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How to ensure equity in health care for ethnic, racial minorities—without succumbing to radical ideology

By Mario J. Paredes

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A PROMINENT PHYSICIAN IS SOUNDING THE ALARM about what he calls US medicine's "turn toward division and discrimination." "At the heart of this," says Dr. Stanley Goldfarb, writing in The Wall Street Journal," is the claim that healthcare is systematically racist—that most physicians are biased and deliver worse care to minorities."

Dr. Goldfarb, former associate dean of curriculum at the University of Pennsylvania's Perelman School of Medicine, argues that the woke and cancel culture, the "radical ideology that has corrupted education and public safety" have begun to infect healthcare.

As evidence he cites much of current medical research, with more than 2,700 of recent papers in the database of the National Library of Medicine dealing with the theme of "racism and medicine." According to Goldfarb, these studies "generally purport to show physician bias leading to racial disparities in health outcomes."

However, Goldfarb charges, "the most commonly cited studies are shoddily designed [and] reach predetermined, sensationalized conclusions that aren't supported by reported results." He speaks in terms of a "corruption of medical science in service to political ideology."

By contrast, his many years "as a medical educator and practitioner" show that across the board "physicians address the needs of each patient, regardless of skin color." Goldfarb adds that "attacking physicians is dangerous. It degrades minority trust om healthcare, while undermining health outcomes for everyone." But a "crusade against medical professionals" is well underway."

For example, "medical schools increasingly are preparing physicians for social activism at the expense of medical science;" "medical schools and residencies are lowering admission standards. The result will be fewer talented physicians providing high-quality care to fewer patients." Harvard's teaching hospital is moving toward "preferential care based on race" and hospitals and doctors who "create and implement and anti-racism plan" are offered "higher Medicare reimbursement rates."

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However, insists Goldfarb, “there’s no credible evidence that physicians that physicians are racist or that minority patients will benefit if healthcare is built on a race-based foundation.”

Still, even if many if not most doctors would tend to agree with Goldfarb’s arguments, the fact remains that there remains significant gap between healthcare provided to white and affluent Americans and that given to people of color, particularly the poor among them. That gap was laid bare during the pandemic. That discrepancy must be acknowledged and addressed.

At the height of the pandemic, research showed that in the US black people were than 3-and-a-half times more likely to die of the coronavirus than white Americans. For the Hispanic population, the risk of death was almost twice that of the white population. Other minorities also suffered disproportionately during the pandemic.

Underlying this morbidity and mortality were the underlying medical conditions—diabetes, obesity, hypertension, cardiovascular disease—that made minorities far more vulnerable to the virus. In still far too many cases these conditions among poor minorities with no or poor health insurance go undetected and untreated, or they are treated with insufficient care or consistency.

Significant fall-out of a healthcare system that fails minorities is found in the realm of health insurance. Research has shown that racial identity is linked to a lack of health insurance, while low-income minorities suffering poor health are almost 70 percent more likely to have no health insurance than affluent whites who are in good health.

Also, those racial and ethnic minorities that do have insurance are disproportionately covered by employers whose plans offer relatively poor coverage. Many of these employees are not eligible for Medicaid, nor for federal subsidies through the Affordable Care Act. They are stuck with subpar health insurance and potentially large out of pocket expenses in the case of significant illness.

Today, discrimination on the basis of race or ethnicity is illegal, but nefarious practices continue in the form of hospitals and other medical institutions discriminating against patients based on insurance status, a practice which disproportionately affects non-white communities.

Plus, across the board, studies find that, compared to whites, Hispanic and black patients are less likely to be given evidence-based cardiovascular care, kidney transplants, age-appropriate screening for breast and colon cancer, timely treatment for cancer and stroke, treatment for reported pain, preventive care across the board, as well as effective and appropriate mental health care.

