

Better
Health
Briefing

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**Ethnic
inequalities
in health:
the impact
of racism**

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Briefing Paper

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Key messages

1

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

2

People respond to racist experiences in different ways. This makes evidence of victimisation difficult to establish. In addition, the particular form it takes and victims' responses to it have an important influence on the health impact of victimisation

3

Services have an important role to play: as a domain for racist experiences and as a source of support for victims. There is evidence that the responses of services to victimisation can influence its health effect, in both good and bad ways

4

Encouraging trust among service users and minority ethnic communities is important for establishing a supportive and protective environment for those potentially at risk of victimisation. There is also a need for service improvement to address exclusion, even in the absence of evidence of racism.

Introduction

It is now well established that people from minority ethnic groups experience poorer health than the 'ethnic majority' (Aspinall and Jacobson, 2004). Opinions on the causes of this tend to focus either on individual/community factors — behavioural or biological influences, for example — or on structural explanations: particularly the health impact of the socioeconomic deprivation experienced disproportionately by people from minority ethnic groups (Nazroo, 1997, 1998, 2001). The influence of racism on these patterns has often been underestimated. The experience of abuse, violence and other forms of negative treatment is part of the everyday lives of many people from minority ethnic groups (Chahal and Julienne, 1999). 'Institutional racism' is endemic in our public services (Macpherson, 1999; Coker, 2001; Blofeld, 2003). According to the Independent Inquiry into the death of David 'Rocky' Bennett: '*At present, people from the black and minority ethnic communities ... are not getting the service they are entitled to. Putting it bluntly, this is a disgrace*' (Blofeld, 2003, p. 58). This paper aims to present the evidence for the relationship between racism and health, and to highlight the need, and possibilities, for service improvement: both for the victims of racism and for people from minority ethnic groups more generally.

Racist victimisation makes people ill. It can explain the health impact of (perceived) 'cultural' or 'biological' differences (which are used as a justification for unfair treatment) and the concentration of people from minority ethnic groups in socioeconomic and other forms of disadvantage. Such experiences can justify the distrust, described by people from minority ethnic groups, in their relationships with individuals from other ethnic groups, including service staff (Grewal and Lloyd, 2002). Effectively reducing health inequalities involves recognising and

responding to the impact of racist victimisation on health: *'if we do not act to address prejudice and negative stereotyping explicitly, whatever action we take to reduce inequality ... can only have partial success'* (Equalities Review, 2007, p. 93).

Racism can manifest itself in a variety of ways

Harassment and *discrimination* involve behaviour or actions which unfairly penalise and offend individual dignity. Discrimination may affect health in a number of ways. It may lead to:

- differences in opportunities (e.g. in education or employment) and living conditions;
- differences in treatment, leading to differences in access to health-promoting resources;
- stress — both acute and chronic — which produces physiological changes and problems for mental well-being. (Frykman, 2006)

Racism is an ideology which identifies a social group according to a particular biological characteristic and uses this to draw negative assumptions regarding that group's nature or capabilities (Karlsen and Nazroo, 2006). *Racial harassment* describes demeaning, threatening, violent or other forms of offensive, racially motivated behaviour by individuals from one ethnic group towards those of another. One in five respondents to the 2005 Home Office Citizenship Survey (HOCS) from minority ethnic groups said that they were worried about being physically attacked because of their skin colour, ethnic origin or religion (Kitchen *et al.*, 2006). Others talk about how racism is endemic in British society (Fenton and Karlsen, 2002). Victims of racial harassment describe their health as being poorer than that of non-victims. Experience of racist verbal abuse or physical violence is related to a greater risk of premature death; high blood pressure; respiratory illness; lower self-esteem and life satisfaction; psychological distress, depression and anxiety; suicidal tendencies; stress and anger; psychosis; and more work-limiting long-term illness and disability (Krieger, 2000; Karlsen and Nazroo, 2002; Williams *et al.*, 2003). It has also been linked to cigarette smoking and alcohol use, and to low birthweight among the children of victims (Williams *et al.*, 2003).

