INSTITUTE of HEALTH EQUITY

STRUCTURAL RACISM, ETHNICITY AND HEALTH INEQUALITIES IN LONDON

Executive summary

CONTENTS

ACKNOWLEDGEMENTS 3

FOREWORD 5

INTRODUCTION 6
Overview 6
Purpose of the review 6
How racism in London is already being tackled 6
Terms, data and evidence 7

RACISM AND DIRECT HEALTH IMPACTS 8

RACISM AND ETHNIC INEQUALITIES IN THE SOCIAL DETERMINANTS OF HEALTH 8
Give every child the best start in life and enable all children, young people and adults to maximise their capabilities and have control over their lives 9
Create fair employment and good work for all 10
Ensure a healthy standard of living for all 11
Create and develop health and sustainable places and communities 12
Strengthen the role and impact of ill health prevention 13

RACISM AND ETHNIC INEQUALITIES IN HEALTH AND SOCIAL CARE 14
Racism and medical practice, technologies and research 14
Racism experienced by healthcare service employees 14

RACISM AND ETHNIC INEQUALITIES IN HEALTH 14
Ethnic inequalities and ill health 14
Ethnicity and risk of disease 18
Maternal and infant health 18
Mental health 19

CONCLUSIONS 20

RECOMMENDATIONS 21

REFERENCES 26

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FOREWORD

What kind of society do we want? That is the question to which this report provides important answers. The question was given new urgency in Britain, this summer of 2024, by the most appalling outbreak of racist-fuelled violence. Our answer is clear: we want a society where all its members, whatever their ethnic background and country of origin, have the conditions, the freedoms, to lead lives they have reason to value. One way we will know that is happening is all groups in society having the conditions for good health. It is those conditions for good health – the social determinants of health – that are the focus of this report.

The UK is remarkably diverse – London, the focus of this report even more so. London, as a great world city, has attracted people from all over the world to make lives here for themselves and their offspring and to contribute to the economy, culture and dynamism of London and the UK. It is a profound injustice if conditions for good health are unequally distributed, depending on ethnicity. Especially so, if that unequal distribution results from the evils of racism.

The UCL Institute of Health Equity (IHE) was funded by the Greater London Authority (GLA) to write this report. The IHE's modus operandi is to review evidence, synthesise it and make recommendations. It is a careful deliberative process. That process has been applied here – hence the lengthy report that follows from this Foreword. But racism, and its ill-effects, the damage it does to people's lives and hence their health, has leant an urgency to our deliberations. As has the testimony of those who have born its brunt. Racism is a scar on society. Social justice requires that we take the action necessary to deal with it and with its underlying causes.

In the IHE's previous reports, for example the 2010 *Marmot Review, Fair Society, Healthy Lives* and the 2020 *Marmot Review: 10 Years On*, there was a clear focus on socioeconomic inequalities in the social determinants of health. One approach to ethnic inequalities in health would be to continue that approach and reduce socioeconomic inequalities in the conditions of life. To the extent, that particular ethnic groups had high levels of socioeconomic disadvantage, that would provide welcome benefits.

There are limitations to this approach. First it fails to address the question of why some ethnic groups are more likely to be in poverty, experience poor housing, suffer in the educational and criminal justice system, be low paid and experience racism and its effects in the labour market. Second, it fails to address the question of how racism directly damages health and well-being. Third, it does not deal with racism that limits access to health and other services. Fourth, there are the impacts of intersectionality. Being poor, Black, disabled, of particular gender, faith or sexual orientation, may be worse for health than being only one of those alone.

For all these reasons we gladly accepted the invitation from authorities in London to conduct this review and make recommendations for decision-makers and stakeholders across London. The fact that London wanted this report reflects the commitment, leadership and ambition to root out racism and prevent its health consequences, building on longstanding efforts. Indeed, we report on many welcome programmes, interventions and approaches in London on which future actions can build. We know that racism is a challenge that transcends boundaries and borders, and whilst this report is for London, we hope that it will have wider impact across the UK. Indeed, much of the data that we cite is for the UK as well as London.

Racism has deep historical roots; it is pervasive; and it is embedded in the structures of society. However, we now find ourselves at a pertinent point in history for our society. When we look back at this time, we hope it will be seen as the moment when London, and the nation, woke up to the scale of inequality – a moment when we decided the future would be different.

In this report, we make recommendations to bolster meaningful change in institutions. In our view it is an important step in removing the scourge of racism from our society and improving health for all.

Michael Marmot and Habib Naqvi (Co-Chairs)

INTRODUCTION

OVERVIEW

Racism in the capital is widespread and persistent, causing damage to individuals, communities and society as a whole. Its impacts are experienced in different ways and to varying levels of intensity related to individual experiences, socioeconomic position and other dimensions of exclusion such as disability, age and gender. The intersections with other dimensions of exclusion can amplify the effects of racism.

Our focus is on the effects of racism on health and its contribution to avoidable inequalities in health between ethnic groups – a particularly unacceptable form of health inequity. It is urgent that society tackle the damage to health and wellbeing as a result of racism.

Structural racism, the subject of this review, is racism which is embedded and normalised in societal norms, cultures, laws, and institutions, affecting the whole population and with origins in longstanding historical processes. Structural racism leads to and reflects other expressions of racism, including institutional and interpersonal racism. This review recognises the interconnections between all these forms of racism.

Repeated exposure to racism leads to an accumulation of disadvantage and poorer health over the life course. (1) (2) (3) (4) Racism affects health in three, interrelated ways. Firstly, experiencing racism directly damages physical and mental health. Secondly, racism may be a cause of socioeconomic disadvantage and adverse exposure to the social determinants of health which undermine health. Thirdly, racism damages health through the operation of the health care system and other services.

The welcome acknowledgement in London of structural racism and its effects has been accompanied by leadership and steps taken to address these ill-effects. More can be done. Much more. Racism is an unacceptable stain on society. Correcting it is a matter of social justice.

PURPOSE OF THE REVIEW

The review is intended to support and encourage efforts to tackle racism and its impacts from a public health perspective, but the breadth of the social determinants of health means that recommendations are for the many sectors and stakeholders in London that have potential to combat racism and its impacts. These include, among others, the GLA, London Councils, the healthcare and social care system, public health, the criminal justice system, education and other public services, employers, legislators and regulators and funders and research bodies.

While many of the recommendations propose actions for organisations to help them tackle institutional racism, there is a need to tackle the structural drivers of health: the inequitable political, economic, legal and cultural systems that facilitate and enable institutional and interpersonal racism. The recommendations include specific recommendations to strengthen regulation and legal mechanisms to challenge and prevent racism. The report does not focus on interpersonal racism except where it manifests in institutions: for instance, emanating from service providers or employers. Interpersonal racism is closely related to structural and institutional racism, so changes in these realms should impact on racism between individuals. Strengthened accountability and sanction for individuals who are racist and discriminatory, as well as for organisations that are at fault, are certainly needed.

HOW RACISM IN LONDON IS ALREADY BEING TACKLED

There are many ongoing and developing programmes which have been set up to tackle racism in London and in some arenas there is strong antiracism leadership including from the Mayor, local government and some employers, healthcare and other service providers and community organisations and leaders, providing evidence of what is possible and encouragement for other organisations to go further. It is too early yet to see the impacts of all these efforts, but leadership, visibility and representation and drawing critical attention to racism matter.

The main report includes a section overviewing leadership and action on antiracism across London and also includes many case study examples of antiracism programmes developed by a range of organisations and services. Despite these impressive efforts racism in many arenas of life persists and continues to damage the lives and health of many

Londoners. In the report we set out how legal and regulatory mechanisms must be strengthened to tackle racism and outline how organisations and policy makers can strengthen approaches to tackling racism. The new Government has committed to greater action and in the 2024 King's Speech proposed new legislation covering the right to equal pay and requirements for ethnic pay gap reporting and further reform of mental health services.

It is important to recognise and learn from the commitment and hard work of many in the voluntary and community sector - and particularly those in London's race equity sector – who have long highlighted and fought against racism and provided support for groups who experience racism in their daily lives. Often community organisations have led the development of antiracism approaches which are now being adopted in many sectors.

TERMS, DATA AND EVIDENCE

There is insufficient data and evidence about ethnicity in many important areas which limits our ability to report on ethnic inequalities in health and the social determinants of health and more broadly has hampered efforts to recognise and challenge racism. We therefore make recommendations for further research and information and to ensure communities with lived experience are at the heart of decision making and policy development and implementation. While there is a lack of data about experiences and impacts of racism and discrimination, there are many surveys, reports and accounts of racism. We include evidence presented in many of the existing analyses and campaigns for racial justice, particularly from community and voluntary sector organisations.

Experiences of racism and outcomes in health and the social determinants differ markedly by ethnic group in London and also within each ethnic group. In a report of this nature, it is not possible to describe every ethnic group's experience and nor is there sufficient data to do so. For example, the data shows Indian and Chinese groups have consistently high outcomes; however, within these ethnic groups there are many people who do not experience these advantages and within other ethnic groups there are also wide differences in experiences and outcomes. Services are often insufficiently sensitive to differences between and within ethnic minority groups.

