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OVERVIEW

Structural Racism In Historical And Modern US Health Care Policy

ABSTRACT The COVID-19 pandemic has illuminated and amplified the harsh reality of health inequities experienced by racial and ethnic minority groups in the United States. Members of these groups have disproportionately been infected and died from COVID-19, yet they still lack equitable access to treatment and vaccines. Lack of equitable access to high-quality health care is in large part a result of structural racism in US health care policy, which structures the health care system to advantage the White population and disadvantage racial and ethnic minority populations. This article provides historical context and a detailed account of modern structural racism in health care policy, highlighting its role in health care coverage, financing, and quality.

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Members of racial and ethnic minority groups have long suffered from health inequities in the United States, and the COVID-19 pandemic has mercilessly worsened many of these inequities. As of November 2021, American Indian and Alaska Native, Black, and Latino people all had suffered from higher rates of hospitalizations and deaths related to COVID-19 compared with White people.[1] These inequities result, in large part, from racial and ethnic minority populations' inequitable access to health care, which persists because of structural racism in health care policy.

Racism includes a complex array of social structures, interpersonal interactions, and beliefs by which the group in power categorizes people into socially constructed "races" and creates a racial hierarchy in which racial and ethnic minority groups are disempowered, devalued, and denied equal access to resources.[2] Racism is often tied to the actions of an individual perpetrator, such as a health care professional denying equitable care to minority people. However, this narrow perspective ignores structural racism in health care, which shapes the many ways in which the US health care system is structured to advantage the White population—the racial group in power—and disadvantage racial and ethnic minority populations.[3] A "characteristic of racism is that its structure and ideology can persist in governmental and institutional policies in the absence of individual actors who are explicitly racially prejudiced. ...[R]acism is [also] adaptive over time, maintaining its pervasive adverse effects through multiple mechanisms that arise to replace forms that have been diminished."[2]

Structural racism operates through laws and policies that allocate resources in ways that disempower and devalue members of racial and ethnic minority groups, resulting in inequitable access to high-quality care.[3] One of the most visible examples of this is health insurance inequities. The federal government has acknowledged that "inadequate health insurance coverage is one of the largest barriers to health care access, and the unequal distribution of coverage contributes to disparities in health."[4] A recent study that considered income, race, and self-perceived health status found not only that racial identity is independently associated with lack of health insurance but also that "low-

income [minority people] with bad health had 68% less odds of being insured than high-income [White people] with good health."[5]

Although there are other aspects of US health care policy that contribute to an inequitable system of care, in this article we provide a comprehensive review of how structural racism, embedded in health care policy, results in inequitable access to high-quality care. We first examine how racism shaped early policy decisions that allowed local governments and private employers to provide inequitable access to health care and health insurance. We then discuss structural racism's continued impact on modern health care policy in the areas of health care coverage, finance, and quality.

Structural Racism In Early US Health Care Policy

Since the Jim Crow era (1875–1968), racism has implicitly and explicitly been an integral part of the US government's structuring and financing of the health care system. For example, in 1946 the federal government enacted the Hospital Survey and Construction Act, commonly known as the Hill-Burton Act, to provide for the construction of public hospitals and long-term care facilities.[3] Although the act mandated that health care facilities be made available to all without consideration of race, it allowed states to construct racially separate and unequal facilities.[3] In addition, federal programs such as the Medical Assistance for the Aged program (also known as Kerr-Mills), which provided health care to the poor, "were underfunded and few states participated, especially states with large populations of Black Americans."[6]

Even if a health care facility was accessible to racial and ethnic minority populations, they often did not have the money or health insurance to pay for the care available. The federal government enacted a number of laws that not only supported the occupational segregation of racial and ethnic minority workers in low-wage jobs in the service, domestic, and agricultural industries but also excluded racial and ethnic minority workers from laws that increased wages and offered protections for collective bargaining that resulted in paid sick leave and health insurance for other workers.[3,6] These laws primarily benefited White workers because either racial and ethnic minority workers were explicitly excluded from the benefits or employers and unions were allowed to discriminate against such workers.[3,7] For example, the National Labor Relations Act of 1935 expanded union rights for workers, which resulted in higher wages and benefits such as health insurance for those represented by unions. However, the act did not apply to the service, domestic, and agricultural industries, and it allowed unions to discriminate against racial and ethnic minority workers employed in other industries such as manufacturing.[7] Thus, in comparison with White workers, racial and ethnic minority workers were more likely to be relegated to low-wage jobs that failed to provide health insurance.

