Structural racism is a root cause of health inequities. The term structural racism refers to differential access by racial group to opportunities, resources, and societal well-being and is mediated through complex health care systems (1). To undergo kidney transplant, patients must navigate a multistep, conditional process that requires multiple health system and clinician interactions. This process exerts a differential burden on patients from marginalized groups. Studies in recent decades have demonstrated that racial minority groups experience lower rates of kidney transplant listing and transplant compared with patients of White race (2, 3). Patients of Black race are four times more likely than patients of White race to have kidney diseases but only half as likely to undergo kidney transplant (3). Even when listing occurs for racial minority groups, these individuals are more likely to be hospitalized while waitlisted, decreasing their overall likelihood of undergoing a transplant (4).

Social determinants of health (SDOH)—social conditions with broad-ranging effects on individuals' health, functioning, and quality of life—have significant impact on kidney transplant outcomes (5). Current data infrastructures for SDOH in transplant, however, are insufficient in quality and accuracy. SDOH data are collected at a basic level across transplant-specific registries, and inclusion of transplant patients in SDOH-focused national databases is limited by population sampling or exclusion criteria (6). Patient-level SDOH data in electronic health records (EHRs) are also poorly standardized, inadequately quality assured, and difficult to extract for analysis due to variability in data entry (7).

As social deprivation is disproportionately concentrated within racial minority groups (1), the absence of expanded SDOH infrastructure leaves kidney care providers with limited clinical understanding of the root causes of racial disparities among their transplant patients. Race is a unique SDOH, in that it is often used as a proxy for biological differences within clinical decision-making algorithms. Known as race essentialism, these algorithms can promote racial prejudice and perpetuate structural racism in diagnosis and treatment eligibility (8). For example, inclusion of the race coefficient in estimated glomerular filtration rate calculations has historically overestimated kidney function in people of Black race, leading to delayed consideration for transplant referral (9). Efforts to improve equity in access to kidney transplant must mitigate these pitfalls of essentialism through enhanced understanding of how SDOHs mediate specific clinical outcomes. This is an essential prerequisite to development of interventions targeted to root causes of inequities at specific stages of the transplant selection process.

Improving availability and efficacy of SDOH data requires national standards for SDOH data collection, incentives through financial or quality metrics, and research that measures the impact of detailed collection (7). To address racial disparities in kidney transplant, kidney care professionals must be strong advocates for thorough and rigorous expansion of SDOH data infrastructure. Primary care, nephrology, or dialysis clinics are excellent sites for early adoption of EHR strategies for standardized and robust SDOH collection. In these settings, areas of social need for racial minority groups (e.g., lack of insurance, unemployment, and food insecurity) can be rapidly classified and addressed through targeted referral to community resources and care coordination. It is important to incorporate these practices early in the disease course when patients first begin treatment and consider repeated visits to the clinic as opportunities to bridge information gaps in EHRs regarding patients' social environments. If your health system does not currently collect or use expanded SDOH data, become a proponent for policy change by evaluating opportunity within current workflows, partnering with your colleagues on advocacy actions, and meeting with health system leadership to offer perspectives on disparities within your kidney transplant populations.

Earlier this year, the National Academies of Sciences, Engineering, and Medicine published a report regarding the establishment of an equitable, transparent, and effective organ allocation system (10). Its recommendations align with our suggestions for improving SDOH data to address racial disparities in transplant, with a focus on modernizing data infrastructure and standardizing quality improvement. We must be conscientious about the value of early and culturally compassionate kidney transplant education for racial minority groups and deliberate about supporting community-, culture-, and faith-based networks that partner with patients to address social needs (e.g., racial-affinity discussion groups; patient and provider collaboration to lead transplant education workshops; and local resources for housing, transportation, and childcare). By integrating invaluable SDOH information into kidney community-driven efforts, significant inroads can be made in achieving racial equity in kidney transplantation.

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The authors report no conflicts of interest.

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