

**The Underlying Factors of Racial Inequalities in Health and Healthcare in
the United States of America and the United Kingdom**

**A faji egyenlőtlenségek mögöttes tényezői az egészség és az egészségügy
terén az Amerikai Egyesült Államokban és az Egyesült Királyságban**

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Abstract

In this essay I aim to provide an insight into racial inequalities in health and healthcare comparing the United States and the United Kingdom. I formulate my research questions based on the literature in the two countries: What might be the underlying factors commonly referred to by researchers, which drive racial disparities in health and healthcare in the United States of America and the United Kingdom? What differences or similarities can be observed between the two countries concerning health-related inequalities?

There are a number of studies, which confirm the existence of racial inequalities in different health outcomes, both in the United States and the United Kingdom, however, the literature is significantly wider in the former. Several factors could account for these disparities, including inequalities in access to certain health-related services, differences in socioeconomic indicators, values and norms, or discrimination. Inequalities in the two observed countries do not always follow the same patterns and may differ across time, age groups, and race groups as well. An explanation for this might be found in the divergence of the healthcare systems, in the diverse ethnic composition of these countries that are a result of their history and current immigration trends, as well as in other country-specific characteristics. Overall, it is hard to generalize the situation of racial minorities, since researchers studying health inequalities are often limited by the poor availability of quality data, and there is still not a wide range of studies in this subject, particularly in Europe.

In the first part of the essay, I highlight some racial inequalities in body weight-related health outcomes, then by synthesizing the literature I outline the main arguments that most often occur as reasons for racial disparities in health. Building on these points I conduct an analysis of OECD data related to healthcare, as well as publicly available 2021 Census data in the United Kingdom, more precisely England and Wales, and American Community Survey (ACS) 2022 data in the United States. Analyzing these data makes it possible to compare the broader context regarding health and healthcare of the given countries. Combining these results with race- and ethnicity-related data separately in the two countries illustrates the disparities and corroborates some of the arguments related to socioeconomic determinants, such as education.

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The Underlying Factors of Racial Inequalities in Health and Healthcare in the United States of America and the United Kingdom

I. Introduction

In general, researchers agree that racial and/or ethnic inequalities exist concerning different health outcomes, both in the United States and the United Kingdom. These disparities are the result of several factors, including inequalities in access to certain healthcare services, differences in socioeconomic indicators, the values and norms of different groups of the society, or discriminative attitudes and behaviors. Inequalities in the two observed countries do not always follow the same patterns and may differ across time, age groups, and race groups as well. An explanation for this might be found in the divergence of the health care systems, which provide their citizens with different opportunities, especially regarding insurances and services, in the diverse ethnic composition of these countries that are a result of their history and current immigration trends, as well as in other country-specific characteristics. Therefore, the experiences of one minority group in a given setting cannot be generalized; the policies that work in one region may not be applied in others, and to tackle the inequalities in health and healthcare different solutions need to be found according to the different contexts. Another limit to the generalizability of the findings of the studies included in this essay is the poor availability of quality data in the subject, and the fact that research focusing on health disparities does not have a longstanding history, especially in Europe.

I formulated two main research questions that provide a starting point for the analyses and structure my writing. What might be the underlying factors commonly referred to by researchers, which drive racial disparities in health and healthcare in the United States of America and the United Kingdom? What differences or similarities can be observed between the two countries with regard to health-related inequalities? Describing all of the health-related racial/ethnic inequalities on both sides of the Atlantic exceeds the limits of this writing, therefore, to illustrate such disparities I will use body weight-related health outcomes in childhood and adulthood as well, such as birthweight, obesity, or diabetes.

In the second part of the study, I provide a synthesis of the explanations that might account for these racial inequalities and the differences between the two observed countries. I briefly present the most important aspects of the healthcare systems in the U.S. and the UK, which can affect the accessibility of health-related services. Then, I summarize some

explanations that are related to the history of minorities and the different immigration trends, for example, from where and when immigrants arrived, what policies constrained or facilitated these processes, and what norms they followed or follow, which can impact health outcomes. I describe socioeconomic indicators that have been found to be strongly correlated with health, such as income, and education. Then, I show how discrimination and racism might affect the inequalities in health. Lastly, in this section I present some policy implications.