Language matters – it relates to power relations and cultural attitudes and impacts communities in tangible ways. For instance, collective terminology leads to policies that do not take account of differing ethnic groups and their specific histories, experiences and outcomes. Language used to describe ethnic minority groups in the UK is contested and is not universally understood nor agreed and definitions change over time. We recognise the strong and sound arguments behind different uses of language in this important area.

The NHS Race and Health Observatory undertook a review of terminology about ethnicity in 2021. (19) Following consultation with stakeholders, its review concluded that there is no one term that is acceptable to all the diverse communities in England, and instead of recommending a particular term, recommended a set of principles: to be specific where possible, to not use acronyms, to specify context, to be transparent about language and to be adaptable as preferences and contexts change over time. (19) This review adopts these principles.

Increasingly organisations are using terms including 'minoritised groups', 'racially minoritised groups/communities', or 'Black, Asian and minoritised groups'. The word 'minoritised' reflects that individuals have been minoritised through social processes of power and domination, rather than just reflecting groups as numerical minorities. It also better reflects the fact that some ethnic groups that are minorities in London are majorities in the global population. While we are in agreement with the emphasis on minoritisation as an active process reflecting social constructs and power relations, this review, reflecting the RHO Review, uses the term 'ethnic minority' where we cannot be more specific. (19) The term minoritised is used in some of the case studies reflecting the organisations' preference.

The data is often summarised in five groupings: 'Black', 'White', 'Asian', 'Mixed' and 'Other'. Where possible the report uses more detailed classifications as broad ethnic categories can be misleading without further disaggregation. However, even these more detailed classifications are summary groupings and often mean that the experiences of particular ethnic groups are overlooked.

Migration policy shapes the health and social and economic conditions of those seeking asylum and heightens racism towards migrants and ethnic minority groups in London. The report highlights how recent hostile policies towards migrants and asylum seekers have made it almost impossible for asylum seekers to experience healthy living conditions or have access to essential services. (5) (6) The requirements for employers, service providers and landlords to check immigration status of applicants, and to be accountable for that, has led to further discrimination against legal migrants and British ethnic minority groups. (7)

RACISM AND DIRECT HEALTH IMPACTS

There is evidence that racism has direct and long-term impacts on mental and physical health. A 2022 study examined the accumulation of impacts over the life course and concluded that repeated exposure to racism leads to increasing disadvantage and poorer health outcomes throughout life. (8) (9) Direct health impacts include psychological distress, poorer self-rated health and hypertension and those who reported racial discrimination had, on average, poorer mental functioning scores four years later. (10) In particular, fear of experiencing racism, expressed through reporting feeling unsafe or avoiding spaces or places, had the biggest cumulative effect on the mental health of people from ethnic minority groups. Furthermore, exposure over the life course, together with having to remain vigilant and the anticipatory stress of possible future racist encounters, is likely to continue affecting the mental health of people from ethnic minority groups in the longer-term. (11)

RACISM AND ETHNIC INEQUALITIES IN THE SOCIAL DETERMINANTS OF HEALTH

Health is largely shaped by factors outside the health care system, the social determinants of health: the conditions in which people are born, grow, live, work and age, and the distribution of power, money and resources which shape the conditions of daily life. At every stage of life racism can affect the social determinants of health, harming health.

The report assesses ethnic inequalities and the impacts of racism in the social determinants of health organised through six policy objectives. In each of these areas we set out inequalities by ethnicity and the reports of racism that shape these inequalities and damage the lives of the many Londoners who experience them.

These policy objectives are based on our previous reviews of the evidence on the causes of health inequalities. (12) (13) They are:

1. **Give every child the best start in life**
2. **Enable all children, young people and adults to maximise their capabilities and have control over their lives**
3. **Create fair employment and good work for all**
4. **Ensure a healthy standard of living for all**
5. **Create and develop healthy and sustainable places and communities**
6. **Strengthen the role and impact of ill-health prevention**

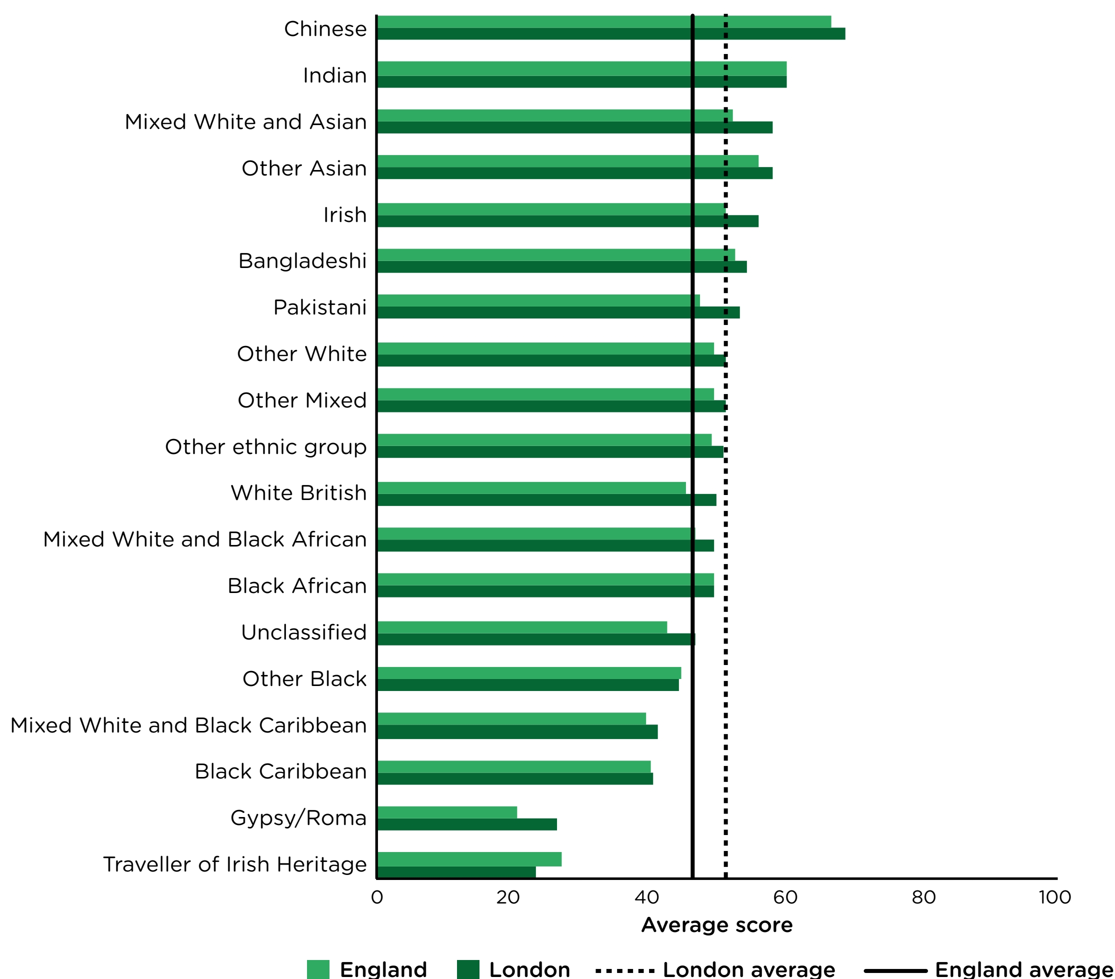
While we divide the report into thematic areas, based around the six policy objectives, it is important to take account of the cumulative impacts of racism throughout life: from inequalities in maternal and child health, in access to nurseries and family services in the early years, to experiences of racism in schools and the criminal justice system, wide inequalities in pay, progression and seniority and much higher rates of poverty, poor quality housing and likelihood of living in an area of high deprivation among many ethnic minority groups in London. Many people from ethnic minority groups have been particularly impacted by government policies of austerity and cuts to essential services and social protection.

GIVE EVERY CHILD THE BEST START IN LIFE AND ENABLE ALL CHILDREN, YOUNG PEOPLE AND ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THEIR LIVES

Children who grow up in poverty are less likely to live in decent housing, be able to eat nutritious food, or have places to play or even sleep, and their educational attainment is negatively affected. Across England and in London there are persistent inequalities in levels of development and educational attainment related to socioeconomic position. In London, there are slightly higher levels of child development at age five than in England as a whole, although young Black children in London have below average levels of good development in Reception year. This is a recurrent theme in London: many Black children have lower levels of attainment than White and Asian groups throughout education and there are many reports of racism within schools and the education system failing to effectively meet the needs of Black Caribbean, Black African and Gypsy, Roma and Travellers of Irish heritage students.

London continues to outperform the rest of England throughout school. At Key Stage 1, there are quite narrow ethnic inequalities in levels of attainment which widen after Key Stage 1 and by age 16, as measured by Attainment-8 scores, many young people in London from Gypsy/Roma and Traveller of Irish heritage, Mixed and Black Caribbean and Other Black backgrounds have Attainment-8 scores well below the England average (Figure 1).

