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Embedding anti-racism in public health practice

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“I can’t breathe.”

Introduction

The killings of Rumain Brisbon, Tamir Rice, Akai Gurley, Dante Parker, Michael Brown, Eric Garner, and many other Black Americans, have brought global attention to racial inequities involving police brutality in the United States and the depth of systemic racism in the U.S.

Amid the outrage and pain related to these acts of overt racism and violence, government leaders as well as health organisations around the world are affirming racism as a serious public health crisis.

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.

Content

1. Reflections on race and racism
2. Racism and health
3. COVID-19, inequalities and structural determinants
4. Embedding anti-racism in public health practice: Where next?

Race and racism

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.
- In a racially stratified society, White lives are inherently valued over Black lives.

Race and Racism

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 is a system based on race that unfairly disadvantages some individuals and communities, and advantages others.

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.

Racism: A public health issue

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 conceptualized and operationalized 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.

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Racism and health in the UK

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

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.’

Lived experiences of Black Asian and Minority Ethnic communities in the UK

The UK has become more ethnically diverse. The proportion of people identifying as White British in England and Wales decreased from 87.4% in 2001 to 80.5% in 2011.

There are disparities between ethnic groups in all areas of life affected by public organisations. Some are more pronounced than others or have a greater impact on people's life chances and quality of life. In some areas, disparities are reducing, while in others, they are static or increasing.

Asian and Black households and those in the Other ethnic group were more likely to be poor and were the most likely to be in persistent poverty

Households of Bangladeshi, Pakistani, Black, Mixed and Other backgrounds were more likely to receive income-related benefits and tax credits than those in other ethnic groups. The ethnic minority population is more likely to live in areas of deprivation, especially Black, Pakistani and Bangladeshi people.

Employment

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.

Housing

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.

Health

There are differences between ethnic groups across a range of health-related behaviours and preventable poor outcomes, and each ethnic group exhibits both healthy and unhealthy behaviours.

More than half of adults in all ethnic groups other than the Chinese group were overweight (having a Body Mass Index of 25 and over), and this was particularly so among the White and Black ethnic groups, affecting 2 out of 3 White and Black adults.

Most Asian groups express lower levels of satisfaction and less positive experiences of NHS General Practice services than other ethnic groups and there are differences in the prevalence of mental ill-health, its treatment and outcomes between ethnic groups.

In the general adult population, Black women were the most likely to have experienced a common mental disorder such as anxiety or depression in the last week, and Black men were the most likely to have experienced a psychotic disorder in the past year.

Of those receiving psychological therapies, White adults experienced better outcomes than those in other ethnic groups. Black adults were more likely than adults in other ethnic groups to have been sectioned under the Mental Health

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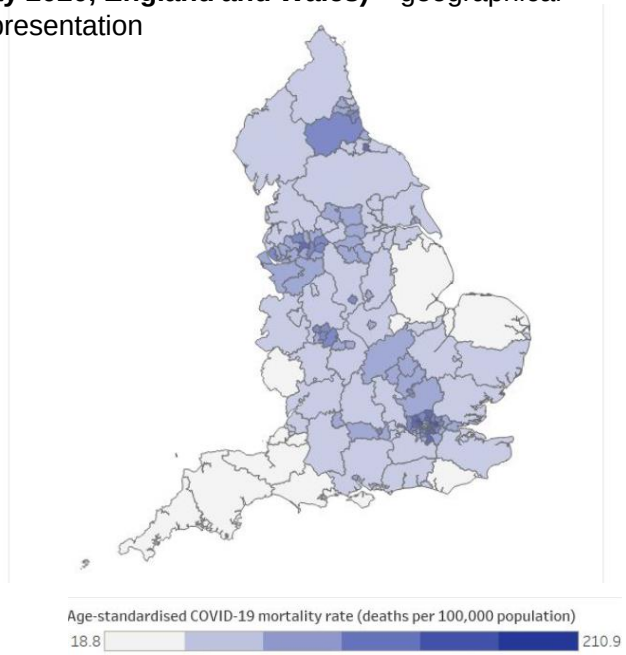
COVID-19: Inequalities and structural determinants