Racial discrimination is sometimes divided into intentional (direct) and unintentional (indirect) discrimination. Unintentional discrimination occurs when someone (from a minority ethnic group) is either unable to comply with a requirement that cannot be justified other than on 'racial' grounds (such as policies using length of residence as the basis for allocating social housing), or is less likely to be able to do so than people from other ethnic groups. This definition recognises that someone who is non-prejudiced may be discriminatory as a result of the policies of the institution for which they work. Thus, although individuals might make substantial effort to eliminate discrimination, institutional rules, culture and habits prevent this from being fully realised (Macpherson, 1999). This is often evidence of *institutional racism*.

Resources 1

Clear guidelines for the development of culturally competent services:

Kapasi, R. and Silvera, M. (2002) *A Standards Framework for Delivering Effective Health and Social Care Advocacy for Black and Minority Ethnic Londoners*, London: King's Fund
www.kingsfund.org.uk/resources/publications/a_standards.html

For good practice guidance on tackling harassment and discrimination, see www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4009459&chk=9XTCv0
 This website also offers guidance on building up a more diverse workforce within the NHS, which sets the standards that will be expected of all NHS employers in tackling racial harassment, while allowing for local actions to be tailored to meet local circumstances, policies and issues.

Institutional racism refers to the continued (conscious or unconscious) use of unfair policies or procedures by large-scale enterprises with no consideration as to how this may disadvantage certain ethnic groups (Macpherson, 1999). It is associated with poor health and bodily function, cardiovascular disease, poorer mental health, and smoking, but its health impact is also indirect. Institutional racism is believed to explain the concentration of people from minority ethnic groups in lower income households, environmentally and economically poorer areas, poorer quality and more overcrowded accommodation, less desirable occupations, and longer periods of unemployment than their ethnic majority counterparts (Krieger, 2000; Nazroo, 2003). However, whereas the health impact of socioeconomic disadvantage is well established (Acheson, 1998), the extent to which this disadvantage is a consequence of institutional racism is difficult to determine.

Almost a third of minority ethnic respondents to the HOCS believed they would be treated unfairly by council housing departments, housing associations and private landlords, and 12 per cent said that they had been refused a job or treated unfairly at work for reasons related to 'race' in the past five years (Kitchen *et al.*, 2006). Evidence provided to the Equalities Review (2007) found that people from minority ethnic groups experience more problems finding work appropriate to their abilities, skills or needs compared with white people. Almost a third of respondents to a survey of social services staff reported racism from colleagues and managers, with 45 per cent describing racism from clients (Brockmann *et al.*, 2001). Almost 60 per cent of the minority ethnic NHS staff responding to Lemos and Crane's (2001) study had experienced or witnessed racial harassment in the previous year. Examples of oppression include a lack of support, impoliteness, derogatory and insensitive comments, unfair treatment and undermining of professional ability (Brockmann *et al.*, 2001; Alleyne, 2004). Respondents talked about a '*grinding down process*', which, over time, produced symptoms of stress. Some victims experienced late onset diabetes, hypertension, chronic fatigue syndrome and clinical depression (Alleyne, 2004, p. 6).

The varied, and sometimes discrete, nature of both harassment and discrimination means that they can be difficult to identify. In addition, discrimination may sometimes mean that things do not happen when they should — such '*non-events*' (Williams *et al.*, 2003) include not being called for an interview, not receiving the right treatment, or being refused assistance by social services. Being aware that other people in their ethnic group have been the victims of racist actions may also affect an individual's health, even if that individual has not actually been victimised themselves (Virdee, 1995; Karlsen and Nazroo, 2004). Recognising racism is not, then, simply about incidents.

Importantly, these different aspects of racism are not unrelated. Racist experiences have a '*corrosive and cumulative effect*' (Blofeld, 2003), as current experiences act like '*salt in wounds*' left by past incidents (Harrell *et al.*, 2003, p. 243). Accordingly, the health impact of racism develops and is compounded over time (Frykman, 2006). '*Institutional racism ... can give the authority of everyday common sense to certain [racist] practices and behaviours*' (Brockmann *et al.*, 2001, p. 1). As a consequence, experiences of racist victimisation become evidence of a deeply embedded societal prejudice, rather than the actions of isolated individuals.