Figure 1. Average Attainment 8 score by ethnic group, London and England, 2022/23



Source: *Department for Education (14)*
Note: *The maximum achievable Attainment 8 score is 90*

There are many reports of racism within schools, including from teaching staff towards pupils, and between pupils themselves. Racism in schools needs to be addressed with stronger and enforced accountability measures. Since 2012, schools have had no legal duty to report racist incidents to local authorities, unless the incident is a crime and there are accounts of racism going unchallenged and not sanctioned even when reported. (15) (16)

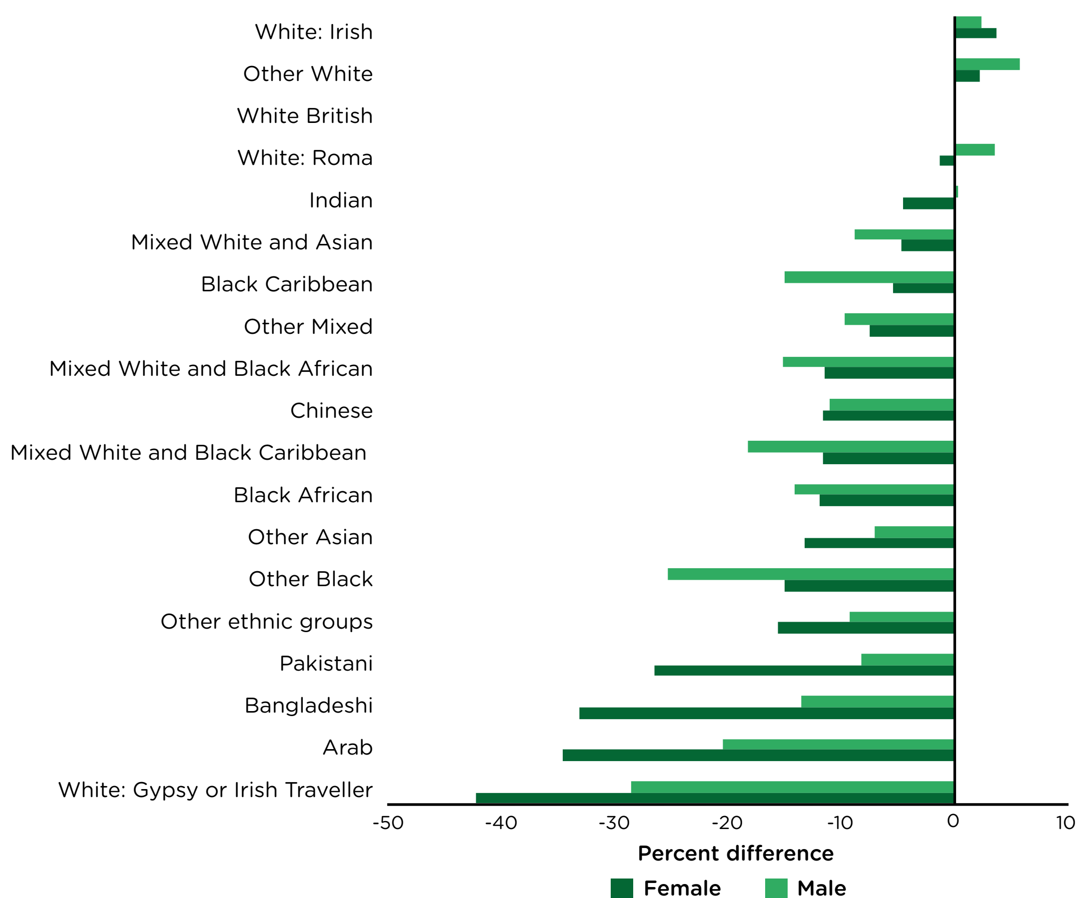
Negatively biased teacher expectations have been found to have a detrimental influence on student achievement, with students from low-income families and ethnic minority groups seemingly more susceptible to these effects. (17) A study in the UK examining teacher biases for seven-year-olds, found that all ethnic minority students are less likely to be judged 'above average' at reading than White students. (18) A 2019 study looking at maths set allocation in 46 secondary schools in England found that Black students were over 2.4 times more likely than White students to be misallocated to lower maths sets than their prior attainment would warrant and Asian students 1.65 times more likely. Conversely, White students were 2 times more likely than Black students to be misallocated to a higher set in maths, and 1.72 times more likely than Asian students. (19) There is some research into attainment levels among Black Caribbean pupils in schools in the UK which show that key factors in this are low teacher expectations, stereotyping, lack of curriculum relevance and institutional racism. (20) There are also clear ethnic inequalities in diagnoses of special educational need, school absences and exclusions in London and reports of racism driving these inequalities. (21) (22) (23) (24)

There have been significant improvements in rates of students from ethnic minority groups going on to tertiary education in London and the capital has the highest rates nationally of state school students entering higher education at 54.2 percent, compared with the national rate of 42.2 percent. However, racism has been identified as a problem in some of the more prestigious universities and studies show systematic bias towards applicants from ethnic minority groups. Some of London's tertiary educational institutions have recently established targets to reduce ethnic gaps in access and attainment through more inclusive practices.

CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

While ethnic inequalities in schools and further education are present in London, it is in accessing employment and levels of pay where ethnic inequalities become particularly starkly apparent and there are many accounts of racism affecting recruitment, progression and pay. Young Black people aged 16–24 have more than double the unemployment rate of young White people, the group with the lowest unemployment rate. (25) Inequalities in employment rates by ethnicity persist throughout working life, although there have been some improvements over time. The highest employment rates are for White people, except White Gypsy and Travellers, shown in Figure 2.

Figure 2 Difference in percent employed between each ethnic group and the White British group at ages 16 to 64, by sex, London, 2021

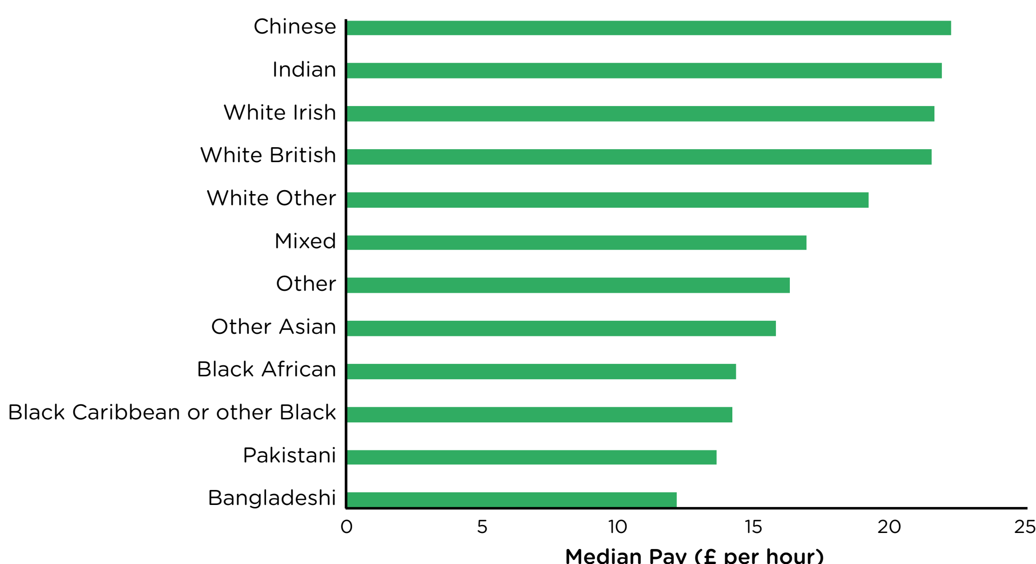


Source: *Census 2021 (26)*

There are many skills programmes in London which help to reduce ethnic inequalities in employment and these can help mitigate some of the impacts of racism among employers, but much more is needed to hold organisations to account when racism is reported. A 2022 TUC report that examined racism in the UK's labour market provides evidence of the scale of workplace racism and discrimination facing ethnic minority groups finding that 40 percent of ethnic minority workers had reported being affected by racism at work in the previous five years. (27) There are frequently reported accounts of racism towards employees in public services, including in healthcare and the police service. Employees in private sector organisations are less frequently asked about experiences of racism, but where this has been done there are also many accounts of racism. (28)

In 2022 the ONS reported that UK-born White employees earnt more than most ethnic minority employees even after holding personal and work characteristics constant, to provide a like-for-like comparison. (29) In London, data from the ONS's Labour Force Survey show that in 2022, Pakistani, Black African and Bangladeshi workers had the lowest rates of pay – approximately £10 per hour less than the highest earning groups which were Chinese, Indian, White Irish and White British ethnic groups, (Figure 3).