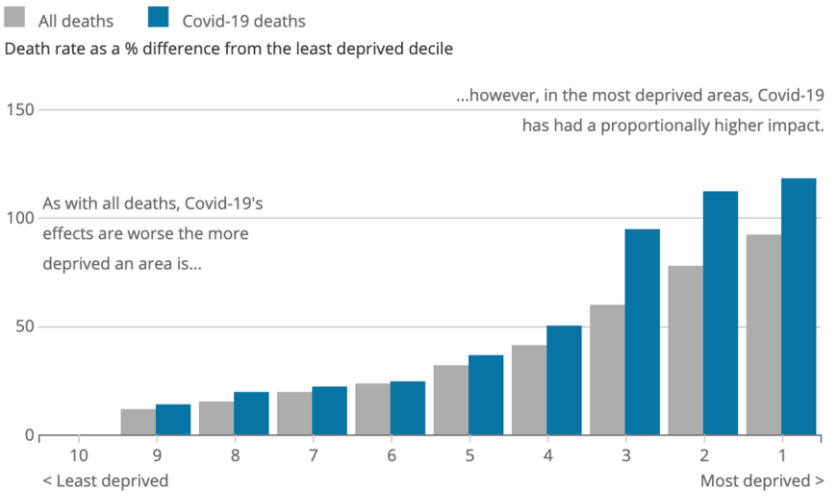
Health inequalities and COVID-19

PHE's recent review: *Disparities in the risks and outcomes of COVID-19* confirms that COVID 19 has replicated existing health inequalities and, in some cases, has increased them. This reinforces the need for targeted action.

Age-standardised COVID-19 mortality rates (March to May 2020, England and Wales) – geographical representation



Age-standardised mortality rates, all deaths and deaths involving COVID-19, Index of Multiple Deprivation, England, deaths occurring between 1 March and 31 May 2020



