How racism shapes our health
Professor David Williams
Wednesday 12th May 2021, 2.30 – 4.00 (GMT) Zoom webinar

Summary and analysis of next steps

'How racism shapes our health', held on the 12th of May 2021, saw Professor David Williams, world-leading expert on the epidemiology of racism and its effects, address an audience in Scotland for the first time. The decision to invite Williams to address an audience of almost 600 representatives including public health leaders, policymakers, researchers and community activists was deliberate and timed. It culminated from over 18-months of collaboration between the Glasgow Centre for Population Health (GCPH), Public Health Scotland, and the Scottish Migrant and Ethnic Health Research Strategy (SMEHRS) Group to increase the profile of racism as a fundamental cause of health inequality.

Scotland's invitation

Our invitation to Williams came 'from Scotland' and was designed to 'make visible' senior level commitment in Scotland's public health system to better understand and address racism and racialisation as fundamental determinants of heath inequality.

Our request built upon the indication of Scottish Government commitment to understand racism and racialisation as determinants of health through the establishment of the Expert Reference Group on COVID-19 and Ethnicity. In particular, the group's 'call for action' (grounded in recognition that racism is itself a harmful exposure, and the cause of other harmful exposures), that Scotland pays attention to the longstanding international evidence whereby racism is known to have a profound effect on health and illness, including at a physiological and epigenetic level.

Williams' focus on how racism 'gets under the skin' was felt to have resonance given Scottish work that developed the epigenetics of socioeconomic inequality (deprivation) through the pSobid study. As we wrote in our briefing to Williams:

> *In Scotland, we are in a situation where there are shortcomings in our understanding of racialised inequalities in health in both their fundamental description through data but also crucially, in understanding the underlying structural, economic and social processes (and specifically racism) that produce differences in outcomes. (…) Something to build on in this regard is the progress that has been made in understanding the contribution socioeconomic circumstances play in the production of poor health outcomes. (…) (The pSobid study) has highlighted that chronic stress*

has a negative impact on wellbeing and cognition throughout the life-course. The current lifespan approach to research on stress and cognition emphasises the long-lasting effects of exposure to early life adversity. By reducing early life adversity, pSobid authors reported, it may be possible to support the development of more resilient phenotypes – individuals who will be less susceptible to stress-associated cognitive disturbances/disorders in later life.

Although the experience of racial discrimination was not conceptualised within the study design, there now exists a cognitive schema among policymakers and researchers in which to incorporate the understanding racism plays as a fundamental cause of health inequality alongside the role played by socioeconomic inequality and poverty.

The seminar panel was carefully curated from the outset to include senior decision-makers from Scotland's public health system framed as 'learners' and a community activist close to the experiences of racism as an 'expert'. This was important in establishing the tone of subsequent activity and recognising that the system responding within its existing modes of operation would be likely to repeat the failings of previous work around racism and health. This built on learning from an earlier seminar held in 2019 (see here).

Context setting

To situate race and racism in Scotland within the longer-term historical context, Professor Helen Minis, University of Glasgow, provided an overview of the legacy of colonialisation and the trans-Atlantic slave trade within Glasgow's history.

Professor David Williams' 'intervention': *How racism shapes our health*

Williams provided an overview of the types of scientific evidence we have that demonstrate racism as a fundamental determinant of health. This started with the current pandemic and the evidence from the USA that compared death rates of the 'White'[1] population with the 'Indigenous native American' population (2.2. times greater), 'Latinx' or 'Hispanic' (2.4 times greater) and the 'Black' population group (2 times greater). His 'bottom line' analysis is that populations of colour, historically disadvantaged, *all have an elevated mortality rate* from Covid-19. Using UK data, he showed these indicate a similar patterning with the death rates 4.2 times greater for the 'Black' population group; 3.2 times higher for the 'Pakistani' group (both figures for males). See slides for all data. Life expectancy in the United States, as a result of Covid-19, has reduced by one year on average. However, for 'Black Males' the observed decline is three years, 'Hispanic Males' 2.4 years; 'Black Females' 2.3 years, and 'Hispanic Females' 1.1 years. Having established the statistical case for large racialised disparities in health, his address continued to provide explanation.

