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A public health approach to incorporating anti-racism and structural discrimination in tackling racial and ethnic health disparities

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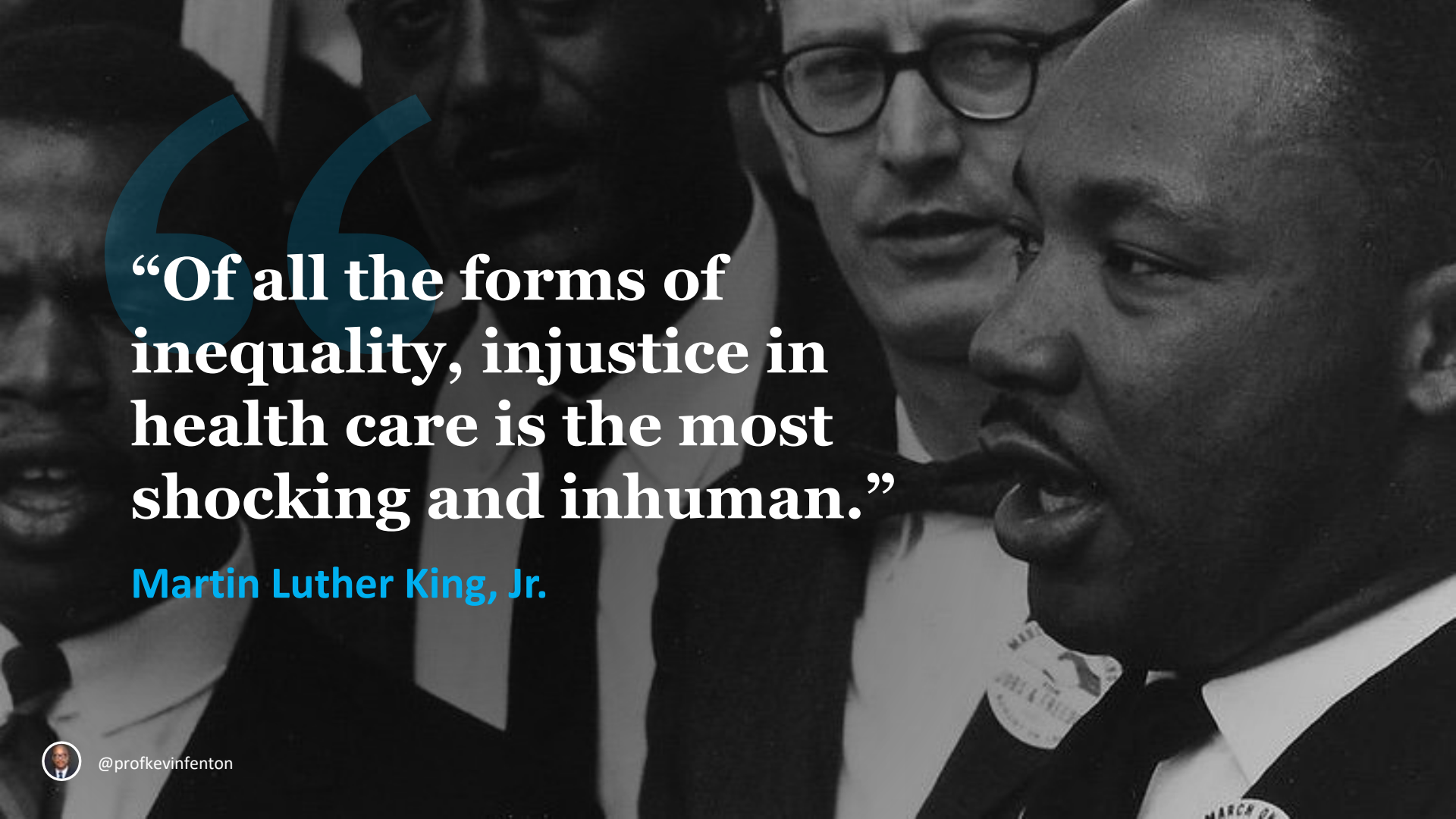
“Of all the forms of inequality, injustice in health care is the most shocking and inhuman.”
Martin Luther King, Jr.
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Racism is a public health issue


“Racism is a system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call “race”), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources.”
Camara Jones
@profkevinfenton

Race and Racism

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- Race and racism are not interchangeable constructs. Each needs its own distinct conceptualisation, measurement, and analysis for public health research.
- Race is a social construction with no biological basis, whereas racism refers to a social system that reinforces racial group inequity.
- Racialisation is the process by which meaning and value are ascribed to socially determined racial categories, and each racial category occupies a different position in the social hierarchy.
    - For example, being Black in America (and increasingly the United Kingdom) has negative implications for educational and professional trajectories, socioeconomic status, and access to health care services and resources that promote optimal health, which in combination, may reduce or exacerbate health risks.
    - There are different forms of racism e.g. anti-black racism, antigypsyism, antisemitism, and anti-Asian racism that link to religion or belief. All share the reality that the value of a person is undermined by stereotypes based on prejudice.
    - Racism can be combined (intersectional) with discrimination and hatred on other grounds, including gender, sexual orientation, age and disability or against migrants.