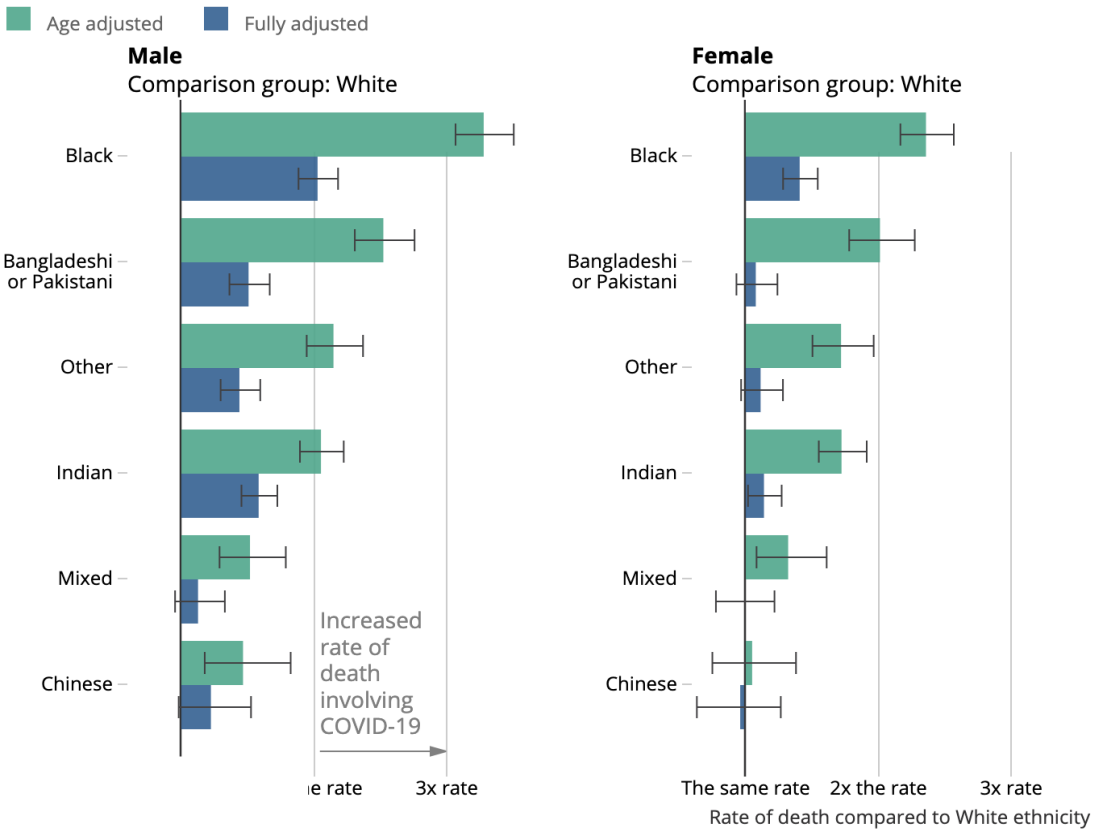
ONS

COVID-19 Ethnicity death rates

Rate of COVID-19 death by ethnic group and sex relative to the White population, England and Wales, 2 March to 15 May 2020

PHE's disparities report and other emerging evidence has also demonstrated a disproportionate impact on BAME communities:

- Critical care admission was 28% more likely in South Asian and 36% more likely in Black ethnic groups, compared to the White group (after taking into account age, sex, location, deprivation and comorbidities)
- Risk of death was between 10-50% higher amongst BAME communities compared to people of White British ethnicity after accounting for the effect of age, sex, age, deprivation and region



Ethnicity

All positive cases with specimen dates up to 19 September 2020

Number of people tested under Pillar 1 and 2, and percentage (%) by ethnic group and week

Ethnic group	Week - number (%)					
	33	34	35	36	37	38
White	3,481 (54.5)	3,912 (61.0)	4,945 (65.5)	9,979 (68.3)	12,551 (69.1)	8,096 (71.0)
Indian (Asian or Asian British)	524 (8.2)	459 (7.2)	423 (5.6)	757 (5.2)	1,060 (5.8)	669 (5.9)
Pakistani (Asian or Asian British)	1,078 (16.9)	833 (13.0)	897 (11.9)	1,487 (10.2)	1,943 (10.7)	1,212 (10.6)
Other Asian / Asian British	451 (7.1)	343 (5.4)	370 (4.9)	763 (5.2)	918 (5.1)	531 (4.7)
Black / African / Caribbean / Black British	413 (6.5)	432 (6.7)	396 (5.2)	728 (5.0)	775 (4.3)	360 (3.2)
Mixed / Multiple ethnic groups	170 (2.7)	160 (2.5)	171 (2.3)	337 (2.3)	365 (2.0)	240 (2.1)
Other ethnic group	272 (4.3)	269 (4.2)	348 (4.6)	550 (3.8)	559 (3.1)	287 (2.5)

Cumulative number and rate of Pillar 1 and Pillar 2 COVID-19 cases (per 100,000) by ethnicity (n=**339,901**)*