Socioeconomic status or social class as an underlying determinant was explored first through data on inequalities in income by ethnic group highlighting that for every dollar earned by the 'White' population group, the 'Black' population group earned 59 cents. The

[1] All terminology referring to ethnic classification is faithful to the terms used by the speaker.

most recent figure is the same as for 1978. Indicating the role political ideology and policy play, during the decade of Reaganomics this disparity went as low as 54 cents. The 1978 'peak' is a consequence of civil rights and anti-poverty policies of the 1970s.

For the UK, Williams showed that for every pound that the 'White' majority earns, the 'Other White' group earn 79 pence; 'Indian', 86 pence; 'Pakistani', 57 pence and 'Bangladeshi', 52 pence. Similar disparities in wealth (as opposed to income) where used to highlight differences in financial vulnerability to indicate that although we are in *"the same storm of the pandemic we are in different boats. When you lack economic resources, you are most vulnerable and your boats are less able to weather the storms because when you have no wealth, you can be one pay cheque away from being homeless or unable to feed your family."*

Williams proceeded to address the long-standing misconception that ethnic disparities in health are "*simply a function of ethnic differences in income or education*." Using data from educational attainment he demonstrated that 'Black' population with college degrees has a lower life expectancy (of 4.2 years) than 'Whites' with college degrees and that 'race'[1] still matters even after we have taken socioeconomic inequalities into account. From this, researchers have been asking the question: *Could racism be a critical missing piece of the puzzle to understand the patterning of racial disparities in health?*

Racism a Social System (or the house that racism built)

Racism here does not refer to the beliefs and behaviours of individuals but a social system interacting with legal, political, economic systems and religious and historical factors. A system that categorises and ranks population groups, empowers some groups differentially and allocates opportunities and resources to groups. Fundamental to racism is the ideology of inferiority and the ranking of human populations. It is important to distinguish the individual from structural or institutional mechanisms. One such structural mechanism is **residential segregation**.

Residential segregation shapes access to opportunity and presence of health risks. In the US and the UK there is evidence of strong residential segregation. For example, 31% of 'Pakistani' group live in the most deprived 10% of neighbourhoods in England; 'Black Africans', 19%; 'Blacks of Caribbean background', 18%; and 'Bangladeshi', 28%.

Williams explained that when you are low in economic status, and in addition to that you live in a disadvantaged, segregated neighbourhood, it leads to higher levels of exposure to numerous stressful life experiences. These include air pollution, stress and allostatic load that means for example, when exposed to Covid-19, people are more likely to get it, more likely for it be severe and more likely to die from it. Normal adaptive and regulatory systems can be affected by the accumulation of adversity, in other words, biological variations observed across racial ethnic groups do not reflect innate biological differences.

Individual level discrimination has also been put forward as a process contributing to health inequalities. Williams introduced the everyday discrimination scale which captures everyday

indignities. It has been used to demonstrate the experience of everyday discrimination as a powerful predictor of health outcomes.

Cultural racism is also implicated as a component of racism, as a system creating stereotypes, stigma, implicit and explicit biases. Empirical evidence of stereotypes was demonstrated in culture through findings from content analysis of words co-existing alongside 'Black', 'White', 'Male' and 'Female' in published literature. These lead to implicit biases that shape interactions, including medical interactions.

In mentioning the Florida Study, Williams highlighted how the existence of **implicit bias in medical care** leads to unequal access to services and treatment. 'Black' infants are three times more likely to die when seen by a 'White' doctor.

The Californian study (RCT) provided 'Black' men with a coupon to access free health screening. Of those who saw a doctor of shared ethnicity (compared with those men who saw a doctor of another ethnicity), they were 29% more likely to talk about other health problems, 47% more likely to be screened for diabetes, 56 % more likely to take the flu vaccine and 72% more likely to be screened for cholesterol. Within the context of this study, there was much greater engagement with health care when patients were seen by someone of their own race.

Another study found that short of being seen by someone of your own race, being seen by a medical professional who scores high on cultural competence leads to better engagement and outcomes. This underlines the requirement for education and the development of cultural competence within medical professions.

What else can we do in addition to improving the diversity of care?

Williams highlighted the creation of 'Communities of Opportunity' to minimise, neutralise and dismantle the systems of racism that create inequities in health. This means most of the action will take place outside of the health care system. It will involve enriching the quality of neighbourhood environments, improving housing quality, the safety of neighbourhood environments, investment in early childhood, reducing childhood poverty and enhancing income and employment opportunities.