Sources: Churchwell (2020); The Commonwealth Fund (2020); American Medical Association (2021); Bailey ZD (2021).

Race and Racism

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- Racism is a “wicked” problem - complex problems that are highly resistant to solutions and that are characterized by high difficulty and disagreement about the nature and cause of the problem and their potential solutions.

- Racism also may be considered a fundamental determinant of health because it is a dynamic process that endures and adapts over time, and because it influences multiple mechanisms, policies, practices and pathways that ultimately affect health.

- The health consequences of living in a racially stratified society are illustrated by a myriad of health outcomes that systematically occur along racial lines, such as disproportionately higher rates of infant mortality, obesity, deaths caused by heart disease and stroke, and an overall shorter life expectancy for Blacks in comparison with Whites.

Sources: Gee GC and Ford CL (2011);

Types of Racism

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Internalised Racism	Acceptance by member of the stigmatised races of negative messages about their own abilities and intrinsic worth.
Institutionalised Racism	Differential access to the goods, services and opportunities of society by race.
Structural Racism	The normalisation and legitimisation of an array of dynamics (historical, cultural, institutional and interpersonal) that routinely advantages White people, while producing cumulative and chronic adverse outcomes for people of colour.

Sources: Churchwell (2020).

Impact of racism at the individual level

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- The experience of racism results in chronic discrimination, stress and depression that adversely impact persons from historically marginalised population.

- Adverse childhood, and adult experiences due to racism and community violence, can result in the phenomenon of toxic stress leading to long lasting and cumulative damage to the body and brain (the weathering hypothesis), resulting in premature morbidity and mortality for Black and minority ethnic populations.

Structural Racism

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- Limits opportunities for social, economic and financial advancement which in turn results in a complex interplay between race, social determinants and health with negative consequences. For example – uneven access to quality schools, good-paying jobs, higher incomes, wealth accumulation, better neighbourhoods and ability to access/navigate the health system.

- Structural racism concentrates power among privileged groups and devalues populations whose health needs to be equitably improved. Its impacts are pervasive.
  - Regardless of socioeconomic status Black people continue to experience striking disparities in morbidity and mortality.
  - College educated Black people in the US are more likely than their White counterparts to experience unemployment and have lower wealth at every income level.

- Structural racism is a barrier to public health's goal to improve the health of all people.

Sources: Churchwell (2020); The Commonwealth Fund (2020); American Medical Association (2021); Bailey ZD (2021).

Racism: A public health issue

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- Racism is common: in one national survey in the United Kingdom, 25-40% of participants said they would discriminate against ethnic minorities; a third of people from ethnic minorities constrain their lives through fear of racism; reported hate crimes have more than doubled between 2013 and 2020, the majority of which were racial (78,991), representing an 11% increase over the previous year.
- Disparities between ethnic minority and majority groups in housing, education, arrests, and court sentencing are believed to be due to racism, not simply to economic sources.
- Although both race and racism are relevant to health, typically only race is included as a research question, variable, or topic in most health studies.
- Race, as it is conventionally conceptualised and operationalised in public health research, is not an adequate proxy measure for racism. In addition, controlling for race in statistical analysis is a common practice in public health research and the research of other health professions.

Racism: A public health issue

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Framing racism as a public health issue compels organisations and governmental units across the country to address the crisis in the broad, systemic ways that other threats to public health have been addressed over time. These can include strategic initiatives in policies, practices, enforcement, education, and support services.

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Racism and Health in the UK

What do we know about racism and its impact on public health?

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Race Equality Foundation (2007)

- ‘People from minority ethnic groups experience poor treatment due to the negative attitudes of others regarding their character or abilities. This occurs in their day-to-day interactions with other people as well as in their access to and interactions with services.
- Racist attitudes have been shown to affect health in a variety of ways. Understanding these processes is important for the development of effective policies to reduce the health disadvantage experienced by people from minority ethnic groups in the UK’

The Health Foundation (2020)

- ‘Racial discrimination affects people’s life chances negatively in many ways. For example, by restricting access to education and employment opportunities. People from black and minority ethnic groups tend to have poorer socioeconomic circumstances, leading to poorer health outcomes.
- The stress associated with being discriminated against based on race directly affects people’s mental and physical health.’

How does **structural racism** operate in our health and care systems?

Access barriers to healthcare

Includes language barriers, cultural differences, migration status, and implicit biases which impact communication between healthcare providers and ethnic minority patients, leading to delays in diagnosis and treatment.

Bias in clinical decision-making

Structural racism can result in implicit bias in clinical decision-making, which can negatively impact patient care including likelihood of referral for further investigations or receive specialist treatment.

