The Health Care Institution, Population Health and Black Lives

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The ongoing existence of institutionalized racism and discriminatory practices in various systems (education, criminal justice, housing, employment) serve as root causes of poor health in Blacks Lives. Furthermore, these unjust social structures and their complex interplay result in inefficient utilization of health services and reactive or futile interactions with medical providers. Collectively, these factors contribute to racial disparities in health and treatment represents a significant portion of the nation's health care expenditures. In order for health care systems to optimize population health goals, racism must be recognized as a determinant of health. As anchor institutions in their respective communities, we offer hospitals and health systems a conceptual framework to address the issue within internal and external constructs.

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INTRODUCTION

While some may assert we live in a post-racial era, a body of scholarship corroborates the presence of structural racism in contemporary settings.[1–5] Most recently, a series of events have elevated social consciousness about the Black experience in America.[6] Consequently, the *Black Lives Matter* movement gained momentum in 2012, serving as a "call to action and a response to the virulent anti-Black racism that permeates our society.[7]" The mission specifically focuses on addressing "ongoing and widespread devaluation of Black Lives and the social, political, and economical structures that result in unequal opportunity.[7]" Such forms of injustice have a profound effect on communities of color and are manifested through inequities in common correlates of health, including access to quality education, healthy foods, livable wages, and affordable housing.

Moreover, a substantial body of evidence highlights the relationship between race, racism and health status.[8–12] Blacks are disproportionately burdened by poorer access and lower quality of care even when controlling for factors, such as income, education, and insurance.[8,13] They also represent higher rates of morbidity and premature mortality when compared with white counterparts. Some of the starkest differences can be found in hypertension, diabetes, and asthma rates, resulting in higher frequencies of treatment for comorbidities and ambulatory care sensitive conditions.[14–19] Such racial disparities have a significant financial impact and are estimated to cost $35 billion in excess health care expenditures and $10 billion in illness-related lost productivity.[20]

In response to these disparities, many health care institutions have demographically stratified and analyzed health outcome data and incorporated best practices to create interventions to reduce or eliminate disparities in care. However, due to broader structural contexts, significant disparities persist. We assert that these trends will remain intractable until structural racism and its effects (bias, discrimination) are recognized as root causes of poor health. This approach is especially relevant as health reform is incentivizing health care leaders to find new and more creative ways to promote wellness, reduce readmissions, and manage the health of populations. By applying a racial equity lens in how they are governed and operated, hospitals, as anchor institutions, can advance their population health goals.[21]

Using health reform as a springboard, we articulate why this approach is important and close with a conceptual framework to stimulate thought and organizational practices that (1) promote racial equity within health care settings; and (2) contribute to the advancement of historically marginalized communities of color.

HEALTH EQUITY AND BLACK LIVES

In light of the magnitude and long-term psychological impact of racism, coupled with a history of implicit and explicit injustices imposed on those of African descent, two definitions in the literature inform our interpretation of health equity within the context of Black Lives. In 2003, Braveman and Gruskin defined health equity as a goal of eliminating systemic disparities in health or in the major social determinants of health (i.e., education, housing, employment) between social groups who have different levels of underlying social advantage and disadvantage –

that is, different positions in the social hierarchy.[22] Camara Jones construes health equity as the assurance of the conditions for optimal health for all people, which requires valuing all individuals and populations equally, rectifying historical injustices, and addressing contemporary injustices by providing resources according to need.[23] Consequently, we assert that it is important for health care leaders to recognize institutionalized injustices in their own communities and carefully examine how they impact the health of the populations they serve.

Note:

The focus of this commentary is on Black Lives; we also use "minorities" and "communities of color" interchangeably based on contextual language.

INSTITUTIONALIZED RACISM AND ITS EFFECTS

In order to be effective in improving health through a racial equity lens, it is important to recognize how the health care institution is a subset of a larger ecosystem with vestiges of institutionalized racism, stemming as far back as the 1600s.[9] The legacy continues to influence how low income communities of color are structured and resourced.[23,24] *Institutionalized racism* is defined as "the structures, policies, practices, and norms resulting in differential access to the goods, services, and opportunities of society by race. It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator.[23]" Despite the passage of prominent legislation that makes explicit forms of racism illegal, remnants of historically grounded policies and practices that perpetuate poor health in contemporary settings are evidenced through racial segregation and unequal distribution of resources.[24,25]

The consequences of these injustices are multifactorial and detrimental to the well being of society, but for the purposes of this commentary, we focus on the relationship between institutionalized racism and health. More specifically, a growing body of evidence suggests racism as a social determinant of health.[24,26] For example, chronic exposure to discrimination creates a physiological or hormonal response (survival stress) that may stimulate or exacerbate chronic disease conditions – making it challenging to improve individual health.[24,26–28] This recognition is especially important to providers as a newly insured cadre of persons enter systems of care – many of whom have low income – encountering day-to-day psychosocial barriers that emanate from discriminatory policies and practices.

Within a historical context of medical care, persons of color have had a profoundly unique experience. Countless numbers of Blacks were medically exploited and subjected to inhumane and traumatic experiences. While the Tuskegee experiment is widely referenced in the literature, it is an isolated depiction of a more systemic, robust and pervasive agenda to advance medicine at the expense of Black Lives.[29] The legacy and trauma associated with the atrocities have deeply affected Black Americans' perceptions about the health care system and how they consciously or subconsciously interact with providers.[8,30] For example, scholars have found Blacks more likely than Whites to distrust the health care system and more likely to prefer racially concordant providers.[30–35] Such distrust, coupled with underrepresented people of color in medicine,[36] impede patient engagement and may be culpable for late stage diagnoses and/or exacerbation of chronic disease conditions in persons of color.[30]

In addition to distrust at the patient-level, providers are susceptible to decision-making based on implicit biases – attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner.[8,12,37–39] Documented occurrences of racially driven decision-making in clinical settings have not been characterized as intentional but partially attributed to subconscious perceptions that emanate from exposure to high frequencies of negative portrayals of Black Lives at a societal level.[40–42] Consequently, actions that stem from biases compromise quality of care through error, miscommunication, no referral or inappropriate referral to specialty care or medical procedures, and misdiagnosis of medical conditions.[10,12,43,44]

POPULATION HEALTH

The gravity of these dynamics must be recognized within the context of *population health* – a term that has progressively increased in the literature since 2010.[45] While the interpretation and its utility tend to vary depending on discipline or profession, health care institutions are likely to perceive population health as clinically managing the patients under the auspices of their care. However, health outcomes for these patients are heavily influenced by structural conditions and the quality of assets that are available across the life span. Therefore, we advocate for a more comprehensive interpretation.

In 2003, Kindig and Stoddart defined the term as "the health outcomes of a group of individuals, including distribution of such outcomes within the group."[46] They posit, "the field of population health includes health outcomes, patterns of health determinants, and policies and interventions that link the two."[46] Young describes