Neighbourhood-based approaches were strongly advocated with robust evidence that communities of opportunity can transform life chances when there is investment in early years, access to health care, and comprehensive and integrated place-based solutions creating 'cradle to college' pathways.

Williams concluded access to economic opportunity is the key. However, three communication challenges exist that prevent progress in policy, practice and understanding.

1. Most Americans do not know that racial inequalities in health exist, even though the data have been reported for a hundred years.
2. There is a need to develop political will and to build empathy. Dubois in 1899 reported that the greatest problem with Black and White differences in health was the fact that we lacked empathy, naming it 'the peculiar indifference'. Today

researchers document a racial gap in empathy across contexts. This racial gap in empathy is not seen in American white children at age five, it becomes evident at age seven and it is pronounced by age ten.

3. We need a commitment to equity over equality. Equality is giving everybody the same things. Equity is giving people what they need to thrive. Or as Martin Luther King put it *"true compassion, is more than throwing a coin to a beggar. It understands that an edifice which produces beggars needs restructuring."* Racism is an edifice that has produced beggars and it needs to be restructured.

Questions from the panel and Williams' response

Following his presentation, Williams, together with a group of panellists chaired by Dr Ima Jackson, Glasgow Caledonian University, explored how we can begin to dismantle the racial discrimination that exists across Scotland's public health institutions and systems.

Claire Sweeney, Director of Place and Wellbeing at Public Health Scotland, asked a two-fold question: *How can Scotland learn from the best and, who are they?*

Williams responded that he is not aware of any society in the world that has solved this problem. Everywhere where there is data, there is a similar pattern, even though some of the particularities of the history are different. There is no single society we could point to that have done it right.

His paper with Lisa Cooper on creating 'communities of opportunity'[2] highlights in bullet-point form what needs to be done to dismantle structures of racism. It is about addressing the social determinants of health; it is about creating opportunities.

He continued to explain that looking at (US) medical care expenditure, only about 3% of expenditure is on prevention. We need to invest in the places where people spend most of their time; our homes, our neighbourhoods or workplaces, and think about how we can build health into those contexts and how we can build the opportunities for health.

The data is striking on early childhood investments in reducing a range of negative outcomes. The North Carolina project is an example of this, where there is highly supportive environment with intellectual stimulation, good nutrition, and good access to medical care. This led to improvements in individuals by age 20 such as higher levels of academic performance, improved vocational skills, reduced likelihood of smoking and lower depressive symptoms by their mid-30s.

Agatha Kabera, Chief Executive at the Baba Yangu Foundation, raised the mental health impacts of discrimination and a racist social system for young people of colour. Particularly, a situation many young people of colour experience where there is a gap in knowledge within the mental health services that are there to help. This is a case of service providers not understanding the impact of racism, stress and hypervigilance as part of everyday

[2] https://scholar.harvard.edu/files/davidrwilliams/files/williams_cooper_reducing_inequities_ijerph_2019.pdf

experience. This prevents people from accessing or returning to services. *Kabera asked, how can we begin to address this?*

Williams responded by reporting the data on mental health across generations of migrant populations. He was involved in the first national study in the US, looking at the mental health of the population with a national sample of 'Blacks of Caribbean ancestry'. They found that the first generation from the Caribbean had lower levels of mental disorder depression and generalised anxiety disorder than the general population. By the second generation (the children of immigrants) the rates were similar to where the rest of the country was. However, the third generation was the highest prevalence seen in any study of mental disorders. Williams still does not fully understand why we see this worsening decline from the second to the third generation despite this cohort being further removed from the migration experience. The study found 56% of third generation female migrants met criteria for one DSMIV (Diagnostic and Statistical Manual of Mental Disorders) listed psychiatric disorder. A similar pattern was found among Latinx third generation at about 40%. Williams noted that there is something about the adaptation by immigrants to a new society that seems to have adverse impacts on their mental health that the drivers of are still not fully understood.

He explained too often there is a stigma of mental health services from within the communities themselves and there is just not an openness to even acknowledge it. One area for progress is to ensure access to adults who are trusted and that they feel comfortable speaking to; who will affirm the challenges and the emotional reaction to distress that young people face.

We can also work with providers within the system to promote the cultural competency described in the California study. There needs to be an awareness and an appreciation of what the lives of clients are like; and a willingness and an openness to learn and understand the challenges they face, so they can more effectively reach them. We need to make it more open and supportive and respectful for those young people.

