

# Racism, discrimination and the health of ethnic minority people: Lessons from the UK

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**E V E N S**

EVIDENCE FOR EQUALITY  
NATIONAL SURVEY



**16** What is your ethnic group?  
 Choose **one** section from A to E, then tick **one** box to best describe your ethnic group or background

**A White**

- English/Welsh/Scottish/Northern Irish/British
- Irish
- Gypsy or Irish Traveller
- Any other White background, write in

**B Mixed/multiple ethnic groups**

- White and Black Caribbean
- White and Black African
- White and Asian
- Any other Mixed/multiple ethnic background, write in

**C Asian/Asian British**

- Indian
- Pakistani
- Bangladeshi
- Chinese
- Any other Asian background, write in

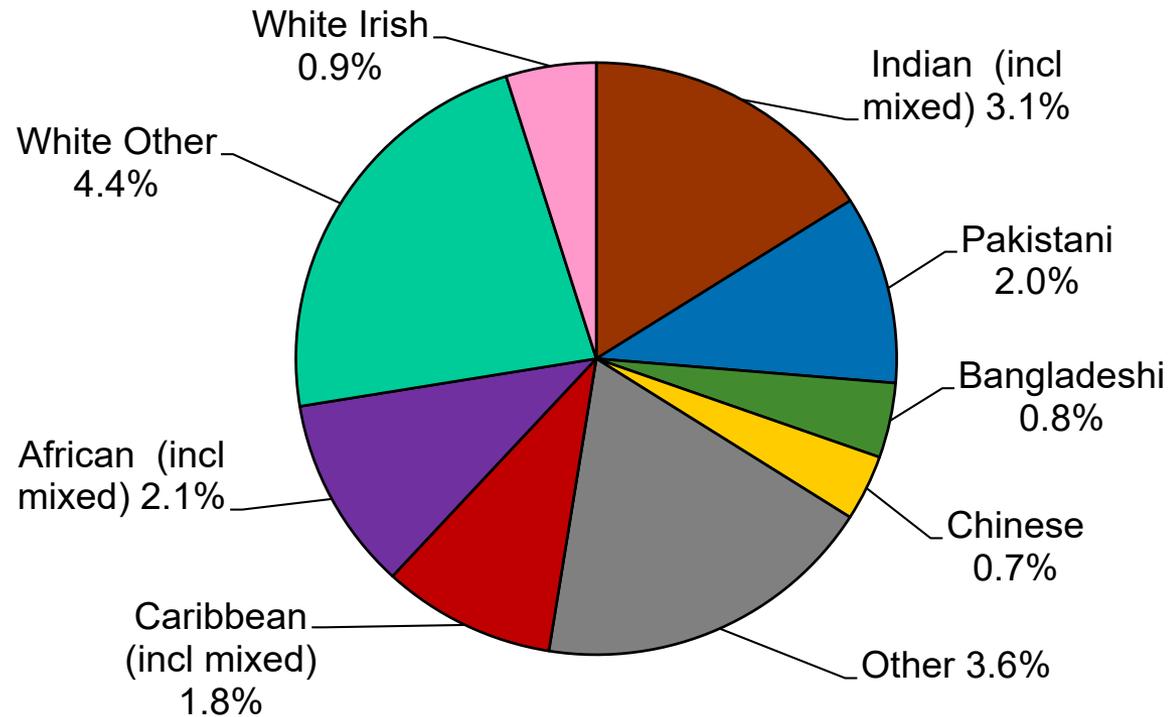
**D Black/African/Caribbean/Black British**