Inequities in patient outcomes

Structural racism can lead to inequities in patient outcomes, with ethnic minority patients experiencing poorer health outcomes, more likely to experience diagnostic delays, receive suboptimal treatment, and experience worse outcomes for certain health conditions.

Workforce disparities

Structural racism can result in workforce disparities - underrepresentation in senior roles, overrepresentation in lower-paid and lower-status roles., more likely to experience bullying and harassment with on the quality of care and better meet the needs of diverse patient populations.

Lack of diversity in clinical trials

Structural racism can result in a lack of diversity in clinical trials, which can limit the generalizability of study findings and impact treatment options for diverse patient populations. This results in limited evidence-based treatment options for diverse patient populations.

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Sources: Churchwell (2020); The Commonwealth Fund (2020); American Medical Association (2021); Bailey ZD (2021).

Ethnic health inequalities in the UK

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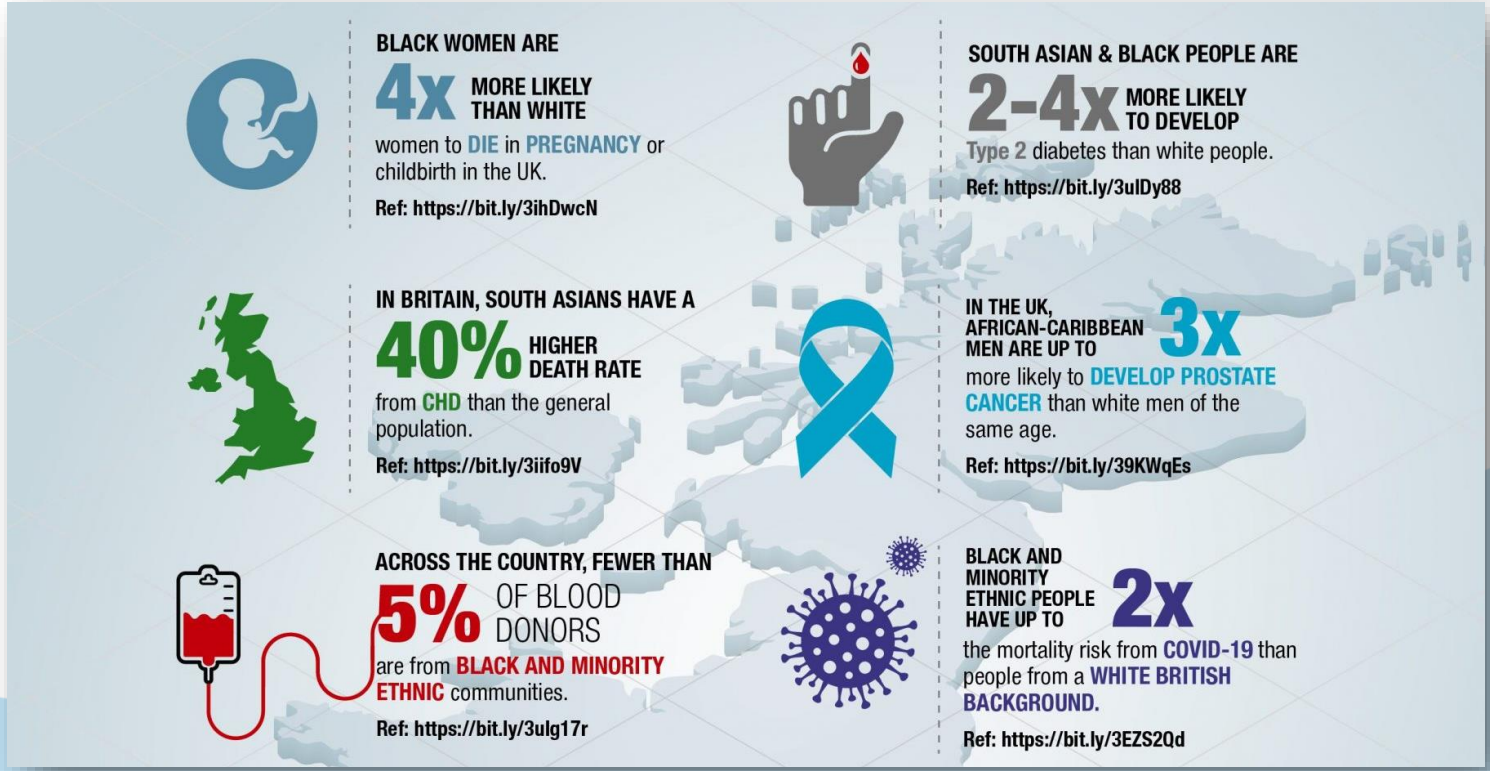

Source: NHS Race and Health Observatory (2021)

