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A Conceptual Map of Structural Racism in Health Care

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Introduction

Longstanding racial and ethnic disparities in health care experiences and outcomes exist and contribute to inequitable health and life outcomes in the United States (AHRQ 2022; Baciu et al. 2017). A growing number of empirical studies seek to quantify the role of structural racism in driving health disparities (LaFave et al. 2022; Krieger, Wright, et al. 2020a; 2020b; Churchwell et al. 2020; Chae et al. 2020; Shonkoff, Slopen, and Williams 2021; Nardone et al. 2020; Hollenbach et al. 2021). Recent work by Furtado and colleagues finds three general approaches used in the health literature to directly and indirectly measure structural racism (Furtado et al. 2023). All the approaches will yield better estimates when researchers have greater clarity about the structures in question and the potential pathways by which they affect health. Policymakers, practitioners, advocates, and communities can use better information about whether and how much specific policies and practices produce health care disparities to make targeted structural changes that will help deliver better health care and health for all.

In this brief, we develop a conceptual map of the role of structural racism in health care that demonstrates the connections between (1) mental models that, in often unnoticed ways, guide how society thinks and acts; (2) inequitable structures, including laws and policies that more formally codify the distribution of resources; and (3) racial and ethnic disparities in health care experiences and outcomes. The development of this map is informed by prior literature and stakeholder perspectives. It builds from existing theoretical work linking structural racism to health and, specifically, health care (Phelan and Link 2015; Williams and Collins 2001; Williams and Mohammed 2013). It also draws on empirical studies of the relationships between structural racism and health, especially those that use the "multiple proportions" or "index of disproportionality" approach, which relies on an underlying

framework that links historical and contemporary variation in policies and practices to measurable differences between groups (Lukachko, Hatzenbuehler, and Keyes 2014; Dougherty et al. 2020).

Addressing structural racism will require understanding the structures that must be changed to produce equitable health outcomes. This map seeks to provide a conceptual deconstruction of the laws, policies, practices, and norms that lead to health care inequities to identify promising opportunities for continued study, intervention, and resource investment.

The key findings of this analysis can be summarized as follows:

- The present-day legacy of structural racism is potent. It is perpetuated not only by historical and contemporary race-based laws and policies but also by policies that are race-neutral at face value but which did not and do not adequately consider and correct for racially inequitable preconditions.
- Structural racism in the health care system is web-like (Krieger 1994; MacMahon, Pugh, and Ipsen 1960). Multiple structures within health care practice and policy connect, lending each other strength and durability. Health care structures also connect to and are supported by policies and practices in other domains, including education, employment, immigration, and others.
- Health care and health disparities are a product of structural racism. Solutions that target disparities and not their drivers may only create temporary or narrow improvements.
- Both within-health care (i.e., incremental, focusing on structures that lie closer to the outcomes) and outside-health care (i.e., transformational, targeting deeper structures or even the mental models and norms) approaches to structural change are likely essential to advancing health justice.
- With greater clarity around structural racism, advocates can more compellingly call for root-cause interventions, policymakers can more effectively develop and implement them, funders can more sustainably support them, and researchers can more rigorously evaluate them.

Laying the Foundation: What is Structural Racism and What Makes a Structure Racist?

At the heart of our conceptual map of structural racism is the fundamental assertion that racism and its effects on health and health care experiences and outcomes must be understood beyond interpersonal racism.¹ Interpersonal racism, defined as acts of prejudice and bias delivered by one person to another, is an often-discussed form of racism, especially in its conscious forms. Those interactions are fueled by people's beliefs, experiences, and ideas. Beyond the individual and interpersonal levels lie institutional and systemic forms of racism that describe how racial oppression is embedded in and across our organizations and systems through creating and maintaining inequitable structures. Structures can be thought of as society's "rules," both written (laws, policies, and practices) and unwritten (norms)

(Braveman et al. 2022). Focusing our gaze on the larger scale (systems and institutions as opposed to individuals) encourages a conversation about how racism creates a hierarchy that benefits one group by oppressing and exploiting other groups.

Examining racism in our structures requires an operational definition of the concept that we can apply to a hypothetical law, policy, or practice. An obvious definition is that a structure is racist when it explicitly limits access to opportunity, power, privilege, and resources based on race or ethnicity. This definition would capture “race-based” policies, for instance, historical laws denying certain racial and ethnic groups entrance into universities.²

However, such a definition would fail to capture policies that may not explicitly or intentionally exacerbate racial disparities by concentrating advantage and/or disadvantage along racial lines but that do so implicitly or in effect (Kendi 2019). Kendi argues for a much broader definition as a result, saying that “A racist policy is any measure that produces or sustains racial inequity between racial groups,” with “inequity” further defined as “when two or more racial groups are not standing on approximately equal footing”(Kendi 2019). The term “equity” has received much attention in recent years, including the creation of several illustrations that distinguish it from “equality.”³ They all essentially point to “equality” focusing on sameness in inputs (e.g., everyone gets health care coverage), while “equity” focuses on sameness in outcomes (e.g., everyone is comparably healthy). These illustrations and Kendi’s definition suggest that we must look beyond a policy’s intentions to consider its impact when evaluating whether it is racist. That is, a facially “race-neutral” structure can still have racist attributes if it does not acknowledge and address inequitable preconditions (i.e., by either overcoming them or removing them).⁴ Our process for considering potentially racist health care structures includes race-based, race-neutral, contemporary, and historical policies, practices, and norms. In subsequent sections, we describe how we built our conceptual map, present our initial rendering of the map, and discuss implications.

Approach to Building the Conceptual Map

Map Inputs

We used three sets of inputs to generate the concept map of structural racism in health care: a literature scan, feedback conversations, and a crude round of “validating” the map using media reports from major news outlets. First, we conducted a literature scan of peer-reviewed literature and health care trade publications using such search terms as “structural racism,” “systemic racism,” or “institutional racism,” and “healthcare” or “health care.” When we found authors publishing on the topic, we looked for their other work, the papers and authors they cited, and the papers and authors that cited them. Using the Braveman definition of a structure (i.e., laws, policies, practices, and norms), the research team evaluated the literature for examples of structures in health care that promote racial disparities in health care outcomes(Braveman et al. 2022). We organized the structures into six categories adapted from the dimensions of effective coverage by Campbell et al. (2013): coverage, affordability of care, finance, access to care, quality, and utilization. A linkage needed at least one high-

quality (peer-reviewed or from an established trade journal) reference to support its placement on the map. The lead author scanned the literature and proposed draft structures, outcomes, and relationships between the two, which the research team then discussed. A scan of more conceptual writing on the root causes of racism, including works by W.E.B DuBois, Camara Jones, and Walter Johnson, yielded the initial slate of mental models of inequity (Du Bois 1947; Johnson 2020).⁵ We constrained our literature search to racist structures, the mental models undergirding them, and their outcomes.