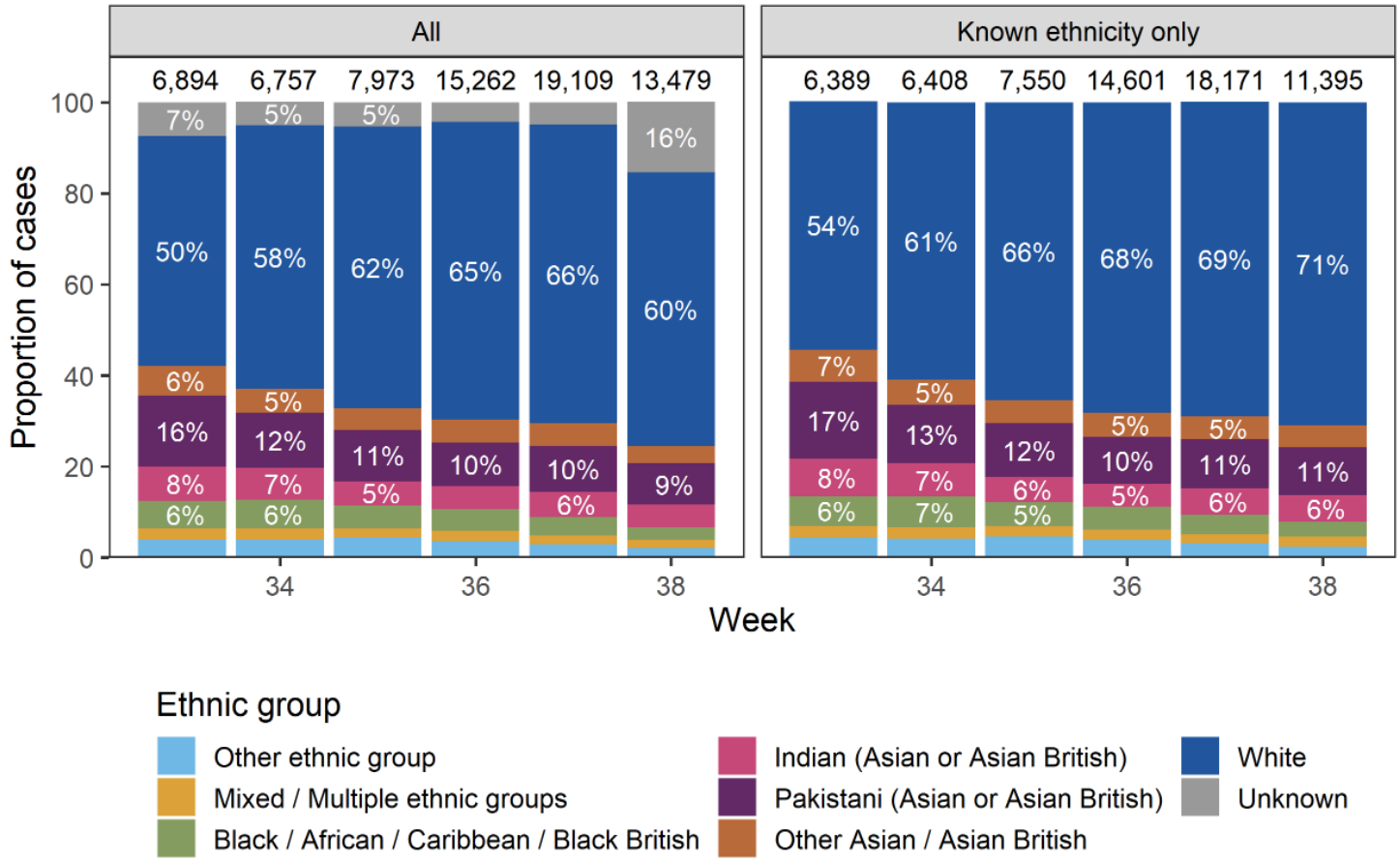
Ethnic group	Count	Population	Rate	95% CI
White	230,451	47,010,723.6	490.2	488.2- 492.2
Indian (Asian or Asian British)	15,596	1,532,380.8	1,017.8	1,002.0-1,033.8
Pakistani (Asian or Asian British)	19,380	1,303,426.3	1,486.9	1,466.2-1,507.8
Other Asian / Asian British	13,692	1,850,400.1	739.9	727.7- 752.4
Black / African / Caribbean / Black British	14,953	2,104,814.3	710.4	699.2- 721.9
Mixed / Multiple ethnic groups	4,701	1,550,543.4	303.2	294.7- 312.0
Other ethnic group	10,856	624,889.4	1,737.3	1,705.2-1,770.0
Unknown	30,272	-	-	-
Total	339,901			

Rates exclude **30,272** COVID-19 cases for whom ethnicity is to be confirmed

Data for ethnicity were available for **91.5%** Pillar 1 cases and **90.7%** Pillar 2 cases