Figure 3. Median pay per hour by ethnic group, London, 2022



Source: *GLA (statistical analysis from ONS Labour Force Survey) (30)*

Analysis from the Living Wage Foundation shows that Pakistani and Bangladeshi workers in London are almost three times as likely to earn below the Real London Living Wage as White workers, while over 18 percent of Black people in London are not earning that wage, 10 percent more than White British people in London. (31)

There has been no mandatory requirement for employers to report on pay gaps by ethnicity although in 2024 the Labour Government introduced the Draft Equality (Race and Disability) Bill, which would enshrine in law the full right to equal pay for ethnic minority groups and disabled people and introduce mandatory pay gap reporting for these groups. (32)

As well as being more likely to be in low-paid work, ethnic minority groups in London are more likely to experience insecure work and less likely to be satisfied with their employment, all of which is harmful to health. (33) (34) Surveys of workers show that racism and discrimination play a role in lack of progression, with people reporting difficulty in accessing training opportunities and being passed over for promotion. (35)

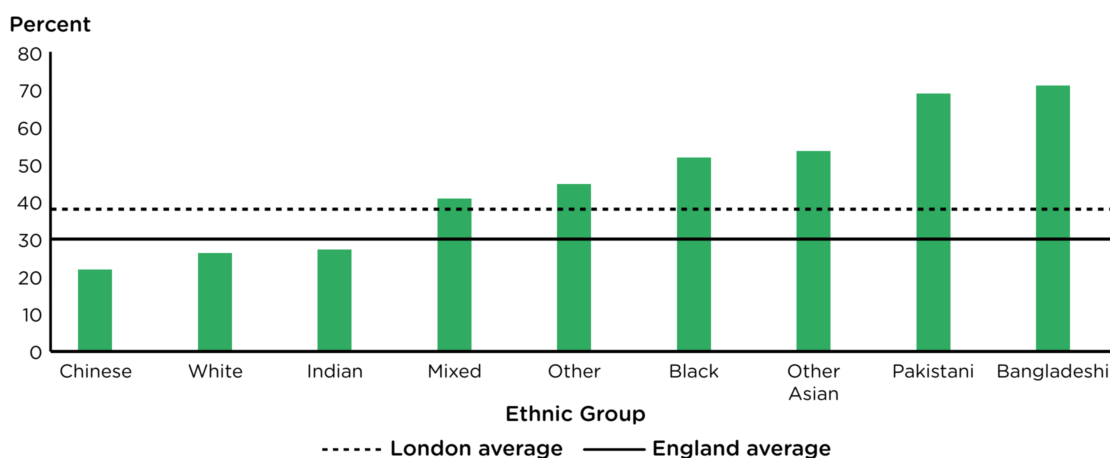
ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

One of the most important drivers of health and wellbeing is income. Racism and the resulting inequalities in policies and institutions that shape education, employment and income drive the disadvantage experienced by ethnic minority groups in London. Poverty is stressful: it reduces the 'mental bandwidth' available to deal with day-to-day challenges as well as causing material deprivation and poor health. There are persistent inequalities in rates of relative poverty by ethnicity in London. White households have the lowest rates of poverty after housing costs in London at 20 percent in

2017–20, whereas at the upper end of the scale, 59 percent of Bangladeshi and 53 percent of Pakistani households in London are living in poverty after housing costs. Out of all ethnic minority groups in London, Indian and Chinese people are the most likely to have higher socioeconomic position and more resources which in general can provide protection from some of the harmful impacts of racism and discrimination. (36) Although these socioeconomic protections do not extend to daily discrimination targeting those who simply do not look White.

Experiencing poverty as a child is particularly harmful to health and a range of other important social determinants of health, including education, employment and income throughout life. Nearly 70 percent of children from Bangladeshi and Pakistani groups in London live in low-income households after housing costs have been accounted for (see Figure 4). The lower level of child poverty among Indian, White and Chinese children contributes to advantages at subsequent stages of life, such as education and employment.

Figure 4. Percent of children living in low-income households (after housing costs) by ethnic group of head of household, London, 2017/18 to 2019/20



Source: *DWP (36)*
Note: *A household is in low income if they live on less than 60 percent of the UK's median income.*

As a result of lower pay and differences in home ownership rates, there are clear inequalities in wealth in Great Britain (ethnic wealth data is unavailable for London). Indian and White British households have the greatest wealth by some margin at more than £300,000 on average in 2018–20, while Black African and Bangladeshi households' level of wealth is under one-tenth of that amount. (37)

CREATE AND DEVELOP HEALTH AND SUSTAINABLE PLACES AND COMMUNITIES

Places characterised by good quality, affordable housing, access to green and other public spaces, clean air, affordable and active travel and community cohesion all support good health. Classifying people by where they live, according to these characteristics, shows there are inequalities in London related to ethnicity as well as socioeconomic position, disability and other dimensions of exclusion. Safety is a particular concern in London and there are marked inequalities by ethnicity in how people perceive their level of safety. (38)

A good quality, secure and affordable home is foundational to a healthy life. There are clear ethnic inequalities in terms of housing affordability, tenure, quality and risk of homelessness. Racism and discrimination are present in the London housing sector, with reports of racism directed at tenants from housing providers, including social housing and private landlords. (39) Regeneration and resultant increasing rents, house prices and retail prices, including food, have negatively impacted many people from ethnic minority groups in London, many of whom are forced to move as a result.

People from ethnic minority groups are also more likely to be a victim of crime, including violent crime, particularly Black people, who, in London since January 2020, have been 70 percent more likely than White people to be recorded as a victim of violence against the person, twice as likely to have been recorded as a victim of rape, and 66 percent more likely to have been recorded as a victim of domestic abuse. (40) Data from March 2023 show that Black people in London are nearly six times more likely than White people to be murdered. (40) There is a clear case for Black people to have significantly more protection from the police and for police forces to implement the many recommendations

made in successive reports to end racist practices. Alongside this, action is needed to address the social determinants of both crime and being a victim of crime – similar to our proposals for the social determinants of health.

The criminal justice system, which is meant to protect residents, is often seen as a source of violence and criminal behaviour by many ethnic minority groups following years of racism within the system. Compared with White people, those from Black groups in London are more likely to experience stop and search and arrest, as well as unfair and racist treatment from the Crown Prosecution Service, probation services and legal professions.

Fear of crime and of being subjected to racism keeps many Londoners from ethnic minority groups out of public spaces and contributes to unequal use of green spaces and physical activity, therefore lessening the potential health benefits of those activities. (41) (42)

STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

Health behaviours such as smoking, alcohol and physical inactivity cause disease and premature mortality; they are shaped by social determinants of health, including commercial, environmental and economic determinants. There are clear socioeconomic inequalities in smoking, obesity and physical activity and harm from alcohol. There are also some clear ethnic differences in health behaviours related to ethnicity.

After adjusting for age, White groups are the most likely to have ever smoked regularly while women of Indian, Pakistani, Bangladeshi and Black African origin are the least likely to have done so. (43) Smoking prevention services need to take into account socioeconomic position, gender, ethnicity and other drivers of smoking such as poor mental health.

In relation to alcohol, individuals from ethnic minority backgrounds are regularly reported to have higher rates of abstention from alcohol compared with their White British counterparts. However, some South Asian men have particularly high rates of mortality associated with alcohol misuse and comparatively less access to support, pointing to a lack of information and culturally relevant services. (44)

Accurate estimates of drug use by ethnicity rely on self-reported information and are therefore unreliable. Numerous studies show drug use spans all social classes and is also widely prevalent among wealthier groups, who are more likely than the less well-off to have consumed a Class A drug. There is strong and longstanding evidence of racism in drug law enforcement and Black people are much more likely to be stopped and searched for suspected drug possession and more likely to be sentenced for it than White people. Black people have the highest rate of arrests for drug possession and drug supply but have relatively low self-reported rates of drug use, according to the Crime Survey. (45)

Obesity, is a significant health risk and is associated with increased risk of diseases including diabetes, heart disease and some cancers and musculoskeletal conditions. (46) Diabetes death rates in England and Wales are significantly higher in every ethnic group except the White group. Obesity also has an impact on people's quality of life and mental wellbeing and is associated with anxiety and depression. (47) Among reception-age school pupils in England in 2021/22, severe obesity was most prevalent among 'any other Black background', Black African and Bangladeshi children. (48) Ethnic inequalities in obesity persist from childhood into adulthood, with the highest rates of overweight and obesity being among Black adults. (49) Asian and Black groups in London are most likely out of all ethnic groups to be physically inactive. (50) Classifications of overweight and obesity are often inappropriate for different ethnicities and questions about the appropriateness of these classifications for many ethnic minority groups need addressing.

RACISM AND ETHNIC INEQUALITIES IN HEALTH AND SOCIAL CARE

There are longstanding and significant concerns about ethnic inequalities in access to NHS services and experiences of discrimination and racism, particularly in maternity and mental health services. The NHS Race and Health Observatory has analysed evidence of ethnic inequalities in healthcare and the reasons for them. (51) Barriers to accessing NHS services for patients from ethnic minority groups include a lack of appropriate treatment for particular health issues; poor quality or discriminatory treatment from healthcare staff; a lack of appropriate interpreting services for people who do not speak English confidently; and delays in, or avoidance of, seeking help for health problems due to fear of racist treatment from NHS healthcare professionals.

