EClinicalMedicine 34 (2021) 100816

Contents lists available at ScienceDirect

EClinicalMedicine

journal homepage: https://www.journals.elsevier.com/eclinicalmedicine

Commentary

The ethical urgency of tackling racial inequities in health

João L Bastos[a,*], Helena M Constante[a], Lisa M Jamieson[b]

[a] Graduate Program in Public Health, Federal University of Santa Catarina, Campus Universitário João David Ferreira Lima, Trindade, Florianópolis, SC 88040-970, Brazil

[b] Australian Research Centre for Population Oral Health, University of Adelaide Dental School, University of Adelaide, Adelaide, SA, Australia

ARTICLE INFO

Article History:
Received 9 February 2021
Revised 15 March 2021
Accepted 16 March 2021
Available online xxx

In a foundational paper [1] from almost 30 years ago, Margaret Whitehead established crucially important distinctions between health differences and health inequities. Through an ethical perspective, she contended that health differences between nations or groups within countries should be taken as health inequities whenever unnecessary, avoidable, and unjust factors were at their core. We see that health differences between racialized categories perfectly fit the definition of health inequity, though mainstream public health research has been reluctant to acknowledge this. Racial health inequities go hand in hand with our inability to address the unnecessary, avoidable, and unjust social process known as racism.

In order to set forth the argument that there can be no effective and sustainable reduction in racial health inequities without promoting an anti-racist research agenda, this commentary is divided into three critical parts. We begin with a brief summary of what we already know on the topic, which is immediately followed by a review of some mechanisms linking racism – a systemic feature of several contemporary societies [2] – to racial health inequities. Recommendations on how to enhance knowledge on the topic, by conducting research whose findings can readily be used to help mitigate the problem, appear at the end of the text.

Having been built upon the colonial legacies of slavery, human exploitation, and racism, numerous countries feature a gloomy profile of racial health inequities at each and every stage of the life course. Whether in the realm of antenatal care[3], infant [4], child [5], or adult [6] health, racial inequities manifest in the form of higher frequencies of adverse physical and mental health outcomes, as well as restricted access to and lower use of high-quality care among racialized minorities. Mounting evidence further indicates that health inequities have not only persisted over time, but have also widened for some particular outcomes [4]. Together with infant mortality, severe mental illness is an enduring racial health inequity, for which available data indicate that it has been in existence since the 1960s [6]. Indeed, racial inequities surrounding the current COVID-19 pandemic are a clear sign that they have a strong tendency to reproduce through various dimensions of the health-disease-care process – extending from incidence, to mortality, including vaccination rates. But there is, unfortunately, more to racial inequities in health: As the latest Oxfam Report [7] revealed, the profound social and economic effects of COVID-19 has forced millions of people into poverty, meaning that the overall pattern of unequal health distribution is expected to worsen in the coming years, particularly for racialized groups.

Sociological and public health scholarship has recently suggested that racism is a multi-level system of oppression with structural, institutional, cultural, and behavioral dimensions [2,8,9]. This literature also contends that racism is a driver of countless mechanisms underlying the poorer health conditions of racially marginalized populations. Racial residential segregation, for example, is regarded as a powerful linking force between formal education, socioeconomic status, health, and healthcare [2]. Racial residential segregation is understood as an expression of structural and institutional racism. By placing racialized minorities in run-down city areas, whose basic services, such as schools, are well below accepted quality standards, racial residential segregation decreases the chances of attending good universities. With a background of no professional degree or even some formal education at all, racialized minorities enter the labor market with less-than-optimal credentials. This forces racially minoritized people into a lifelong experience of unstable, underpaid jobs, and poor working conditions, which are, in turn, highly detrimental to health. Their sometimes-higher health demands are then hardly met by often underfunded and lower-quality healthcare available to them. Residing in such poor, often densely populated locations, without the benefits of green spaces, also leads to increases in both domestic and general violence, family breakdowns, exposure to gangs and drugs.

The health impacts of structural, institutional, and cultural racism have rarely been backed by scientific evidence. In fact, extant knowledge almost exclusively focuses on the behavioral expression of racism within core, but not periphery countries [10]. The next generation of studies on the topic should thus help us determine which interventions against structural, institutional, and cultural racism work best, and under which conditions they succeed. Instead of repeatedly documenting the breadth and magnitude of racial health inequities, studies would be better served by broader, theoretically-informed research questions, such as these: (1) Does neighborhood

* Corresponding author.
E-mail address: joao.luiz.epi@gmail.com (J.L. Bastos).

https://doi.org/10.1016/j.eclinm.2021.100816

desegregation contribute to mitigating racial health inequities? (2) Can increased racial diversity in the labor market, particularly among positions of prestige/power, help diminish racial health inequities? (3) Is reduced mass incarceration, which typically targets racially marginalized groups, associated with lower levels of racial health inequities? It is high time we engaged with the ethical urgency of tackling racism and the resulting racial health inequities. Promoting such an anti-racist research agenda is certainly one way to achieve this. Something without which we cannot move on.

Declaration of Competing Interest

The authors declare no potential conflicts of interest with respect to the literature search and synthesis, authorship, and/or publication of this commentary.

Funding

João Luiz Bastos was partially supported by the Brazilian National Research Council (Research Grant 304503/2018-5).

References

[1] Whitehead M. The concepts and principles of equity and health. Int J Health Serv 1992;22(3):429–45.
[2] Reskin B. The race discrimination system. Annu Rev Sociol 2012;38(1):17–35.
[3] Mesenburg MA, Restrepo-Mendez MC, Amigo H, Balandrán AD, Barbosa-Verdun MA, Caicedo-Velásquez B, et al. Ethnic group inequalities in coverage with reproductive, maternal and child health interventions: cross-sectional analyses of national surveys in 16 latin American and Caribbean countries. Lancet Glob Health 2018;6(8):e902–e13.
[4] Singh GK, Yu SM. Infant mortality in the United States, 1915−2017: large social inequalities have persisted for over a century. Int J MCH AIDS 2019;8(1):19–31.
[5] Mehta NK, Lee H, Ylitalo KR. Child health in the United States: recent trends in racial/ethnic disparities. Soc Sci Med 2013;95:6–15.
[6] Nazroo JY, Bhui KS, Rhodes J. Where next for understanding race/ethnic inequalities in severe mental illness? structural, interpersonal and institutional racism. Sociol Health Illn 2020;42(2):262–76.
[7] Oxfam. The Inequality Virus: Bringing Together a World Torn Apart by Coronavirus through a Fair, Just and Sustainable Economy. Oxford: Oxfam International; 2021.
[8] Bailey ZD, Feldman JM, Bassett MT. How structural racism works - racist policies as a root cause of U.S. racial health inequities. N Engl J Med 2020;384:738–73.
[9] Phelan JC, Link BG. Is racism a fundamental cause of inequalities in health? Annu Rev Sociol 2015;41(1):311–30.
[10] Krieger N. Measures of racism, sexism, heterosexism, and gender binarism for health equity research: from structural injustice to embodied harm-an ecosocial analysis. Annu Rev Public Health 2020;41:37–62.