Caroline Lamb, Chief Executive of NHS Scotland and Scottish Government Director General of Health and Social Care, was interested in how we join up across government, the public sector and fundamentally across society. *Lamb asked for reflections on how we can provide leadership for collaboration across all the opportunity indicators that are needed to start to address some of the fundamental issues?*

Williams replied that good integration of the healthcare system with a social care system is needed. These services are often provided separately, but in the lives of the individuals who are facing various challenges, the challenges are integrated in their lives. The more we can create a seamless integration of linkages from the health care system to the social care system, the further we can get in solving the challenges that individuals face. It takes commitment. It takes a deliberate intentional strategy.

It will involve screening people for social determinants and ensuring the right supports, services and referrals are made. It will need to come alongside the general practitioner and provide access to the additional resources that individuals need. These are all examples of

strategies that take the context of the individual's life seriously and is trying to think of them comprehensively.

Kabera asked a second question. In research, that we read or participate in, we have found that people within African and Caribbean communities are often grouped with many minority groups, and we feel over-represented in health research. It is difficult for us to understand the prevalence of common mental health disorders within our own communities. *Kabera asked, is there a way for us to understand ourselves and for those who continue to research in this area to rethink this?*

Williams acknowledged that this is a challenge in many places, and they still have it in the US as well. He explained that there are two issues, one relates to global racial categories used. This includes the ones in use in the US i.e., Black or White, Asian, Hispanic which capture enormous heterogeneity variation. He explained that if you look at the Asian category, this has the highest levels of median household income but there are subgroups within this category that have lower levels of income than 'Blacks' or 'American Indians'. You miss the pocket of need if you just look at the 'Asian' data overall. The point could be made for any category, including the 'White' population.

There is variation within each group. The ideal thing to do is to understand the ethnic category that is relatively small, in a context, country, community and so on, when someone says they belong to the 'Black' group. In any given year there is insufficient data to do any analysis and give us any insight. Williams recommended to collect the data anyhow. This can sometimes be collapsed over three years or four years, and it can tell us something about the smaller sub-groups.

Pete Seaman, Interim Associate Director at GCPH provided a response highlighting Scotland is now in a position where poverty is understood as a risk factor for poor health on a par with some of the biological risk factors, indeed the cause of many biological risk markers. However, we do not understand to the same degree the impact that racism has on health compared to what we know about economic impacts. Recently the Expert Reference Group on Covid-19 and Ethnicity highlighted the shortcomings and the evidence on ethnicity and health in Scotland. Seaman indicated that the absence of this evidence is an example of systemic biases, of choices that have been made and that haven't been made.

There is an issue of knowledge and evidence, and it would be a positive first step if Scotland could adopt the Everyday Discrimination Scale – a measurement of micro-aggressions so we can understand some of the processes which lead to racial inequalities in health. But looking at evidence and knowledge alone will not be sufficient in isolation. He highlighted the need to also consider workforce diversity, the issues of knowledge and workforce diversity are inseparable. We are required to open-up decision making and ensure a broad range of experiences are within professions related to public health and public health intelligence. This is also about recruitment and about how the workforce reflects some of the decisions made by what research we prioritise.

Seaman outlined that GCPH will facilitate a space for the development of next steps, and that will include more focused events. It is only by making ourselves open to a process of

learning and unlearning will we be able to show leadership in acknowledging the impact that living in a racialised society can have on health. He reminded us that there are still some that do not acknowledge systemic racism as a problem, but this acknowledgement is required before we can proceed to understanding and action. He concluded by saying that until our model of the social determinants of health includes understanding issues of race and racialisation, our model will remain incomplete and, consequently, so will our policies.

What the audience thought?

This seminar brought together over 600 community members with experience of racialisation and public health leads in research, policy and service provision in Scotland, to listen and learn together in our pursuit to mainstream the understanding of racism as a fundamental cause of health inequality in Scotland.

Feedback indicates interests in finding out more and taking action to increase cultural competency, to develop and improve neighbourhood opportunities and approaches, and implement the Everyday Discrimination Scale.

What are the key messages from the Williams' seminar for continuing work?