- African
- Caribbean
- Any other Black/African/Caribbean background, write in

**E Other ethnic group**

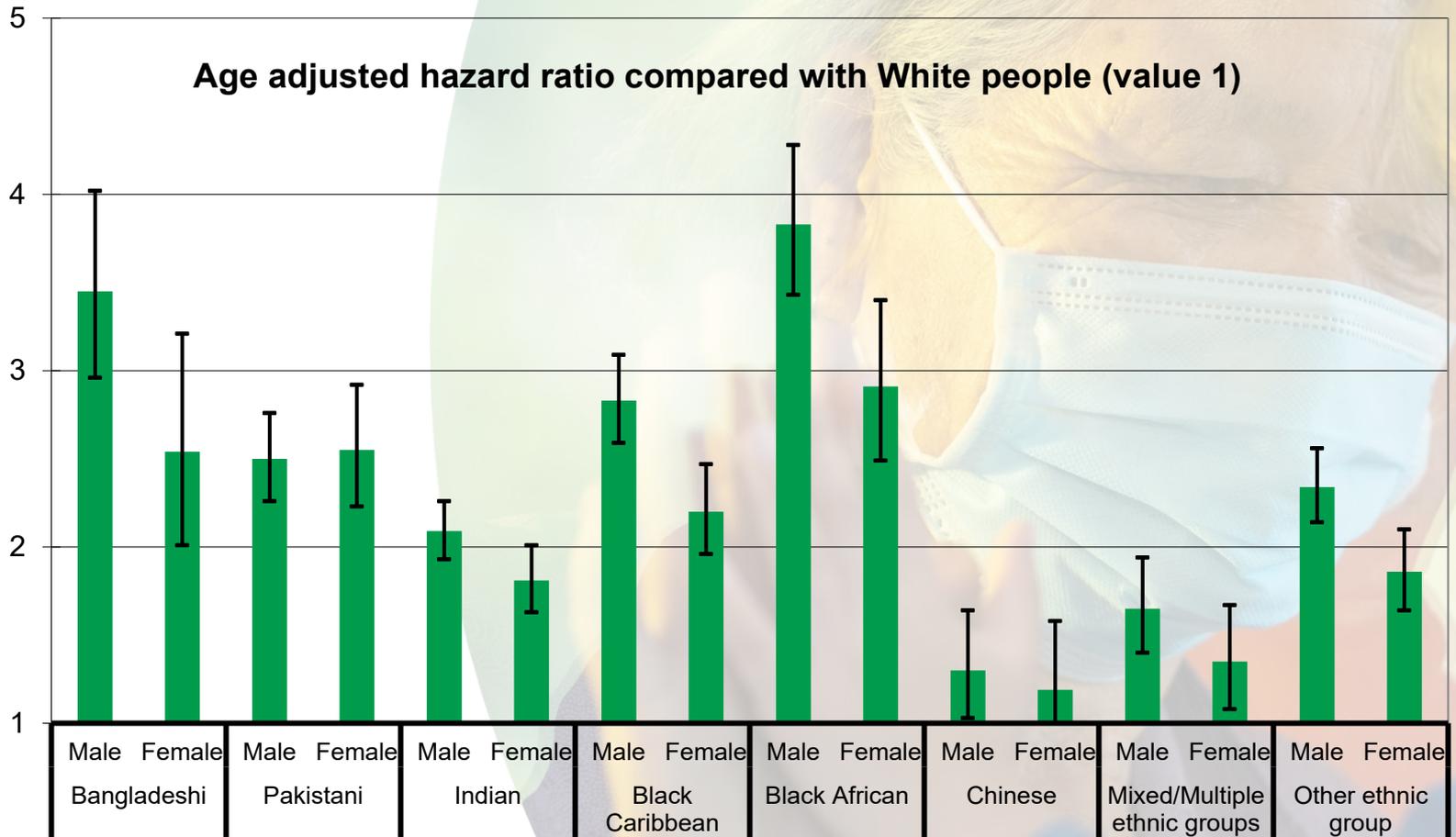
- Arab
- Any other ethnic group, write in