Employment

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- 76% or white people were employed in 2021, compared with 67% of people from all other ethnic groups combined. The difference in the employment rates for white people and all other ethnic groups combined went down from 16% in 2004 to 9% in 2021.
- Substantial differences remain in their participation in the labour market; around 1 in 10 adults from a Black, Pakistani, Bangladeshi or Mixed background were unemployed compared with 1 in 25 White British people.
- Although women from Pakistani and Bangladeshi backgrounds were the least likely to be employed, the proportion who were in work has increased substantially since 2004.
- While employment rates among people from Pakistani and Bangladeshi backgrounds have been improving, these populations remain more likely to be in low skilled, low paying occupations than other ethnic groups.
- They also have higher rates of self-employment. Pakistani or Bangladeshi employees received the lowest average hourly pay, which was £4.39 per hour less in the last three months of 2016 than Indian employees who received the highest average hourly pay.

Sources: UK Government – Employment – Ethnicity facts a figures. GOV.UK

Housing

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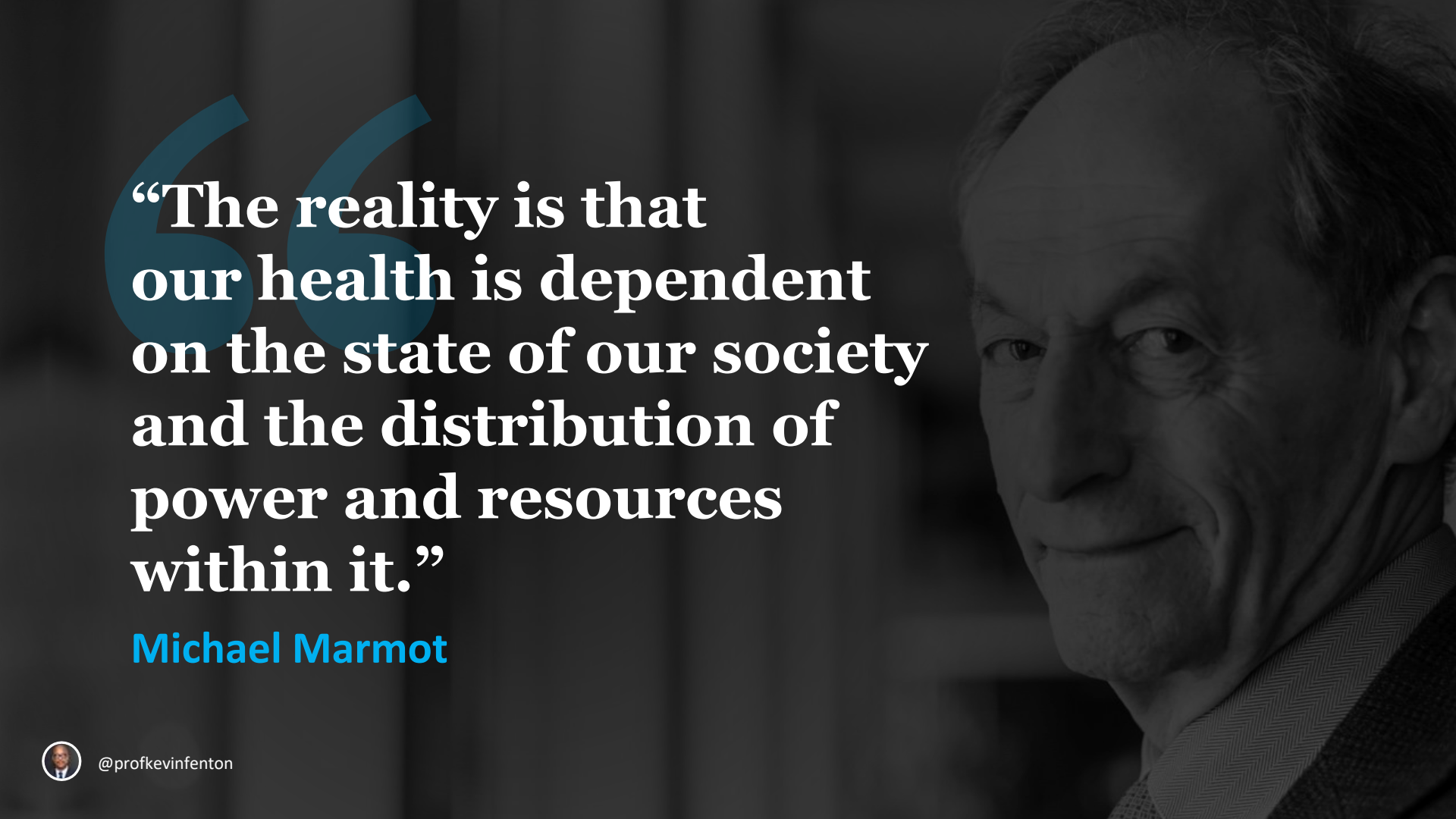
- The households that are most likely to rent social housing were headed by someone in the African, Caribbean, Other Black, Bangladeshi, Irish and Arab groups, or the Mixed groups other than Mixed White and Asian.
- As a group, ethnic minority households are also much more likely to rent privately than White British households and to spend a higher proportion of their incomes on rent, regardless of whether they rent from a social or private landlord.
- Their housing tends to be of lower quality, particularly among households of Pakistani origin, and overcrowding is more common, especially among households of Bangladeshi origin.
- Overcrowding affects ethnic minority households disproportionately, and London had one of the highest rates of overcrowding of all regions of England.
- Post-COVID-19, the escalating housing costs are hitting BAME communities greatest with a quarter of BAME workers paying housing costs that are unaffordable. 2 in 10 BAME households across the UK live in unaffordable housing, double the White average.

