

# PRINCIPLES ON STRUCTURAL RACISM AND HEALTH CARE

Members of America's Essential Hospitals provide high-quality care for all, including the most vulnerable. Our more than 300 member hospitals and health systems are vital to the nation's health care safety net, with three-quarters of our patients having no insurance or covered by Medicaid or Medicare. People of color constituted more than half our members' discharges in 2018. We acknowledge that structural racism—the normalization and legitimization of historical, cultural, institutional, and interpersonal dynamics that routinely advantage white people while producing cumulative and chronic adverse outcomes for people of color—is a barrier to health. As an association, we are dedicated to acknowledging and addressing the deeply entrenched and historical racism that plays a critical role in determining the health and well-being of each member of our communities. As policymakers look to address ways in which structural racism impacts health care, we urge them to consider these principles:

## **1. Structural racism causes harm and is a public health threat.**

Structural racism is widespread and has caused harm to minority populations. For example, the National Center for Health Statistics reports that the death rate for Black mothers (per 100,000 live births) was 2.5 times the rate of white mothers in 2018, illustrating serious racial and ethnic gaps in maternal mortality health.<sup>1</sup> The COVID-19 public health emergency further illustrates racial disparities in health care, as Black people are dying at 2.3 times the rate of white people from the virus nationwide.<sup>2</sup> Inequities in the health care space that stem from structural racism threaten the lives of racial minorities in the United States.

## **2. Long-standing policies and practices have led to racial inequalities. This institutionalized discrimination must be identified and corrected to eliminate the impacts of racism on health care and beyond.**

In the health care space, long-standing policies and practices exist that further inequalities. For example, low Medicaid base rates are discriminatory policies that widen the equity divide in the nation. Similar examinations are necessary outside of health care policy, including in

housing, lending, education, criminal justice, employment, and environmental policy. Examining and acknowledging these long-standing policies is an important step toward eliminating harmful practices. Hospitals should advocate for changes to policies, such as payment rate inequities, that currently preserve discrimination.

## **3. The health care workforce must be educated about the impact of racism and how to provide unbiased care. Likewise, those health care workers who have been impacted by racism or racist behavior must be supported.**

To improve health care for all, the workforce should understand the role of structural racism in furthering racial inequalities. Funding for implicit bias training and other self-assessment tools will provide health care facilities with appropriate tools to improve their practices. Policies should also be implemented to support workers who have been impacted by racism.

## **4. The health care education system has an obligation to address historic and current discrimination and to educate a diverse pool of candidates for the next generation of health care professionals.**

The health care workforce should reflect the community it serves. As such, there is a need for increased diversity in the health care workforce pipeline, and the health care education system should actively recruit students from underrepresented communities. Case studies that include diverse patients should be included in the health care and medical curriculum. These improvements could be made most thoroughly through federal investments to address disparities in the medical education system.

## **5. Hospitals and other stakeholders must work together to identify opportunities for cross-sector, upstream collaborations aimed at dismantling historic and current social barriers, including housing and education.**

Social determinants, such as housing stability, education level, and food availability, are strong indicators of one's health. When community members suffer from social barriers, their health also is at risk. Federal investment in

addressing social determinants can drive collaboration between community stakeholders to dismantle existing barriers.

**6. The federal government, states, localities, and civic partners must work with hospitals and other stakeholders to invest in the economic growth of vulnerable and minority communities.**

Economic status and health are closely linked. While higher incomes are associated with better health, it also is believed that investments in health and health care can increase economic growth in a community. Policymakers at the federal, state, and local levels should provide incentives for investments in marginalized communities, and they should work with hospitals and other stakeholders to promote strategies such as inclusive purchasing policies and local hiring and contracting practices.

**7. Resources must be allocated to research and address environmental factors, such as toxic stress, that impact health in historically marginalized communities.**

We are learning more about the causes of toxic stress and the damage it may do. However, there is much that remains unknown about how environmental stress impacts health. The study of how environmental factors impact gene expression, known as epigenetics, is a new field, with the potential to expand our understanding of the long-term impacts of structural racism. More funding is needed to expand basic and applied research in these areas and promote implementation of best practices. For example, research shows that screening for adverse childhood experiences can improve health outcomes for those who may be especially vulnerable.<sup>3</sup> Policies that offer incentives to promote and adopt best practices in these areas are needed.

**8. Hospitals and other stakeholders must work with patient and community groups to gain trust among minority populations.**

Distrust in medical institutions and public health has a long history in the United States—from the failures of the Freedman’s Bureau to the Tuskegee trials in the 1930s and other transgressions—and is felt today as the COVID-19 pandemic disproportionately impacts minority communities. Research shows that individuals’ general trust varies and is associated with race and ethnicity, age, education, and household income.<sup>4</sup> Nonwhites, those younger than 50, and those with less education or income are more likely to have low trust overall.

**9. Patients and community-level stakeholders must be engaged in the dialogue on racism and health care.**

Successful policy change can only occur when patients and community-level stakeholders are involved in the dialogue and have opportunities to address their own health care needs. Policymakers should include representatives from marginalized communities when they discuss policy changes. Hospitals and other providers should ensure patients’ voices are heard when they implement changes in their facilities.

*Notes*

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2. The COVID-19 Racial Data Tracker. The COVID Tracking Project. The Atlantic Monthly Group. 2020. <https://covidtracking.com/race>. Accessed October 8, 2020.
3. Bryant C, VanGraafeiland B. Screening for Adverse Childhood Experiences in Primary Care: A Quality Improvement Project. *Journal of Pediatric Health Care*. Mar-Apr 2020;34(2):122-127. <https://pubmed.ncbi.nlm.nih.gov/31704177/>. Accessed October 8, 2020.
4. Stephens J, Lambalot H, Ramiah K. *Patient Trust: A Guide for Essential Hospitals*. Essential Hospitals Institute. July 2020. [https://essentialhospitals.org/wp-content/uploads/2020/08/20-057\\_AEH\\_Report5.26.pdf](https://essentialhospitals.org/wp-content/uploads/2020/08/20-057_AEH_Report5.26.pdf). Accessed October 8, 2020.