## Classifying ethnicity: The English and Welsh Census



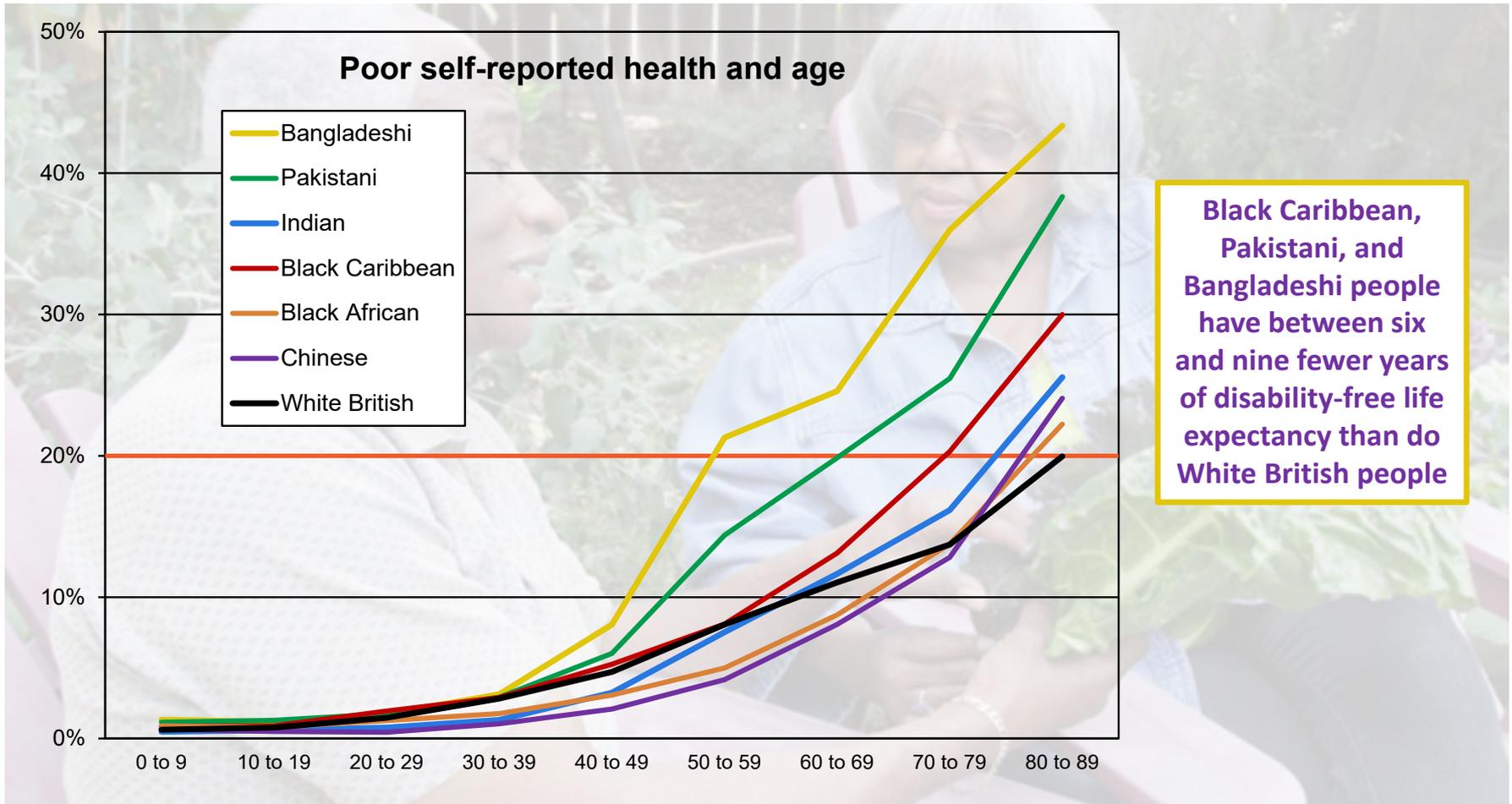


## ETHNIC DIFFERENCES IN COVID-19 RELATED MORTALITY





## Longstanding and stark ethnic inequalities in health in the UK



**Black Caribbean, Pakistani, and Bangladeshi people have between six and nine fewer years of disability-free life expectancy than do White British people**



## PROPOSED EXPLANATIONS FOR ETHNIC INEQUALITIES IN HEALTH

- The social and economic inequalities that are faced by ethnic minority people (finances, employment, neighbourhoods, housing, education, precarity).
- Greater likelihood to be exposed to hazard (for example, increased exposure to COVID-19 when working in transport and delivery, security, cleaning, health care assistants, social care, as well as nursing and medicine).
- Underlying chronic illness (diabetes, hypertension, cardiovascular disease), multi-morbidity and consequent vulnerability to future illness and mortality.
- Biological and genetic vulnerability (for example, vitamin D deficiency has been repeatedly discussed in the context of COVID-19).
- Cultural vulnerability (ways of living that increase exposure to hazards, less protective health behaviours, etc.).
- But we should think differently about possible explanations, we should consider the central role of racism and how this operates.
- That means a focus on the processes that lead to the racialisation of ethnic identities, and how these processes shape life chances – what might be called fundamental causes.





## THINKING DIFFERENTLY ABOUT THE SIGNIFICANCE OF ETHNICITY

Racial and ethnic groups ... are discursive formations, calling into being a language through which differences are accorded social significance, and by which they may be named and explained. What is of importance for social researchers studying race and ethnicity is that such ideas also carry with them material consequences for those who are embraced by them and those who are excluded from them.'

Solomos 1998

'The boundaries of ethnic groups are symbolically represented – as the bearers of a specific language, religion, or more generally, 'culture'; but they are also materially constituted within the structures of power and wealth. Thus ethnicity should be regarded as materially and symbolically constituted.'

Fenton 1999

'The ways in which identities are perceived, valued, mobilised and interacted with are shaped by resources: economic, cultural, legal, political and symbolic. Important here is how emotions are attached to symbolic resources, emotions around risk, danger, fear and disgust, which then shape the practices of individuals and institutions. 'Racial life [is] suffused with shared passions, imageries and fantasies'.