Sources: The Joseph Roundtree Foundation (2021); The Commonwealth Fund (2020); American Medical Association (2021); Bailey ZD (2021).


“The reality is that our health is dependent on the state of our society and the distribution of power and resources within it.”
Michael Marmot
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The impact of COVID-19

The Role of Poverty and Racial Discrimination in Exacerbating the Health Consequences of COVID-19

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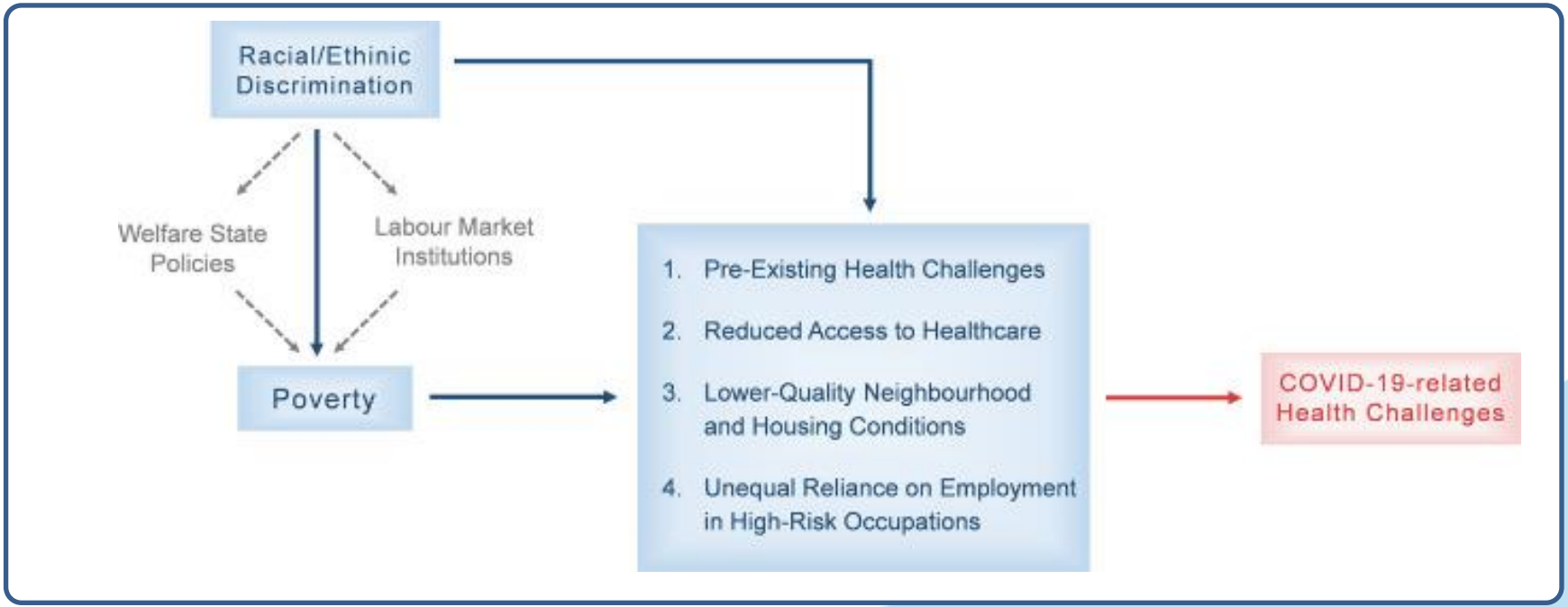

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Zachary Parolin,a, * and Emma K. Lee,b The Lancet Regional Health - Americas 2022;7: 100178
Published online 7 January 2022 https://doi.org/10.1016/j. lana.2021.10017

COVID-19 highlighted new inequalities in the likelihood of being **infected**, being **admitted**, having **severe disease** and of **dying** from infection

People who lived in **overcrowded** or **multi-generational households**

People who worked in **jobs with increased risk** of coming into contact with the virus

People who live in **poorer parts of the city** were more likely to die.

People with low engagement due to **stigma, low trust and confidence** in health services.

