



Racial inequity in low value care

Addressing low value care and equity together is essential to improve patient outcomes

Christopher Moriates,^{1,2} Utibe R Essien^{3,4}

¹ Department of Internal Medicine, Dell Medical School at the University of Texas at Austin, Austin, TX, USA

² Costs of Care, Boston, MA, USA

³ Division of General Internal Medicine and Health Services Research, David Geffen School of Medicine at the University of California, Los Angeles, CA, USA

⁴ Center for the Study of Healthcare Innovation, Implementation & Policy, Greater Los Angeles VA Healthcare System, Los Angeles, CA, USA

Correspondence to: C Moriates
cmoriates@austin.utexas.edu

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Decreasing low value care (health services where potential harms exceed potential benefits) improves patient outcomes and is the target of multiple initiatives across the world, including the Choosing Wisely campaign.¹ Most research and implementation efforts have focused on areas of overuse that seem common, without examining potential inequities in the receipt of those services. If there are differences in who receives low value care, then it could inform existing health equity gaps.

While it seems clear that Black patients receive fewer evidence based, recommended services than White patients,^{2,3} whether they also receive fewer low value services has remained uncertain.^{4,5} In a linked study in *The BMJ* (doi:10.1136/bmj-2023-074908), Ganguli and colleagues aimed to characterize differences associated with race in the receipt of 40 low value services.⁶ This retrospective cohort study of nearly 10 million Medicare beneficiaries (aged 65 or older) across 595 health systems in the United States found that Black patients had higher rates of low value acute diagnostic tests and lower rates of low value screening tests and treatments than White patients. These findings, along with previous evidence of underuse of recommended services, support the notion that people often simultaneously receive too few interventions that have been shown to improve outcomes (high value care) and too many interventions that are more likely to cause harm than benefit (low value care).⁷

At first glance, the heterogeneous results—Black and White patients differed significantly in receipt of 29 low value services—appear complicated, but several patterns emerged that are potentially informative. Black patients were more likely to receive low value acute diagnostic tests commonly performed in acute care settings (such as imaging for uncomplicated headaches, dizziness, or syncope). Black patients were also more likely to be prescribed two or more antipsychotic drugs or receive a feeding tube in the setting of advanced dementia. Exposing people from underrepresented racial and ethnic backgrounds to low value care amplifies the hazards they already encounter in healthcare systems.⁸

This study could not identify why these differences occurred, although it raised several hypotheses. For example, while Black patients had a higher proportion of ambulatory visits with primary care clinicians, there was evidence of worse continuity of care, perhaps contributing to increased urgent care or emergency department testing. The authors also hypothesize that perhaps structural racism could contribute to care seeking delays such that Black adults are “sicker when they present with acute

conditions, potentially leading clinicians to order more low-value tests.”⁶

White patients had higher rates of 20 low value services, including nine screening tests, one acute diagnostic test, two monitoring tests, and eight treatments. These results align with those of a recent study reporting decreased rates of low value prostate and cervical cancer screening among Black patients compared with White patients within the Veterans Health Administration.⁹

Racial differences in low value care appeared largely driven by differential care within systems, rather than being attributable to Black and White patients receiving care in different settings. Further efforts are therefore 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.

Most racial differences were modest in this study, and overuse was widespread across both groups. For example, more than 30% of Black patients (and over 35% of White patients) were prescribed unnecessary antibiotics for acute upper respiratory tract infections. Between <1% and 37% of eligible patients received each of the 40 examined low value services, rates similar to other studies on the prevalence of low value care globally.¹⁰ Decreasing overuse in healthcare remains an essential goal.

What are the clinical and policy implications of these findings? The intersection of low value care and equity appears complex, but as studies such as this one shine a light on this critical crossroad, a roadmap emerges with implications for patients, doctors, researchers, and policy makers.

Differing patterns of overuse suggest that equity should be factored into the design and implementation of future initiatives to reduce low value care. Healthcare systems, doctors, and policy makers could focus their efforts on those areas of low value care that are most overused among those who are already at risk of poorer outcomes. For example, decreasing acute diagnostic studies, such as imaging for uncomplicated headaches, could have the dual benefit of improving outcomes while narrowing health equity gaps. Conversely, programmes that decrease inappropriate cancer screening remain important, but programmes that neglect equity risk further widening the outcome gap by disproportionately improving outcomes for White compared with Black patients. Cancer screening

recommendations could use emerging findings on racial inequities to instruct programmes to help counteract these biases.

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

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