Tracey ([00:00](https://www.rev.com/transcript-editor/Edit?token=Rh2L1H7WZEjm7_9f0i6BP_PafL3fTco71Bzgt3IsxDTYZeZABq_BabHMWQZ6sx-XQwKWV00fu81HachRAsAP3UIpMaQ&loadFrom=DocumentDeeplink&ts=0.17)):

Hello, and welcome to NC State's Audio Abstract. I'm your host, Tracey Peake. A recent study by assistant professor of psychology, Vanessa Volpe, found that systemic racism doesn't just impact access to employment or education, it also affects healthcare quality and availability for black populations. Vanessa is joining us today to talk about the study and its implications. Welcome, Vanessa.

Vanessa ([00:27](https://www.rev.com/transcript-editor/Edit?token=MfCPzUFdFIorn-Eh5vMPeEEaXJMzv9i1HKOj6vwmkGJmV4ABN7wviQ4SOCuyB9vxICTqE2VQjjBYndrabzOQ3xmMPsE&loadFrom=DocumentDeeplink&ts=27)):

Thanks so much for having me.

Tracey ([00:28](https://www.rev.com/transcript-editor/Edit?token=_zDv0CyiexjSTltvWtRfAu4jm4DLUqI2RqCLGI5WvpWHfwFmCf88zWHJo8hsS55rv439D7moHC1XxrYte9Si0r5ChEA&loadFrom=DocumentDeeplink&ts=28.83)):

Thanks for being here. Let's start by talking about what we mean when we say healthcare inequity. Is it that medical care is just not there? Is it harder to travel to? Is it out of reach financially? What's going on here?

Vanessa ([00:46](https://www.rev.com/transcript-editor/Edit?token=f0qY9CVkIDEIGZEcD_bCQIxSiolrP9M9GotIgiKloAjTdJBx2RKXKaAQxs6fuH9lLtjrHf0IQzJ3dsLcukEKRq59tG8&loadFrom=DocumentDeeplink&ts=46.96)):

Iinequity in healthcare can mean a lot of different things. Our investigation specifically focused on black and white individuals, which is important to note because of course, healthcare inequity can apply to many different groups and differences between groups. And we looked at the United States context. And this was from the Association of American Medical Colleges Consumer Survey of Health Care Access. So they asked individuals to self-report about their healthcare experiences and access.

Vanessa ([01:43](https://www.rev.com/transcript-editor/Edit?token=i_aFimGmAEPpcRAPI0TThzHuyG6TRYyp3XS-VEYzAb_TaOyx2NfymxWgWExpV0qaTiJZ6IVlfDCK7Lyduo3rZ6AiL4Q&loadFrom=DocumentDeeplink&ts=103.53)):

So with all that context, healthcare inequity and healthcare access and quality can mean a bunch of different things. And so we looked at the self-reported experiences of folks who said they needed healthcare within the past year and we looked at three different aspects of access. So able to access care is one aspect, but delay in care and choice in care are also important aspects of healthcare inequity. So if you needed care but you were delayed in getting the care that you needed or that your doctors believed is necessary, that's another important aspect of access that we looked at. And then how much choice do you feel like you have in care? Do you have enough options for where to get care? And do you feel like you have those choices in that agency to make those decisions related to access?

Vanessa ([02:49](https://www.rev.com/transcript-editor/Edit?token=zQG8_foOqLQ2s6syyZjS1x_aM5E5QV7qaqwaaNkQnITRAaJxjisKIGjgPN6NwPRZTSTSgd9kXqev3-HzovAoZcvuCyk&loadFrom=DocumentDeeplink&ts=169.48)):

And these access factors can be for a variety of reasons like you mentioned. So it could be travel considerations, financial considerations, insurance considerations. We didn't actually look at the reasons for differences in access in this paper, but we did control and account for things like health insurance, urbanicity, so if people lived in a rural, suburban, or a rural place. So we did account for those things. So we have those three different aspects of care, ability to access care, delay in care, and choice in care.

Vanessa ([03:32](https://www.rev.com/transcript-editor/Edit?token=T8FDwYJUQay8vaelFGxcFHjU7LiWZw7yVE8tErNQOjq2Fu6T5Jm6Eiv6XPG9E9nQXWlKDk9aqqsJnIq0OP1xIpOpHLE&loadFrom=DocumentDeeplink&ts=212.83)):

And then we also looked at what we call quality of healthcare. And for us, that was people's reports about specifically the quality of communication and their provider-patient relationship.And we looked at if people reported that their providers explained things in a way that was easy to understand. If they reported their providers answered all their questions adequately, and if they reported that their providers spent enough time with them, because these are three really important dimensions of quality healthcare that makes sure that folks have all their questions answered, they understand things, that they're getting care that fits their needs and that their providers are receptive to that.