Ensuring equitable access to healthcare must include dissemination of culturally appropriate information; the provision of timely, relevant and culturally sensitive services; and receiving a respectful and dignified experience in quality of care. (51) The NHS Race and Health Observatory sets out the importance of people working at all levels in the NHS being provided with support to understand ethnic health inequalities, their causes and the actions needed to address them. Diversity of leadership that enables ethnic minority representation is fundamental and equitable accountability mechanisms must be enforced. (52)

RACISM AND MEDICAL PRACTICE, TECHNOLOGIES AND RESEARCH

There is increasing evidence showing that some clinical standards and medical practice developed for White patients may not be appropriate and in fact harmful for some ethnic minority patients. For instance, the use of pulse oximeters, some neonatal assessments and dermatology diagnoses which are formulated on the basis of White skin are inappropriate for darker skin tones and have led to harm and misdiagnoses. (53) (54) Evidence also shows that there can be variations by ethnicity in response to medical treatments and medicines which have been overlooked. (55) (56) (57) Diseases which only or mostly affect specific minority groups in the UK, for instance Sickle Cell Disease are often poorly funded and there are many reports of racism which has led to poor and harmful medical practice. (58)

Medical research can exacerbate ethnic health inequalities and there is a lack of diversity in research which contributes to inappropriate and harmful medical practice. Reports also show that algorithms used in AI reflect and reinforce historical bias in medical practice and treatments. (59)

RACISM EXPERIENCED BY HEALTHCARE SERVICE EMPLOYEES

There are many reports of racism experienced by employees within health and social care, including from employers, other employees and the public which have not improved despite increasing awareness and reporting. There are a series of practical recommendations to address racism within health and social care employment, which have not been taken up at sufficient scale or speed. (60)

RACISM AND ETHNIC INEQUALITIES IN HEALTH

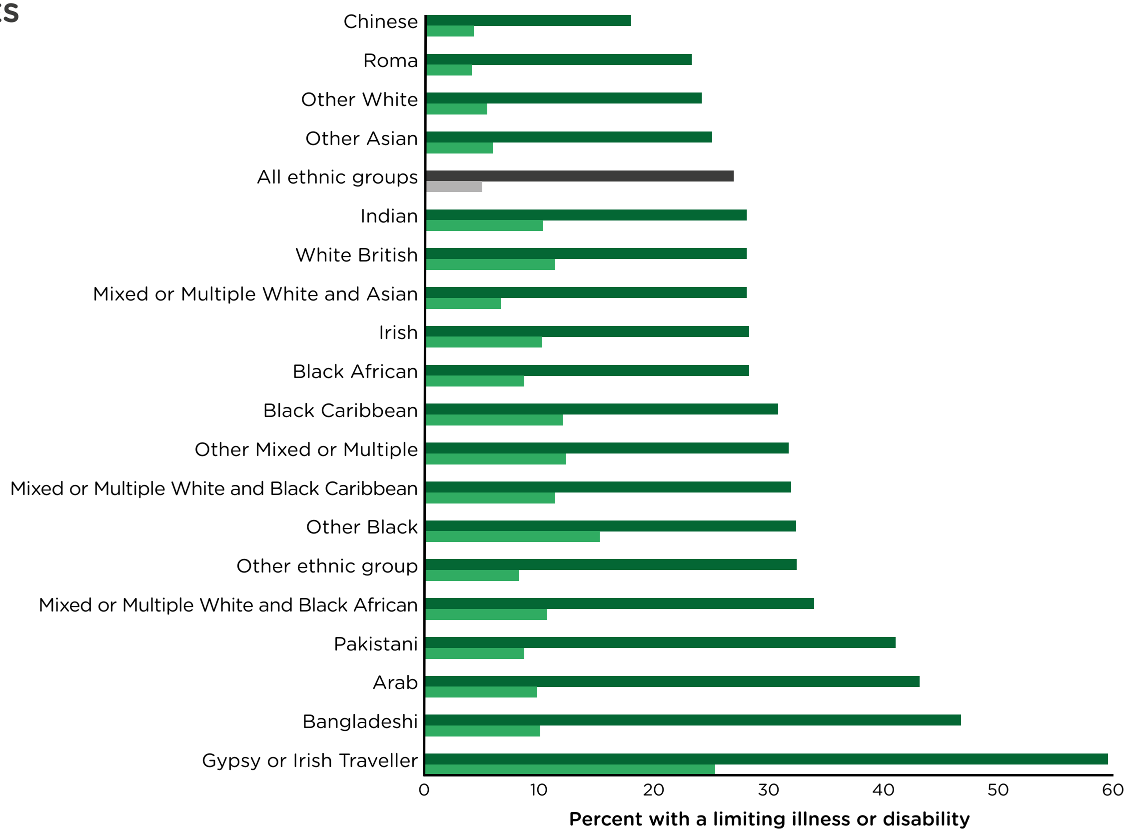
Across the UK, health is deteriorating and health inequalities widening. This is due in large part to worse outcomes and growing inequalities and in the social determinants of health, which have been damaged by government policies of austerity and associated cuts to services, local government, benefits and the public realm more broadly since 2010. Many ethnic minority groups experience the brunt of these cuts as they are disproportionately represented in lower-income groups and more deprived areas. That said, there is complexity in health by ethnicity related to duration of stay in the UK, age structure of different ethnic groups, immigration history and socioeconomic position, which impact on health and experiences of racism and discrimination. There is currently no published data on life expectancy by ethnicity that takes these factors into account and therefore the data and technical information is included in the main report as an appendix and does not form part of the analysis of ethnic inequalities in health.

ETHNIC INEQUALITIES AND ILL HEALTH

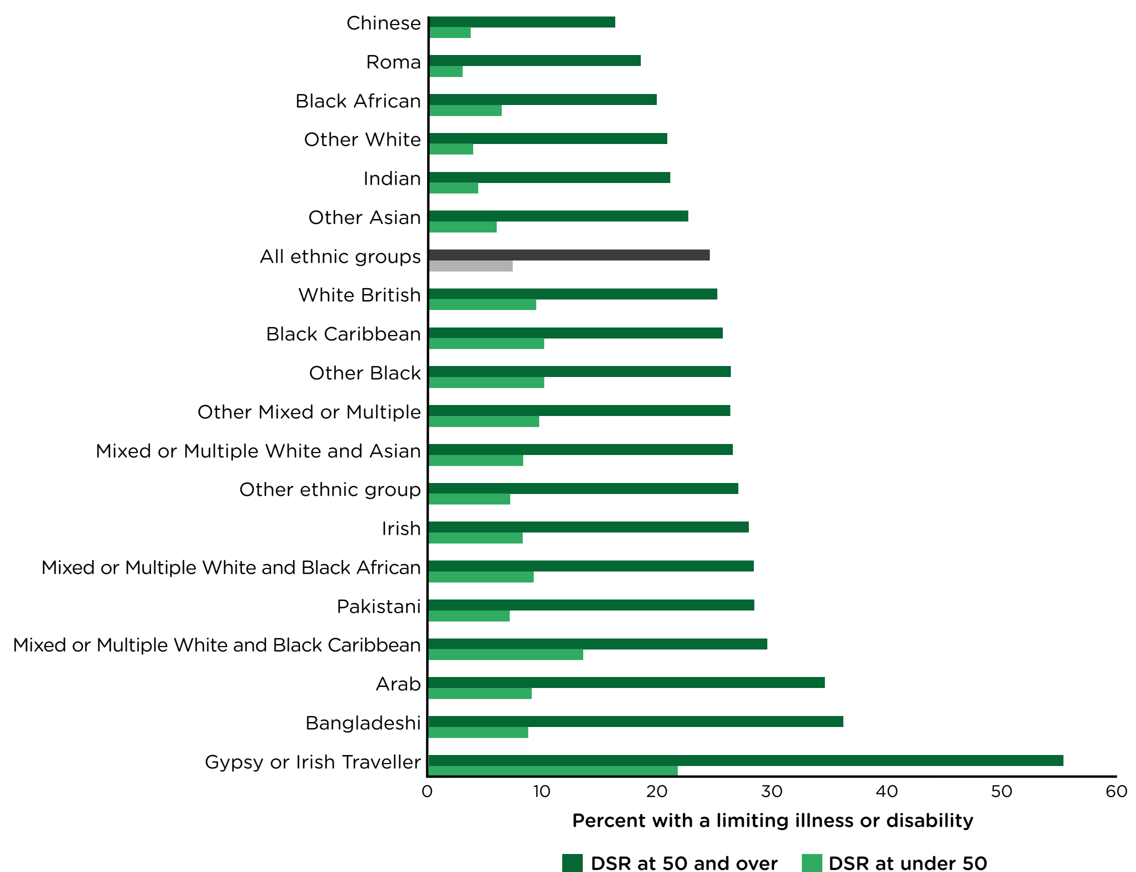
In London higher proportions of men and women from many ethnic minority groups report having a limiting illness or disability compared with White British groups, particularly among those aged over 50 (Figure 5). For both sexes, Gypsy or Irish Travellers, Bangladeshi, Arab and Pakistani and Mixed White and Black groups are most likely to report higher levels of ill health or disability than other groups at ages 50 and over.