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This is hard to believe, but as recently as 2016 a study found that many white medical students believed that black people have a higher tolerance for pain than white people, under the assumption that blacks have thicker skin, less sensitive nerve endings or stronger immune systems. Such shocking beliefs go back to the nineteenth century, with roots in the mistreatment of African slaves.

Contrary to Dr. Goldfarb, there clearly remain numerous examples of injustice in healthcare that hurt ethnic and racial minorities—even as effective solutions need not be driven by radical ideology and charges of systemic racism.

Smart(er) spending can be a major part of the remedy of healthcare inequities, as demonstrated by the success of SOMOS Community Care. It is a network of 2,500 doctors (most of them primary care providers) serving more than 700,000 of the poorest Medicaid patients in New York City, most of them minorities, Hispanics, African Americans, and Asian Americans.

SOMOS got its start in 2014 thanks to an innovative Medicaid program launched by the New York State Department of Health, called the Delivery System Reform Incentive Payment program. DSRIP has demonstrated the viability of upending traditional Medicaid by offering patients superior care, including preventive care at lower cost—the best of both worlds.

This model presumes a dedicated physician. That dedication is rewarded by the core formula of DSRIP: Value-Based Payment (VBP). Traditional Medicaid—prone to waste and fraud—pays doctors for discrete procedures, services rendered, an office visit, a test, etc. The Value-based Payment formula stipulates doctors are compensated according to the longer-term health outcomes of patients; the better the patients do, the greater the compensation for the provider. Hence, the cultivation, the construction of a holistic, comprehensive plan of action that addresses all the needs of a patient.

Among those needs, beyond the strictly medical, are those dictated by social factors, such as poverty, unemployment, sub-par housing, etc. These are known as Social Determinants of Health and they are a key indicator as to the needs and challenges of patients, especially for the most vulnerable among them. SOMOS doctors rely on teams of Community Health Workers, who visit patients' homes and are doctors' eyes and ears in the community.

SOMOS doctors also have a cultural and ethnic affinity with their patients, in whose very neighborhoods they themselves live and work in many cases.

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In sum, with doctors having intimate knowledge of their patients' lives, a genuine doctor-patient bond of trust is created—which holds the key to treatment success. Testimony to that success? Savings for New York State taxpayers of more than $300M thanks to SOMOS doctors reducing by 25 percent unnecessary trips to the ER and unnecessary hospitalizations.

SOMOS doctors are reaping the rewards of their hard work, as patients flourish thanks to excellent care. Smart spending holds the key to DSRIP and SOMOS has high hopes that there will soon be a DSRIP2.0 to continue to transform health care for poor minority communities. It can be done and the SOMOS model can be replicated elsewhere in New York State or even nationally. Significant savings and magnificent results are a great incentive for city, state, and national government to focus on smart spending. This approach makes for non-ideological activism.

Goldfarb insists, and SOMOS doctors will agree, that "there's no credible evidence that physicians are racist or that minority patients will benefit if healthcare is built on a race-based foundation," adding that "unwarranted accusations of racism are contributing to physician burnout and early retirement, making it harder for patients to receive care, especially in vulnerable communities. Such accusations also sow profound distrust in the treatment room, eroding the doctor-patient relationship that's crucial to better health outcomes."

Indeed, for SOMOS, that doctor-patient bond of trust holds the key to transforming healthcare for poor ethnic and racial minorities. The SOMOS model of care harmonizes with what Dr. Goldfarb describes as the goals of his new nonprofit, Do No Harm, "which will help medical professionals and concerned Americans protect and promote the principles at the heart of healthcare: fairness, equal access, and the best, most personalized treatment for every patient."

What drives good healthcare for vulnerable minorities is not dependent on ideological formulas governing care distribution and medical training—quality care will always depend on the goodness and dedication of individual doctors.

Mario J. Paredes is CEO of SOMOS Community Care, a network of 2,500 independent physicians—most of them primary care providers—serving close to a million of New York City's most vulnerable Medicaid patients.