During the Civil Rights era the federal government enacted two of the largest public safety-net programs: Medicare and Medicaid. They were both created to cover people deemed to be deserving of help who did not have health insurance. Medicare is a federal health care program that primarily covers the elderly and the disabled,[8] whereas Medicaid is a joint federal and state health care program for certain categories of the very poor, such as pregnant women, children, the elderly, and people with disabilities.[9]

The Medicare and Medicaid programs played an important role in beginning to address racial and ethnic minority populations' limited health care access. Medicare funding, in particular, provided powerful financial leverage for the early and proactive efforts of the Department of Health and Human Services Office for Civil Rights to secure the racial integration of hospitals.[10] These programs also provided funding to encourage physicians, hospitals, and other providers to serve underserved communities, in which racial and ethnic minority populations disproportionately lived. Thus, these programs reflect the racial paradox of the safety net: It is a product of a structurally racist health system in which racial and ethnic minority groups were disproportionately excluded from employer-sponsored health insurance, yet it is also an important, if limited, tool for helping fill this gap.

Notwithstanding the benefits that racial and ethnic minority populations received from Medicare and Medicaid, early funding and policy decisions shaped by racism helped embed inequity in these safety-net programs. For instance, as long as nursing homes made a good-faith effort to use nondiscriminatory language in marketing materials, the government certified the homes to participate in Medicare and Medicaid even if they continued to use discriminatory practices to deny admission to members of racial and ethnic minority groups.[10] Moreover, to overcome opposition by southern states resistant to civil rights gains, the federal government gave states tremendous flexibility that allowed them to underfund Medicaid or limit Medicaid eligibility in a manner that disproportionately kept racial and ethnic minority populations from qualifying for Medicaid coverage.[6]

Although recent coverage, financing, and

Early funding and policy decisions shaped by racism helped embed inequity in Medicare and Medicaid.

quality reforms have been partially aimed at rectifying these problems, structural racism continues to shape modern health policy, limiting racial and ethnic minority populations' equitable access to health care.

Structural Racism In Modern US Health Care Policy

There are four main payers or sources of health care financing: employers, insurance companies, the federal government, and the states. Laws and policies across the various payers have created a two-tier health care system that limits racial and ethnic minority populations' equitable access to high-quality care. The Affordable Care Act (ACA) was expected to help reduce these inequities, yet they persist in the areas of health care coverage, financing, and quality.

COVERAGE Under the ACA, individual insurance market reforms have banned insurers from denying coverage based on risk, abolished individualized risk rating and preexisting condition exclusions, and offered federal subsidies for people between certain income levels. This made individual insurance more affordable, yet inequities remain for low-wage racial and ethnic minority workers and those seeking Medicaid coverage.

Most Americans continue to obtain health care through employer-sponsored insurance. However, as during the Jim Crow era, many racial and ethnic minority workers are employed in low-wage jobs that do not provide adequate health insurance. As of 2019, 58 percent of Americans were covered by employer-sponsored health insurance, with 66 percent of White workers covered by this insurance compared with 47 percent of Black, 43 percent of Latino, and 37 percent of American Indian and Alaska Native workers.[11] Those without employer-sponsored health insurance are often uninsured, with Black and Latino people approximately 1.5 and 2.5 times more likely, respectively, to be uninsured than White people.[12]

If low-income racial and ethnic minority workers are insured, they are disproportionately covered by employer-sponsored plans that provide poorer coverage, leaving them with higher out-of-pocket expenses (as a result of higher premiums and cost sharing) than ACA Marketplace plans.[13] Unfortunately, such workers are not eligible to switch to Medicaid and also do not qualify for federal subsidies offered through the ACA Marketplaces. Referred to as the ACA "firewall," this limit was originally instituted to minimize disruption to employer-sponsored insurance markets and risk pools.[14] However, the firewall has effectively limited many low-wage minority workers' options, locking them into plans offered through their employers that provide less protection.

