



sa.jeraj@gmail.com

Cite this as: *BMJ* 2021;373:n821<http://dx.doi.org/10.1136/bmj.n821>

Published: 16 April 2021

HEALTH INEQUALITY

Doing the work to end health inequalities caused by systemic racism

Covid-19 is a stark recent example of how health inequalities persist for people of ethnic minorities. How can communities, professionals, and services tackle the systemic injustices that affect everything from diabetes to mental health? **Samir Jeraj** reports

Samir Jeraj *freelance journalist, London*

When the patient Sanisha Wynter sought help for her mental health, she struggled to access services, treatment, and support—and above all to be heard by the professionals she saw and the services she attended. Her story is disturbing yet familiar. One clinician told her she was a “strong Black woman,” drawing on a racialised stereotype that downplays the emotional and physical pain that Black women experience.

Later, Wynter was referred to a therapist who told her that she had never treated a Black or bisexual woman before, placing the onus on Wynter to educate her about race and sexuality. “My trauma took a back seat to facilitating her understanding,” she said.

Wynter’s story opened an event on 9 March organised by National Voices, a coalition of 160 health and social care charities, which aimed to examine ways to tackle racial inequalities in health. Unless experiences like Wynter’s are publicised and considered, she told the conference, “racial injustice and health inequity can be dismissed.” The risk is that biases “overshadow the conversation,” ultimately leading to poorer health outcomes.

Undermined trust in services

Individual professionals’ biases and actions can create poor experiences for patients and give rise to the narratives that undermine trust in health services. But this is just one part of a much larger picture of structural inequalities across health, housing, work, and education.

Another speaker, Habib Naqvi from the NHS Race and Health Observatory—launched after *The BMJ* highlighted last year the sustained impact of racism in medicine (bmj.com/racism-in-medicine)—explained that the observatory focuses on these “causes of causes” in health inequalities, looking for the reasons that people of ethnic minorities are more at risk of developing diabetes and hypertension, for example. The observatory works with community organisations as the “eyes and ears” on the ground, hoping to create “meaningful and sustained change.”

Among the first questions the observatory considered was why Black women experience higher risks in pregnancy and maternity. MMBRACE, a UK collaboration that looks at maternal and infant deaths, in 2020 found that Black women were four times more likely to die in childbirth than white women; Asian women were twice as likely. Like many

racial health inequalities, this discrepancy had been known about for years, if not decades, but had not been the focus of the sustained work needed to change these outcomes.

Naqvi said that responses to racism needed to look at the level of the individual, such as “racial bias in clinicians’ assumptions around things such as pain management,” as well as policies and practices and the evidence on which health interventions are commissioned. For example, although the number of older people of ethnic minorities with dementia is growing,^{1–3} poor data collection by the NHS means that the ethnicity of about half of dementia patients is unknown.⁴

“If we don’t talk about the outcomes and results, we’re pushing blame and responsibility onto patients who are seeking treatment and might have different needs,” said Halima Begum, chief executive of the race equality think tank the Runnymede Trust.

She emphasised the importance of socioeconomic class to understanding why people of ethnic minorities have poorer health outcomes. In the labour market, people of ethnic minorities continue to be over represented in the occupations that place an individual at high risk of infection with covid-19: transportation, health and social care, and the food sector. They are also more likely to live in poor quality and overcrowded homes, to experience poverty, and to be in poorer physical health. There is a “socioeconomic duty” in the 2010 Equality Act, which would compel public organisations to address class inequality, but it has never been implemented.

Begum added that there had been a “continuous sense of racial injustice” over recent years, encompassing the Grenfell Tower fire, the Windrush scandal, and now covid-19. Having constantly to respond to the next outrage has exhausted activists and professionals working to address race equality. “To really get at the ‘causes of the causes,’” she said, “you need a dedicated effort to unpack what those solutions might be, but because there is a crisis every year we are unable to get to that piece of work.” This illustrates the “vicious circle of racial inequality”: that the most affected have to work the hardest to change the system. One such area is organ transplantation (box).

Reducing inequality in organ transplantation

People of ethnic minorities are more likely to need an organ transplant but less likely to find a matching donor,

leading to longer waits and higher mortality. NHS Blood and Transplant (NHSBT) has put effort into sustained community work in its response to racial inequalities in England.

NHSBT has worked for years with organisations such as the charity the National BAME Transplant Alliance to develop community support and encourage more people to donate to help tackle these inequalities, explained Andrea Ttofa from NHSBT. “We needed to be open to ideas and accept criticism and feedback,” she added. Too often, she said, NHSBT had been fielding white spokespeople for these issues, and when people shared their experience of donation these were just pushed out on the organisation’s channels rather than in a way that might actually reach the communities they were seeking to speak to.

