Medical Xpress

Study examines racial differences in care among older Americans

October 25 2023

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Older Black Americans are more likely to receive low-value acute diagnostic tests than older white Americans, while older white Americans were more likely to receive low-value screening tests and

treatments, finds a study published by *The BMJ* today.

Low-value care refers to services that provide little to no benefit yet have potential for harm, which can include laboratory tests, scans, and medication.

These differences were generally modest and were largely driven by differential treatment within health systems. But the researchers say the results "highlight the need for health systems to track internal data by race on low-value care to identify, understand, and address the sources of racial differences."

Existing evidence shows that Black patients in the United States are less likely than white patients to receive high value health care, but evidence on racial differences in low-value care is scant and mixed.

To address this uncertainty, researchers used Medicare claims data to identify racial differences in the receipt of 40 low-value services among nearly 10 million patients (aged 65 or older) at 595 health systems in the United States between 2016 and 2018. These services fell into four distinct categories: screening tests, acute diagnostic tests, monitoring tests, and treatments.

After adjusting for variables that could influence the results such as patient age, sex, and previous health care use, the researchers found that Black patients were more likely to receive low-value acute diagnostic tests, including imaging for uncomplicated headache (6.9% v 3.2%) and head scans for dizziness (3.1% v 1.9%).

White patients had higher rates of low-value screening tests and treatments, including preoperative laboratory tests (10.3% vs. 6.5%), prostate-specific antigen tests (31.0% vs. 25.7%), and antibiotics for upper respiratory infections (36.6% vs. 32.7%).

Further analysis showed that these differences persisted within given health systems and were not explained by Black and white patients receiving care from different systems.

This is an observational study, so can't establish cause, and the researchers note several limitations. For example, the 40 services examined represent a fraction of all low-value care and claims data lack clinical details to confirm clinician intent.

They also point to underlying sources of racial differences, such as clinician-patient interactions (bias, mistrust) or structural issues (access to high quality primary care or differential referral patterns) that may explain why these differences occurred.

"In general, we found Black patients were at modestly greater risk of receiving low-value acute diagnostic tests commonly performed in acute care settings, while white patients were at modestly greater risk of receiving low-value screening services and treatments," the researchers write.

"These patterns suggest potential individual, interpersonal, and structural factors that researchers, policymakers, and health system leaders might investigate and address to improve care quality and equity," they conclude.

In a linked editorial, researchers argue that addressing low-value care and equity together is essential to improve patient outcomes.

They say further efforts are needed to explore underlying mechanisms for these inequities, and interventions targeted at narrowing gaps, including addressing implicit and explicit racial biases. It is also worth investigating possible upstream contributors to low-value care suggested by this study, such as improving continuity of care as a means to

decrease overuse of acute diagnostic tests, they add.

"Bringing together the burgeoning fields of low-value care and equity will provide an integrated path toward improving outcomes for all patients," they conclude.

More information: Racial differences in low value care among older adult Medicare patients in US health systems: retrospective cohort study, *The BMJ* (2023). DOI: 10.1136/bmj-2023-074908

Editorial: *The BMJ* (2023). DOI: 10.1136/bmj.p2293

Provided by British Medical Journal

Citation: Study examines racial differences in care among older Americans (2023, October 25) retrieved 2 May 2024 from
https://medicalxpress.com/news/2023-10-racial-differences-older-americans.html

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