Second, we shared the draft map with 12 researchers nationwide who are studying the quantitative measurement of structural racism in health or are examining structural racism in health care and health care providers. They participated in conversations on the map's general composition; specific mental models, structures, outcomes, and relationships; and design. The research team also spoke with community members with a lived experience of marginalization in and by the health care system through two rounds of conversations with a community advisory board focused on health equity that serves a Robert Wood Johnson Foundation project at the Urban Institute.⁶ We then conducted a thematic analysis of the notes from all feedback interviews and conversations and any written feedback provided. We discussed those themes before producing a second draft of the map.

Third, we pressure tested the map by assessing whether the map contained any inequitable structures or health care outcome disparities discussed in a selection of 26 news articles in *The New York Times*, *The Washington Post*, and *NPR* in the past five years on health care inequities. If an article raised any potential new structures that were not already on the map, we discussed them as a team and sought out additional supporting peer-reviewed or industry literature before adding them to the map. We added three structures in this way.

When a connection seemed likely but difficult to empirically validate, we used a dashed line (see more in the legend on page 8). One common use case for dashed lines was for relationships that seemed likely to exist but were indirect and that could be further decomposed if the map included all the requisite intermediaries. Relationships between historic structures and their likely contemporary effects represented one subset of this use case.

Relevant Frameworks

We relied heavily on the iceberg model for systems thinking when building our model. The Iceberg Model, a fundamental tool in system science, describes how singular events are parts of patterns that result from structures, which in turn are driven by mental models (Goodman 2022; Monat and Gannon 2015). We adapted the model to provide the high-level organization of the map, as described further on page 8.

We also closely examined the conceptual model of how racism operates and results in inequities in maternal morbidity and severe maternal mortality (Hardeman et al. 2022). This model was developed by a multidisciplinary Maternal Mortality Review Information Application racism and discrimination working group convened by the CDC Foundation. The conceptual model depicts how historical context (namely centuries of racism and white supremacy) led to contemporary racism, which shows up in

interpersonal, internalized, institutional, and structural forms. These forms contribute to inequities in the social determinants of health and in the health care system specifically, ultimately contributing to racial disparities in maternal mortality and severe maternal morbidity. We found the authors' consideration of what drives racism, including racist structures and the downstream effects of racism on health care experiences and health to be highly relevant to our endeavor. While our scopes differed (we looked at health care provision more broadly and focused on structural racism while Hardeman et al. focused on maternal health care and all forms of racism), we built on this model's content, organization, and design.

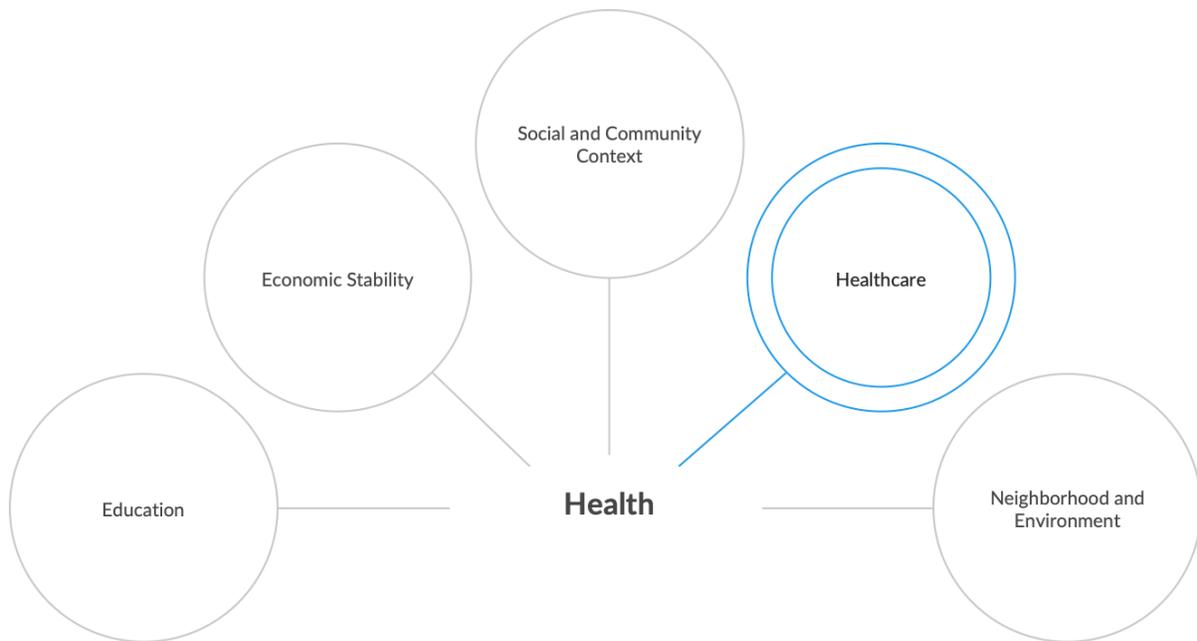
Map Boundaries

We set boundaries that defined the scope of our work. We largely defined health care in clinical terms, focusing on experiences with providers and their institutions. This meant entirely excluding the pharmaceutical and medical device industries.

The social determinants of health framework argues that health is driven by an array of factors embedded in the domains that capture where people live, work, play, learn, and worship.⁷ As we depict in figure 1, our map focuses on a portion of one of those domains: health care. To a limited degree, we consider the indirect effect other domains have on health through their effect on health care by including three “tiers” of structures. The inner tier, where we focused the most, contains structures in health care and health insurance. The next tier contains structures that drive access to health insurance and health care (immigration and citizenship, occupational segregation, etc.). The outer tier contains structures that more indirectly affect one's use and experience of health care (related to wealth building, human capital development including education and residential segregation, infrastructure, and criminal justice).

FIGURE 1

The Social Determinants of Health Framework and the Coverage of This Conceptual Map



Source: Authors' analysis.

Notes: The social determinants of health (SDOH) framework asserts that health is driven by an array of factors embedded in where people live, work, play, learn, and worship.⁸ This figure, inspired by conventional visualizations of the SDOH framework, shows those domains and their direct effects on health. The conceptual map of structural racism in health care focuses on a portion (shaded blue) of one of these determinants (health care) with some consideration of how structures in other social determinants affect health care experiences and, indirectly, health outcomes. Mediation of this sort is generally not the focus of SDOH.⁹

The Conceptual Map

Figure 2 presents the conceptual map, which was generated using Miro. Appendix C contains enlarged segments of the map to facilitate closer scrutiny for those who prefer a printed product.¹⁰ The sections of the map should be viewed from left to right, starting with mental models and ending with manifestations of structural racism and the health disparities they produce.