One recent project has sought to shift power from NHSBT to community organisations by funding and supporting their work on under-donation. “It was really important that we built trust with the community organisations so it was something they felt they could and should engage with,” Ttofa said. They recognised they could not do this by themselves as a “majority white” team that lacked representation from many of the target groups. So the community engagement work included recruiting an advisory group of people from other ethnic backgrounds with professional expertise, community expertise, and experience of the problems users encounter, to help build that trust.

Racist assumptions

A major systemic problem is that the voluntary and community sectors have a poor record of action on racial inequalities, and in representation among staff and board members. In 2019, the Charity So White campaign encouraged current and former staff, volunteers, and service users to highlight problems, from racist assumptions in training, to tokenistic action in workplaces, and the “white saviour complex” exhibited by some people in the sector.

This campaign, together with events such as Black Lives Matter, led to some charities confronting these challenges. Birthrights, which focuses on the human rights of pregnant women and birthing people, has made efforts to become a more inclusive organisation and to act on racial inequalities in pregnancy and maternity.

The charity currently is running an inquiry into systemic racism in maternity care, drawing on patient experience, medical expertise, and partnership with other organisations to advance understanding of the issues behind the data and to develop solutions.

“We were an all-white team and an all-white board of trustees, like many in the charity sector,” said Amy Gibbs, chief executive of Birthrights. It recruited new board members, changed how it runs staff recruitment—for example, sharing interview questions in advance, which is recognised to help “level the playing field” for candidates from under-represented backgrounds by focusing on performance rather than experience—and started an internal programme of ongoing training. Gibbs is clear, however, that Birthrights is still on its journey.

The phrase “doing the work” is often applied to the individual efforts that we should all be making to understand our prejudices, ignorance, and biases, and how they affect the people around us. Organisations and institutions will also need to “do the work” if we are to unpick centuries of compounded racial inequalities. Many have already started meaningful change, many others will need resources and accountability to tackle racial inequalities in health.

What can doctors do?

Medical professionals have an important role in tackling racial injustices, from individual practice to taking leadership. Sanisha Wynter, a patient, has been working with medical students on how to overcome some of their biases and assumptions when faced by real situations. “It was opening up conversations with the students about when somebody

presents to you, not assuming “this is what a mental health patient looks like,” she explained. Research has shown that clinicians can struggle to diagnose conditions such as depression in people of ethnic minority backgrounds.⁵

Professionals are also part of the communities of colour affected by health inequalities and are working to tackle them. The British Islamic Medical Association, a charity representing Muslim clinicians, works in Muslim communities on several health matters, from encouraging more organ donation to training people how to perform cardiopulmonary resuscitation.

In the NHS, people of ethnic minority backgrounds are more likely to be in junior roles, more likely to go through disciplinary processes, and less likely to raise concerns about their workplace. One outcome of this was that 60 of the first hundred NHS staff to die from covid-19 were from Black, Asian, or minority ethnicities that make up about a fifth of NHS staff.⁶

Competing interests: I have read and understood the *BMJ* policy on declaration of interests and have no relevant interests to declare.

Provenance and peer review: Commissioned; not externally peer reviewed.

- 1 UK All-Party Parliamentary Group on Dementia. Dementia does not discriminate. The experiences of black, Asian, and minority ethnic communities. 2013. https://www.alzheimers.org.uk/sites/default/files/migrate/downloads/appg_2013_bame_report.pdf
- 2 Race Equality Foundation. Black and minority ethnic communities and dementia: Where are we now? 2013. <https://racequalityfoundation.org.uk/health-care/black-and-minority-ethnic-communities-and-dementia-where-are-we-now/>
- 3 UCL. Likelihood of dementia higher among black ethnic groups. 2018. <https://www.ucl.ac.uk/news/2018/aug/likelihood-dementia-higher-among-black-ethnic-groups>
- 4 Pham TM, Petersen I, Walters K, et al. Trends in dementia diagnosis rates in UK ethnic groups: analysis of UK primary care data. *Clin Epidemiol* 2018;10:949-60. doi: 10.2147/CLEP.S152647 pmid: 30123007
- 5 Adams A, Vail L, Buckingham CD, Kidd J, Weich S, Roter D. Investigating the influence of African American and African Caribbean race on primary care doctors’ decision making about depression. *Soc Sci Med* 2014;116:161-8. doi: 10.1016/j.socscimed.2014.07.004 pmid: 25014268
- 6 Cook K, Kursumovic E, Lennane S. Exclusive: deaths of NHS staff from covid-19 analysed. *HSJ* 2020 <https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article>