Racism in health and health care in Europe: reality or mirage?

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Importance of racism in Europe—present and past

Racism is a belief that some races are superior to others, justifying actions that create inequality by favouring the supposedly superior groups. In practice, the definition of race is broadened to include ethnic, religious, and other similar groups, so discrimination on such grounds is also termed racism. Some people deny that racism is common in modern, industrialized, multi-ethnic societies. Wherever research is done, however, it shows racism is important. In a national representative survey in the 1990s by the UK Policy Studies Institute, for example, 20–26% of the White participants admitted in an interview to have prejudice against Asian, Caribbean or Muslim ethnic minorities. In fact, the figure is likely to be larger, for some people do not give publicly unacceptable answers in interview. It would be interesting to see comparable data from other European countries; the results would surely be equally or perhaps even more uncomfortable.

Among the many historical lessons Europe should never forget is the one from Nazi Germany. Hitler’s views were published in Mein Kampf (vol. 1 in 1925) to widespread acclaim and support, acting as an inspiration to much of the German public, and the medical professionals in particular. Silver’s review demonstrates the central role of the medical profession—the staunchest supporter of the Nazi regime—in issues important to ethnic minority groups, for example, eugenics and race medicine. The economic, social, scientific, and political circumstances that allowed Hitler’s policies to flourish could return. Eugenics is currently out of favour but its return is a likely outcome of the genetic revolution. Only open racism remains off-side in mainstream politics though there are signs that racism as a component of right-wing political policy is making a comeback.

A rapid rise in ethnic minority populations in European cities, easy international travel, increasing pressures of migration from developing countries, and a rise in the number of refugees are among factors likely to fuel racism in health and welfare services in the twenty-first century Europe, so it is time to take it seriously.

Racism in service delivery, ethnocentrism, and equity

The causes of the inequalities in health status and quality of health care that are so easily demonstrable by race and ethnicity are complex and difficult to disentangle. One of the most contentious factors underlying such inequalities is racism. It is by no means the sole or even dominant cause, but it has special social, political, and scientific significance. Inequality is a value-laden issue, one that is undesirable in modern, democratic, and, ostensibly, egalitarian states.

Most research and commentary in relation to health, health care and racism is in the USA, and much of the work in Europe comes from the UK. Paradies reviewed 138 empirical population based studies of self-reported racism and health, finding 12 in Europe and 118 in the USA. He found overwhelming evidence of a strong and positive association between racism and poor health, particularly in the mental health field.

Some lessons could usefully be derived from the USA, where the experience is extensive. For example, Afro-American men live 7–8 years less on an average than White American men. The deficit arises from excess mortality due to several causes, particularly from chronic diseases such as coronary heart disease (CHD) and stroke, which is partly explained by income differentials. African-Americans receive less health care, especially for high technology procedures than White Americans. The USA experience over the twentieth century, which has seen widening rather than narrowing inequalities, teaches us that racial and ethnic inequalities may worsen even as they are studied and even though they are socially and politically deplored. Despite much research there is no consensus on the causes of Black/White health disparities in health status and health in the USA, but racism is one of the proposed explanations. Naturally, this explanation is highly controversial in the USA as it would be in Europe.

Two major European reports have just been released raising major concerns about continuing discrimination and inequality in services, including health care. One report from the UK is called Fairness and Freedom (www.thequalitiesreview.org.uk/publications/interim_report.aspx), and the other one from Sweden is called Discrimination-A Threat to Public Health (www.fhi.se/shop/material_pdf/r200622_diskrimination_eng.pdf). The similarity in the tenor of the two reports is striking. They leave little doubt that Europe’s health and other services, despite their excellent policies and intentions, have a great deal of work to do.

In Europe, racial discrimination in the fields of employment (including health services) is, relatively speaking, clearly documented and, anecdotally, accepted as a reality. Minority groups generally, but not always (particularly in the period after immigration when there may be a healthy migrant effect), have worse health than the ethnic majority. Almost invariably, however, they have lower quality of health care, that is less likely to meet their needs, sometimes in the face of higher utilisation rates.

One topic that features in mainland Europe is the health and health care of the Roma (Gypsy Travellers), which is a concern. There are some studies examining equity and health care utilisation.
Mostly, they show a high level of need, a high level of utilisation of primary care facilities, comparatively low level use of other health care and social services, and suggestions that there is inequality in the quality of service. Surveys of health professionals indicate a lack of confidence and skills in meeting the needs of ethnic minority groups.

There is awareness of continuing prejudice against, and stereotyping of, ethnic minority populations within European nations. The book *Racism in Medicine* provides evidence, particularly in relation to equal opportunities, that racism in medicine matters. Research has demonstrated that the race or ethnicity of people, even the name, and not the place of graduation or qualification, was a key factor in obtaining entry to medical school and subsequent employment opportunities. Health and other services may offer a poorer result to ethnic minority groups for the following broad reasons:

(i) An individual member of staff treats the patient badly because of racial prejudice, or employment practices applied in shortlisting or interview are discriminatory. This is an example of direct racism, which occurs where people are treated less favourably because of their race, ethnicity, religion etc. Most people equate racism with this type of action and in modern societies such racism is both abhorred and illegal (although persistent).

