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Racial Inequalities in Health

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[MUSIC PLAYING]

JENNY DOUGLAS: Racial inequalities that we saw during the pandemic merely reflected and amplified the racial inequalities that existed previously.

DOROTHY ROBERTS: Black Americans have really borne the brunt of sickness. They've contracted and died from the virus at far higher rates than white Americans.

ANGELA SAINI: To jump to a kind of genetically or biologically deterministic explanation I think is the very last thing we should be doing.

WINSTON MORGAN: There are also studies that have shown, for example, with pain medication, where, for the same conditions, Black people are much less likely to be given pain medication than their white counterparts.

LURRAINE JONES: What are you going to do after you've paid homage to George Floyd and put the black square up, and et cetera, et cetera? What are you actually going to do after that?

[MUSIC PLAYING]

ANGELA SAINI: It was really instructive for me, what happened in 2020, because we have always known that there are inequalities in health care, even in a system like Britain, where we have the NHS. There have always been inequalities not just along racial lines, but also along class lines. Why we didn't expect that to play out in the event of a pandemic is a mystery to me. And I was surprised that, in the early days of the pandemic, when we had very little data, all we really had were death rates and critical illness rates, that people would look at that, see these inequalities play out, and yet jump to the conclusion that there could be something biological underpinning the differences in death rates and critical illness rates.

DOROTHY ROBERTS: Now, it's interesting, when these disparities were first exposed in the US, some scientists and politicians automatically speculated that there must be some peculiar problem with Black people's bodies that made us more susceptible to illness and death.

ANGELA SAINI: If it were the case that a virus would hit people of different races differently, that would be the first time in history that would ever have happened. It has literally never been the case.

DOROTHY ROBERTS: But a much better explanation is that the conditions created by structural racism in the United States put Black people at greater risk.

MICHAEL MARMOT: But then something else was revealed. And that was the shockingly high mortality from COVID-19 in Black African, Black Caribbean, Bangladeshi, Pakistani-British, and, to a lesser extent, Indian. Much of that excess could be attributed to where

people live, density, deprivation, other socioeconomic characteristics, and some of the excess, particularly in Bangladeshi and Pakistani groups, could be attributed to prior ill health.

DOROTHY ROBERTS: Even before the COVID pandemic, Black people were more likely to live in segregated communities, with less access to high-quality health care, less access to nutritious food, to secure housing, to clean air and water.

WINSTON MORGAN: You look at the numbers, and you see, for example, the proportion of a population defined by race. And remember, race is a social construct. So don't-- yeah, but we define people in terms of race. And when you see, for example, I don't know, 30% of 60-year-olds might be diabetic, whereas for the Black community, it might be 60%. That kind of thing.

JENNY DOUGLAS: And therefore, Black and minority ethnic patients experience racism. And this is in a number of different ways. For example, we know that Black women are four to five times more likely than white women to die in pregnancy and childbirth.

WINSTON MORGAN: But those are still statistically significant differences that shouldn't exist. And the only explanation for those are generally around racial discrimination and living in a world where there is more inequality based on race.

DOROTHY ROBERTS: Black women in the United States have a longstanding history of being devalued by the health care system. And this is reflected in stereotypes about Black women. For example, their reckless childbearing. It also is manifested in really horrible health inequities. For example, the extremely high rates of maternal mortality in the United States among Black women.

JENNY DOUGLAS: I think that racism within the health service continues to exist because of longstanding historical perceptions about Black and minority ethnic people. And these perceptions stem back to slavery and the research that was done on biological racism, which tried to show that there were differences between so-called races. But we know that biological racism, we know that there are no differences between races in terms of biology, and this is all totally socially constructed. Therefore, we should be able to try and stop racism from occurring.

MICHAEL MARMOT: We don't have good data on health by ethnic group. So, when I did my Marmot Review in 2010 on health inequalities, and again when I did the 10-year follow-up, Health Equity in England-- The Marmot Review 10 Years On, we said what we could about ethnic differences, but we lamented the lack of data.

DOROTHY ROBERTS: I have to say, I was really dismayed by the similarity in racial disparities in deaths in the US and the UK. So, in May 2020, African Americans made up only 13% of the US population, but they suffered 30% of COVID-19 cases in the 14 states that were collecting racial data at the time. So, a big over representation of Black Americans in COVID cases.

And that was very similar to what the UK was reporting at the time. So, although the categories are different because of some of the differences in how the racial demographics are classified, right, in the UK, but the UK reported at the time that 30% of its critically ill COVID patients were from ethnic racial minority groups, mostly South Asians, which made up about 14% of the UK population. So, the statistics, the disparity statistics were virtually identical, even though the categories were a little different.

But if we look at it as comparing racial or ethnic minorities to white people, it's basically the same dynamics of discrimination and racism. And in England, the highest age-adjusted diagnosis rates were in people of Black ethnic groups and the lowest were in people of white ethnic groups.

ANGELA SAINI: So, the other thing that happened in the same year as the big pandemic lockdowns was the murder of George Floyd in the US, which caused this huge debate around race globally, including in Britain. And suddenly, I could see it myself, this palpable shift from

doctors and scientists talking about race in biological and genetic terms as a factor in COVID-19 to looking instead at the social determinants of health and demographics and other factors, including racism, structural racism, that might have played out.