Ethnicity cases by week

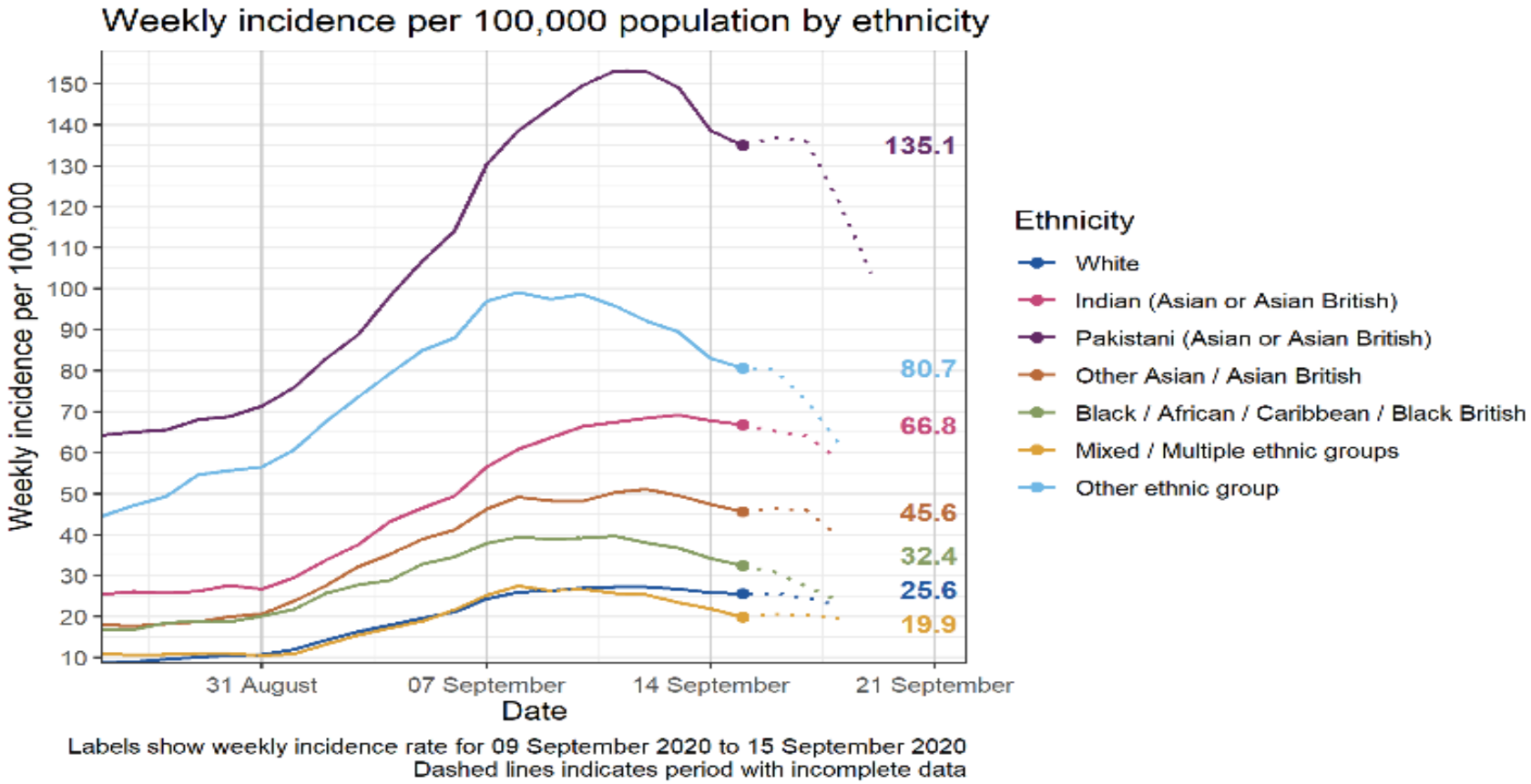
All positive cases with specimen dates up to 19 September 2020



