Racism is the root cause of ethnic inequalities in health

This briefing summarises key points from a research article by Sarah Stopforth, Laia Bécares, Dharmi Kapadia, and James Nazroo, which examines the fundamental role of racism in leading to ethnic inequities in health, both directly, and indirectly via socioeconomic disadvantage.

Background

Britain is an increasingly diverse nation with minoritised ethnic people or groups playing an ever-greater part in its economy and cultural life. Diversity is not met with equity, and studies have found ethnic inequalities in health across the life course. In childhood, clear patterns of ethnic inequalities have been reported in birthweight, and developmental milestones. In adulthood, some minoritised ethnic groups are up to 50% more likely than White British people to report poor health, and similar patterns of health inequalities have been observed in other health outcomes, including severe mental illness. In later life, we have shown stark and persistent ethnic inequalities in limiting long-term illness and self-rated health.

Explanations for ethnic health inequalities are complex, but it is now well-documented that racism is the root cause of poor health for minoritised ethnic groups. Racism is a system of oppression which unjustly disadvantages people from minoritised ethnic groups, and unfairly advantages people from White 'majority' groups. Racism leads to poor health for minoritised ethnic groups, both directly (for example, through increasing stress, or worsening mental health), and indirectly (for example, increased exposure to toxins in the environment, and targeted marketing of harmful substances like tobacco and alcohol). A key mechanism underlying the poor health of minoritised ethnic groups is the way racism leads to socioeconomic opportunities and outcomes, which have been strongly linked to poor health.

In the UK, people from minoritised ethnic groups are more likely than people from the White majority group to live in more disadvantaged areas; have poorer housing or insecure tenures; have higher rates of unemployment; and work in less advantaged, lower paid occupations. Overall, evidence shows that socioeconomic inequalities make a substantial contribution to ethnic inequalities in health. However, most academic and policy discourses on ethnic inequalities rarely name racism as the underlying cause of socioeconomic disadvantage.

Our research

Here, we present recent work where we make explicit both the direct and indirect role of racism in leading to poor health for minoritised ethnic groups. We use nationally representative, large-scale, longitudinal survey data from Understanding Society, to examine (i) the direct effect of experiences of racism and racial discrimination on physical and mental health, and (ii) how these racist experiences affect socioeconomic circumstances, which in turn influence health (i.e., indirect effects). These different effects are presented in Figure 1.

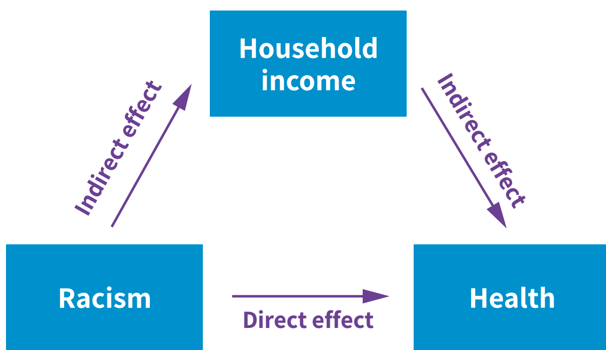

Figure 1. Direct and indirect effects of racism on health

In our analyses, we wanted to better understand the effects of racism on the health of minoritised ethnic groups over time, capturing both the direct effects of interpersonal racism on health, and the indirect effects of racism on health via socioeconomic inequality, i.e., reduced household income.

We measure the associations between experienced racism at each point in time when data are collected, with health in all subsequent points in time, to capture the long-term direct effects of racism on health. We examine associations between racism and income, racism and health, and income and health, in each time point and the next adjacent point in time. Figure 2 represents the cross-sectional and longitudinal associations.

Our sample includes a total of 4,444 participants from minoritised ethnic groups.