The ACA also expanded Medicaid to cover all adults younger than age sixty-five with incomes below 138 percent of the federal poverty level.[15] Data show that the uninsurance rate for Black and Latino people in Medicaid expansion states has decreased.[16] In Louisiana, for example, the uninsurance rate among eligible Black people dropped by 14.7 percentage points after expansion.[17] Early evidence also shows that since the implementation of the ACA, Black and Latino people have reported fewer cost-related access problems,[16] Black people have reported disproportionately larger improvements in having a usual care provider,[18] and Black people in Michigan's Medicaid expansion have reported the largest reduction in days of poor physical health.[19] Nonetheless, inequities in Medicaid coverage persist.

The Supreme Court's decision in *National Federation of Independent Business v. Sebelius* made Medicaid expansion optional for the states, leading to a policy debate among certain states—primarily located in the South—about whether or not to expand Medicaid access. As with early resistance to the creation of Medicaid, there is evidence that current opposition to Medicaid expansion is driven by assumptions about whether or to what extent racial and ethnic minority groups or "foreigners" will benefit from expansion.[20,21] Predictably, this reinforces racial hierarchy and results in inequities in coverage. This is especially evident in southern states with large numbers of Black and Latino residents.

Among those who fall into the Medicaid coverage gap—people too poor to afford private insurance but who do not meet the narrow eligibility categories of traditional Medicaid—about 60 percent are people of color, who disproportionately live in Southern states that chose not to expand Medicaid.[16] Black people are more than

twice as likely as White people and Latino people to fall into the coverage gap.[16] Research shows that state Medicaid expansion decisions are not correlated with the level of support among racial and ethnic minority populations.[21] Instead, "White [people's] opinion is significantly associated with expansion decisions."[21] When White people's support of expansion is low, which is highly correlated with measures of state-level racial resentment, "the state is less likely to expand Medicaid."[21]

Structural racism is also evident in some states' attempts to impose additional eligibility restrictions on Medicaid expansion populations, especially recent work-reporting requirements. These requirements have been defended as necessary to encourage work among the "able-bodied" poor, reflecting assumptions that the poor must be coerced to work as a condition of insurance. These assumptions have historical roots in racist beliefs that Black people are lazy and have a poor work ethic, heard today with lawmakers emphasizing the "urban poor" (which some understand as code for inner-city Black people) as the primary targets of these requirements.[22]

Indeed, Michigan lawmakers proposed a work requirement carve-out that would have exempted residents of a county with a high unemployment rate (over 8.5 percent), but not city residents with similarly high unemployment rates if the city is located within a county with an unemployment rate that fell below the 8.5 percent threshold.[23] Because of racial and ethnic residential patterns, most White people located in rural counties would be exempt from the work requirement, whereas Black people in urban areas with comparable unemployment rates would not be.[23] The proposal was ultimately abandoned amid public outcries of racism.[24]

Even without discriminatory carve-outs, Medicaid work requirements threaten coverage and risk exacerbating inequities.[25] For example, work requirements in Arkansas caused huge coverage losses among working people who encountered reporting challenges and others who should have been exempted.[25] Moreover, an analysis of five states' proposed work requirements found that the percentage of Black people who would be affected by these requirements greatly exceeded the percentage of the Black population in all five states, and in three states it would represent the largest percentage of the affected population.[26–30] Judging from its actions and stated priorities during its first year, the Biden administration seems unlikely to approve Medicaid work requirements. Nonetheless, extreme coverage losses and predictable inequities have not deterred states from continuing to push for such restrictions.