2 The responses of victims to racism may influence its health impact

Partly influenced by variations in the nature of the incident itself, people's interpretations of whether an experience is evidence of racism will vary. The effects of racism may be attributed to something else, or people may believe it is in some way justified, so that the blame for the incident is 'internalised'. Establishing a racist motive is sometimes difficult, especially when no racist terminology has been used or racist motivations have been purposely disguised. Indeed, there is evidence that reports of incidents of racism have declined since racist victimisation has been made

unlawful, as perpetrators have become more covert in their methods (Dovidio and Gaertner, 2000). As Cooper (1993, p. 137) puts it, '[t]he lynch mob was an effective instrument of social policy in its day, but too clumsy for a time when appearances count for more than reality'. More subtle incidents may also encourage victims to feel that their experiences are too trivial to justify reporting. It is difficult to overstate the problems associated with addressing issues that cannot be properly identified, but ignoring the more subtle aspects of racism may seriously underestimate its impact on people's lives.

Reluctance to acknowledge the existence of prejudice may be a form of resistance or coping. The nature of such responses also influences the way in which racism impacts on health experience. Problem-focused coping styles (which involve direct action in response to an incident) have been found to be more effective in reducing the negative health impact of victimisation, compared with coping styles that involve passive acceptance or a lack of acknowledgement (Noh and Kaspar, 2003). Simply the action of reporting an incident to an agency that can respond to it may therefore have a positive effect on the health consequences of racism.

In a study of minority ethnic staff working in social services, factors influencing whether abuse was reported included the particular context and form of the abuse and the occupation and age of the victim (Brockmann *et al.*, 2001). Individual coping strategies appeared to be influenced by the perceived motivation underlying the abuse — particularly if it could be rationalised in terms of patient vulnerability (and 'explained away') (Lemos and Crane, 2001). They also appeared to be influenced by staff awareness of wider discussions around the recognition of the need to challenge racism, including their familiarity with the language and concepts of equal opportunities (Brockmann *et al.*, 2001). Incidents of racism that were more personal and specific to the staff member, as well as those that were more subtle in nature, had more serious effects on the sense of self, as a professional and a person, than those that were considered more general, or were more overt. This work suggests that discussions around a need for equality may provide support to victims in the workplace (Lemos and Crane, 2001). There is a concern that service responses are preventing some victims from reporting their experiences, however (Lemos, 2000).

Support services may discourage the reporting of racist incidents

3

Most hate crime goes unreported. Only 8 per cent of respondents to the Fourth National Survey of Ethnic Minorities, who reported being the victim of racist abuse, had reported it to the police (Virdee, 1997). In 2005, the police recorded 50 000 racially or religiously motivated hate crimes. The British Crime Survey indicated that the figures were closer to 260 000 (Equalities Review, 2007). There is evidence that people under-report incidents of racism to victim support agencies because they believe the response will be ineffective,

Resources 2

Support for those improving the cultural competence of their services:

Race Action Net

www.raceactionnet.co.uk

This website has been created as a means of sharing good practice in challenging racist harassment.

The Race for Health Programme

www.raceforhealth.org

This supports a network of thirteen primary care trusts (PCTs) around the country, working in partnership with local black and minority ethnic communities to improve health, modernise services, increase choice and create greater diversity within the NHS workforce.

Citizen Advocacy Information and Training

www.leevalley.co.uk/cait

The European Commission

www.stop-discrimination.info/

This is the European Commission's website on anti-discrimination.

unsympathetic or trivialising (Virdee, 1997; Chahal and Julienne, 1999). Some people believe that the police or housing authorities, for example, cannot prevent or effectively deal with racist actions, so reporting will be inconsequential. Others perceive them to be part of the problem. A quarter of minority ethnic respondents to the 2005 HOCS felt that they would be treated worse by the police than people from other ethnic groups (Kitchen *et al.*, 2006).

People describe feeling isolated and abandoned by the services set up to support them (Chahal, 2003; Bowl, 2007). Reporting arrangements are sometimes patchy and victims feel that their complaints are not taken seriously (Lemos, 2000). Agencies are considered to be slow to act to resolve situations, and action against perpetrators is rare. Feedback is typically irregular and services are uncoordinated. In these situations, GPs often become an important source of support: as witnesses and confidantes, and by liaising between victims and other agencies, such as housing associations (Chahal and Julienne, 1999). Caseworkers also play a critical supporting role, in the provision of coordinated and dedicated services to clients through empowering, advocacy-type relationships (Chahal, 2003).