People with historic and current experiences of **racism and discrimination**

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Sources: The Impact of COVID-19 on BME Communities, 2020 (Kings Fund); Beyond the data, 2020 (PHE)

Disparities in risks and outcomes for COVID-19: May 2020

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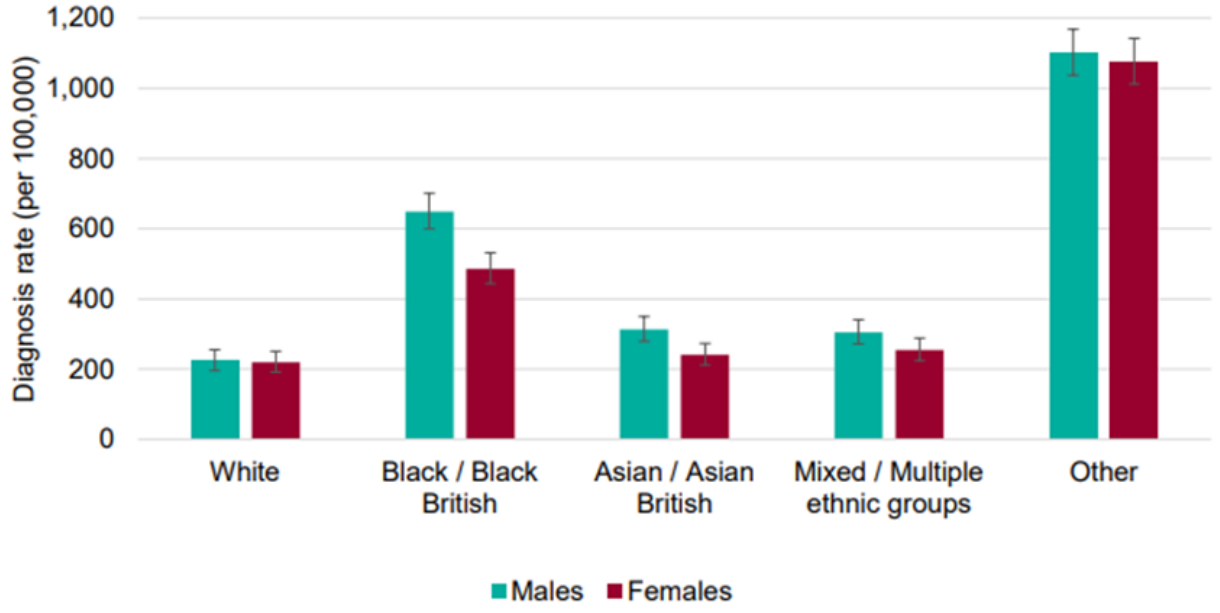

Figure 4.2. Age standardised diagnosis rates by ethnicity and sex, as of 13 May 2020, England. Source: Public Health England Second Generation Surveillance System.

Disparities in risks and outcomes for COVID-19: May 2020

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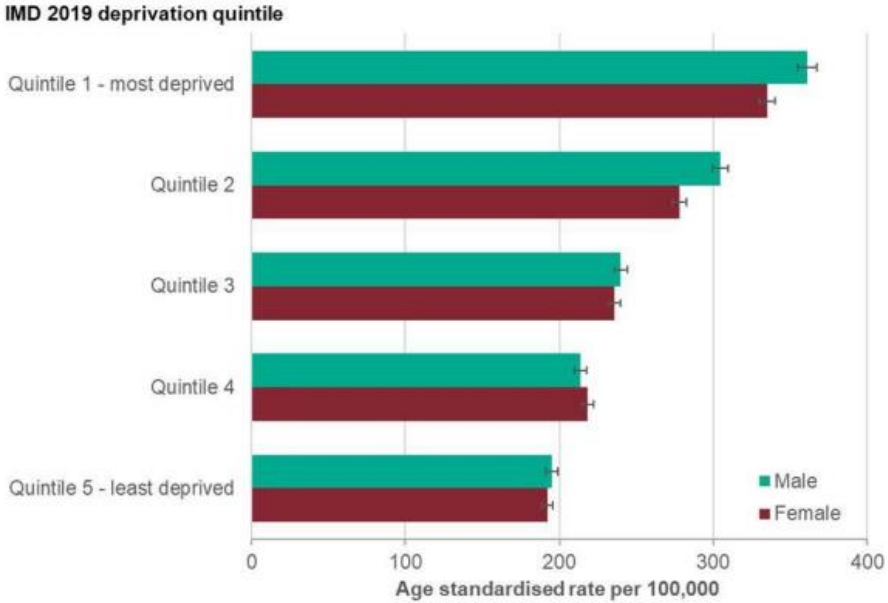

Figure 3.2. Age standardised diagnosis rates by deprivation quintile and sex, as of 13 May 2020, England. Source: Public Health England Second Generation Surveillance System.