Note: Partial data for latest week

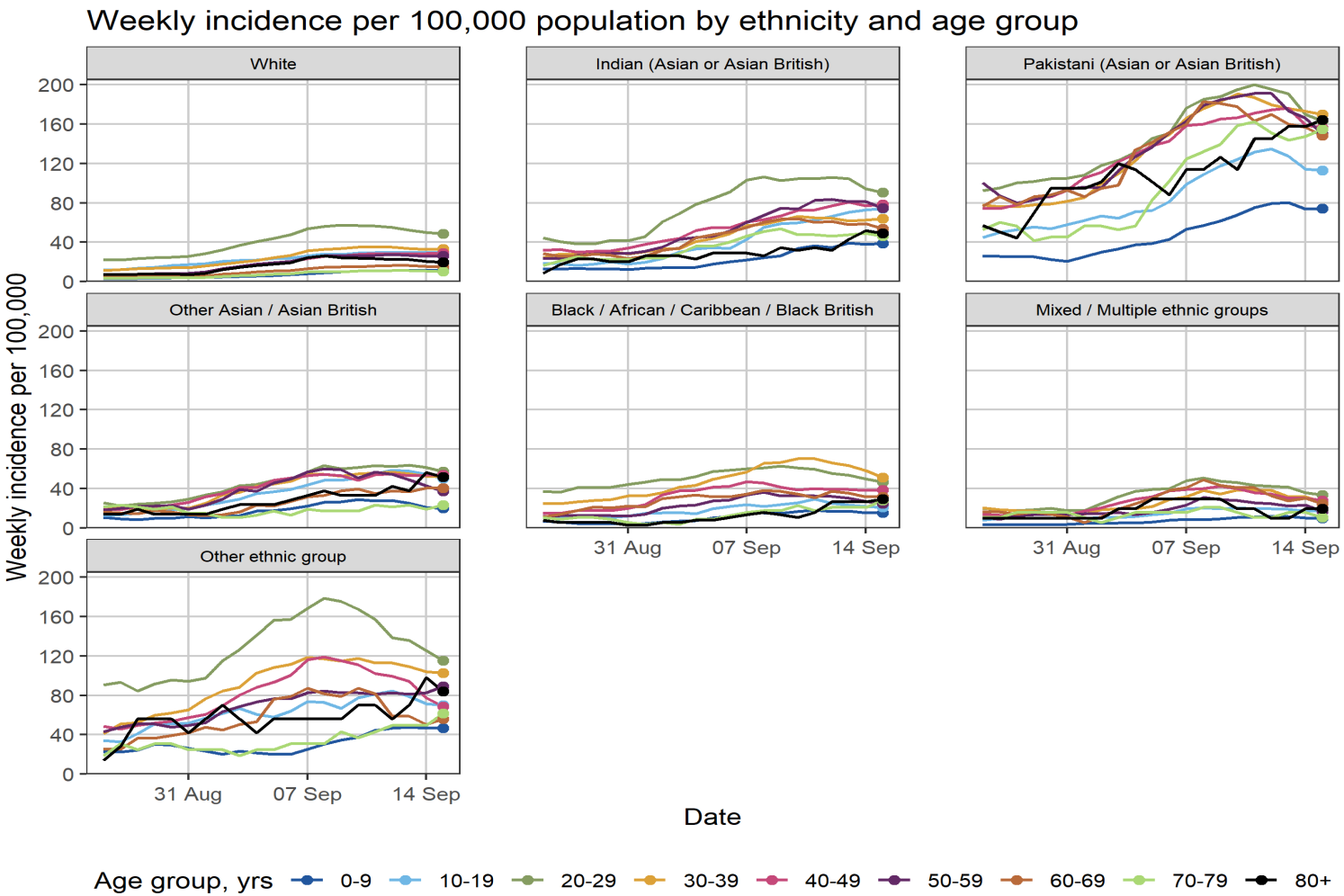
Ethnicity cases by week

All positive cases with