Emirbayer and Desmond 2015



## WHAT ROLE DOES RACISM PLAY

- Work on socioeconomic determinants of ethnic differences in health typically focuses on individual risk, so a consequence of:
  - Lower incomes, lower status occupations, poorer employment conditions, higher rates and longer periods of unemployment, poorer educational outcomes, etc.;
  - Exposure to environmental hazards (concentrated in economically and environmentally depressed areas, poorer housing quality);
  - Socially inflicted trauma (experienced, witnessed, or vulnerable to);
  - Targeted promotion of unhealthy consumption.
- But a thorough understanding of the distribution of these risks across ethnic groups needs us to pay attention to the ways in which such factors, and institutional responses to them, are shaped by processes related to racism.
- Racism has its origins in ongoing historically and politically determined systems of domination that serve to marginalise and inferiorise groups on the basis of phenotypic, cultural or symbolic characteristics; thereby generating a racialised social order.
- Explanation needs a conceptually robust approach that recognises how this racialised social order leads to ethnic inequalities in health, and to policy and practice responses to these inequalities.



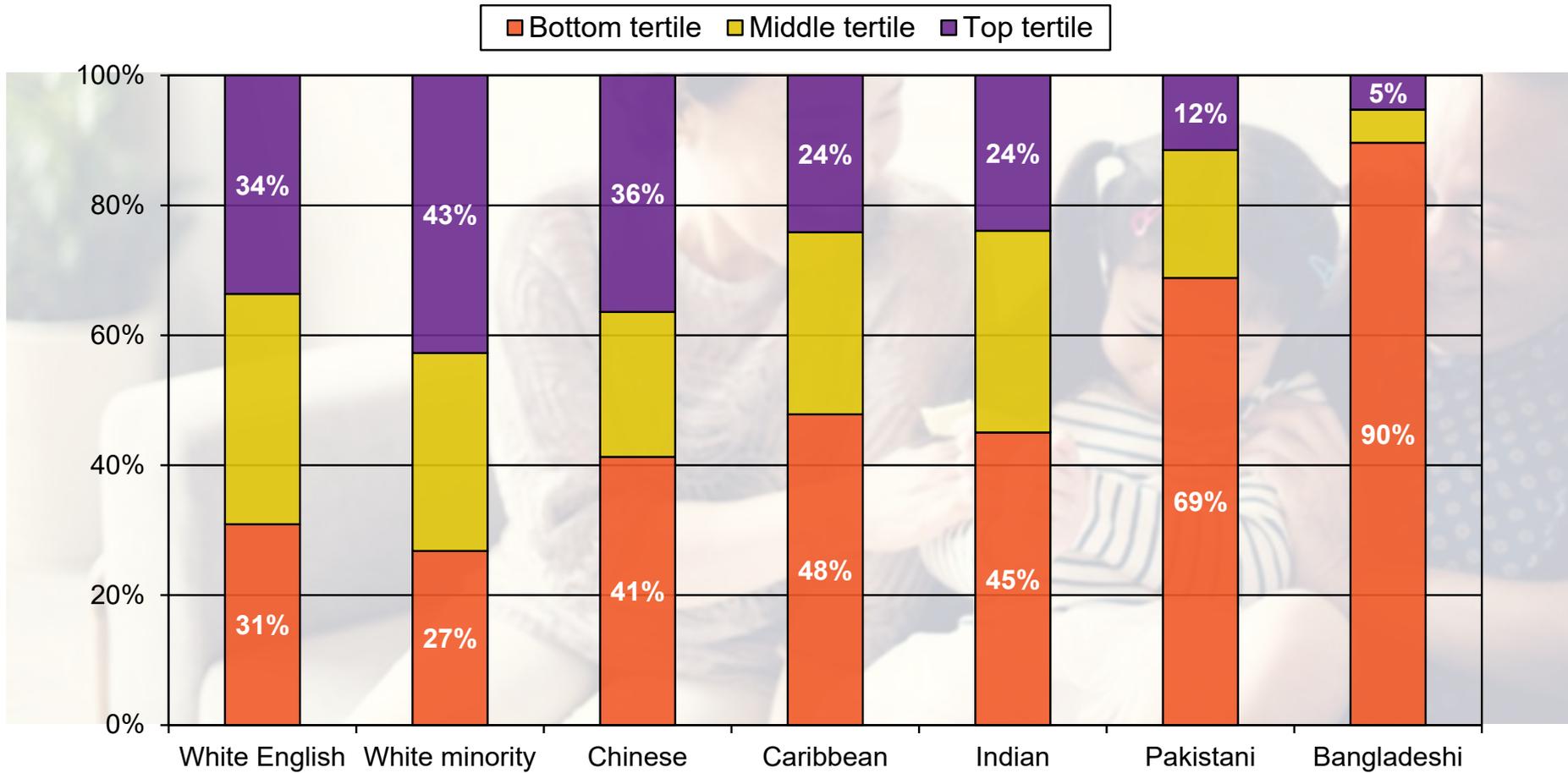
## DIMENSIONS OF RACISM

- **Structural racism:**
  - Reflected in disadvantaged access to economic, physical and social resources;
  - Deep and persistent inequalities with **little change across generations and periods;**
  - Not just material implications, but also cultural and ideological dimensions, the justification of material inequality through the denigration of others;
  - The resulting level of disadvantage, and how it accumulates across a life course, makes a substantial contribution to ethnic inequalities in health outcomes.
- **Interpersonal racism**
- **Institutional racism**