Figure 5. Age-standardised percent reporting that they have a limiting illness or disability by broad age group and sex, London, Census 2021

(A) FEMALES



(B) MALES



DSR at 50 and over   DSR at under 50

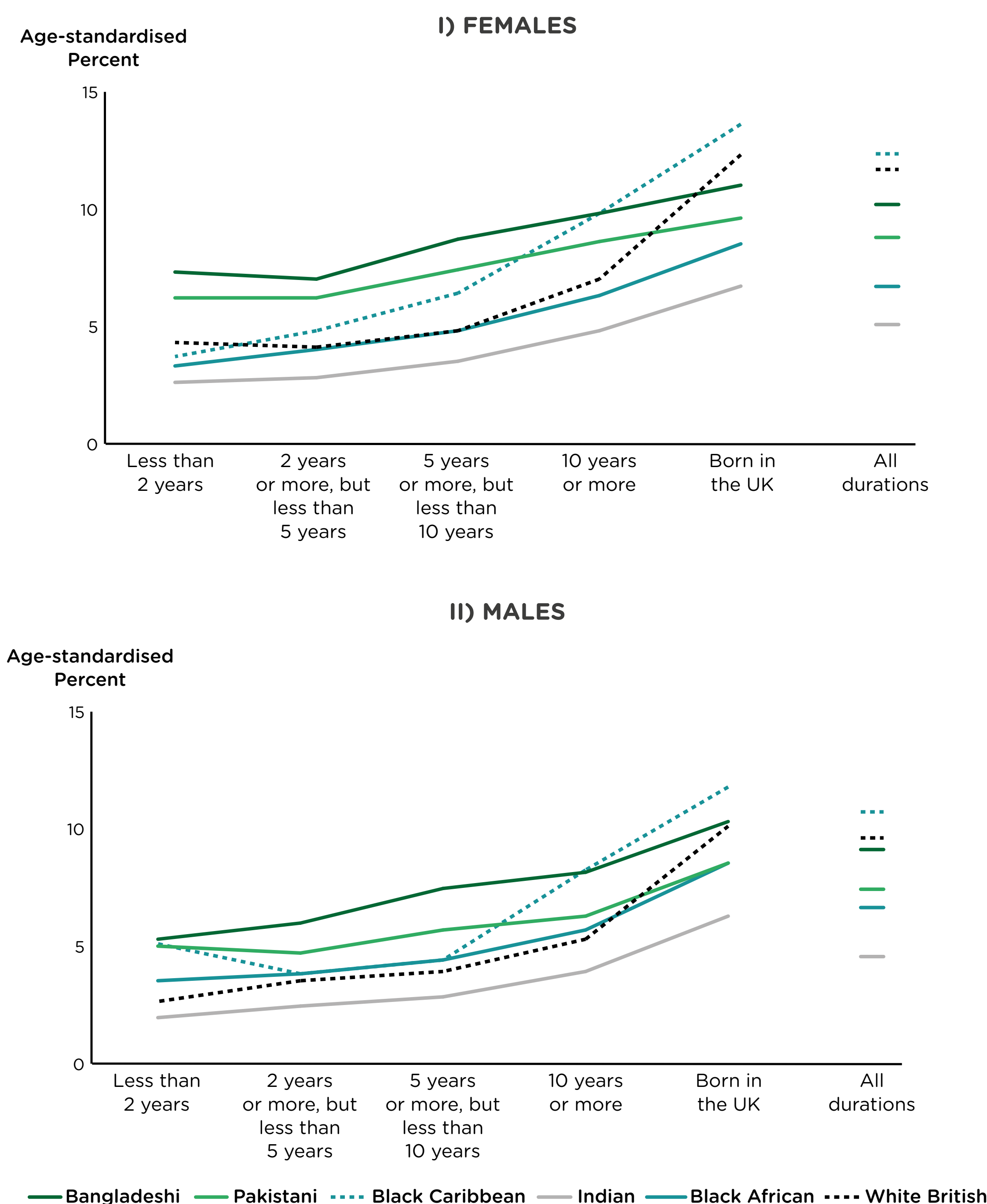
Source: *ONS (2023) (61)*

Note: *In this graph DSR is the directly age-standardised rate of reporting a limiting illness or disability, expressed as a percent of population*

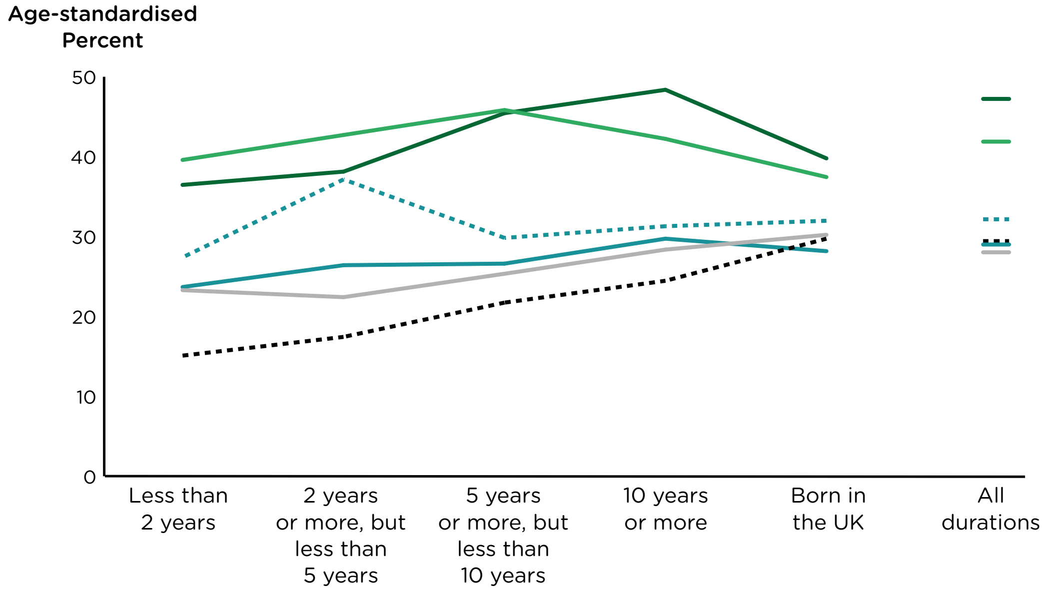
People from ethnic minority groups in London who were born in the UK experience worse health than those born overseas, as measured by rates of limiting long-term illness (Figure 6). Rates of poor health increase with increasing length of residence in the UK. The only exceptions are among Bangladeshi and Pakistani groups aged over 50. There are several plausible reasons for this. Firstly, greater exposure to racism and its impacts on the conditions of daily life lead to cumulative deteriorations in health, and the longer a person lives in London, outside their place of ethnic origin, the longer they have to potentially experience this (although White British groups born abroad and now living in the UK see similar deteriorations). Secondly, changes in UK immigration policy mean that increasingly, immigrants are highly educated and healthier than earlier waves of immigrants. Thirdly, there is a 'healthy migrant effect', whereby healthier people are more likely than those with pre-existing ill health to migrate in the first place, but this wears off over time as migrants develop health problems usual for their age group. Fourthly, living in the UK is bad for health. It may, of course, be that all four reasons play a role.

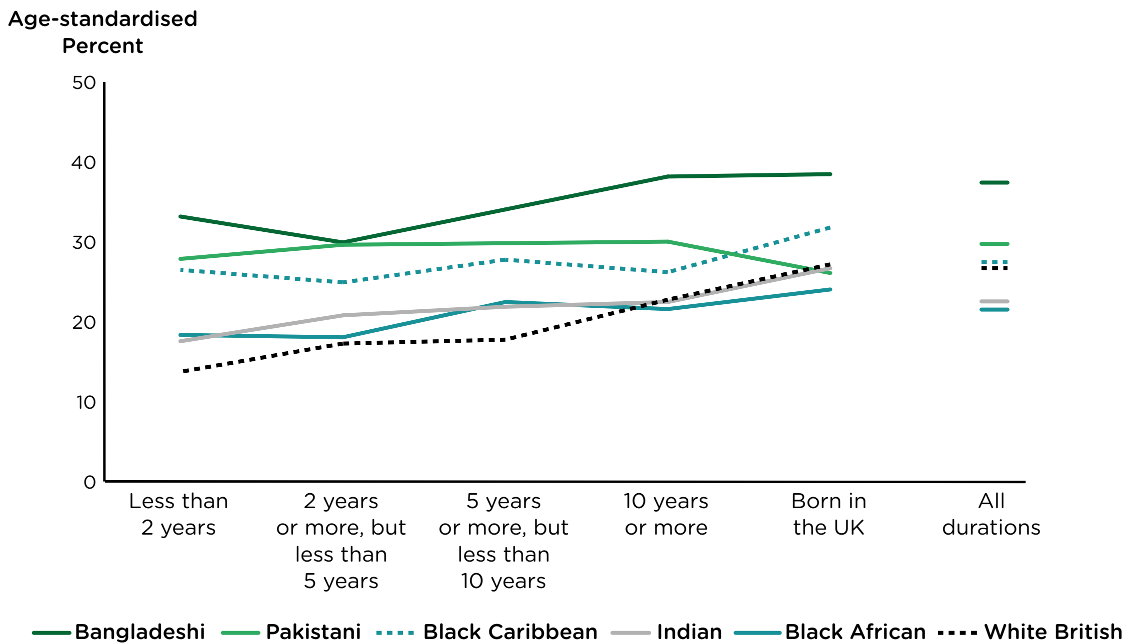
Figure 6. Age-standardised percent reporting that they have a limiting illness or disability by broad age group, sex, ethnic group, whether born in the UK and, if not, length of residence in the UK, London, Census 2021

A) AGE UNDER 50



B) AGE 50 AND OVER





Source: *ONS (2023) (61)*

ETHNICITY AND RISK OF DISEASE

There are several clear ethnic patterns in risk of disease and there is a need for NHS and public health professionals to be much more attuned to the differing health needs of different ethnicities. In particular, the risk and propensity for some specific diseases to vary by ethnicity as well as age and socioeconomic position. Of particular note, South Asian groups, including Bangladeshi, Indian and Pakistani groups, have higher mortality rates from ischaemic heart disease, cerebrovascular disease and higher prevalence of diabetes than those in White ethnic groups. Mortality rates for major cancers are highest among White British people in England due in part to higher rates of smoking, although Black men have high rates of mortality from prostate cancer.