specimen dates up to 19 September 2020



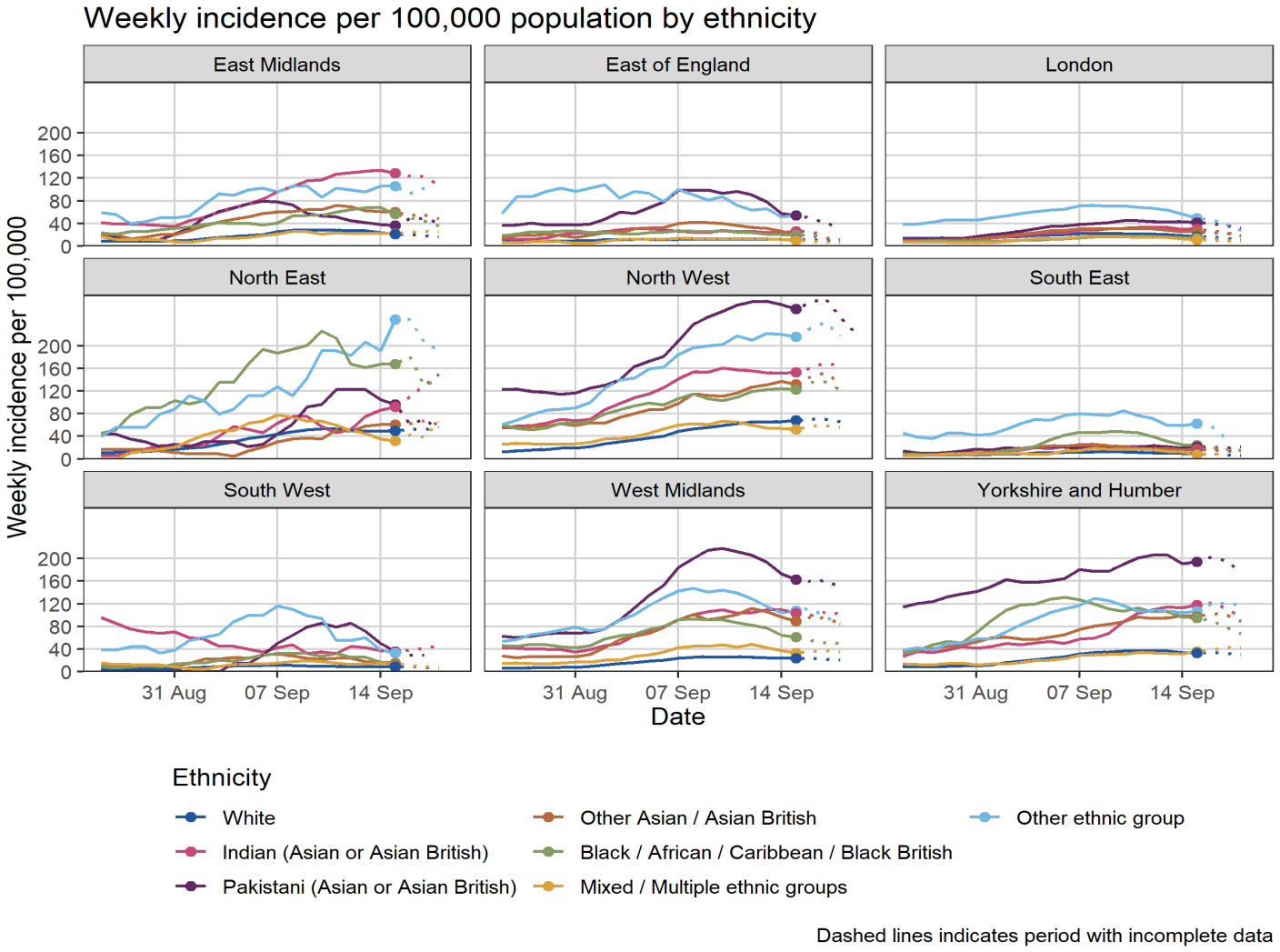
Ethnicity cases by week and by age group

