Social factors, including economic, environmental, and living conditions, are potent determinants of health and health inequities. Affected by policies and social conditions, institutional contexts, social contexts and relationships, and physical contexts, social factors serve as fundamental influences on the health of people and communities (Figure 1) (1). Race is one of the most powerful sociopolitical constructs in the United States because of its omnipresence and entrenchment in racialized policies, norms, and practices. US racial categorizations were directly conceived and influenced through a centuries-long political system in which Black and other individuals have been historically enslaved, disenfranchised, marginalized, and treated unequally through systemic means that remain “baked in” to our daily lives. Race and other social categories (e.g., immigration status) influence individuals’ health and well-being in innumerable ways through differential access to health-promoting factors, including education, employment, health care, living conditions, and wealth. Restricted fundamental opportunities and resources have led to poorer access to health care; lower health literacy; greater exposure to resource-constrained neighborhood environments; greater exposure to the trauma of police violence and incarceration; and a greater burden of poverty, food, and housing insecurity for racial and ethnic minorities and other socially disadvantaged individuals. Health care providers’ personally mediated implicit or explicit bias/racism during patient-provider interactions and their inadequate attention to these social factors may exacerbate health inequities. Yet, health care providers are often inadequately equipped to consider how these contextual, nonbiologic factors influence health and health behaviors.

CKD care is not immune to sociopolitical influences, which affect the full continuum of CKD prevention and management. For instance, racial minorities with modifiable CKD risk factors are more often than nonminorities unaware of their CKD risks, and they may not receive appropriate preventive therapies (2). In primary care, discussions between socially disadvantaged Black patients at risk of CKD incidence or progression and their clinicians are often cursory and fail to enhance patients’ understanding of CKD (3). As a result, patients may not consider themselves as susceptible to CKD in comparison with other chronic conditions, resulting in their relative deprioritization of CKD treatment recommendations (2). Additionally, racial and ethnic minorities are less likely than nonminorities to receive timely referrals to nephrology care or adequate predialysis care, leading to poorer outcomes and greater mortality (4). Differential practices in specialty care also have profound effects on the health of racial minorities and other socially disadvantaged individuals. For instance, racial and ethnic minorities have been persistently less likely than White individuals to receive home dialysis treatments (5) or to be referred for or receive kidney transplants. These differences in treatment practices have been linked to bias in patient-provider discussions, referral practices, and transplant evaluation processes. They are also compounded by other social factors, including poor health literacy and financial challenges, which disproportionately affect racial and ethnic minorities (6).

Other less traditionally acknowledged social contexts also influence kidney health, including where individuals live. Because of historic racist US policies including redlining (i.e., discriminatory lending policies that systematically restricted housing access on the basis of race) and present day housing discrimination/disinvestment, socially disadvantaged groups are more likely than others to live in poorly resourced communities, which increase their exposure to “health-harming” factors ranging from tobacco to environmental toxins. Individuals living in neighborhoods with lower socioeconomic status (SES) (as defined by income, wealth, education, and/or occupation) have higher risk of CKD progression (7), higher incidence of kidney failure (8), and lower transplant waitlist rates compared with others. Racial minorities who live in low-SES neighborhoods have greater mortality compared with those who live in higher-SES neighborhoods (9), suggesting neighborhood context may act independently to influence racial disparities. Dialysis care has been shown to be poorer when delivered in low-income neighborhoods when compared with care delivered in higher-income neighborhoods. These neighborhood contextual associations with poor health outcomes may reflect how racism-mediated residential segregation constrains health-promoting resources including healthy foods, which could slow CKD progression (10), and nephrology care. They may also reflect the presence of harmful exposures to environmental...
toxins, such as lead, or the effects of chronic stress related to individuals’ daily exposures to discrimination or violence. Low-resource neighborhoods may also have fewer health-supporting infrastructures, including local pharmacies or public transit routes necessary to physically access care. These less “visible” parts of individuals’ social contexts likely have significant effects on patients’ opportunities and resources to improve their health and adhere to treatment recommendations. Often, however, these social and environmental contexts are not addressed in CKD care, despite studies demonstrating that when socially disadvantaged individuals from low-resource areas receive assistance to address these contexts, CKD care is improved (11).

Layered, interdependent, systemic racism and social biases clearly provide common underpinnings that collectively contribute to unequal CKD care. As a medical and scientific community, it is time for our actions to move beyond describing and acknowledging these inequities. Rather, we must commit to enacting solutions that rectify inequity through multidimensional approaches that address fundamental causes. As a first step, at least four strategies targeting social policies, systems of health care delivery, and the attitudes and behaviors of health care providers are needed.

- Dismantle systemically racist and biased policies and practices that limit individuals’ access to CKD care. Primary care, nephrology, and transplant professionals should advocate for policy reform that promotes universal access to high-quality care, including prevention and treatment of CKD, and the delivery of kidney-protecting therapies. Equality, or “the state of being equal in status, rights and opportunities,” is an elusive goal without equity-enhancing policies, which are tailored to ensure the conditions necessary for optimal health across all groups. These policies should strive to rectify inequalities across a range of health-promoting social drivers (i.e., education, employment, housing) and incentivize the provision of values-aligned kidney treatments, including home dialysis, transplantation, and/or conservative and palliative care.
- Create systems to eliminate bias and enhance accountability in clinical care. Inequities in referral and treatment at multiple junctures of CKD care likely result from variation in subjective provider assessments and decision making. Systems that over-ride potentially biased provider judgments and rely on unbiased, evidence-based decision-support tools are needed. Establishing a culture of accountability for equitable health care delivery is also critical. This can be achieved through population-based approaches that measure benchmarks in key processes of care (e.g., practice or system-level transplant referral rates) that can be tracked, made transparent, reformed when deficient, and incorporate stakeholder (including patient) input.
- Establish models of clinical care that address individuals’ social contexts. Models of care addressing patients’ health-related social needs (e.g., insurance/payment difficulties, transportation needs) through personnel (e.g., social workers or community health workers) and through partnerships with community organizations (e.g., social services, housing agencies) are needed to extend support for patients’ health-related social needs. These models should be extended throughout primary and specialty care settings.
- Adopt antiracist, antibiased, and culturally humble approaches to clinical interactions. Person-centered, tailored communication about CKD with patients is essential. Further, critical social contextual factors (e.g., health insurance or food insecurity), which affect patients’ capacities to follow CKD-related treatment plans, should be assessed and addressed during clinical encounters. Enhanced provider training is needed to increase antibiased, contextually
sensitive, empathetic, and culturally humble interactions with patients. Providers’ thoughtful attention to patients’ social contexts and lived experiences is critical to understanding and rectifying mistrust, which may stem from patients’ experiences of discrimination and other forms of marginalization. New longitudinal pre- and postprofessional educational curricula should be designed to help aspiring and established health care professionals understand how interlocking systems of social and institutional bias influence assumptions, judgments, and policies in clinical settings. Such education is necessary for equity-promoting practice, earning trust, and the “undoing” of existing bias/inequity. Systems to create accountability for antiracist and antibiased clinical practices through professional licensing requirements and quality ratings are also needed.

As the scope of racial and social inequities in CKD care is broad, so is the platform for intervention. Early efforts to dismantle racism and bias in CKD care will require sustained strategies that are continually tracked, evaluated, and revised. As the political systems of racial and social inequities are deeply entrenched, effective interventions will require steadfast and sustained efforts to ensure we achieve health equity for all our patients.

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