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FEATURE

INTERVIEW

Harnessing the outrage: it's time the NHS tackled racial bias

To call itself fair and equitable, the NHS must act on racism, says David Williams, the global expert on the effects of race on health. **Lilian Anekwe** reports

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There comes a tipping point in all campaigns when the evidence is irrefutable and the only way to proceed is with action. According to David Williams, global expert on societal impacts on health, the time to tackle the disproportionate effects of race on patients in the UK is now.

It was Williams's Everyday Discrimination Scale that, in 1997, launched a new scientific approach to assessing social influences, such as racism, on health. Its use has shown that people who experience everyday acts of discrimination—like getting poorer service in a bank or a restaurant, or being treated with less courtesy—will over time have worse health outcomes, including higher rates of heart disease, lower life expectancy, and greater infant mortality.

While he has been spreading this message globally, and calling for policy changes to tackle it, Williams has also been watching NHS England's efforts to put its house in order in terms of race equality.

Call for research

Williams says that he would like to see a health observatory or similar body established in the UK to look at the disproportionate effects that race is having on patients. Research in this area is currently lacking, he says, and is crucial to bring about the scale of organisational change the NHS needs.

"It takes commitment and deliberate concerted action to change an organisation's culture and make a difference," he says. "The rhetoric must be matched by behaviour and policies that have teeth and the authority to implement change."

It will require investment too: "The most successful programmes in the US are those with money—and leadership that puts that money where its mouth is."

The UK may not be able to ignore the problem any longer, Williams says, because "we are now getting to a point where the crescendo of research from around the world is such that it cannot be ignored."

Williams sums up his more than 30 years of research as showing that "any type of unfair treatment has negative effects on health."

His career has taken him from Yale University, where he held posts in sociology and public health, to professorships in epidemiology and public health at the University of Michigan, then to Harvard University, where he's been since 2006. He's now a professor of public health, African and African-American studies, and sociology.

His mission has been to highlight and understand the effects of racial discrimination and racism on physical and psychological health. He says this requires a broad approach and the combined strengths and techniques of sociology and public health, because "we cannot understand race and health if we don't understand the role of race and racism within larger society and within our world."

Racial health gap

Data from the US show that there is a clear racial gap in health—at the age of 25, the average white American can expect to live five years longer than the average black person. The gap by education is larger: even the better off black person with a college degree or higher level of education has a lower life expectancy than a white high school graduate.

"These data clearly say there is something about income and education that drive health regardless of your race. But it's something else about race that matters, and matters profoundly for health, even after you've taken income and education into account," says Williams.

He has tasked himself with understanding how racism in wider society leads to these negative health effects.

Williams gives the example of a study of African-American and white women which found that higher levels of everyday discrimination had a dose-response relation to visceral fat[1]—a predictor of cardiovascular disease, diabetes, and high blood

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pressure. In addition, a study of adults followed over time found that higher levels of everyday discrimination were an independent predictor of premature death.[2] "It's literally killing people prematurely," Williams says.

In the UK, qualitative research has found that racism has direct effects on both mental and physical health.[3] A systematic review of 121 research studies on racism and health found evidence of negative effects, particularly relating to mental health. Another study of young people in London found that "unlike other measures of adversity, perceived racism was consistently associated with poorer psychological wellbeing across gender, ethnicity, and age."[4]

Williams concludes, "We know from a statistical, empirical point of view that discrimination is one of the reasons there are racial disparities in health."

Changing views

Michael Marmot, professor of epidemiology at University College London and director of the UCL Institute of Health Equity, described Williams as "a terrific scholar and an important researcher in the field."

Marmot says he has changed his views on racism in relation to health outcomes in part because of the evidence highlighted by Williams when he was director of the Robert Wood Johnson Foundation's Commission to Build a Healthier America,[5] which was set up to investigate factors outside of medical care that influence health.

"My thoughts 10 years ago had been that the reason people of colour and indigenous people had worse health was because of the social determinants of health," Marmot says. "In other words, you could explain it all through poverty.

"But my view has changed. Rather than explaining it away—saying we can explain healthcare inequality through social determinants—we should ask why there are these adverse distributions of the social determinants of health according to people's ethnicity or indigenous status."

He describes structural racism and ongoing colonialism as one of the three structural drivers of health inequality, along with macroeconomic forces and environment. "The evidence shows that on all the health parameters we look at, people of African descent have worse measures," Marmot says.

A concern for all

Williams stresses that these disparities in health outcomes are a matter that everyone in healthcare—and indeed in society—should be concerned about. We should all "have some outrage" about health inequalities and what drives them because "these inequities violate some core beliefs that all of us in the civilized world have. We believe in equity; the playing field should be level in terms of access to opportunity. It's one of the core values that British society has," he says.

And the research shows that "when people don't have access to equality and don't have access to enjoy the health that is potentially possible in society, all of us pay." And it is costly: in the US, research has shown that racial gaps in health cost the country's economy hundreds of billions of dollars a year in lost productivity and healthcare costs.[6]

Implicit bias

Williams's work focuses on interpersonal discrimination, but it's another layer, that of implicit bias—the discrimination that we are unaware of that is driven by unconscious, negative stereotypes that we all have—that requires more research, he says.

There has been very little research into the impact of implicit bias in the UK. But in the US, a review of records of patients seen over one year in the emergency department at the University of California Los Angeles medical centre found that, after controlling for other predictive factors, ethnicity was the biggest predictor of whether patients with a suspected long bone fracture received pain medication.[7] It found that 56% of Hispanic patients received no medication, compared with about 25% of white patients. "That pattern has been documented in the US across virtually every area of medical treatment," Williams says.

Implicit bias is part of the "normal brain processes of how all of us as human beings process information," he argues. Interestingly, a small randomised controlled trial of 36 people by researchers at the University of Oxford in 2012 found that a single 40 mg oral dose of the β blocker propranolol reduced implicit negative racial bias.[8] These results prompted the researchers to suggest that the drugs affect the "beta-adrenoceptors that play a role in the expression of implicit racial attitudes" by mediating "noradrenaline related emotional mechanisms."[8] The result was striking, Williams says, "because it illustrates that there are fundamental biological processes in the brain" that can be mediated to prevent bias.

This doesn't mean though, that tackling the different matters he focuses on—racial differences in quality and in access to medical care, as well as racial inequities in health that are driven by larger, social inequality largely determined by geography, education, and employment—should not and cannot be challenged. It's key to recognise that we need to work on both improving access to high quality healthcare and also improving health overall, he argues. But this can only happen once the UK is "in a place where we're able to be frank and honest and say that implicit bias exists."

Williams adds, "The individual doctor has to have the realisation: 'This could be me. I could be treating people differently based on the social categories to which they belong'."

Lilian Anekwe is assistant news editor at the *New Scientist*. She interviewed David Williams by Skype.

For more articles in *The BMJ*'s Racism in Medicine special issue see bmj.com/racism-in-medicine.

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