The positive contribution of minority ethnic community sector organisations is related to the variety of services offered and their ability to focus on the specific needs of a community, group, family or individual, rather than adopting the 'one size fits all' approach of more mainstream services. Clients discussed the ability of these projects to offer a non-judgemental and coordinated approach. Such an approach allowed them to recognise their rights and retain control of the direction of the action regarding their complaint, while receiving support to address the multiple consequences of their racist experiences (Chahal, 2003; Mclean *et al.*, 2003). Elsewhere, a lack of understanding of the experience and impact of victimisation on people's lives means that the policies and procedures developed to challenge racist victimisation are often ineffective (Chahal and Julienne, 1999). The approaches adopted by many support agencies — which treat individual events as isolated without addressing the repetitious and cumulative impact of harassment and discrimination — cannot account for the enduring and pervasive influence of racist victimisation on people's lives.

4 Services must do more to address exclusion

Cultural insensitivity leads to a lack of service engagement among users. For example, there is concern regarding the level and typical pattern of health service use by people from minority ethnic groups (Blofeld, 2003; Aspinall and Jacobson, 2004; Equalities Review, 2007). Those who justify this under-use, by making assumptions about the reliance of people from minority ethnic groups on family support and informal caring, ignore the evidence from potential service users: which describes prejudice, discrimination, distrust and a lack of appropriate services (Grewal and Lloyd, 2002; Mclean *et al.*, 2003). A study undertaken by the Commission for Health Improvement found ethnic differences in service users' rating of their care in terms of:

- service access and coordination;
- the environment in which services were provided;
- the provision of information;
- their involvement in healthcare decisions;
- the level of choice regarding care pathways;
- consideration of their physical and emotional needs;
- being treated with respect.

(Raleigh *et al.*, 2004)

People describe a lack of specialist, culturally competent services able to meet their needs: whether these are related to language, religion, culture, gender, deprivation or discrimination (Grewal and Lloyd, 2002; Mclean *et al.*, 2003; Bowl, 2007). Services are considered to be lacking:

- a representative workforce and staff from minority ethnic groups;
- sufficient policies and practice guidelines relating to working with minority ethnic users;
- minority ethnic clients;
- effective relationships with the minority ethnic voluntary sector;
- staff with sufficient awareness or confidence working with diversity;
- appropriate, targeted information about services.

(Chahal and Ullah, 2004; Bowl, 2007)

Providing more effective services involves listening to users and recognising that they may evaluate services and support in different ways from service providers.

Empowering, inclusive services can:

- achieve the outcomes defined by service users;
- recognise the complexity of a user's identity, beyond their ethnicity;
- offer a better trained workforce that can be more responsive to diversity and facilitate prejudice reduction;
- offer effective and sustainable partnerships with the range of minority ethnic communities and informal support networks in the local area;
- develop strategies to recruit and retain minority ethnic staff;
- encourage the development of a minority ethnic management class in the care sector, and thus a culturally competent service and workforce, through training, policies, practice guidelines and effective leadership.

(Mclean *et al.*, 2003; Chahal and Ullah, 2004)

Conclusion

The Independent Inquiry into the death of David Bennett reported that: *'if a patient's cultural, social and religious needs are not scrupulously considered, these will inevitably affect his reactions and may exacerbate his symptoms'* (Blofeld, 2003, p. 23). Insensitive treatment compounds the sense of injustice felt by those who are the victims of harassment and discrimination. We must act to reduce racist harassment and discrimination, disrupt its negative impact on health and improve the sense of social support among those who are victimised, by treating them as complex individuals and as members of families and communities: as dictated by the Race Relations (Amendment) Act 2000 and the NHS Plan (Secretary of State for Health, 2000). *'If the National Health Service does not look at the whole man or woman ... it is failing in its duty'* (Blofeld, 2003, p. 30). It may also be directly contributing to ill health and premature death.

Resources 3

The NHS Health Improvement Plan

www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Modernisation/NHSPlan/fs/en?CONTENT_ID=4082690&chk=/DU1UD

The NHS Health Improvement Plan involves putting the patient at the heart of public services.

The NHS Commissioning Framework for Health and Well-Being

This was published in March 2007, and includes guidelines for person- and community-centred health services commissioning.

For further information and guidelines, see:

www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4143857&chk=qj0MmR

Race Relations (Amendment) Act 2000

www.opsi.gov.uk/acts/acts2000/ukpga_20000034_en.pdf

A print version is also available and is published by The Stationery Office Limited

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We welcome feedback on this paper and on all aspects of our work.

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