined and redefined by members of the dominant group to carry out the system of racism. It is time-dependent and place-dependent and is not reflective of inherent genetic difference.

Racism
A societal system built by a dominant racial group based on a belief of their intrinsic superiority, which categorizes individuals into 'races' and uses collective power to structure society in a way that provides unearned advantages to the dominant race whilst creating structural disadvantages for non-dominant races deemed inferior[8].

Cultural racism
The process through which the ideology of racism is accepted and instilled, implicitly or explicitly, by individuals, institutions, and the broader society.

Structural or institutional racism
The policies, practices and norms that serve to collectively discriminate against non-dominant racial groups[8]. The interplay between cultural and structural racism serves to uphold this unequal system within societal institutions. Health-care institutions are no exception to this pattern.

Many members of the health-care community are not aware of how racism drives racial disparities, which is also evident in contemporary medical literature[6]. To effectively eliminate racial disparities, members of the health-care community must be made aware of their existence and understand that addressing racism is at the core of addressing racial disparities in healthcare. Thoughtful training to address racism in healthcare, reduce biases, and increase patient centered care should be integrated throughout the health-care community and provided to all members, regardless of training level[7]. In one study, primary care physicians with high, self-rated cultural competency provided higher quality and equitable care to patients with HIV compared with physicians who had lower cultural competency[7]. In this study, indicators of competency included being aware of the importance of family, friends and social history to health, the necessity to inquire about perceived cause of illness and alternative therapy use, and patient inclusion in decision making.

Addressing racism must be prioritized throughout health-care institutions and must be viewed as the professional responsibility of all staff, students, clinicians, researchers and educators in this setting. This can be achieved by creating requirements for health-care organizations to demonstrate active work towards the elimination of racial inequities in their organizations. For example, health-care institutions and licensing boards could create mandatory antiracism trainings that are eligible for Continuing medical education (CME) and required for recertification. Accreditation bodies could consider including metrics around workforce representation, measures of diversity and inclusion climate, and health equity in patient outcomes on the list of quality standards by which institutions are evaluated and compared[7]. Academic journal editors can consider strict publication standards that include the acknowledgement of racism as a fundamental cause of racial disparities, and grant agencies can increase funding for this work[10]. Special attention must be given to support and uplift members of the health-care organization from marginalized backgrounds, as well as community voices of patients and populations served by the institution, through thoughtful inclusion practices. Improved diversity in the health professions is also essential in reducing racial disparities in healthcare. Increased diversity among trainees has been shown to reduce implicit racial bias and increase confidence in caring for diverse populations[7]. Institutions should be held accountable to demonstrate meaningful improvements in representation, particularly in the representation of historically marginalized groups. With this increase in representation, it is important to ensure that health-care organizations foster a culture of respect, promote psychological safety, and create accountable and transparent reporting systems of bias and discrimination[7].

> "Addressing racism must be prioritized throughout health-care institutions …"

For many, it can be uncomfortable, unfamiliar, and overwhelming to address racism in healthcare. Fortunately, there are strategies for individuals and institutions to begin and continue this important work. At the core of each of these examples is the need to acknowledge, identify and address racism and its manifestations as a fundamental cause of racial health-care disparities through prioritization at the individual and institutional level. Racism is a system that was built over time. It is not unchangeable or insurmountable despite its pervasiveness. By understanding how it was built and identifying its manifestations, members of the health-care community can work together to combat racism and effectively eliminate racial disparities in healthcare.

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Competing interests
The authors declare no competing interests.