Mortality rates from Covid-19 also showed clear ethnic as well as socioeconomic inequalities. (62) Evidence suggests some of these differences resulted from racism from healthcare services and also from poor outcomes in the social determinants of health. For instance, many ethnic minority groups were more likely to be living in overcrowded conditions, or working in frontline services, both of which were factors for raising the risk from Covid. (63) (64) (65) (66) (67) Reluctance to have the Covid vaccines also showed the lack of cultural relevance and mistrust many ethnic minority groups have towards the health care system and broader political leadership. (68) (69)

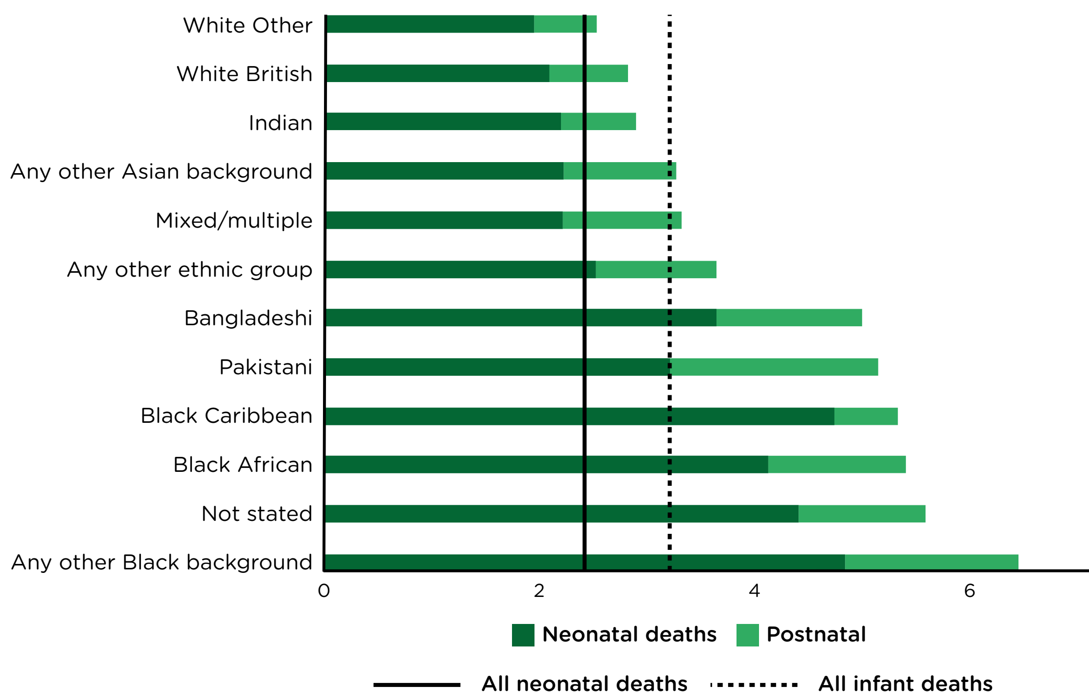
MATERNAL AND INFANT HEALTH

Maternal and infant health show particularly concerning ethnic inequalities which go well beyond what would be expected given relative levels of deprivation; there are many accounts of racism from service providers.

The 2024 *Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries* report found that Black women are almost three times more likely to die from pregnancy and childbearing-related complications than White women, while women from Asian ethnic backgrounds are almost two times more likely to die. (70)

As well as ethnic inequalities in maternal mortality, in 2020, rates of infant mortality were particularly high in England and Wales for many Black, Pakistani and Bangladeshi babies, Figure 7, while babies from Indian, White British and other White backgrounds have lower than average rates. These ethnic inequalities indicate issues with living and working conditions for pregnant women, maternal health, access to maternity and obstetric services and the appropriateness of those services.

Figure 7. Infant mortality rate per 1,000 live births by ethnic group and whether in the first 28 days or not, England and Wales, 2020



Source: *ONS (71)*

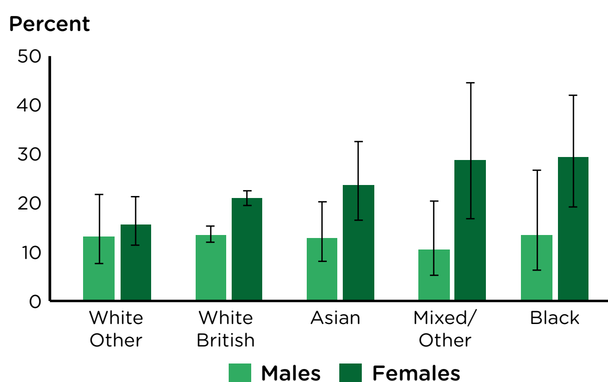
Note: *Neonatal deaths are those occurring during the first 28 completed days of life per 1,000 live births. Post-neonatal deaths are those occurring subsequently, in the first year of life.*

There is persisting evidence about barriers to access to maternity services and poor experiences of those services for many ethnic minority women in London and across the UK which contribute to wide inequalities in maternal and infant health and mortality. (72) (73) (74) These poor experiences include negative interactions, stereotyping, disrespect, discrimination and cultural insensitivity. (51) System-level factors, such as the lack of accessible and high-quality interpreting services, together with the attitudes, knowledge and behaviours of healthcare staff, contribute to ethnic minority women feeling disregarded and poorly cared-for. (75) (74) Over 42 percent of Black women surveyed about their experiences of maternity care in the UK reported feeling discriminated against during their maternity care, with one of the most common stated reasons being their ethnicity. (76)

MENTAL HEALTH

There are stark ethnic inequalities in diagnosed common mental disorders in England for women but not for men (Figure 8). Rates are higher for women than for men in all ethnic groups, and highest for Black and Mixed/Other groups and lowest among White British and White Other groups. In contrast to common disorders, severe mental illness diagnosis is particularly pronounced among Black men. (77)

Figure 3.8. Percent of adults who experienced a common mental disorder in the past week by sex and ethnic group, England, 2014



Source: *NHS Digital (78)*

Despite the incidence of mental health problems being reportedly higher in ethnic minority groups in England, rates of treatment and diagnosis have been higher among White groups, pointing to greater access to services for White groups than for ethnic minority groups.

Reports suggest that access to mental health services is also heavily impacted by racism, fears of being discriminated against, consequential distrust of care providers, and a lack of appropriate interpreting services, all of which deter help-seeking behaviour for mental health conditions. (51) Service users highlight in particular the lack of understanding of the lived experience of people during assessment and treatment and report a lack of cultural awareness, including a lack of understanding of religion, culture and individuals as parts of systems and families. (79)

CONCLUSIONS

We began the main report by recognising that racism in the capital is widespread and persistent, despite impressive antiracism leadership and programmes developed by some organisations in London. The report then sets out the many ways in which racism, often unacknowledged, damages individuals, groups and society. Our focus has been on the effects of racism on health and the social determinants of health and how racism contributes to avoidable inequalities in health between ethnic groups – a pattern that is quite unacceptable. It is urgent that society tackle the damage to health and wellbeing as a result of racism.

While there are many new and longstanding efforts to reduce racism in London the impacts of racism remain starkly evident, manifesting in ethnic inequalities in poverty rates, employment, pay, career progression, experiences and outcomes from the criminal justice system, housing and health care services; particularly maternity and mental health services. In all these areas there is weak, inconsistent or non-existent accountability and sanction for racism which enables racism to continue unchecked, harming the lives and health of people who experience it, and undermining trust in services, governance systems and weakening social cohesion.

While we divide the report into thematic, social determinants of health areas it is important to take account of the cumulative impacts of racism throughout life. At every stage of life and in all the key determinants of health we looked at there were reports of racism.

We highlight three interrelated ways in which racism negatively impacts physical and mental health that are often experienced simultaneously: Firstly, experiencing racism directly damages physical and mental health. Secondly, racism may be a cause of socioeconomic disadvantage and adverse exposure to the social determinants of health which undermine health. Thirdly, racism damages health through the operation of the health care system and other services. All are manifestations of structural racism which lead to institutional and interpersonal racism.

Several conclusions can be made from this review.

- First, racism in London is widespread and affects many ethnic minority groups in ways likely to damage health.
- Second, health and the social determinants of health show substantial variation among ethnic groups. To address the effects of racism on health, it is necessary to address all the key sectors that contribute to the 'social determinants of health' and health and social care.
- Third, the review shows the importance of intersectionality: poverty, disability, age, faith, gender and duration of living in the UK may all add to the effects of racism on health of certain ethnic groups.
- Fourth, we found that despite recent efforts there is potential for more systematic action to tackle racism within organisations and services, in recruitment, employment practices and in service design and delivery. The development of antiracism approaches by some organisations is promising.