Vanessa ([04:23](https://www.rev.com/transcript-editor/Edit?token=cQnZ0m4PcuPqpELf0oo-cUvC_Oaam-IBP4kN4bTL5q-6JMsXJfCjgumdhj1B-kDa6fa1tt7pEX4mk4OIRkfaZCJHWqs&loadFrom=DocumentDeeplink&ts=263.21)):

So those are the aspects of healthcare that we looked at. And in our study, of course, we found what previous research has already highlighted, which is that more white participants were able to get care than black participants. They reported that. And in our sample, there were not differences in delay in care or choice in care by race, but white individuals did report receiving better quality care than black individuals on all of those indicators. So that was just descriptively. That's not tied to state-level factors, but we do see those racial differences.

Tracey ([04:58](https://www.rev.com/transcript-editor/Edit?token=yt2Ldn5VWkFwhEMYXy4h5MdSGNE9yW6vaSnaV88_LRaHjkUv-60Jz8sWxTLr8a8QSOFwu6iBChU8OVgxy4Loxz3zMYk&loadFrom=DocumentDeeplink&ts=298.21)):

In the study, you did find a link between states that you said had more racism, I guess, structural racism or inequality and healthcare inequities. So how did you score states on structural racism? Like how did that work?

Vanessa ([05:20](https://www.rev.com/transcript-editor/Edit?token=dFkjVRN6ryJlddwX9-rAKRX-hnfL_X2S99U2DEEpcRa684vROdQOdDtSrFnABto9o1bMWdRsvMBgDZxd1AhzUHD4ns8&loadFrom=DocumentDeeplink&ts=320.08)):

Yeah, so our measure of state-level racism was a measure of state-level racial inequity between black and white people in a given state. So what we did was we used publicly available data from the US Census and some also came from the Department of Labor and Statistics and the Department of Justice. So these were statistics by state. And we looked at eight different indicators. So the number of people who earned a bachelor's degree or higher, number of people who are registered to vote, the number of people who actually voted, the number of people who were in the civilian labor force, the number of people who are employed in executive or managerial positions and professional specialty positions, and the number of people who are incarcerated. So these are indicators, of course, that are socioeconomic and judicial and civic engagement indicators.

Vanessa ([06:14](https://www.rev.com/transcript-editor/Edit?token=fewg_eXWBYeb0coGtHkOJFgoZ3ZzRAtUjcArx1vYxz9UhYfCOU8rjVvYFuzmSfiG8aBmLfFk-1PIrhxRnOZV94BCo_Y&loadFrom=DocumentDeeplink&ts=374.11)):

So what we did is we calculated ratios of black to white individuals after accounting for the numbers of black and white individuals in that state. So a lower score on a given indicator meant that black individuals were underrepresented and positive indicators like voting, employment, educational attainment, and a higher score meant that they were overrepresented in incarceration. And so what we did is we used cutoff values to then classify states as low or high on each of the indicators, and then we add up all the indicators to get a continuous score. So if you have a higher state-level racism score, then that means that black people don't have as equally positive political, educational, socioeconomic, and judicial outcomes as white people in that state.

Vanessa ([07:01](https://www.rev.com/transcript-editor/Edit?token=wKSITYqRGlQWhG_qonG8bWXxtqKMMc2d5q2QwOU_w3XjAe_ZJB-DD6bCaa2rZBC3xBpWa1W81NcizA5aXWgG_tHmohc&loadFrom=DocumentDeeplink&ts=421.22)):

And this is a form of structural racism in the sense because these race-specific inequities in the socioeconomic, political, and judicial and civic engagement indicators indicate differences in potential policies, procedures, and practices, and opportunity structures at this larger state-level that disproportionately disadvantage black folks and advantage white folks.

Tracey ([07:34](https://www.rev.com/transcript-editor/Edit?token=tk67CaAc4FOdM00k_h8UeT_FHvlFqCcRig0KVl5KTCu1nRGzVsKjMkjE2A4-FV5f1kRZCnqbeWAQXBzYCVh0YPl9om4&loadFrom=DocumentDeeplink&ts=454.17)):

Quality of healthcare seemed to be the big sticking point here. Like overall in the study, that was where the most, I guess, stark difference was noticed according to race and inequity.