All positive cases with specimen dates up to 19 September 2020

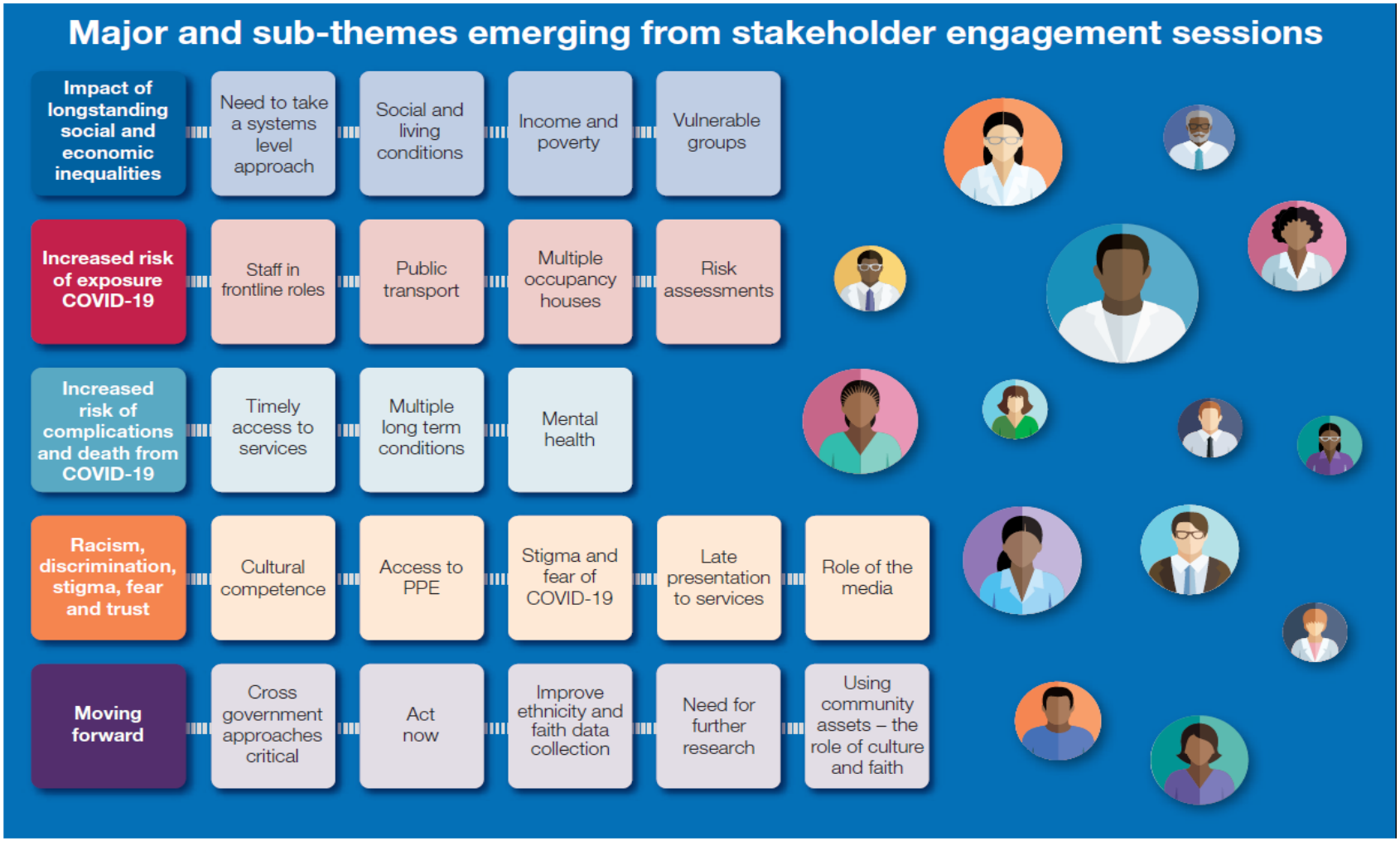


Ethnicity cases by week by region

All positive cases with specimen dates up to 19 September 2020



COVID-19 and BAME groups
Social, cultural and structural determinants



COVID-19: Understanding racism's impact

Stakeholders stressed that considering racism as causative is an important step in developing the COVID-19 research agenda and response from health services. It moves the discussion away from biological differences and access and towards prevention and the impact of societal structures on rates of illness.

The investigation of specific risk factors for COVID-19 in ethnic minority groups may be vital if we are to develop equity in efficacy of treatment. For example, is the higher likelihood of severe disease or poorer response to COVID-19 treatment in African-Caribbeans due to biology or is it a reflection of the role of perceived racism in its development and persistence?

Stakeholders felt that the investigation of racism's pathophysiological, cognitive, or psychophysiological correlates could offer new avenues for treatment and more efficacious management.

Developing a deeper understanding of possible links between racism and health should be seen as a prerequisite for initiatives to decrease impact at a community and individual level.

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Anti-racism in public health

What is anti-racism?

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.

What is anti-racism

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

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.

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Summary

Summary

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 will YOU do next?

1. Training

How do we advocate for the integration of race-conscious curricula in public health programs based on the social justice principles and history of public health? These curricula can include models, theories, and methodologies that explicitly recognise racial injustice as a threat to health.

2. Research

To advance our understanding and analysis of race, racism, and health, how might we advocate for more support of racism-related research? A racism-focused research agenda can include the collection and provision of the data necessary for developing and testing measures of racism, as well as delineating relevant pathways for health.

3. Community-Engaged Advocacy

As public health researchers and practitioners how can we more actively engage with BAME communities to deepen our understanding of the pervasive and complex ways that structural racism affects individual and community-level health?

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