Further, due to the significant differences in experiences and outcomes between ethnic groups there is strong empirical support for being specific about ethnicity and for the avoidance of the blanket term ethnic minority although we use the term when the sources we cite report the data that way.

In our research for this report we found many examples of organisations developing practices and interventions to end racism and reduce ethnic inequalities, some of these are included as case studies through the report. These include actions from businesses, the healthcare system, public health, education and other public services, the community and voluntary sector and London boroughs. The Greater London Authority has developed new approaches in collaboration with affected communities and many NHS organisations have strengthened their approaches as well. It is too early yet to see the enduring impacts of these efforts, but leadership, visibility and drawing critical attention to racism matter.

RECOMMENDATIONS

We make recommendations covering the six areas of social determinants of health. Our general approach rests on proportionate universalism: universalist policies with effort proportionate to need. Ethnic inequalities and the health effects of racism make a simple appeal to universalism insufficient. We also make recommendations to develop a more racially equitable system across London including health and social care, based on organisational antiracism approaches and leadership and strengthening legal and regulatory mechanisms.

There is insufficient data and evidence about ethnicity in many important areas. This limits our ability to report on ethnic inequalities in health and the social determinants of health. We therefore make many recommendations for further research and information. There are also gaps in the evidence about experiences and impacts of racism and discrimination, which means racism can be overlooked.

The following five principles apply:

1. Public health to take a leading role in highlighting the impacts of racism in health and the social determinants and in putting racial equity at the heart of policy and interventions.
2. Spending and resource allocation must be proportionate to the scale of inequities in health and its social determinants and address racism and its intersection with socioeconomic disadvantage and other dimensions of exclusion.
3. Services must be culturally appropriate and designed with ethnic communities that are most affected.
4. There must be effective action to combat racism with sufficient accountability and appropriate sanctions.
5. There must be appropriate data and evidence to strengthen accountability to enable the effects of racism to be monitored and anti-racism policies and interventions evaluated.

The recommendations in this report are high level. By their nature, the high-level recommendations will not be sensitive to the many and varied forms of racism experienced by individuals and between different ethnic groups. The GLA has commissioned the Race Equality Foundation to consult with community groups and experts to co-produce more detailed actions relevant to their experiences and specific institutions and sectors. The community engagement and co-production of more detailed recommendations should enable further adaptation to these differing impacts and experiences. The intention is that all the sectors in London, and indeed in other places across the UK, contribute positively to antiracism and take up both the high-level and the more detailed, co-produced recommendations.

RECOMMENDATIONS: GIVE EVERY CHILD THE BEST START IN LIFE

1. Increase the spending on early years provision at a minimum meeting the OECD average and ensure allocation of funding is proportionately higher for more deprived areas and excluded ethnic groups.

2. Reduce levels of relative child poverty in all ethnic groups to 10 percent – level with the lowest rates in Europe.

3. Ensure programmes that tackle child poverty and mitigate its impacts are designed appropriately to meet the needs of different ethnic groups.

ADDITIONAL RESEARCH AND EVIDENCE

- Carry out routine collection of data by ethnicity to establish the extent of ethnic inequalities in the early years.
- Analyse whether early years services and assessments of levels of development are culturally appropriate for the diverse populations and wide range of socioeconomic backgrounds in London.
- Undertake further studies on the experiences of racism and their effects among parents and children in the early years and ensure these are incorporated into actions to tackle racism and improve outcomes.

RECOMMENDATIONS: ENABLE ALL CHILDREN, YOUNG PEOPLE AND ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THE LIVES

1. Reverse the cuts that have happened since 2010 in per pupil funding in schools and youth services.
2. Schools to strengthen antiracism approaches through capacity building and enforcement of legal obligations and additional duty to report and to act on racism in school settings.
3. Strengthen enforcement of legal requirements for non-discriminatory recruitment.
4. Increase the number of programmes to support young people's mental health and fund youth services and safe spaces that are culturally appropriate.

ADDITIONAL RESEARCH AND EVIDENCE

- Conduct further research into why many Black pupils do not benefit from being at secondary school in London as much as other ethnic groups.
- Assess why some young people from ethnic minority groups do not continue the good levels of attainment in primary school into secondary school and into good quality employment.
- Assess SEN diagnoses and referrals and support by ethnicity in London.
- Carry out further research into racism and discrimination by employers in London and their impact.
- Strengthen data on young people's mental health and wellbeing by ethnicity in London.

RECOMMENDATIONS: CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

1. Ensure all employers pay the London Living Wage and eliminate inequalities in pay by ethnicity.
2. GLA to develop and lead an antiracism approach for all employers in London.
3. Ensure that programmes to support people into work and skills building programmes are appropriate for different ethnic groups and are developed with them including in-work training.
4. Reports on racism to be investigated by independent bodies not by employers.

ADDITIONAL RESEARCH AND EVIDENCE

- Implement mandatory collection of pay data by ethnicity.
- Carry out research to understand the reason for inequalities in employment rates by ethnicity for men and women.
- Institute annual surveys of experiences of racism in employment.

RECOMMENDATIONS: ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

1. Tax and benefit system reoriented to reduce ethnic as well as socioeconomic inequalities.
2. Universal Credit should meet the cost of daily life essentials.
3. Develop advice and support services in collaboration with the ethnic groups who are most affected by poverty to ensure they access the financial support they are entitled to including uptake of benefits.
4. Increase the coverage of programmes to insulate cold, poor-quality homes, working with ethnic minority groups who are particularly affected.

ADDITIONAL RESEARCH AND EVIDENCE

- Assess the tax and benefit system for impact on ethnic as well as socioeconomic inequalities.

RECOMMENDATIONS: CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

1. While increasing supply of affordable housing enforce the Decent Homes Standards across all housing sectors and inform tenants about their housing rights by offering culturally appropriate free advice, support and advocacy services.
2. Assess housing providers, including the private rental sector, for racism and regulate the sector appropriately, enforcing sanctions.
3. Ensure that the views and concerns of ethnic minority residents are incorporated into planning including regeneration, access to green spaces and safety.
4. Implement the recommendations of the Casey and Lammy Reviews to end systemic racism in the criminal justice system.

ADDITIONAL RESEARCH AND EVIDENCE

- Assess the differing housing needs of ethnic groups through the life course.
- Conduct further research into racism within the housing sector in London.
- Expand research and evidence about racism in the criminal justice system including Gypsy and Travellers.

RECOMMENDATIONS: STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

1. Ensure that the focus of the public health system incorporates the fundamental role of social determinants, ethnicity and experiences of discrimination and racism in shaping health.
2. Redesign public health approaches to smoking, alcohol, drugs and obesity to ensure they are culturally appropriate for ethnic minority groups in London.
3. The health system to take a longer-term, prevention focussed approach to tackling health inequalities.

ADDITIONAL RESEARCH AND EVIDENCE

- Ensure that data on health behaviours are disaggregated by ethnicity as well as socioeconomic position, gender, disability and age.
- Further research on ethnic dimensions of alcohol misuse, obesity and physical activity and ethnicity.

RECOMMENDATIONS: END RACISM IN HEALTH AND SOCIAL CARE

1. Eliminate racism and ethnic inequalities in access to NHS services and in quality of experiences and outcomes through coproduction, increased investment, education and training, provision of appropriate support and culturally informed practices.
2. Address racism and systemic bias in diagnoses, treatments, medical devices, AI and resource allocation.
3. Eliminate racism in NHS and social care employment with greater equity in recruitment, pay, progression and seniority.
4. Ensure awareness of racism in the NHS and social care among both providers and users and apply appropriate sanctions.

ADDITIONAL RESEARCH AND EVIDENCE

- Further research on the extent of racism in all NHS and social care services.
- Through collaboration with ethnic minority groups improve the collection of data on outcomes and experiences in health and social care services by ethnicity.

RECOMMENDATIONS TOWARDS A MORE RACIALLY EQUITABLE SYSTEM: THE ROLE AND IMPACT OF INSTITUTIONS AND ORGANISATIONS

1 → **Strengthen legislation, regulation and enforcement**

- Establish a separate national body to focus on race equality covering both private and public sectors.
- The Equality and Human Rights Commission to prioritise enforcement of the Public Sector Equality Duty.
- Restore EHRC budget to its previous level and strengthen powers to ensure regulatory bodies uphold the Equality Act and the PSED in the organisations for which they have responsibility.
- Implementation of the Equality Act to be more proactive and require private and public sector organisations and regulatory bodies to root out and be accountable for racism.

2 → **Aim for all London organisations to develop and apply antiracism approaches**

- Strong antiracism leadership to ensure equitable employment opportunities, appropriate representation, pay and progression.
- Develop training and support for all employees to ensure they understand racism and and are empowered to report it.

3 → **Ensure communities are central to the development of approaches to tackle racism.**

4 → **Ensure there are sufficient resources for all organisations to tackle racism and evaluate and monitor antiracism approaches.**

5 → **Develop data, research and evaluation to better identify and tackle racism.**

6 → **Strengthen national advocacy and development of social movements to support antiracism.**

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