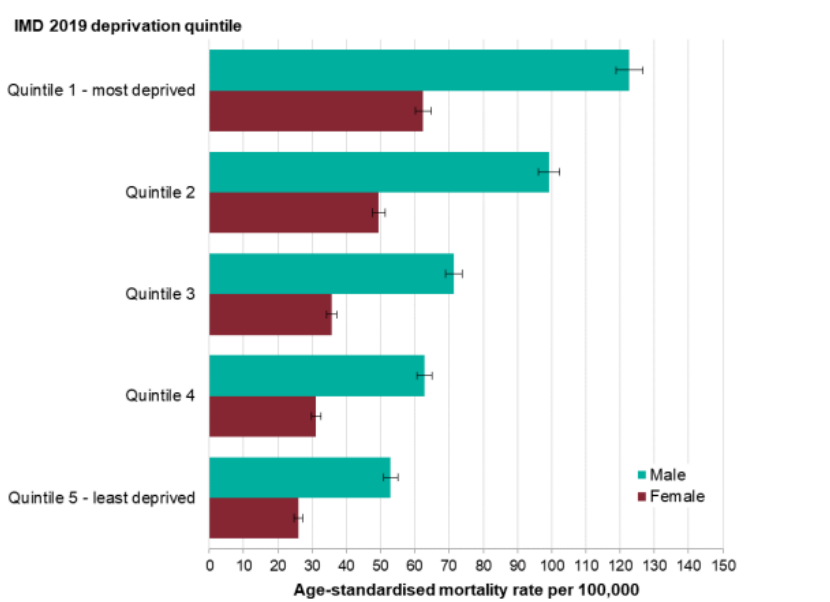

Figure 3.4. Age standardised death rates in laboratory confirmed COVID-19 cases by deprivation quintile and sex, as of 13 May 2020, England. Source: Public Health England COVID-19 Specific Mortality Surveillance System.

Excess deaths and mortality from COVID-19 in England since the start of the pandemic were highest in black, Asian and mixed ethnic groups

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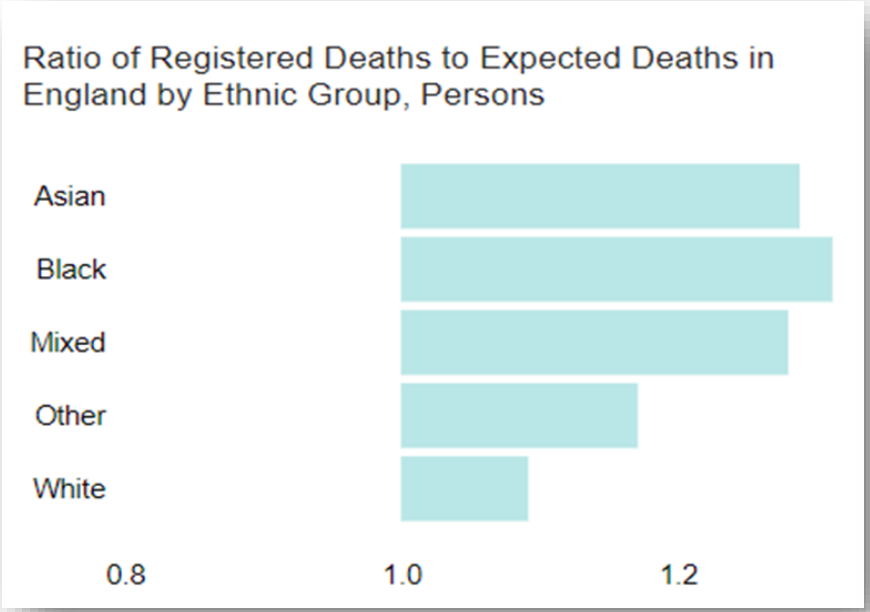

Summary of Deaths in England by Ethnic Group, Persons

Ethnic group ▲	Registered deaths	Expected deaths	COVID-19 deaths	Excess deaths	Ratio: registered / expected
All	1,414,830	1,282,070	177,151	132,760	1.10
Asian	51,297	40,016	11,925	11,281	1.28
Black	27,439	20,997	5,669	6,442	1.31
Mixed	6,326	4,937	951	1,389	1.28
Other	5,192	4,445	903	748	1.17
White	1,324,575	1,211,676	157,704	112,899	1.09

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Tackling racism: Learning from the COVID-19 pandemic

Learning and legacies from the COVID-19 pandemic

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What works in tackling structural racism?

Individuals Lifestyle Factors

Cultural Competence & Patient education

- ✓ Group/one-to-one education led by health professionals
- ✓ Skills-building using videos/testimonials
- ✓ Peer-led education in groups, including faith groups

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Social & Community Networks

Community participation

- ✓ Participation in decisions & design of care
- ✓ Community health workers (CHWs)

Health Care Services

Integrated & personalised care

- ✓ Colocation of services
- ✓ Collaborative care
- ✓ Case management

Living & Working Conditions

Leadership & workforce

- ✓ Anti-racist recruitment & retention policies:
- ✓ Diversity training – meaningful and sustained for all
- ✓ Visible leadership commitment

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Anti-racism in public health

What is anti-racism?