FIGURE 2

Conceptual Map of Structural Racism in Health Care

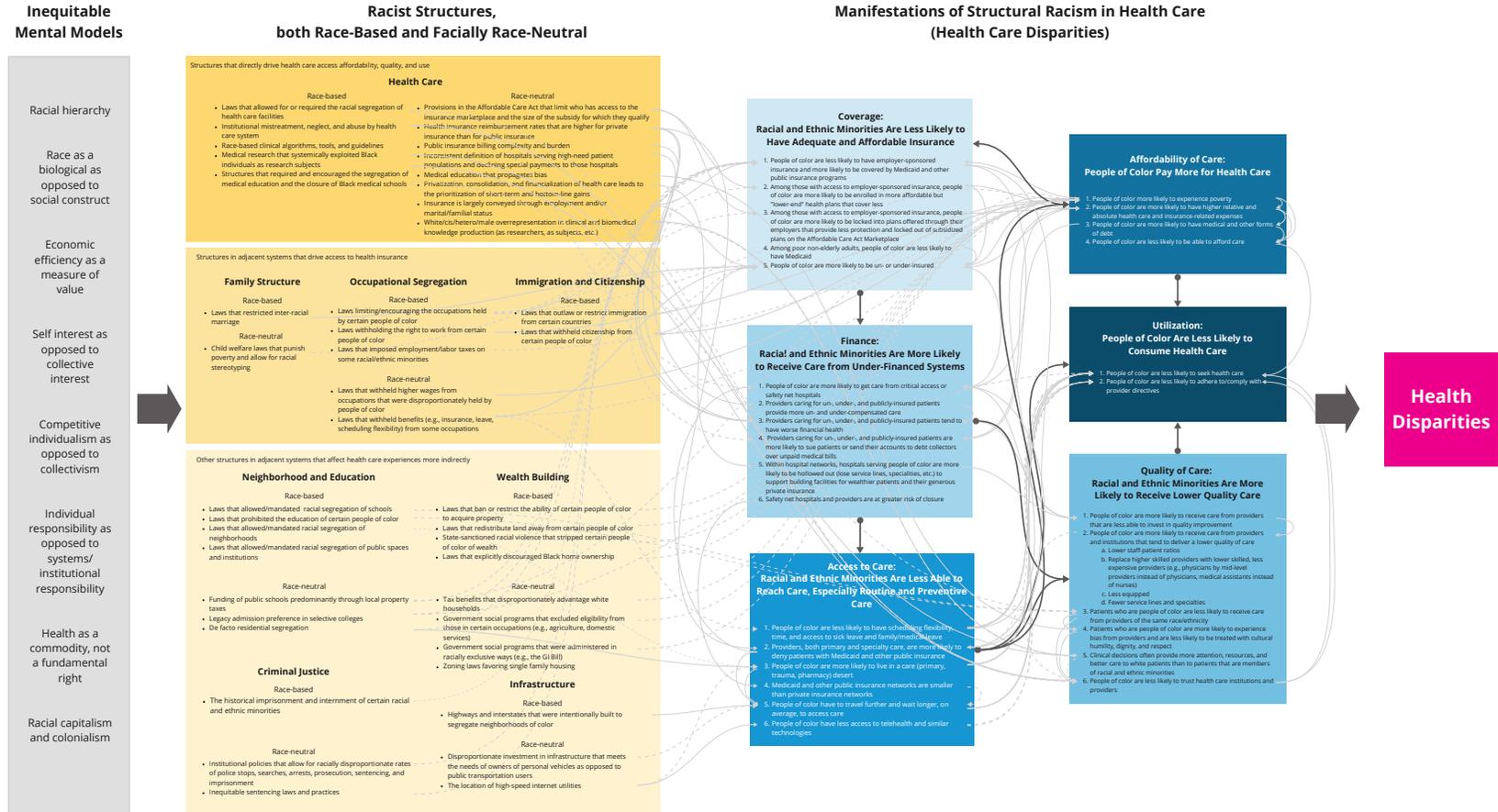


Figure Legend

Element	Description
●	Inequitable mental models Inequitable norms and paradigms embedded in our society (e.g., racial hierarchy, health care as a market good, etc.)
●●●	Racist structures Laws, policies, and institutional practices, both race-based and facially race-neutral, that promote or outright engineer racial disparities Examples include historical de jure and contemporary de facto residential, occupational, and educational segregation
●●● ●●●	Manifestations of structural racism Outcomes of structural racism, also commonly recognized as disparities within health care We organize these into six categories: coverage, affordability of care, finance, access to care, quality, and utilization
→	Solid thin grey line arrows Used to communicate specific causal relationships between individual structures and health care disparities that are supported by existing evidence (e.g., residential segregation leads to people of color being more likely to live in a health care desert)
→	Dashed thin grey line arrows Used to communicate specific causal relationships that, while conceptually likely, are more indirect and therefore harder to empirically validate (e.g., between an historical structure and a contemporary outcome)
→	Heavy dark grey line arrows Used to summarize the thin solid and dashed grey arrows at the category level (e.g., inequities in access lead to inequities in utilization)

Source: Authors' analysis.

Notes: For a closer view at each map box, see Appendix C and a digital version, both available at: <https://www.urban.org/research/publication/conceptual-map-structural-racism-health-care>. The sections of the map should be viewed from left to right, starting with inequitable mental models; then moving to the race-based and facially race-neutral structures born of those mental models; then to the manifestations of structural racism in healthcare, which we present in six categories; and finally, to the health disparities they produce.

Mental Models of Inequity

Inequitable mental models comprise the durable and often hidden norms and paradigms deeply embedded in American society. In the light grey box on the map, we list eight mental models of inequity, many of them informed by seven values targets for anti-racism action.¹¹

First, we include a cluster of mental models of racial dominance, including beliefs in racial hierarchy—both the superiority of whiteness and the inferiority, to varying degrees, of nonwhiteness (Wilkerson 2020). These beliefs are sustained by and help sustain beliefs in race as a biological fact.¹² Next, we have a set of norms related to economic interests, including efficiency as a central measure of value, the centrality of self-interests when making decisions, and the belief in competitive individualism (defined as the idea that success is a function of merit and therefore competition is the right way of distributing limited resources)(Bowles and Carlin 2021). These economic mental models can encourage a conception of health not as a fundamental human right but as a commodity to be sold and purchased.