Structural racism is evident in some states' attempts to impose work-reporting requirements.

FINANCING Structural racism also shapes the financing and payment system. Despite some ACA coverage gains, the government's inattention to equity has reinforced existing inequities, and some payment reforms have exacerbated inequities. This is apparent in the government's hands-off regulatory approach—specifically, its failure to ensure that federal incentives and funding provided to employers, insurers, and states do not cause or exacerbate racial and ethnic minority populations' inequitable access to health care. For example, although the ACA expanded coverage, it did not change the financing and payer system that still relies heavily on private insurance, leaving significant coverage gaps that affect minority populations.[17] Employer-paid premiums for employees' health insurance remain exempt from federal income and payroll taxes, lowering employers' taxes,[31,32] and the government pays insurers to offset losses from participating in the ACA.[33,34] Yet these incentives are not linked to measures ensuring racial and ethnic minority populations' equitable access to coverage. There is also little to no oversight of tax-exempt, nonprofit health care organizations despite federal and state laws creating charitable obligations. This allows some organizations to use their tax savings to improve their employee and administrator benefits instead of providing better access to high-quality care at lower costs to the communities in which they reside, which tend to be predominantly minority.[35]

A similar lack of oversight plagues Medicaid provider reimbursement and disproportionate share hospital (DSH) payments, which are intended to subsidize uncompensated care provided by hospitals that serve a large number of low-income people, including patients with Medicaid and the uninsured.[36] Despite federal laws requiring reimbursement to be sufficient to ensure equitable access to high-quality health care for Medicaid beneficiaries, Medicaid payments are notoriously low and have been cited as a reason for low provider participation.[37] The fed-

Structural racism in coverage and financing has created a two-tier system of racially segregated care.

eral government has repeatedly rubber-stamped state rates even when states make cuts solely in response to budget shortfalls and without any consideration of access or quality. Numerous lawsuits have challenged low rates as violations of federal Medicaid requirements. In 2017 Medicaid beneficiaries and providers in California also challenged rates on antidiscrimination grounds, alleging that the low Medicaid rates were discriminatory against the growing Latino population, creating "a separate and unequal system of health care."[38]

States also have broad discretion over the distribution of DSH payments to different hospitals, but this is often discordant with the amount of uncompensated care being delivered to low-income, underserved racial and ethnic minority populations. In 1981 Congress passed legislation requiring better state accountability for DSH payments, but oversight gaps remained. In some states larger portions of DSH funds were directed to state- or local-run hospitals, which effectively allowed some of the funds to be transferred back to the state to fund other measures instead of funding care for underserved minority people served by these hospitals.[39] Despite follow-up legislation addressing this funds-transfer problem, it remains unclear whether DSH payments are actually benefiting the low-income racial and ethnic minority people who need the most aid.[36]

When the federal government does take an active role in trying to increase the accountability of health care systems and physicians, its focus and methods can have the perverse effect of exacerbating inequities. For example, the government has incorporated value-based payment reform through numerous Medicare pay-for-performance programs (targeting hospitals, skilled nursing facilities, dialysis centers, and others) and alternative payment models such as accountable care organizations, bundled payment for episodes of care, and patient-centered medical homes. The objective of these programs is to improve health care quality and reduce costs. However, almost none of the programs account for how the social determinants of health—including unequal social structures—shape health status and need when determining provider performance, ranking, and payment. These "colorblind policies" can have a disparate effect on racial and ethnic minority groups and the providers that serve them when they fail to account for underlying issues of structural racism and unequal social structures.[40] For safety-net providers disproportionately caring for low-income minority people with poorer health status, the result has been devastating because they are more likely to be penalized and to receive lower Medicare reimbursement under value-based payment programs.[41] In contrast, pay-for-performance programs tend to financially reward providers that care for more affluent and White populations. This effectively creates a regressive tax for providers disproportionately serving racial and ethnic minority populations, leaving them with fewer resources than non-safety-net providers as a result of payment reform.