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- Anti-racism is the practice of identifying, challenging, and changing the values, structures and behaviours that perpetuate systemic racism. Anti-racism is an active way of seeing and being in the world, in order to transform it.
- Being antiracist is based on the conscious efforts and actions to provide equitable opportunities for all people on an individual and systemic level.
- People can act against racism by acknowledging personal privileges, confronting acts of racial discrimination, and working to change personal racial biases.
- Anti-racism is an educational and organising framework that seeks to confront, eradicate and/or ameliorate racism and privilege (Bonnett, 2000).
- An anti-racism approach often includes a structural analysis that recognises that the world is controlled by systems, with traceable historical roots, that batter some and benefit others.

Sources: European Commission (2020); The Commonwealth Fund (2020); American Medical Association (2021); Bailey ZD (2021).

What is anti-racism?

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- Because racism occurs at all levels and spheres of society (and can function to produce and maintain exclusionary "levels" and "spheres"), anti-racism education/activism is necessary in all aspects of society.
- A person who practices anti-racism is someone who works to become aware of:
  - How racism affects the lived experiences of people of colour within our society
  - How racism is systemic, and has been part of many foundational aspects of society throughout history, and can be manifested in both individual attitudes and behaviours as well as formal (and "unspoken") policies and practices within institutions
  - The role, benefits and damage of “White Privilege” including how white people participate, often unknowingly, in racism and learning how whiteness—often without them recognizing it—shapes their place in society, and its impacts.

Developing an anti-racism approach

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CIPD has developed six principles to develop a robust anti-racism strategy for organisations:

- Clarify the **organisation's stance and values**: Set clear expectations of what the organisation stands for and maintain zero-tolerance to racism.
- Co-create a **systemic approach** for practical action by working across the organisation: Scrutinise all operational processes, ways of working and people management policies.
- Commit to sustained action through **visible leadership** and a willingness to change: Sustained action needs a long-term plan, led with firm commitment from the top.
- Critically appraise your **people management approach** from end to end.
- Connect your people by **creating safe spaces,** systems and times to talk, share experiences and learn from each other: Ensure your plan is informed by employee voice, and bring in experts where necessary.
- **Communicate** your messages consistently and ensure the conversation is two-way: Leave the workforce and wider stakeholders in no doubt about your key messages. Ensure they are reflected in people's behaviour, in the organisation's operations, and in the organisation's interactions with stakeholders.

Operationalising the London Approach to Anti-Racism, Structural Discrimination and Racial/Ethnic Health Inequalities

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1. Leadership
- Public commitment to being anti-racist organisation with actions
- Board level review of strategy and monitoring objectives indicators, including health outcomes by ethnic groups
- Assure anti-racist approach in all policies

5. Working with communities: to rebuild confidence and trust
- Include community voice in decisions, design and delivery of services though participation in governance, funding and integrated delivery structures
- Embed co-production
- Supporting community groups with resources – funding and training to allow meaningful participation

2. Workforce
- Monitor and act on ethnic inequities in recruitment, workforce wellbeing and promotion
- Provide training and support to address cultural bias and discrimination, incl safe spaces
- Implement and monitor robust equality, diversity and inclusion policies

4. Becoming Anchor institutions
- Address wider determinants of health through anchor actions with a focus on race equity in local populations
- Support education, employment and opportunities to reduce structural determinants of ethnic health inequalities

3. Health Equity programmes
- Embed anti-racist lens on health equity programmes such as Core20P5, Marmot framework
- Data-led insights to prioritise areas of work with community groups to improve health and healthcare access
- Integrated and personalised care that is culturally competent.

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Summary

Summary

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- Racism permeates our everyday lives, even if we do not readily acknowledge its power or pervasiveness.
- Addressing racism is central to eliminating racialised health disparities, and therefore, should be central to public health research and practice.
- As public health practitioners many of us will share the belief that collective efforts can help evoke social change and more generally reduce racialised health disparities and inequality.
- Now is the time for us to develop a reformed public health agenda that recognises the connection between structural racism and racialised disparities in health.
- Implementation of this agenda requires a multipronged, multilevel, and interdisciplinary approach. However, as public health professionals, we are uniquely positioned to facilitate the following responses.

What can you do?

Say it.

- ✓ Name racism
- ✓ Say the whole word
- ✓ We MUST name a problem to get started on solutions

See it.

- ✓ Ask, “How is racism operating here?”
- ✓ Whether the setting is small or large
- ✓ Identify early targets for action and levers for intervention.

Act on it.

- ✓ Organise and strategise to act
- ✓ Use your individual power to do things differently
- ✓ Use collective action to inform, support and protect us all

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“You see our glorious diversity, our diversity of faiths, and colours and creeds; that is not a threat to who we are – it makes us who we are.”
Michelle Obama
@profkevinfenton

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