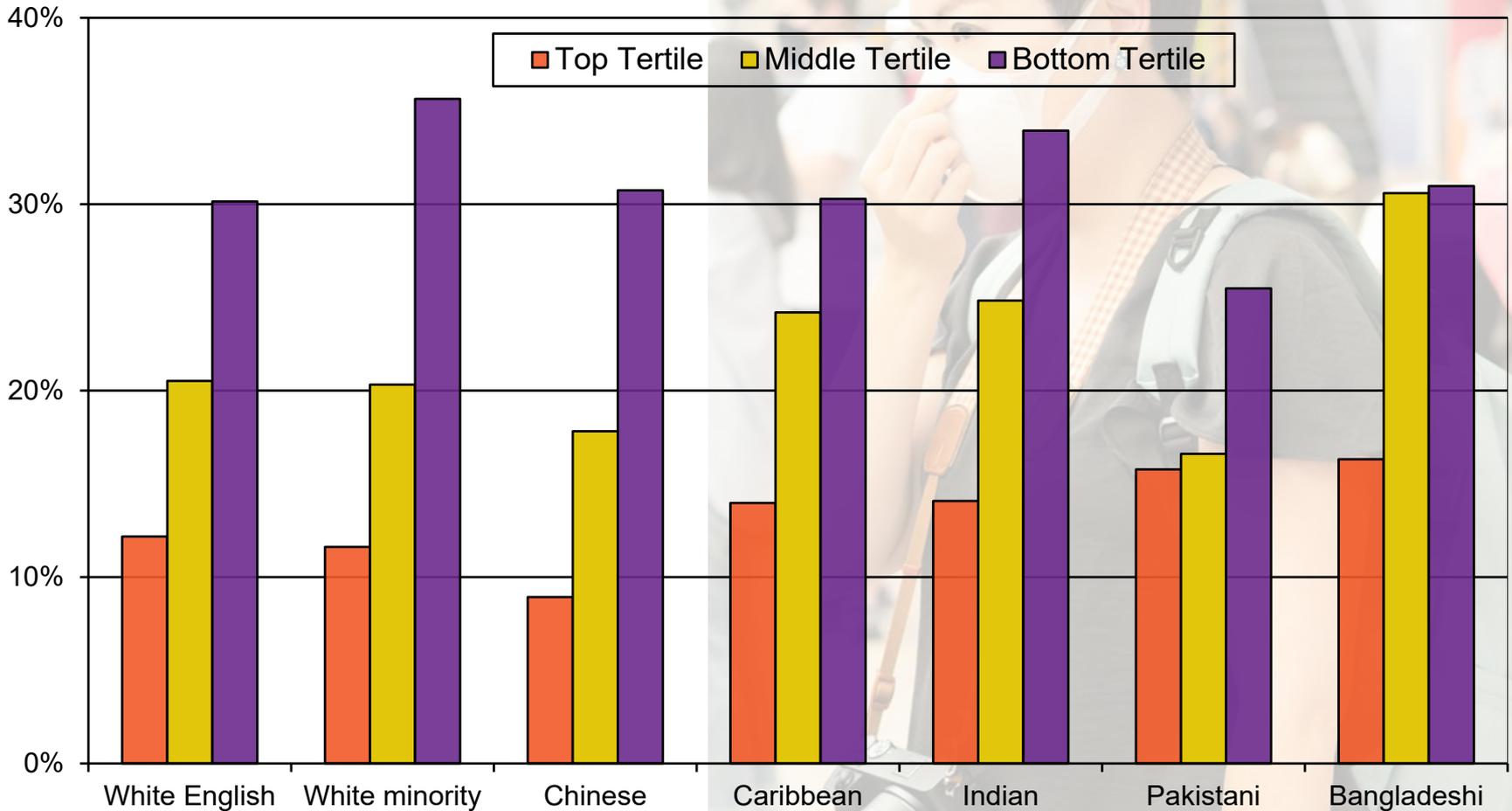


## ETHNIC DIFFERENCES IN EQUIVALISED HOUSEHOLD INCOME





## INCOME, ETHNICITY AND REPORTED FAIR OR BAD HEALTH



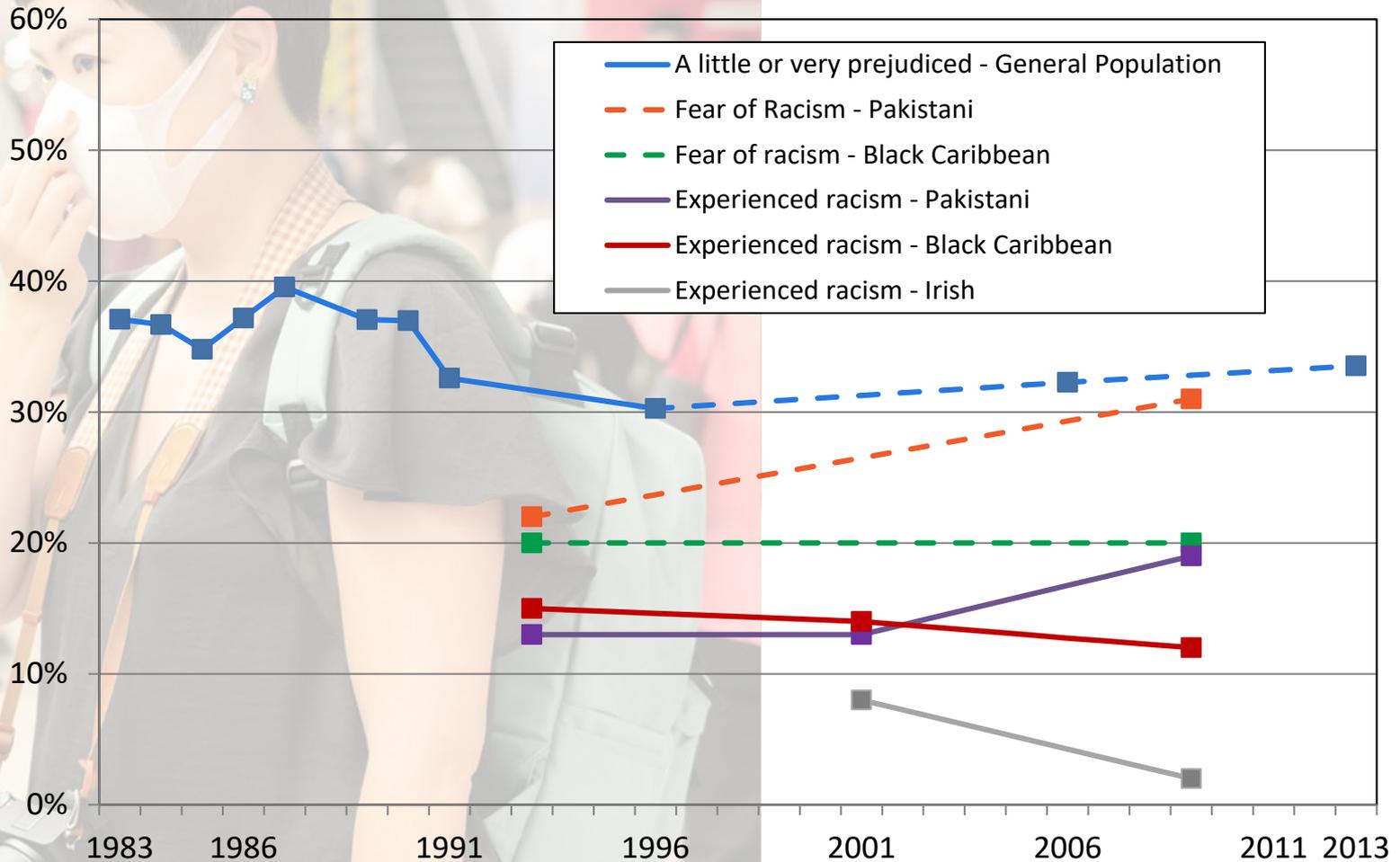
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- **Interpersonal racism:**
  - Ranges from 'everyday' slights, through discrimination, to aggression;
  - A form of violence that emphasises the devalued and fundamentally insecure status of those targeted and those who have similarly racialised identities;
  - Consequently generates meaningful psychosocial stress and impacts on health;
  - Evidence suggests that there has been **little change in the prevalence of racism or prejudicial attitudes over the past three decades**.
- **Institutional racism**