Finally, beliefs in racial dominance and economic organization can also intersect to reinforce mental models of racial capitalism and colonialism, whereby capitalism is fueled by the extraction of social and economic value from people of marginalized racial and ethnic groups (Robinson et al. 2019; Johnson 2020).¹³ Altogether, these mental models are the engines of our sense of who and what matters and why, deeply woven into the American narrative, cutting across political and other ideologies.¹⁴

Inequitable Structures

These mental models lead to creating and maintaining inequitable structures, both race-based and facially race-neutral,¹⁵ as indicated by the grey block arrows. As described in the Map Boundaries section on page 5, we organized racist structures into three tiers, each a different shade of yellow, based on the directness of their impact on health care experiences. When identifying inequitable structures, we focused on policies, practices, and laws. When possible, and in keeping with Yearby (2020), we also considered, when possible, political processes, rules, regulations, statutes, budgetary processes, and enforcement mechanisms that sustain or worsen racial inequities in health care experiences. More detail and supporting literature describing each structure can be found in the Appendix.

Manifestations of Structural Racism in Health Care

The blue boxes in the third section of the map include the manifestations of structural racism in health care, which, according to the Iceberg Model, are generated by our inequitable systems and structures. Following Campbell et al. (2013), we organized these into six categories: coverage, affordability of care, finance, access to care, quality (in terms of costs and network), and utilization.

Health Disparities

Finally, all these manifestations are likely to contribute to health disparities, which we see on the far-right side of the map, and which are affected by many upstream forces, illustrated in figure 1, beyond those documented on the map (e.g., the social determinants of health).

Proposed Causal Relationships

The thin, light grey arrows and thicker, dark grey arrows convey the proposed causal relationships between structures and manifestations. The thinner arrows are more detailed, moving between a specific structure and manifestation. The thicker arrows are more general, connecting a category of structures or manifestations and summarizing the thinner arrows. References supporting our conclusion that a likely causal relationship exists between two manifestations or between a structure and a manifestation can be found in the Appendix.

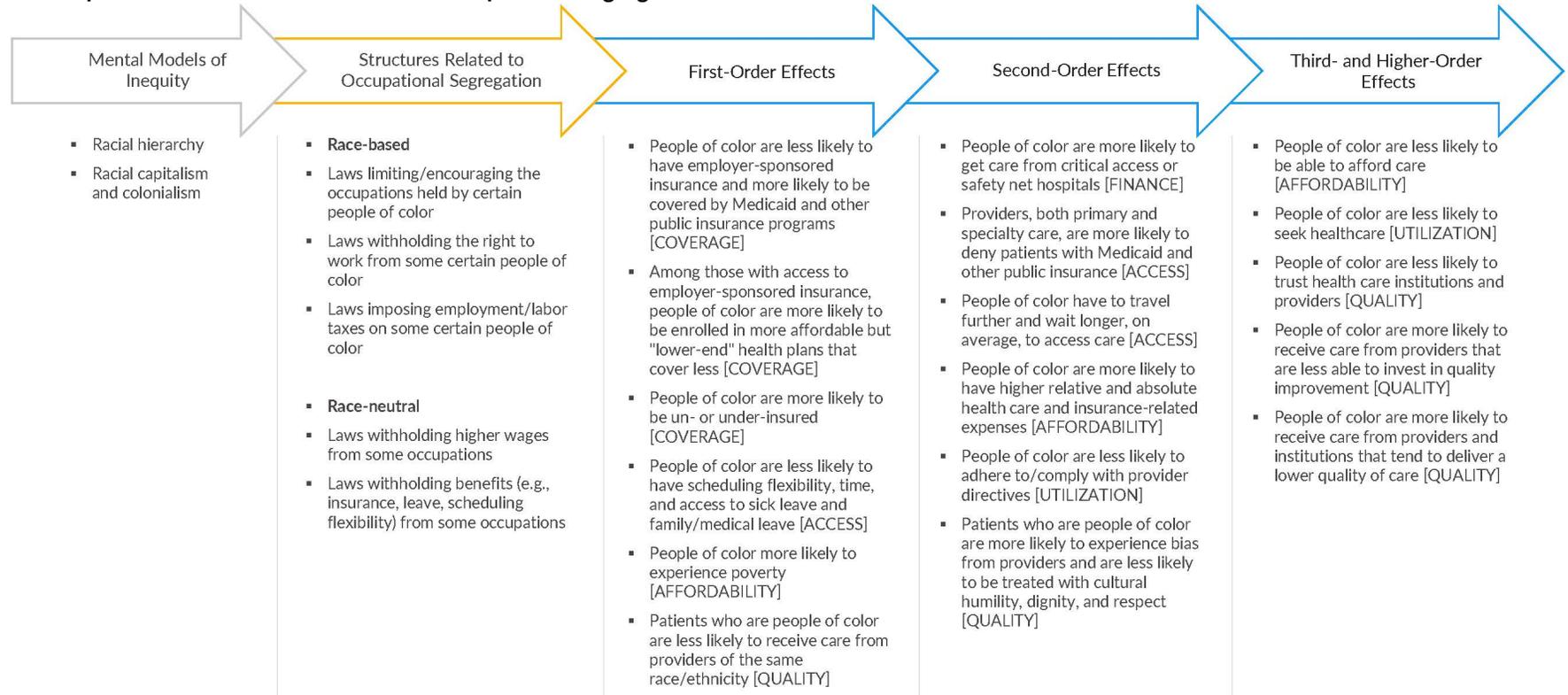
The resulting map is complex by design. While this is partly because of the limitations of a static visualization, in a larger sense, the complexity is the point. The effects of structural racism are profound, and its impacts are reinforcing and self-sustaining, playing out in vicious cycles over multiple domains over lives and across generations. That is to say, the visual chaos of the map is a feature and not a bug.

A Path through the Map: Occupational Segregation, Health Care Disparities, and Possible Health Care Policy and Practice Solutions

To illustrate how inequitable mental models give birth to inequitable structures that generate health care disparities, we provide an example focusing on racist employment structures, their origins, and their downstream effects on health care, drawing especially on Yearby, Lewis, and Gibson (2023). Figure 3 depicts how mental models of inequity give way to occupational segregation structures, which lead to first-, second-, third-, and higher-order health care effects.

FIGURE 3

The Proposed Serial Effects of Structural Occupational Segregation on Health Care



URBAN INSTITUTE

Source: Authors' analysis. References are provided in the appendix.