Vanessa ([09:09](https://www.rev.com/transcript-editor/Edit?token=Hpy7UElB7WnqfUyntnGIO1ogW6vxr7quAHWzPLJk5O2Cjf8imfyeWSDqjnHFZFojerm-MeFY0RZSckwvwdfaOY_sw9c&loadFrom=DocumentDeeplink&ts=549.49)):

So interestingly, for both black and white participants residing in a state with more racism was affected in terms of access, but in different ways. So for black people, they had lower odds of being able to get care. For white people, they had higher odds of being able to get care. And this was specifically when they resided in a state that was higher in state-level racism. So access, specifically the ability to get care component, not as much delay in care or choice in care was important for both black and white folks but in different ways. And then healthcare quality we only found was affected by state-level racism for white folks. So healthcare quality surprisingly was not associated with residing in a state with more or less state-level racism for the black subsample. And for white people actually, if they resided in a state with more state-level racism, they had higher odds of having sufficient time with their provider. So the time component was especially important there.

Vanessa ([10:18](https://www.rev.com/transcript-editor/Edit?token=R-RqiYqAjUGOBxhHkCOpXGPWlGH0d5McgJcCbx74jNAQY-5i41dTsnjmYI4BNNIN50GiO3rOlN2kzmcBqjYLteNobK8&loadFrom=DocumentDeeplink&ts=618.91)):

So there are these differences that we're seeing. And of course, we also looked at black folks reports of individual discrimination from providers, their providers themselves, and that of course was associated, as many others have found, for black folks. If they reported more experiences of discrimination from their provider, then of course, that was associated with them also saying, yes, my provider's not explaining things to me, they're not answering my questions, they're not spending enough time with me. So we did see that as well, but the state-level kind of more structural racism was not associated in this sample. And I'm happy to talk a little bit more about why we think that was the case as well.

Tracey ([11:05](https://www.rev.com/transcript-editor/Edit?token=bEfeaaZEaXGfuxiDwWwvnME787SUvowXq6vTKfK9u6J8OL-GHFADIYjZu6vzXrZ2mHR9PA6RXKcpIbWdar_5vtZl7Rg&loadFrom=DocumentDeeplink&ts=665.05)):

Yeah, if you could elaborate on that, that'd be great.

Vanessa ([11:08](https://www.rev.com/transcript-editor/Edit?token=PDwgcIBaS-f3mXV_p0BOYwNFgy0VL01YF-BaVyIDWGwGSZQYuZsqLpotf2EpeakTK8R4bpfr1ArPzfLq7mmOIRhNcac&loadFrom=DocumentDeeplink&ts=668.9)):

Yeah. So it is important to note that this sample, right? So we combined the census level data with this national sample of folks who self-reported their healthcare access and quality. And even though we did find that there were differences between the black folks and the white folks in this national sample in terms of how much access they had in general and how the quality of their care was, we didn't see a lot of variability overall in terms of access or quality as we might see for those that we are not as able to reach.

Vanessa ([11:47](https://www.rev.com/transcript-editor/Edit?token=8pJnunaEg50DrRMzlm27hYO-T8-6UuPR6FYtT7l_Dadof5ATySuAJYM9sWT_yWV_KZ4vwBKgL7djBK2Y_IufWGWqFVs&loadFrom=DocumentDeeplink&ts=707.52)):

So for example, the sample overall had pretty high endorsements of being able to access care and being able to have quality care in the first place. And so even though we did see these differences by race or racial group, it might just be that we're not also able to fully reach or capture in the national sample those who don't have as much access to completing the survey for a variety of reasons. They might be in more rural areas, they might not have had stable internet access to complete the survey, for example. And those things are just some examples that might be the reason they're not in the sample but they're associated with already these structural racism indicators. So that might be a reason that we didn't see that as much in our sample.

Tracey ([12:43](https://www.rev.com/transcript-editor/Edit?token=KTvAs--_pE50hUAGy0uPGWwK0uJMpZDPBpE7WMJeqHSW0PAGoFyB-9GCuAjG233JJ5fsoTF_6eEj5T1raRcCMxXAUWU&loadFrom=DocumentDeeplink&ts=763.76)):

Given all of this information, is there anything that policymakers or anyone can do to address the problem? Because it almost seems like from the survey, you're finding that it's almost like an on an individual level, the issue here with providers and patient relationships. So is there any policy remedy for this?

Vanessa ([13:11](https://www.rev.com/transcript-editor/Edit?token=AohsO3fw7ekGdVTv8pWQHRZZPr8EcyoFY2tX2JH0QD6X6C2cw6aMVJM9rSsdi6h5qb7hCCK54PJYu92NvFoO-n-JQlI&loadFrom=DocumentDeeplink&ts=791.17)):

Yeah, absolutely. So as you said, there's the individual level component for black folks where if they are reporting experiencing discrimination from their providers and that is associated with the quality care they're receiving. And at that level, provider racial discrimination remains an important determinant of healthcare quality. So state-level policies could address provider bias to a certain extent through something like cultural humility or cultural competency requirements that might help assist at the state-level providers and developing training to mitigate effects of intentional or unintentional aspects of bias that are creeping into their practice. So even though that's an individual provider type thing, at the state-level, we can certainly support that with policies, practices, or programs.