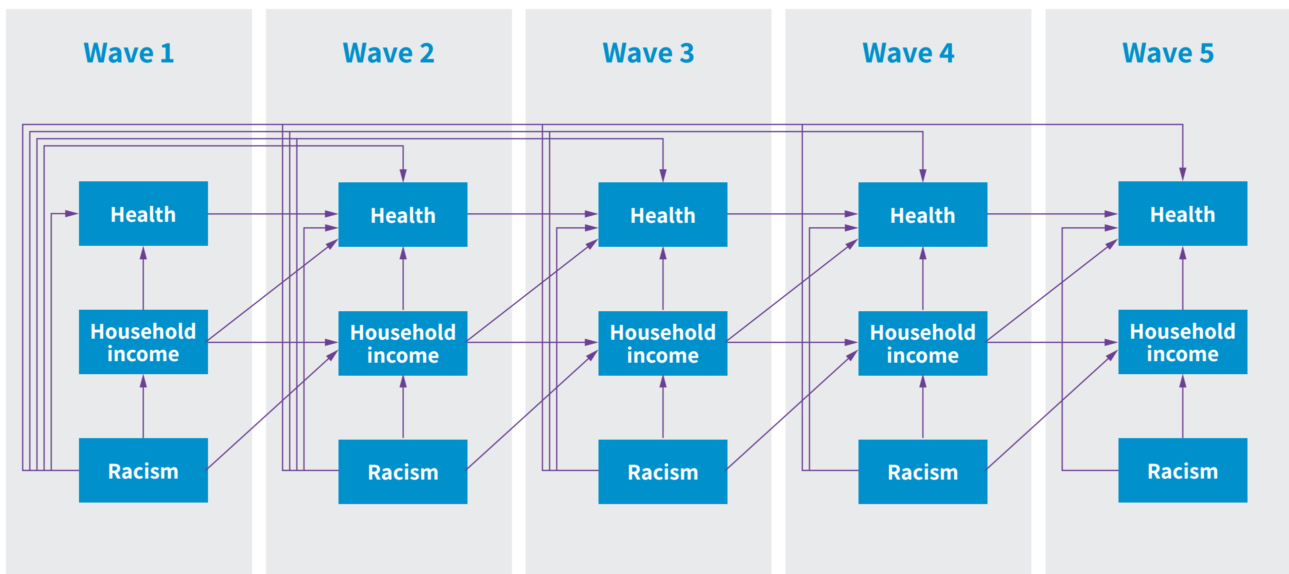

Figure 2. Cross-sectional and longitudinal associations of racism, income, and health

In our analysis, we use data covering a 10-year period (from wave 1 (2009/2011) to wave 9 (2017/2019)) of Understanding Society data to analyse these associations. We examine two different aspects of health: physical health and mental health. Both measures come from the 12-Item Short Form Health Survey (SF-12), a widely used, validated self-reported measure of health.

We also measure experiences of racial discrimination with a set of questions that asked respondents whether, in the past 12 months, they had experienced any of the following because of their ethnicity, nationality, or religion: have you been insulted, called names, threatened or shouted at; have you been physically attacked; have you felt unsafe; and have you avoided going to or being in public places.

To capture socioeconomic position we use a measure of net household income which takes household size into account. We also take into account gender and age differences in the association between racism and health.

Findings

Our findings show that mental health scores are worse for people who report experiencing verbal or physical racist abuse, or who felt unsafe in public places due to their ethnicity, nationality, or religion. We also find clear worsening of physical health scores for people who report experiences of racism and racial discrimination, and these differences increase over time (see Figures 3 and 4).

