

VIEWPOINT

Addressing Systemic Racism Through Clinical Preventive Service Recommendations From the US Preventive Services Task Force

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Viewpoint



Supplemental content

Wellness and disease prevention are the foundations of health. The US Preventive Services Task Force (USPSTF) is congressionally mandated to make evidence-based recommendations about clinical preventive services, which, if delivered equitably to the intended population, can prevent many premature deaths. All USPSTF recommendations are based on a rigorous and objective methodology that has been continually refined since 1982. This methodology was cited by the Institute of Medicine as a gold standard for making guidelines.¹ In addition, the Patient Protection and Affordable Care Act mandated coverage by private insurers without cost sharing for USPSTF grade A and B recommended clinical preventive services, reflecting the importance of these recommendations.

However, when making recommendations, the USPSTF often finds substantial data that potential life-saving benefits of recommended services are not equitably available to Black, Indigenous, and Hispanic/Latino people. For instance, the 2020 systematic review to inform modeling for the USPSTF colorectal cancer screening recommendation found consistent evidence of inequities across the screening-to-treatment continuum that encompassed access to screening, quality of screening, time from diagnosis to treatment, and quality of treatment.² This underscores the need to improve systems of care to ensure consistent delivery of high-quality preventive and treatment services, with special attention to groups experiencing worse health outcomes.

As described in the 2003 Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, health inequities emerged from a “historic context in which healthcare has been differentially allocated on the basis of social class, race, and ethnicity”³ and are sustained by systemic racism. The USPSTF considers systemic racism to be a pervasive set of societal and interpersonal practices within and outside health care institutions that foster discriminatory practices to create systematic disadvantage and health inequities in a racial group. Health inequities manifest as disproportionate risk, incidence, morbidity, or mortality. These inequities are due to social, economic, and structural factors stemming from systems in which public policies, institutional practices, and other norms work to perpetuate systemic racism. Even when deemed unintentional, well-documented structural inequities are evident within the health care ecosystem that span the entire prevention-to-treatment continuum. Being a member of a racial ethnic minority group is associated with multiple dimensions of social disadvantage, which in turn is associated with worse health care access, affordability, and quality of care.

The 2018 Quality and Disparities Report from the Agency for Healthcare Research and Quality, which included measures on healthy living (eg, receipt of smoking cessation counseling), patient-centeredness of care, care coordination (eg, for diabetes and asthma care), and effective treatment (eg, outcomes of cancer care), showed an improvement in the quality of health care from 2000 through 2017 on most, but not all, measures.⁴ Also, while there were some improvements, disparities persisted across many priority areas. Overall, compared with White people, Black people received worse care on 76 of 190 measures (40%) and Hispanic/Latino people on 58 of 167 measures (35%). The influence of these disparities is reflected in life expectancy data. For 2016-2018, estimated life expectancies were 75.5 years for Black people, 76.9 years for American Indian/Native American people, 78.8 years for White people, 83.7 years for Hispanic/Latino people, and 87.7 years for Asian people.⁵ These disparities are likely further exacerbated by the disproportionate effect of the COVID-19 pandemic in Black, Indigenous, and Hispanic/Latino communities.⁶

The USPSTF has sought to address health equity. As described in 2017, the evidence review for Recommendation Statements includes identifying populations that have a higher prevalence or experience greater morbidity or mortality from the condition.⁷ Evidence is then sought that can address the gaps identified in recommendations for groups disproportionately affected by the condition of the review. However, the same factors that affect unequal health outcomes (eg, access, affordability, and quality of health care) also influence inclusion in key clinical trials for prevention. In the development of recommendation statements, the USPSTF has consistently found a limited evidence base for Black, Indigenous, and Hispanic/Latino populations. For example, despite knowing for more than half a century that Black men are twice as likely to die from prostate cancer as White men, the US-based Prostate, Lung, Colorectal, and Ovarian Cancer screening trial included only 3370 Black men in its 76 683 study sample.

In some cases, the USPSTF has derived evidence to inform recommendations that may promote health equity. For example, a modeling study commissioned to inform an updated USPSTF lung cancer screening recommendation showed that initiating screening at a younger age and lower smoking intensity may improve life-years gained.⁸ Because Black men are at greater risk than White men for lung cancer at lower pack-years of smoking, lowering the pack-year level at which to start screening, as the USPSTF is now recommending, may reduce racial disparities in lung cancer health outcomes if

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implemented with fidelity. Clearly, across clinical preventive services, more evidence is needed to move beyond the current state of merely knowing that certain groups have higher disease prevalence and worse health outcomes to understanding effective evidence-based interventions to improve health outcomes.

The USPSTF thus commits to advancing its methods to better identify when systemic racism contributes to health inequities and to include evidence-based strategies that will reverse the negative effects of systemic racism on preventable disease. The development of recommendations on clinical preventive services must therefore be inclusive and more fully consider effects of the social, economic, and structural contexts in which disease and related sequelae occur. This requires an intentional focus on embedding health equity into every step of the recommendation development process to ensure alignment with the needs of populations adversely affected by systemic racism.

To do this, the USPSTF is creating a roadmap that will be guided by a workgroup commissioned to develop and advance the USPSTF approach to how systemic racism affects preventive health care. Throughout this process, the USPSTF will assess the effect of changes made in its approach and methods for making recommendations and iteratively modify its actions to achieve the goal of improving health equity through evidence-based clinical preventive services. As detailed in the eTable in the Supplement, the USPSTF commits to the following several specific actions:

1. Consider race primarily as a social and not a biological construct and use consistent terminology throughout recommendation statements to reflect this view.
2. Promote racial and ethnic diversity in addition to gender, geographic, and disciplinary diversity in membership and leadership of the USPSTF and foster a culture of diversity and inclusivity as an enduring value of the USPSTF. This will be assessed annually prior to soliciting nominations for new members and internally assigning leadership roles.

3. Commission a review of the evidence, including an environmental scan and interviews with clinicians, researchers, community leaders, policy experts, other guideline developers, and patients from groups that are disproportionately affected to summarize the evidence on how systemic racism undermines the benefits of evidence-based clinical preventive services and causes preventable deaths. This will be completed by June 2021.
4. Iteratively, update USPSTF methods to integrate the best evidence and consistently address evidence gaps for Black, Indigenous, and Hispanic/Latino populations. This includes measures to identify and track strategies to demonstrate progress in addressing health inequities regarding clinical preventive services.
5. Use a consistent and transparent approach to communicate gaps in the evidence related to systemic racism in preventive care in Recommendation Statements and the USPSTF's annual report to Congress. This includes an ongoing assessment of how the effects of systemic racism on the quality of the evidence and receipt of clinical preventive services perpetuate health inequities.
6. Collaborate with other guideline-making bodies, professional societies, policy makers, and patient advocacy organizations on efforts to reduce the influence of systemic racism on health.

There is convincing evidence that systemic racism causes health inequities,⁹ including for disease prevention and health promotion. The USPSTF may be able to have a role in mitigating the adverse consequences of systemic racism by assessing the evidence, making recommendations, identifying evidence gaps, clearly communicating the evidence and limitations, and advocating for health equity in the implementation of clinical preventive services. The roots of systemic racism are deep, and solutions to address systemic racism and its consequences go beyond development of recommendations by the USPSTF. Therefore, clinicians, health care systems, other guideline groups, professional societies, research funding agencies, public health agencies and practitioners, and policy makers must collectively address the key issues that perpetuate systemic racism in the US.

ARTICLE INFORMATION

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