Notes: Mental models of inequity give way to structures related to occupational segregation, which in turn lead to first-, second-, and third- and higher-order health care effects. Effects listed in the boxes above only appear once (at their earliest conceptual point), though several repeat on the map, driven by multiple structures and upstream effects.

Beliefs regarding racial hierarchy, colonialism, and capitalism paved the way for employment laws that valued profit over people, especially people of color (Robinson et al. 2019; Johnson 2020).¹⁶ Those mental models have led to race-based and facially race-neutral employment policies.

As described in the yellow panel of figure 3, several historical race-based policies encouraged racial occupational segregation, including ones limiting the occupations certain racial groups could occupy, laws withholding the right to work from certain groups, and laws imposing employment taxes on certain racial and ethnic minorities (Yearby, Lewis, and Gibson 2023). In addition, historical and contemporary facially race-neutral policies that withheld higher wages and better benefits from certain occupations disproportionately disadvantaged people of color and lowered their incomes and access to employer-based health insurance coverage (Yearby, Lewis, and Gibson 2023). For instance, soon after slavery was abolished, to hold on to the inexpensive labor that allowed wealthy white owners to amass and retain wealth, southern states passed “Black Code” laws, including laws that kept Black Americans from migrating north and restricted them to working in agriculture or domestic services. As a result, by the 1930 Census, 65 percent of employed Black Americans worked in those two sectors (DeWitt 2010). New Deal policies establishing worker protections like minimum wage, Social Security, and overtime are examples of facially race-neutral employment structures that maintained and exacerbated racial disparities by intentionally omitting domestic and agricultural workers, sectors in which Black workers were overrepresented (Dixon 2021). Some researchers argue that policymakers’ decision to exclude these workers was racially and economically motivated. (Poole 2006; Stoesz 2016; Quadagno 1988)

Yearby, Lewis, and Gibson point to the National Labor Relations Act as another example of a facially race-neutral law that, because of occupational segregation along racial lines, sustains and worsens racial inequity. The National Labor Relations Act, implemented during the New Deal era, protects employees’ rights to organize and engage in collective bargaining and, to this day, excludes all agricultural workers. The Migrant and Seasonal Agricultural Worker Protection Act of 1983, still in place today, similarly withholds the right to organize or collectively bargain from these workers (Yearby, Lewis, and Gibson 2023).¹⁷

An example of explicitly racist employment laws is the Chinese Exclusion Act of 1882. Anti-Chinese xenophobia and racism was rampant in the late 19th and early 20th centuries, a product of white workers feeling threatened by the influx of Chinese railroad and factory workers, farmers, and miners. The Chinese Exclusion Act banned immigration to the United States by Chinese laborers, except for merchants, teachers, students, travelers, and diplomats.¹⁸ However, only a few types of businesses qualified for special merchant visas, including, starting in 1915, restaurants. In the years that followed, the number of Chinese restaurants in the country increased rapidly—because they were among the few legal routes into the country for their owners and employees.¹⁹ The Act was first implemented for 10 years but was extended and harshened in subsequent years.²⁰ It was repealed in 1943.

The legacy of these policies is evident in contemporary employment patterns. In 2019, 52.4 percent of domestic workers were black, Hispanic, or Asian American/Pacific Islander, and 49 percent of restaurant workers were minorities (Wolfe et al. 2020; National Restaurant Association 2022). These

occupations are less likely to have paid time off, scheduling flexibility, and compensation that encourage seeking and utilizing health care (Yearby 2020; Yearby, Lewis, and Gibson 2023).²¹

The first blue panel in figure 3 shows the first-order effects of structures related to occupational segregation. Most obviously, these structures lead people of color, who are more likely to be employed in low-wage jobs with poor benefits like sick leave and scheduling flexibility, to be less able to afford and access health care (Yearby, Clark, and Figueroa 2022). The effects are also seen in the underrepresentation of people of color in medicine, which in turn contributes to lower quality care experienced by people of color who are less likely to see providers of the same race and ethnicity (Salsberg et al. 2021; Gonzalez et al. 2022). The health care ripple effect of structures related to occupational segregation may have been contained to these were it not for the United States having a dual, private-public health insurance model, with access to private insurance conveyed largely through employment. Exceptions to which employers must provide insurance and the quality of insurance that must be provided means that workers in lower-paying jobs are less likely to be covered by high-quality private insurance and more likely to be un-, under-, or publicly insured (first-order effects in figure 3).²²

The second blue panel contains some of the consequences of the first blue panel, i.e., the second-order effects of occupational segregation on health care. For example, the lower reimbursement rates offered by public insurance compared with private insurance affect the providers available to those with public health insurance coverage and make them more likely to get care from critical access or safety net hospitals (Sarkar et al. 2020; Ahonen et al. 2018).²³ Low-income individuals are more likely to live in de facto segregated care deserts and must travel further and wait longer to access care (Probst et al. 2007). Poverty and a lack of scheduling flexibility and sick pay likely make it harder for people of color to adhere to provider directives that require follow-up or additional expense. People of color who see few providers of the same race and ethnicity may be less likely to feel treated with cultural humility, dignity, and respect (Shen et al. 2018).

The third blue panel in figure 3 shares some of the third- and higher-order health effects of occupational segregation. For instance, institutions that serve patients with Medicaid and Medicare coverage often receive lower reimbursements for those patients compared with those they collect from privately insured patients, which makes them less financially stable and less able to invest in quality improvement, leading to people of color receiving lower quality care (Zuckerman et al. 2021; Gaffney and Michelson 2023; Werner et al. 2008). This likely contributes to a lack of trust, diminishing health care seeking.

Health Care Policy and Practice Responses to Counteract Racist Structures

As with most of the racist structures described in this map, policy or practice responses in one downstream sector are unlikely to fully dismantle the structure, but there may be responses that can ease the harmful effects in that sector. As an example of a policy response, a system of all-payer rate setting like that tested in Maryland between 2014 and 2018 could eliminate one reason for differential access and treatment linked to occupational segregation (RTI International 2019; Singletary and Chin 2023). In Maryland's model, each hospital's payment rates were set at the same level across Medicare,

Medicaid, and private insurance. While the federal evaluation of the all-payer demonstration did not find consistent evidence that it narrowed racial disparities, it did find that hospital expenditures for white residents fell relative to nonwhite residents, while hospital admissions fell more for nonwhite residents (RTI International 2019).²⁴ These findings may suggest that per-admission reimbursement grew more for nonwhite residents. Holding constant the complexity of cases, this could indicate that admitting nonwhite patients became relatively more attractive to hospitals, counteracting some disadvantages tied to historical occupational factors.

