Intersection of Bias, Structural Racism, and Social Determinants With Health Care Inequities

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Race, and more specifically, racism, is recognized as an important social determinant of health (SDoH) and a key driver of health inequities.[1–3] The study "Race, Postoperative Complications, and Death in Apparently Healthy Children" in this issue of *Pediatrics* provides new evidence of race as a critical social determinant of surgical outcomes.[4] The investigators demonstrate that apparently healthy Black children had a higher risk of postoperative mortality, complications, and serious adverse events than their white counterparts. Identifying these disparities using the National Surgical Quality Improvement Program pediatric database highlights the importance of health care practices to more deliberately consider equity in their quality improvement portfolios. The analyses were done among children with American Society of Anesthesiologists physical status 1 (normal healthy patients) or 2 (patients with mild systemic disease, such as mild asthma). By excluding children with significant comorbidities, this study helps advance knowledge beyond most previous pediatric disparities research focused on identifying disparities by exploring potential root causes. The findings suggest that, although preoperative comorbidities have previously been proposed as a factor contributing to postoperative disparities, they do not explain the results in the current study.

Implicit racial bias has been proposed as another potential source of health care disparities.[5] Implicit bias is pervasive in society, and research has demonstrated that health care providers have similar levels of implicit racial bias as the general population.[6] Research on the impact of provider bias on medical decision-making has been focused largely on adult patient populations and has revealed mixed results.[6] However, one study revealed that pediatric providers with greater implicit bias were more likely to prescribe narcotic medications for postsurgical pain for white children than Black children.[7] In adult patient populations, there is robust evidence that physicians with more implicit bias demonstrate higher verbal dominance in their communication styles and are rated lower in patient-centered care measures, including trust and interpersonal treatment (eg, showing care, concern, and respect).[8–14] Patients of providers with more implicit bias also report less satisfaction with care and less confidence in treatment recommendations.[14] Although more research is needed to understand the impact of bias on communication and medical decision-making in pediatric patients, there is sufficient evidence to suggest that eliminating health care disparities requires providers to identify and mitigate the effects of their own implicit bias on patients and families.

Others have suggested that the association of patient-level sociodemographics with postoperative mortality is related to system-level

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factors, including access to care, location of care, and institution type.[15] This highlights the important intersection of structural racism and SDoHs with health care inequities. Structural racism refers to policies, laws, and regulations that systematically result in differential access to services and opportunities in society based on race.[16] One example of structural racism is redlining, which refers to a practice by the federal Home Owners' Loan Corporation in which neighborhoods were marked as hazardous with red ink on maps largely on the basis of racial demographics.[17] This resulted in not only systematic denial of mortgage lending but also denial of other capital investments and services, such as public transportation, supermarkets, and health care facilities in communities of color. Historic injustices, such as redlining, orchestrated the current residential segregation that we see in society, which fuels health care disparities by systematically influencing health care access, use, and quality.[18–20] More recently, gentrification in cities across the country is leading to marginalized populations being priced out of neighborhoods and displaced into the peripheries of society with inadequate transit systems. This results in decreased access to supermarkets, employment opportunities, and high-quality health care.[21] Addressing pediatric health care disparities, therefore, requires dismantling policies that drive SDoHs disproportionately experienced by communities of color. Health care systems can address SDoHs by serving as anchor institutions and supporting economic growth in communities that have historically experienced systematic denial of capital investments from policies like redlining.[22] Pediatric medical and surgical providers can address SDoH by advocating for policies that have a positive impact on where children live (eg, fair housing, healthy food markets), learn (eg, equitable education system), and play (eg, safe playgrounds).

Eliminating disparities also requires addressing systems in place in clinics and hospitals that perpetuate inequities. For example, health care systems should consider which health insurance plans they accept and how this may disproportionately deny access to care for children of color.[23] Health care leaders should also be mindful of strategies to improve their payer mix, which has been described as coded language for restricting or denying care to publicly insured patients.[23] Instead, efforts should be made to bring high-quality health care to underserved communities as a strategy to reduce pediatric health care inequities. Providers should also consider the American Academy of Pediatrics' recently published policy statement, "The Impact of Racism on Child and Adolescent Health,"[24] which provides several strategies on how to optimize clinical practice to ameliorate the effects of racism on child health and health care. Policies and programs that support racial diversity in the medical workforce are also needed as a strategy to reduce disparities.[25]

Although this research sheds light on concerning pediatric disparities and examines potential root causes, there remains a critical need to develop and rigorously evaluate effective interventions to reduce avoidable and unjust inequities in pediatric health care. In addition to traditional quality improvement and research approaches to address disparities, achieving child health equity necessitates dismantling the policies and structures that perpetuate inequities. Pediatric providers and organizations can begin by identifying and confronting our own biases and serving as antiracism advocates within our institutions as well as in our communities.

ABBREVIATION

SDoH: social determinant of health

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