QUALITY Structural racism in coverage and financing has created a two-tier system of racially segregated care in which minority people receive poorer-quality care. Ample evidence suggests that Black and Latino people receive lower-quality care compared with White people, even after insurance coverage and income are adjusted for.[42] For example, compared with White patients, racial and ethnic minority patients are less likely to receive evidence-based cardiovascular care, kidney transplants when indicated, age-appropriate diagnostic screening for breast and colon cancer, timely treatment related to cancer and stroke, appropriate mental health treatment, and adequate treatment when presenting suffering from pain.[43]

Inequities in nursing home care provide a particularly vivid example.[44–46] For instance, a study of several states, including New York, Kansas, Mississippi, and Ohio, found that when White and Black patients reside in the same facility, Black patients traditionally receive poorer-quality care.[44] Furthermore, there are significant inequities when White and Black patients reside in different nursing homes. A recent study found that Black patients in nursing homes were at higher risk of developing pressure sores compared with White patients, which was linked to the fact that nursing homes that serve a high concentration of Black patients tend to "have lower staffing levels of registered nurse and certified nurse assistance, and to be larger, for-profit, and urban facilities."[47] Stark racial segregation in nursing homes persists today.[48] Ac-

cording to data from 2013, just 28 percent of nursing homes accounted for 80 percent of all nursing home admissions of Black patients, and these nursing homes performed worse on the quality measures of rehospitalization and successful discharge to the community.[48]

Beyond nursing home care, members of racial and ethnic minority groups are more likely to reside in areas that suffer from physician shortages, including shortages of primary care doctors, surgeons, and mental health providers, which is also a product of structural racism.[49] One reason racial and ethnic minority communities are underserved is that they have been drained of vital health resources through public hospital closures and the flight of nonprofit hospitals from minority communities to predominantly White communities.[50] In the most comprehensive study of hospital restructuring, which focused on cities in the Northeast and Midwest from 1937 to 1980, the authors documented significant correlations between race and the location of hospital closings or removal of services.[51] This conclusion was supported by another study of hospital restructuring that documented an even stronger racial correlation between the likelihood of closures and the racial makeup of the inpatient population of the hospital.[52]

This has implications for access and quality. The most obvious effect of closure is a disruption of hospital services to residents in the affected community, such as inpatient acute care, outpatient services, obstetric and gynecologic care, and emergency department or trauma services. A less obvious effect of hospital closures is the disruption in primary care services, in part as a result of "physician flight" after hospital closures, because these hospitals are a critical base for physicians' practice.[50] These effects are evident through the increasing dependence of racial and ethnic minority communities on hospital emergency departments and public hospitals for routine and other nonemergency care, increasing the risk that patients will be sicker by the time they do seek care.

In addition, although safety-net providers play a valuable role in reducing health inequities because of their commitment to and experiences with underserved communities, the safety-net hospitals and clinics on which racial and ethnic minority populations depend are often underresourced and financially constrained, and they provide a disproportionate amount of uncompensated and low-reimbursed care.[50] These hospitals and clinics tend to score lower on patient satisfaction surveys, underperform on evidence-based metrics, and report higher rates of adverse safety events and complications.[49] Lower-quality institutions are considered a major source of inequities in health care quality.[49,53]

As long as structural racism continues to shape health care policy, racial and ethnic minority populations will suffer from inequitable access to high-quality health care. Existing reforms have not remedied this problem because the eradication of structural racism in health care policy has not been a primary goal.

Conclusion

The time has come to eradicate the structural racism in health care policy that perpetuates inequitable access to high-quality health care. If not, the racial and ethnic inequities that have occurred throughout the COVID-19 pandemic, which not only devastate minority communities but also harm the entire country, will continue. Yet this change will only come from intentional and sustained focus on addressing inequities in system reform so that health equity becomes the norm. ■

Ruqaiijah Yearby received an honorarium from VirginPulse to give a keynote about structural racism and employer wellness programs.

NOTES

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