One can also imagine changes in practice that may counteract the effects of broader occupational segregation. For example, hospitals and other health care systems are often large or dominant employers in their communities (Kenney et al. 2019). To the extent that a local labor market is influenced by large employers, decisions about employee compensation and benefits may reduce, if only locally, some of the downstream effects of occupational segregation by reducing income disparities and improving access to health care.²⁵ Hospitals and hospital systems, insurers, and other health care system actors can also make direct investments and purchasing decisions that improve economic and health care conditions in minoritized communities more generally (Zuckerman and Parker 2016).²⁶

Key Observations about the Map

The example of occupational segregation's impact on health care disparities and the many other paths to health care disparities identified in the map highlight several important implications about structural racism in health care and the potential interventions for addressing it.

Structural Racism, Both Facially Race-Neutral and Race-Based, Is a Potent Driver of Health Care Outcome Disparities

As indicated above, despite emphasizing interpersonal forms of racism (e.g., explicit and implicit bias) as the driver of health care disparities, structural forms of racism in health care are widespread and constitute a key driver of disparities. This is visible in the array of bullets, numbers, and arrows on the map, corresponding to inequitable structures, racial patterns in health care experiences, and the relationships between the two. Perhaps the most commonly identified form of structural racism, residential segregation features prominently on our map, affirming the powerful connection between place, opportunity, and outcomes. In the health care system, we depict a direct relationship between residential segregation and access to care (Williams and Collins 2001). People of color are more likely to live in care deserts (Gaskin et al. 2012) and are less likely to have access to transportation to care outside their neighborhoods (Smith et al. 2023).²⁷ Indirectly, segregation also influences health through its adverse effects on the quality of education, housing, and physical environment in communities of color (Steil and Arcaya 2023).

Much of the structural racism in health care is attributable to contemporary policies that are facially race-neutral but that do little to acknowledge and address inequitable preconditions left by past race-based policy and that, therefore—whether intentionally or not—maintain or worsen racial disparities.²⁸

Such policies emphasize how political and positional power represent a latent force on our map that, under the status quo, can allow those who have it to manipulate the contexts in which health care is debated and dilute the voice of the marginalized.

Disparities Trace Their Roots Back to Inequitable Norms, Values, and Mental Models

Norms and values related to racial hierarchy, profit, and growth are deeply embedded in structures broadly and in health care specifically. Above, we walk through an extended example of how historic racial capitalism contributes to current racial disparities in health care experiences and outcomes through the intermediate of occupational segregation. Elisabeth Rosenthal argues in her “economic rules of the dysfunctional medical market” that the health care system is designed to exploit (Rosenthal 2017).²⁹ Numerous examples show how that exploitation is often racialized, from the historical practice of medical research on Black patients without their consent (Baptiste et al. 2022), to hospital systems’ use of safety net hospitals to tap lucrative federal programs and funnel those resources to hospitals serving relatively wealthy, disproportionately white patients.³⁰ As one interviewee for this project observed, “those with the least power and privilege are the least able to protect and defend themselves within this fundamentally unfair and untrustworthy system: the risks of undertreatment, overtreatment, even worse health, lost time/trust, and financial ruin are all real.”

Structural Racism in the Health Care System Is Web-like

In our map, arrows ricochet from one category to another. They connect to form reinforcing loops. They support structures outside of the health care system and are supported by adjacent systems and structures. Structures from multiple systems compound each other's effects. For example, occupational segregation combined with the structure of granting access to private insurance through employment, a lack of universal eligibility for public coverage, and a lower reimbursement rate for physicians under public insurance creates a cascade of effects. Health care is another reminder that separate, all too often, is not equal. Occupational segregation and racialized poverty contribute to separate health systems for the wealthy and the disadvantaged, which results in health care inequity.

Addressing the Structural Drivers of Disparities Will Require Multipronged Policy Changes

Recognizing health care disparities as manifestations of structural racism reinforces the importance of questioning competing narratives that suggest that those disparities are the result of individual behavior and decision-making. Those who assert, for example, that providing equal access to health care is an adequate commitment to population health and well-being should consider the numerous structures that make it disproportionately challenging, on average, for people of color to avail themselves of that access and to receive high-quality care. Interventions targeted at racial health disparities that operate from an individualistic diagnosis of the problem will yield fleeting, if any, improvement or will require levels of resources that would be difficult to scale. The same applies to more programmatic interventions (e.g., free mobile health clinics) than policy-oriented and structural.³¹

While addressing the proximal causes of health care inequities is important for bringing swift relief to those suffering, such interventions will need to be complemented by efforts to address root causes as well if they are to eliminate inequities in health.

Systems Change Can Be Both Incremental as Well as Transformational and Can Focus within and beyond the Health Care System

Efforts at structural change can operate within existing systems and be more incremental, focused on structures that lie closer to the outcomes. They can also operate outside existing systems by targeting the deeper structures, mental models, and norms from which structures emerge. Both the within-systems and outside-systems approaches to structural change are essential to advancing justice (Balu et al. 2023). The work being done by Mass General Brigham's multi-pronged United Against Racism initiative and the Healing ARC, a health care reparations pilot implemented at Brigham and Women's Hospital, are examples of incremental health care systems change.³² Likewise, efforts underway in New York City's Department of Health and Mental Hygiene, Southern Jamaica Plain Health Center, and Mount Sinai Health System have been held up as promising examples of antiracist institutional change in health care by Harvard's Institutional Antiracism and Accountability Project (Muhammad and Rodriguez 2023). Sources of structural racism exist outside the health care system, a product of the same mental models, values, and norms identified on our map. This means there are many places across multiple sectors where interventions would also be needed to complement efforts in the health care system to produce equitable health outcomes.

Limitations

This map has several limitations. First, while it includes many structures across several different policy domains and illustrates many connections between those policies and their manifestations in the health care system, we have not created a comprehensive map of the effects of structural racism more broadly. We do not claim to portray all the ways that structural racism drives disparities in health outcomes. Many of these pathways exist outside of the portion of the health care system we examined; thus, even eliminating the manifestations in the health care system would not eliminate health disparities. A second limitation is that the map does not indicate the strength or durability of any specific relationship. While each linkage identified has support in prior literature, we have not undertaken a systematic review to assess the relative quality of the evidence in that literature. Third, at this point, we have not limited the manifestations of structural racism to those that can be readily measured in a way that is useful for assessing the impact of structural racism, though we recognize that empirical studies will be limited by what can be measured.