Williams offered Scotland important insight about how to critically rethink our understanding of what systemic racism is and how it shapes our health. He presented evidence demonstrating why interpersonal racism is one facet but that addressing systemic processes are the mechanisms to truly dismantle and tackle racialised inequalities in health. The seminar:

- Establishes incontrovertibly that racialisation and systemic racism are an additional factor in shaping health inequalities and not solely a function of economic inequality.
- Argues that dismantling systemic racism requires action across the system. Both Lamb and Sweeney in panel responses note the need for cross-system work *'beyond health'* (*'this is everybody's game'*).
- However, health workforce matters particularly in relation to being able to see practitioners of one's own ethnicity or, short of that, high degrees of cultural competence – necessary to understand lived context of patient. This point was underlined strongly through Kareba's point about mental health and an absence of understanding from practitioners within the system of the realities of everyday racism and effects of hypervigilance. This points to actions required not just in diversifying the workforce but also supporting the development of cultural competence particularly, as in Williams' response, around understanding the mental health implications of systemic racism.
- The Everyday Discrimination Scale will undoubtably garner interest. The point that they can be operationalised to capture a range of discriminatory experiences may help with challenges around intersectionality. This offers something positive within the 'data and evidence realm' and gets closer to the processes that produce racialised health inequalities and avoids analytical and identity-based problems associated with categorisations of population by ethnic group. However, as a

potentially 'easy win' for data we must be cautious. This may well 'prove' (if proof is still needed) the existence and continuing effects of racial and other forms of discrimination on health. Alone it will be insufficient without action to address the systematic causes. We need an agreed position on the usefulness and limits of the usefulness in the application of such scales.

Williams proposes (evidence based) place-based approaches (building 'communities of opportunity') with services that 'wrap around the child, cradle to college' akin to neighbourhood programmes such as Children's Neighbourhoods Scotland. Would we propose such a model for Scotland? What would it look like? What would be the risks? Are there issues of geographic segregation? What do we know about this process in Scotland?

- The point that most Americans do not know that racialised inequalities in health exist raises the question: Is this the case in Scotland too? And if so, what is the implication of that for what we do and for whom? The measurement of racialised inequality and experiences of discrimination would provide evidence. There is then a question of how that is used across different groups, e.g. policymakers, service planners, practitioners and populations, specific and general.
- There is the need to develop political will and to build empathy. What is the practical implication of this? What can be done? What can GCPH do? Can we build empathy around the issue? Build the political will and understanding? Build understanding of the experience, micro-aggressions, and what racialisation looks like?
- Williams raised that we need a commitment to equity over equality. This is often understood through the term 'proportionate universalism' in the UK. Are there limitations to this term when it comes to racialised inequality? What would operationalising it for racialised inequalities mean?

Connections to planned work and next steps for GCPH and partners

The Williams seminar was never intended as an end point but rather an important staging post to establish visible recognition of the need for Scotland's public health system to recognise and increase visibility of racism as a fundamental cause of heath inequality.

An earlier paper produced as an outline plan for a series of seminars addressing race and racialisation in Scotland's public health identified a number of key areas of interest and development. It proposed the creation of space for discussion leading to recognition of, and action to address, the current absences and capacity issues in understanding and addressing race and racialisation as fundamental causes of health inequality in Scotland. A series of 90-minute seminars over a year would raise awareness of the public health implications of Scotland's current framing of health inequalities in a manner which has historically muted the role of race and racialisation.

Following Williams' address the remaining seminars, to be led by GCPH in collaboration with partners, could focus on:

- Demographic change with significant contribution in terms of lived experience. Refocus to separate out 'data' element to focus on service needs. Points about

workforce representation and cultural competence. How are services prepared? What more do they need to do?

- Diversity in public health leadership. A focus on current experiences and barriers to senior decision making? Implicit assumptions and biases within systems (including methodological). How to ensure a range of experiences are prioritising and interpreting evidence.
- Data. Supporting the adoption of discrimination scales? Developing a network of support and evaluation of their implementation (Universities of Glasgow and Edinburgh, NHS Boards).
- How racialised inequality can be considered in social recovery and renewal (taking a focus on Glasgow).

GCPH is committed to working in collaboration with partners, Public Health Scotland and the Scottish Migrant and Ethnic Health Research Strategy (SMEHRS) Group, to increase the profile of racism as a fundamental cause of health inequalities and will continue to reflect on Williams.

Pete Seaman
Shruti Jain
Jennie Coyle
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