JENNY DOUGLAS: And racism operates in many ways in relation to structures. So, for example, it starts with education, that Black and brown young people have different opportunities because of the education that they experience and the discrimination that they experience at school. And then in the workplace, Black and brown people experience discrimination within the workplace.

LURRAINE JONES: So, it has been proven that many Black researchers are not resourced to do the research that they want to do, and often, but not always, again, because Black people are not homogeneous, as I will keep saying.

JENNY DOUGLAS: In terms of getting affordable housing, it's often in areas that are socially deprived, and where, for example, you have very high levels of pollution, lots of housing in a very small space, very little green space.

LURRAINE JONES: There's the deficit model. So, this is well-meaning academics and medical professionals placing the emphasis on the patient or the student, that they have a deficit. So, for example, in higher education, the idea that I've heard, oh, the student is from a single-parent family, or they are a single parent, or they can't speak English very well, so therefore let's do something to help that poor student, which is really-- it's really disingenuous. Rather than looking at the structures within the institution in health and in education, what are you doing? Are you looking at yourself, are you looking at your own practice? Is your education or health based on Eurocentricity? And by that, I mean, certainly in education, lots of the curriculum is based on Eurocentric theorists. Lots of medicine is based on white people and white theorists.

So therefore, the idea that the student, oh, the poor student, really you should be looking at your own institution. Rather than the student coming in, trying to fit in, how about you trying to make the organization much more diverse, much more inclusive? So, this is where we get the parallels between health and education, as they are institutions.

ANGELA SAINI: The British Medical Journal released a special issue on racism in medicine that showed not just patients, but also staff in the NHS suffer racism.

JENNY DOUGLAS: This has been documented for many years about the ways in which Black staff are less likely to get promotion, Black staff are less likely to get any career development. Black staff are more likely to undergo disciplinary action. And this happens within the NHS, but as I say, it happens across organizations.

And this is because of an assumption about Black staff. And there was a very interesting book that was written in the US called Presumed Incompetence. The stereotypes that exist about Black staff is that Black staff are presumed incompetent.

WINSTON MORGAN: It's about class and that kind of thing, and education, but there's been studies in America that, for example, that show that college-educated Black women, the chances of their children dying, infant mortality is still less than a non-college-educated white woman in America. It gives you some protection, but it never gives you the level of protection you'd expect, simply because of discrimination. Because most of the time, people don't see your education, they just see your race. And they start to treat you-- it doesn't matter how well-educated you are. It's not going to protect you.

ANGELA SAINI: In the UK, unlike in the US, where there is a huge life expectancy gap between Black Americans and white Americans, in the UK, we have a life expectancy gap between the rich and the poor.

MICHAEL MARMOT: So, you could say the British are obsessed with class and the Americans with race. So, we've done much less about it. And I think one of the effects of the

COVID shocking data will be to put much more effort into making sure we can monitor the racial ethnic differences more completely and more continuously.

ANGELA SAINI: So, the Marmot Review, which was updated in 2020, last came out 10 years ago, it showed that the gap, the life expectancy gap for men and women between the least deprived and the most deprived areas had got bigger. We never biologize that. Nobody says poor people are fundamentally genetically different from rich people, and that is why we see these big gaps that we do, and we can't do anything about it.

JENNY DOUGLAS: Here in the UK, we tend to have a body of research that focuses on class, a body of research that focuses on gender, and a body of research that focuses on ethnicity. What the COVID pandemic has shown us is that, actually, we need to do intersectional research. So, we need to look at how socioeconomic circumstances, gender, and racism-- so poverty, sexism, and racism-- actually affect individuals. And we need to have the research methodologies that can start to look at that. And once we have the research evidence, then there is better opportunity for us to start to dismantle racism.

WINSTON MORGAN: One of the individuals I like who's done a lot of work on this is Professor David Williams from Harvard University. And he's shown that not only is discrimination likely to lead to poorer health outcomes, but even if you live in a world where you perceive that you're being discriminated against, even if discrimination isn't taking place, just the perception of discrimination will lead to poorer health outcomes. If you imagine you're surviving in a world where you're constantly worried about overt and non-overt what they call microaggressions, it's going to have an impact on you. And you will produce more, for example, stress hormones.

MICHAEL MARMOT: If you're poor and female and a woman of colour, oh my gosh, now you've got three strikes against you. And that's intersectionality, I think, simply put.

DOROTHY ROBERTS: But then there has to be action. And the only way that we can get radical change is for people to organize together. And that means collective action by professionals in the health care system, by students who are training to be health care professionals, and then by the communities that they are supposed to be serving.

LURRAINE JONES: I'm a firm believer in diversity of thought. If you don't have a diverse range of people in your organizations with the power to make change, then nothing does change.

WINSTON MORGAN: You can't separate health inequalities from wider inequalities in society.

JENNY DOUGLAS: If we didn't have so much difference between the experiences of different sectors of the society, we would have better health for everybody.

ANGELA SAINI: But I am optimistic because I see, far more than people doggedly maintaining their biases and misconceptions, people challenging them.

[MUSIC PLAYING]