Future Uses

Despite these limitations, several potential stakeholder groups may find this mapping exercise useful for facilitating incremental reform and imagining and organizing around larger-scale health care system

redesign. First, community members and advocates might use the map's structure as a starting point to which they can add linkages based on their own lived experiences, and organize and call for interventions that can lessen the burden of racist structures on population health. Second, health care policymakers and administrators might use the map to develop and target individual and multi-pronged interventions at specific structures. Third, funders can use the map to support the accumulation of knowledge and direct action to eliminate sets of structures. Fourth, researchers seeking to study health care disparities through a structural lens can use the map to generate testable hypotheses, including those of a more incremental nature, informed by the more proximal drivers of inequity on the right side of the map, and those of a more transformational nature informed by the mental models on the left side of the map. Researchers can also evaluate structural change interventions. Finally, all groups might find this map useful as a starting point for imagining a new map—one built on values and mental models organized around the proactive goals of health justice and health promotion as opposed to the more reactive goal of caring for sick people (Wiley et al. 2022).

In our future work, we aim to use the map as the basis for conducting empirical analyses that try to operationalize structural racism in health care and estimate its role in contributing to health care disparities.

Conclusion

Our intention in illustrating the root causes of disparities in health care outcomes is not to engender a sense of despair or paralysis. Hospital administrators didn't create structural racism and likely do not feel they can do much about it. Quantitative researchers find modeling health outcomes daunting even without considering the multidimensional, intergenerational, and intersecting inequitable structures at play. Individual providers cannot dictate the incentive structures embedded in hospital and insurance systems.

We present this map and our hypotheses of the fundamental drivers of health care disparities despite reasonable assertions of our limited individual influence over them for a few reasons. First, we believe the map to be fundamentally true in its broad strokes, if ultimately incomplete in its details. Second, policymakers, practitioners, advocates, researchers, and community members will be better able to make more enduring change toward health equity if they are clear-eyed about the magnitude of structural drivers of inequity and, from there, the changes that may be needed. And third, while they (and we) might not have created the root causes of inequity, we are all implicated in allowing them to persist, which is an opportunity to play a role in reforming them.

With greater clarity about the nature of structural racism, advocates will be better positioned to compellingly call for root-cause interventions, policymakers will be better positioned to develop and implement them, funders can more sustainably support them, and researchers can more rigorously evaluate them. Achieving full racial health equity will require structural reform outside the health care system, but undoubtedly health care providers, administrators, policymakers, and researchers have an essential role to play.

Notes

- ¹ For one framework for understanding the different levels of racism, see Nikhil Bumb, “Inner Work: The Heart of Organizational Equity Work,” FSG, April 4, 2022. <https://www.fsg.org/blog/inner-work-the-heart-of-organizational-equity-work/>.
- ² William Gale, in a reflection on the makings of racist policies, explains that this definition should not be used to confuse policies like affirmative action and reparations that explicitly advantage marginalized and minoritized groups as structurally racist and race-based. He instead points to the term “race-conscious” to describe policies that attempt to correct for longstanding systemic discrimination; William G. Gale, “Reflections on What Makes a Policy Racist,” Tax Policy Center, Urban Institute and Brookings Institution, November 4, 2021.
- ³ For example, ones using the visual symbology of a fence and baseball game, a ladder and apple picking, and bikes and conveyance; “Illustrating Equality vs. Equity,” Interaction Institute for Social Change, January 13, 2016, <https://interactioninstitute.org/illustrating-equality-vs-equity/>; Nikki Erdmann, “Defining: Equity, Equality, and Justice,” Achieve Brown County, May 27, 2021, <https://achievebrowncounty.org/2021/05/defining-equity-equality-and-justice/>; Joan Barlow, “We Used Your Insights to Update Our Graphic on Equity,” Robert Wood Johnson Foundation, November 21, 2022, <https://www.rwjf.org/en/insights/blog/2022/11/we-used-your-insights-to-update-our-graphic-on-equity.html>.
- ⁴ William Gale works through a helpful thought experiment with real-life policy examples in his short and illuminating Reflections on What Makes a Policy Racist.
- ⁵ Camara Phyllis Jones, “Seeing the Water: Seven Values Targets for Anti-Racism Action,” *Harvard Medical School Primary Care Review* (blog), Harvard Medical School Center for Primary Care, August 25, 2020, <https://info.primarycare.hms.harvard.edu/review/seven-values-targets-anti-racism-action>.
- ⁶ For more on the community advisory board, see “Centering Racial Equity and Community Voice to Improve Research Development, Execution, and Analysis,” <https://www.urban.org/events/centering-racial-equity-and-community-voice-improve-research-development-execution-and-analysis>.
- ⁷ “Healthy People 2030: Social Determinants of Health,” US Department of Health and Human Services, accessed June 16, 2023, <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>.
- ⁸ “Healthy People 2030: Social Determinants of Health.”
- ⁹ More fully examining the inequitable structures contained within the other determinants is beyond the scope of this brief but could help policymakers, advocates, practitioners, and researchers achieve health justice through structural reform.
- ¹⁰ Appendix C is available at <https://www.urban.org/research/publication/conceptual-map-structural-racism-health-care>.
- ¹¹ Jones, “Seeing the Water: Seven Values Targets for Anti-Racism Action.” The values targets identified by Jones in this article include narrow focus on the individual, a-historical stance, myth of meritocracy, myth of a zero-sum game, limited future orientation, myth of American exceptionalism, and white supremacist ideology.
- ¹² “Confronting Anti-Black Racism Resource: Scientific Racism,” Harvard Library, accessed July 14, 2023, <https://library.harvard.edu/confronting-anti-black-racism/scientific-racism>.
- ¹³ See also Richard Pryor’s explanation of racial capitalism available at “Richard Pryor Calls Out Racism In The System,” YouTube, accessed September 6, 2023, https://www.youtube.com/watch?v=gKhGA9SMQGM&ab_channel=TYTSports; Matthew Desmond, “In Order to Understand the Brutality of American Capitalism, You Have to Start on the Plantation,” *The New York Times Magazine*, August 14, 2019, <https://www.nytimes.com/interactive/2019/08/14/magazine/slavery-capitalism.html>.
- ¹⁴ Jones, “Seeing the Water.”
- ¹⁵ For more on the terms “race-based” and “facially race-neutral,” see the “Laying the Foundation: What is Structural Racism and What Makes a Structure Racist?” section on page 3.