Vanessa ([14:16](https://www.rev.com/transcript-editor/Edit?token=oOUPPzk00uzmQIYfRy19hBdqAas4eK33-gs5XvtQPEkz8O1Q4xKvW33QdsMCYUKhHs0HuHzoaQkw9o6yDK82HyZVWiE&loadFrom=DocumentDeeplink&ts=856.35)):

And then the other piece of this is of course at the structural state-level, racism does appear to benefit white individuals access to and quality of healthcare while decreasing black individuals access to healthcare. And so these results suggest that racial disparities in healthcare may be driven by both white advantage and black disadvantage. A lot of time we just focus on the black disadvantage, which is important, but also there is an advantage to some folks. And so examining, revising, or abolishing policies that engender these inequities using a health equity lens is going to be really important. And what I mean by that is educational, employment, political, judicial policies that we have in our states, do they disparately impact racial groups intentionally or unintentionally? So that this doesn't include disadvantaging black people, but also do they confer benefits for one group? So of course we don't want to do harm, but also if we're conferring benefits for one group, that policy may not be as effective as we think it is to actually mitigate inequity.

Vanessa ([15:25](https://www.rev.com/transcript-editor/Edit?token=OePNtqUVAjGoLOXaELdFf4FT7JHKFdRLq6w0wQB_zbGa3bWYnHGQwSiJgfYAqtdAbqT67iWDU90_pMtD-ecmw9aINNY&loadFrom=DocumentDeeplink&ts=925.86)):

And we did find that incarceration rates for black individuals and employment and education rates for white individuals are especially important in our supplemental analysis. And so these might be particularly important levers for change. So we suggest looking into things like income redistribution, avoiding employment related healthcare policies such as like medical leave, provision of insurance through employment that disproportionately improve the health of advantaged racial groups, and specifically thinking about how we can divest a little more from the prison industrial complex, which is also a major driver of some of these access and quality disparities that we're seeing.

Tracey ([16:09](https://www.rev.com/transcript-editor/Edit?token=nhv2rfqAR8TWomocPxjnaUnvAqIHspCwf99XM1tM2FKzCMIvxvZ1BxLIqFnHB4NHlJQh4Svs4-3g5ylC_Jr63PJS20g&loadFrom=DocumentDeeplink&ts=969.73)):

Okay. Well, thanks for that. I always like to ask researchers was there anything surprising that you came across while you were conducting this work?

Vanessa ([16:24](https://www.rev.com/transcript-editor/Edit?token=mSY2CUg2zE7Om6yNvNZ5yL71iUtzQzmmWz3rQPrO2O5U5Gg7GVAxTDxNkpZtEnKvaYqMdFXeYGNYgW-4THhnLtWw1ck&loadFrom=DocumentDeeplink&ts=984.05)):

Yeah, I think it was a little surprising that we did find that white advantage in some of these domains was linked to white folks having better access and quality care. And I think that it makes sense given the previous work, but it's just not talked about as much. And I think that it's an important component because if certain policies or practices impact certain groups and they might be beneficial, it's harder to change them. And sometimes we don't focus on that enough. So I think that it was surprising that it had as big of an impact in this national sample and across these states.

Vanessa ([17:23](https://www.rev.com/transcript-editor/Edit?token=o_gRBnejkYekJeo1nj-EBomFgb7PCLuMrZtw2-Ovnd7i3tebI70PaOJT9y1ddgj5Lnc4boRhXNK0lYDtH-ybEH0fi4Y&loadFrom=DocumentDeeplink&ts=1043.5)):

It provides such a great opportunity to really unpack in further research, what are the processes that are really connecting these structural state-level inequities with these different individually reported benefits for white individuals? So right now we've kind of set the stage and we know they're linked, but thinking about the exact mechanisms and processes, how does that stuff that happens at the state-level really translate to that advantage I think is going to be an exciting and important area for future research to really, really understand these inequities and disrupt them.

Tracey ([18:07](https://www.rev.com/transcript-editor/Edit?token=dlbDYjnd-2tjp5bytWzBL733z6h5iKDhe3UzjAVWMg1iAcBCskUWCFnTdNI1ydZXC9dzz5d5I6nPx6oV1yL_H8EVn20&loadFrom=DocumentDeeplink&ts=1087.84)):

We've been speaking today with Vanessa Volpe, an assistant professor of psychology here at NC State. This has been Audio Abstract. I'm your host, Tracey Peake. Thank you so much for listening.