(ii) The policies of the service are based on the needs of the ethnic majority population and not those of the minority populations, thus creating inequity. The special resources required to meet the needs of minority groups simply do not exist even though they are recognized by policy-makers. These are examples of indirect racism where services are provided, on the face of it equally to all people. The form in which they are being provided, however, favours particular groups at the expense of others.

The concept of institutional racism further develops indirect racism as applied to organizations. Institutional racism is defined in the Macpherson report as:

The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes, and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantage minority ethnic people.

Macpherson (1999: para 6.34, p8) An example of institutional racism would be the failure of the health care system to make accurate diagnoses because it fails to provide the training and interpreting facilities to achieve communications for an accurate medical history. Sceptics may wonder why such practices are wrong, and argue that failing to learn to communicate is a problem for the minority populations, not for the service. While counter-arguments are usually couched in terms of social justice, morality, ethics (particularly beneficence), and rights, increasingly the argument is being made on good business practice, that is, meeting the needs of the patient in an efficient and effective way.

Using race and ethnicity to combat racism and achieve equity

Race and ethnicity serve important functions, including the development of identity, belonging, and social relations. Trying to remove race and ethnicity from the social mindset is both impossible and self-defeating. A denial of difference is not the solution, mainly because the social and service norms and policies are based on the needs of the White European population. The resulting ethnocentric (Eurocentric) approach can be tackled only after an analysis based on examination of similarities and differences. We need a governing principle to help us interpret and utilise this analysis and this principle is equity.

An equitable service would meet equal needs equally, but this requires a diversity in the organization of services, to ensure uniformity in access, use, and quality at the point of delivery. A service where everyone got exactly the same would not suffice. There will sometimes be extra costs and more efforts required to achieve equity. Savings will also be possible, for example, women in several ethnic minority groups are comparatively less likely to smoke cigarettes and to drink alcohol heavily.

Training for staff is needed on the issue of ethnicity and health, including population size and structure; living circumstances and lifestyles; languages spoken and read; religions both in terms of their tenets and as practised; and the implications of all these for modification of care. Equal opportunity policies will have to result in sufficient employment of minority ethnic people within the workforce to act as role models and give all staff insights to serve ethnic minority populations. This may require proactive recruitment of staff with particular language skills or cultural understanding.

The example of Scotland—a late starter, making rapid progress in the context of social justice in the UK

In the UK, as in most of mainland Europe, the focus in the area of race, ethnicity and health has been on immigrants and their descendants. Each group of immigrants, whether Irish, Jewish, or Indian, has been accused of raising the risk to the wider society from infectious diseases and environmental hazards. Since the 1970s the potential value of studying variations in disease patterns epidemiologically has increased attention on ethnic minority groups. The 1990s and early twenty-first century have seen the rise of a social justice agenda accompanied by powerful legislation to promote equality in the UK’s multi-ethnic society. Health inequalities are a priority for the health service in Scotland, as in Europe as a whole.

Race equality in Scotland is not an isolated issue. It cannot be swept away without dismantling the entire edifice of equality because it is integral to it. Some of the many other strategies for equality in NHS Scotland include: The Sex Discrimination Act (1975), The Human Rights Act (1998), The Spiritual Care Policy in Health Department Letter (2002) and The NHS Reform Bill (2004). The 1976 Race Relations Act with the 2000 Amendment intends to remove all racial discrimination, direct or indirect, in the UK. All public organizations, including the NHS, have a statutory general duty to work to eliminate unlawful racial discrimination, and to promote equal opportunities and good race relations. The scheme publicly shows that a health organization is executing the duty. A Scottish Executive policy document called Our National Health (1999) laid down NHS Scotland’s commitment to ensure that‘NHS staff are professionally and culturally equipped to meet the distinctive needs of people and family groups from ethnic minority communities’. A culturally competent service was defined as a service which recognizes and meets the diverse needs of people of different cultural backgrounds. The Scottish Executive commissioned an assessment of ethnic health policies of the 15 National Health Service Boards that are responsible for the delivery of health care to the Scottish population. This led to a comprehensive policy, issued in the form of a Health Department Letter...
Racial discrimination is a sensitive and difficult topic. The lack of systematic evidence of racism in many European countries leads to an automatic assumption that racism does not play a role in society. Where evidence exists, there is reluctance to acknowledge the reality of discrimination.

Bhopal touched on this sensitive topic and emphasised that if discrimination is left unchecked, the economic, social, scientific and political circumstances that allowed Hitler's policies to flourish could return.1 To most well-meaning people in Europe, the notion of history repeating itself will make very uncomfortable reading. However, recent experiences, including the Srebrenica massacre, the increasing popularity of the right-wing political parties exacerbated by islamophobia, and the social tensions in a number of European countries clearly support this depressing notion.

Racism in health and health care
Inequalities in health and health care of ethnic minority groups are evident in many countries. These inequalities are the result of a complex, inextricably linked set of factors, of which racism might be one of the elements. Indeed, evidence suggests that experiences of racial harassment and discrimination is central to the lives of many minority groups and these contribute to ethnic inequities in health.2

Tackling the issue of racism in health is often fraught with difficulties. It becomes unthinkable by health professionals that such an ugly word could be directed at the very professionals that should be protecting equality in health. However, histories such as the notorious Tuskegee Syphilis Study, where many African-Americans with syphilis were deliberately denied treatment, illustrate that health professionals are not immune to racism. (http://www.infoplease.com/spot/bhtuskegee1.html)