- ¹⁶ Desmond, “In Order to Understand the Brutality of American Capitalism, You Have to Start on the Plantation.”
- ¹⁷ 29. *Congressional Statement of Purpose US Code § 1801*, available at Legal Information Institute, accessed September 6, 2023, <https://www.law.cornell.edu/uscode/text/29/1801>.
- ¹⁸ Maria Godoy, “Lo Mein Loophole: How U.S. Immigration Law Fueled A Chinese Restaurant Boom,” *NPR*, February 22, 2016, <https://www.npr.org/sections/thesalt/2016/02/22/467113401/lo-mein-loophole-how-u-s-immigration-law-fueled-a-chinese-restaurant-boom>.
- ¹⁹ Heather Ruth Lee, “In Pursuit of Merchant Status: The Migration Strategy of Early Twentieth Chinese Restaurant Owners under Chinese Exclusion,” *The American Historian*, Organization of American Historians, <https://www.oah.org/tah/issues/2022/food-history/in-pursuit-of-merchant-status/>.
- ²⁰ “Chinese Immigration and the Chinese Exclusion Acts,” Office of the Historian, Foreign Service Institute, US Department of State, accessed June 16, 2023, <https://history.state.gov/milestones/1866-1898/chinese-immigration>.
- ²¹ “Domestic Workers and Underpaid and Unprotected by Labor Law during the Coronavirus Pandemic,” *News from EPI* (press release), Economic Policy Institute, May 14, 2020, <https://www.epi.org/press/domestic-workers-are-underpaid-and-under-protected-by-labor-law-during-the-coronavirus-pandemic/>.
- ²² Joshua Aarons, Steven Brown, Lisa Dubay, and Genevieve M. Kenney, “For Most Workers, the Latest COVID-19 Vaccine Developments Won’t Mean Protection Just Yet,” *Urban Wire* (blog), Urban Institute, January 5, 2021, <https://www.urban.org/urban-wire/most-workers-latest-covid-19-vaccine-developments-wont-mean-protection-just-yet>.
- ²³ Cindy Mann and Adam Striar, “How Differences in Medicaid, Medicare, and Commercial Health Insurance Payment Rates Impact Access, Health Equity, and Cost,” *Advancing Health Equity* (blog), The Commonwealth Fund, August 17, 2022. <https://www.commonwealthfund.org/blog/2022/how-differences-medicaid-medicare-and-commercial-health-insurance-payment-rates-impact>.
- ²⁴ In the Maryland model, only hospital providers were affected by the rate setting modification. It may well be that reduction of racial disparities tied to insurance type requires rate setting intervention beyond a single type of provider.
- ²⁵ “To Save Money, These 13 Health Systems Are Raising Wages. (Yes, Really),” *Daily Briefing* (newsletter), Advisory Board, February 05, 2019, <https://www.advisory.com/daily-briefing/2019/02/05/hospital-wages>; Ryan Grenoble, “Dallas Executives Rase Hospital’s Minimum Wage by Scrapping Their Own Bonuses,” *HuffPost*, June 14, 2014, https://www.huffpost.com/entry/dallas-minimum-wage-increase_n_5507718; Steven Porter, “Hospitals Hike Minimum Wage in Geographic Clusters,” *HealthLeaders*, December 27, 2018. <https://www.healthleadersmedia.com/finance/hospitals-hike-minimum-wage-geographic-clusters>.
- ²⁶ Johnny Magdaleno, “Hospitals Can Be Key to Healthy People, Healthy Economies,” *Next City*, November 29, 2016, <https://nextcity.org/urbanist-news/hospitals-jobs-workforce-revitalizing-local-economies>; “Collaboration between Cleveland Clinic and Evergreen Cooperative Laundry Supports Health and Wellbeing of Local Community,” Cleveland Clinic, May 20, 2018, <https://newsroom.clevelandclinic.org/2018/05/10/collaboration-between-cleveland-clinic-and-evergreen-cooperative-laundry-supports-health-and-wellbeing-of-local-community/>; “What Works: Collectively, Midtown Anchors Spark Urban Renewal,” Initiative for a Competitive Inner City, accessed August 21, 2023, <http://icic.org/anchor-institutions/works-collectively-midtown-anchors-spark-urban-renewal/>.
- ²⁷ Christina Stacy, Alena Stern, Kristin Blagg, Yipeng Su, Eleanor Noble, Macy Rainer, and Richard Ezike, “The Unequal Commute: Examining Inequities in Four Metro Areas’ Transportation Systems,” The Urban Institute, October 6, 2020, <https://www.urban.org/features/unequal-commute>.
- ²⁸ In these polarized times, when racial animus and rhetoric are a reliable part of the social and political discourse, there are contemporary examples of race- and ethnicity-based policy, for instance, Florida’s 2023 law that prohibits certain foreigners from owning property; Douglas Soule, “Chinese Influence Bill Passes Legislature, Signed by DeSantis, despite Discrimination Concerns,” *USA Today*, May 8, 2023, <https://www.tallahassee.com/story/news/politics/2023/05/08/desantis-signs-florida-crackdown-on-foreign-property-chinese-groups-worried/70187172007/>.

- ²⁹ Rosenthal's rules include: (1) More treatment is always better. Default to the most expensive option. (2) A lifetime of treatment is preferable to a cure. (3) Amenities and marketing matter more than good care. (4) As technologies age, prices can rise rather than fall. (5) There is no free choice. Patients are stuck. And they're stuck buying American. (6) More competitors vying for business doesn't mean better prices; it can drive up prices up, not down. (7) Economies of scale don't translate to lower prices. With their market power, big providers can simply demand more. (8) There is no such thing as a fixed price for a procedure or test. And the uninsured pay the highest prices of all. (9) There are no standards for billing. There's money to be made in billing for anything and everything. (10) Prices will rise to whatever the market will bear.
- ³⁰ Katie Thomas and Jessica Silver-Greenberg, "How a Hospital Chain Used a Poor Neighborhood to Turn Huge Profits," *The New York Times*, September 24, 2022, <https://www.nytimes.com/2022/09/24/health/bon-securus-mercy-health-profit-poor-neighborhood.html>.
- ³¹ Starsky Wilson, "The Crucial Difference Between Policies and Programs," *Voices of the Governing Institute* (blog), Governing, November 1, 2015, <https://www.governing.com/gov-institute/voices/col-social-equity-crucial-difference-policies-programs-ferguson.html>.
- ³² Usha Lee McFarling, "So Much More to Do': A Hospital System's Campaign to Confront Racism—and Resistance to Change—Makes Early Strides." *Stat News*, August 25, 2022, <https://www.statnews.com/2022/08/25/mass-general-brigham-campaign-confront-racism-early-progress/>; Brian Wispelwey and Michelle Morse, "An Antiracist Agenda for Medicine," *Boston Review*, March 17, 2021, <https://www.bostonreview.net/articles/michelle-morsebrian-wispelwey-what-we-owe-patients-case-medical-reparations/>.

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