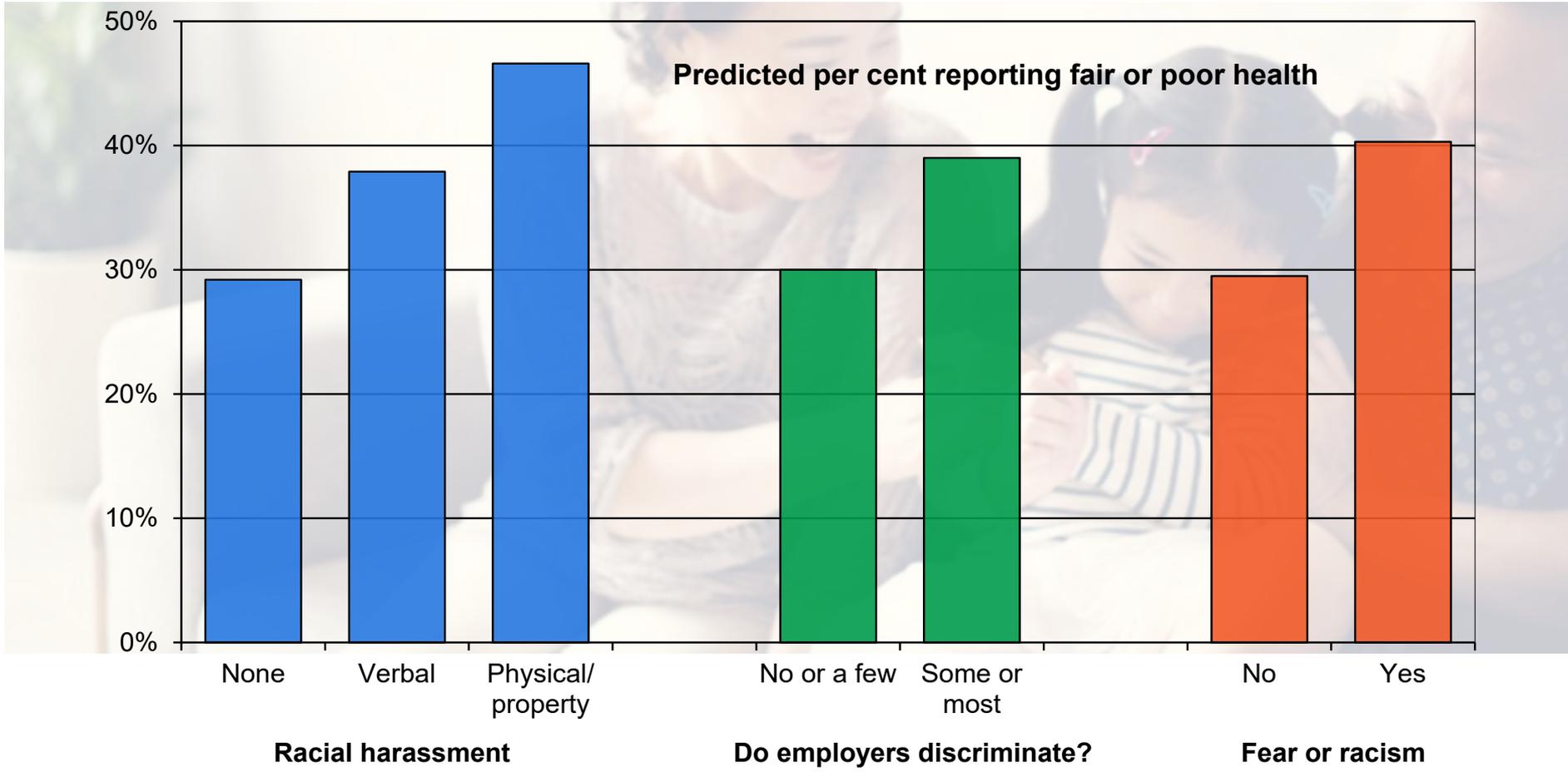
## TRENDS IN PREJUDICE AND RACISM OVER TIME