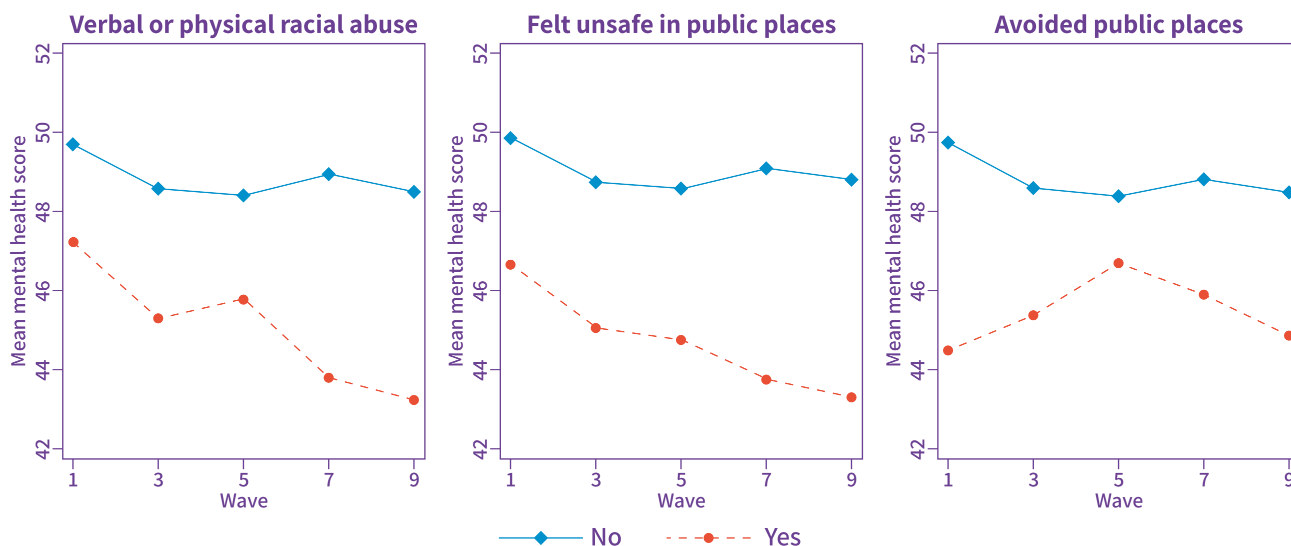

Figure 3. Mean mental health scores by experiences of racism over time

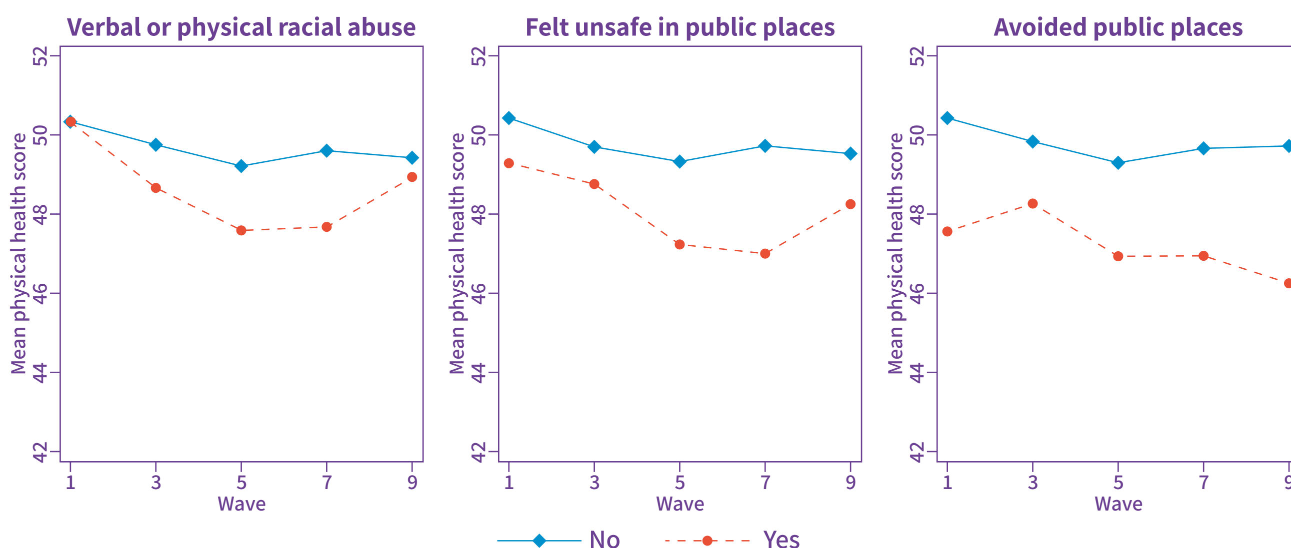

Figure 4. Mean physical health scores by experiences of racism over time

When we combine the direct effect of racism with the impact of racism on socioeconomic position, we find it has a substantial impact on health (coefficients ranging from -0.06 to -0.18). The direct effect of racism on health is immediate, with smaller and inconsistent effects into the future. This is consistent with the effects of racism on stress related biological and psychological pathways that impact on health. The indirect effects of racism on health, operating via its impact on socioeconomic position, operate over a longer time frame. This is consistent with the longer-term impact of racism on socioeconomic position and the longer-term impact this has on health.

Our analysis demonstrates the persistence and insidiousness of racism in severely and negatively impacting the health of people from minoritised ethnic groups in the UK. This happens directly, by leading to poor mental and physical health at the same time that racial discrimination is experienced, and indirectly, via leading to reduced socioeconomic resources over time, which in turn lead to poor mental and physical health.

Conclusion

The Understanding Society data only captures experiences of interpersonal racism – experiences of racial discrimination between people, either on purpose or by omission – and does not capture the existence, or effect, of institutional and structural racism on health (directly or indirectly). In addition, the measures of racism and discrimination relate to experiences within the past 12 months, so we cannot assess the effects of racism occurring earlier in people's lives. Therefore, it is likely we are underestimating the full range of racism faced by people from minoritised ethnic groups in the UK, and importantly also underestimating the role of racism as the root cause of ethnic inequalities, in health and socioeconomic outcomes, in the UK.

Data limitations in the UK mean that we cannot adequately study life course effects of racism on health. Existing surveys do not have suitable sample sizes of ethnic minority people of different ages, or suitable measures of racial discrimination in their questionnaires. Future data collection, investment, and infrastructure, needs to better represent older ethnic minority people and adequately capture historical experiences of racism and discrimination, to enable more robust understandings of the effects of racism on health outcomes over the entire life course.

As we've previously argued, current policy actions to address ethnic inequities in the UK (for example, in Inclusive Britain), reflect the false dichotomy presented in the Sewell report that separates deprivation and ethnicity. Historical and current racism is the root cause of ethnic inequalities in individual and area-level socioeconomic inequalities, and health. Ignoring racism as the main explanatory factor leading to ethnic inequalities in health and area-level deprivation will only partially address ethnic inequalities in the long-term. Importantly, it also means that we ignore what can be changed. A national race equality strategy with a clear plan to tackle ethnic inequities in health and socioeconomic conditions must be produced and implemented to prevent the production and reproduction of ethnic inequities.

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www.nuffieldfoundation.org/project/ethnic-inequalities-in-later-life

For more details on the study please see:
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