Virdee 1997; Karlsen and Nazroo 2014, Storm *et al.* 2016; Kelley *et al.* 2017



## IMPACT OF INTERPERSONAL EXPERIENCES OF RACISM AND DISCRIMINATION ON HEALTH



## DIMENSIONS OF RACISM

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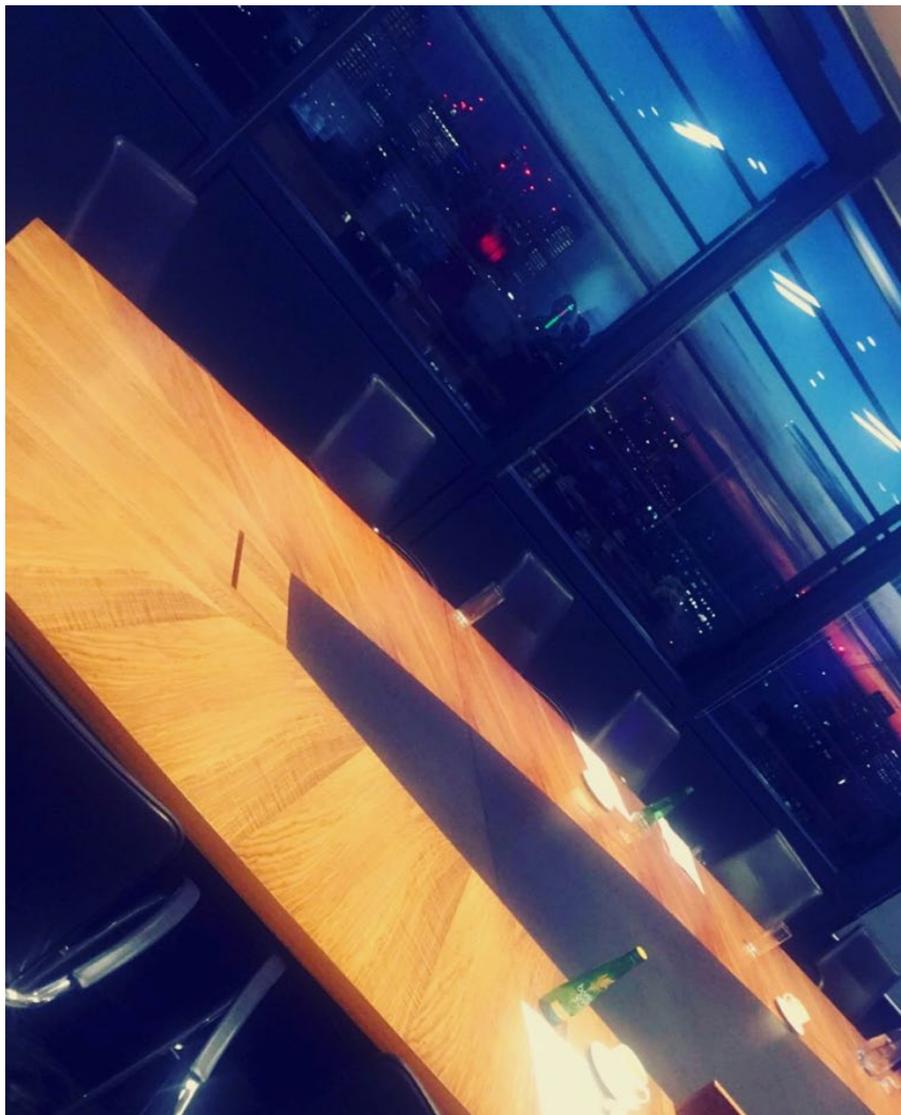
- **Institutional racism** (first coined by Carmichael and Hamilton 1967) is reflected in routine processes and procedures that translate into actions that negatively shape the experiences of racialised people within institutions.



## INSTITUTIONAL RACISM IN HEALTH SERVICES: THE CASE OF THE NHS

- No inequalities in access to GP services.
- No inequalities in outcomes of care for conditions that are largely managed in primary care settings (hypertension, raised cholesterol and diabetes).
- The effect of healthcare systems – a health service with universal access and standardised treatment protocols?
- But marked inequalities in access to (fees-based) dental services.
- And institutional racism is evident in other areas of the UK NHS:
  - Some inequalities in access to hospital services – longer waits for referrals, less likely to receive specialist treatments (revascularisation and thrombolysis) and less likely to get follow-up services;
  - Lower levels of satisfaction with care received, poorer quality of GP practice infrastructure, longer waits for appointments, language barriers during consultation;
  - Very high rates of preventable maternal death;
  - Hemoglobinopathies, such as sickle cell anaemia;
  - And, mental illness and psychiatric services ...





To anybody else these pictures may seem like just a day in the life but to me they represent something a lot deeper. For example, the picture with the wonderful sunset in the boardroom is in the buildings where I speak about my experiences as being a service user and how things can change ...



... then when I come down I am stopped by the police as my car has a log on the system stating I am a forensic mental health patient.

## CONCLUDING COMMENTS

- Racisms are fundamental drivers of observed race/ethnic inequalities in risk of illness and mortality.
- In investigating this, it is important to examine the ways in which **structural**, **interpersonal** and **institutional racisms** operate and are mutually constituted.
- Structural conditions of socioeconomic disadvantage and interpersonal experiences of racism both create an increased risk of illness for ethnic minority people.
- They also shape encounters with institutions that have policies and practices that lead to unequal outcomes – education, employment, housing, criminal justice, politics, etc., as well as health and social care.
- Institutional settings, the meso level, represent sites where we see the concentration and mediation of structural forms of disadvantage and interpersonal racism. This is produced via both the overt agency and unwitting practices of individuals operating within particular structural conditions.
- Institutional settings may be the places where the greatest change could be achieved. However, the way in which institutional racism operates will vary, depending on their focus. For example, the functions of institutions dealing with screening, compared with those dealing with severe mental illness.