In the next part of the paper, I conduct an analysis of health-related OECD data to highlight some differences between the general contexts of the U.S. and the UK. Then, using Census 2021 data for the UK and Census 2020 and American Community Survey 2022 data for the U.S. I illustrate some of the arguments explaining inequalities within these countries. Finally, I summarize the limitations of this essay.

II. Racial Inequalities in Body Weight-Related Health Outcomes

II.1. Health in Childhood

Racial and ethnic inequalities are already present from early childhood. Since child health is strongly related to health trajectories later in adulthood, it is essential to consider and understand these inequalities. (Florian et al., 2021) Low birthweight, body mass index (BMI), child obesity and overweight are the outcomes that are most often included in studies related to body weight. These factors can later lead to asthma, obesity, diabetes, cardiovascular diseases, and can impact morbidity and mortality in adulthood, therefore they are often used as indicators of population health. (Choi – Martinson, 2017)

II.1.1. Low Birthweight

In most studies, births where the infant weighed less than 2500 grams are considered low birthweight. Low birthweight children are at higher risk of delayed cognitive development and experiencing more diseases in childhood. In both the United Kingdom and the United States, racial and ethnic inequalities can be observed in low birthweight: it is twice as likely for minority groups as for Whites. (Choi – Martinson, 2017) Immigrant low birthweight varies by nativity and the duration of residence in the host country. Being born in a foreign country often has a protective effect on low birthweight, which might be a result of different country-specific characteristics that will be described later. (Martinson et al., 2017). Some researchers found a difference between natives and immigrants in the U.S. that favors the latter, and natives in the

UK are also at higher risk of low birthweight than immigrants, but results vary significantly across racial groups, for example mothers of African and Asian origins have higher rates of low birthweight than immigrants from English-speaking countries. However, even if there is a slight advantage for immigrants in the first years of their stay in the host country, this later disappears, and the rates become similar to those of natives. (Martinson et al., 2017)

We must also distinguish between immigrant minorities and native-born minorities since the latter tend to be more disadvantaged with regard to low birthweight ratios than the former and the native-born majority. Children of native-born black mothers have a doubled probability of being low birthweight than Whites in the United States. In England as well, children whose mothers are Asian or Black are more likely to be low birthweight than foreign-or native-born Whites. (Martinson et al., 2015)

II.1.2. Obesity, Overweight and Body Mass Index

In developing countries child obesity and overweight are a growing concern, since these are linked to several adulthood health outcomes, such as diabetes, cardiovascular and other diseases. Racial/ethnic disparities can be observed in favor of the majority population in both countries (Martinson et al., 2012) and in some cases these gaps already emerge by the time children enter school (Martinson et al., 2015). Around age seven-nine, Black and Hispanic children both with native-born and foreign-born mothers in the U.S. have higher rates of obesity and overweight compared to Whites and similar patterns apply for England as well, where black Caribbean/black African and Asian, mostly Pakistani, Bangladeshi and Indian children are more likely to be obese than white children, especially Blacks with foreign-born mothers. Although other studies find no difference between Asian children with foreign-born mothers and with native-born white mothers. (Martinson et al., 2012) Overall, obesity rates are higher in the United States than in England. (Martinson et al., 2015)

BMI trajectories are also predictive of later obesity and other health issues. Body Mass Index is calculated from weight and height measurements, and in most studies the CDC 85th percentile represents overweight children. The highest mean BMI is that of Hispanics in the US and Blacks in England. Hispanic children in the U.S. already have a higher BMI at age three and their growth trajectories – as well as those of Black children – are steeper, meaning that they gain weight more rapidly than white children. In England, the growth of Asian and Black children follows similar patterns compared to native-born Whites, despite Asian children being

thinner at age three. In the case of Whites, there is no difference between the BMI trajectories of native-and foreign-born children. These steep growth trajectories between age 3 and 7 imply that by adulthood the disparities between the White population and racial minorities will become even wider. (Martinson et al., 2015)

II.2. Health in Adulthood

II.2.1. Obesity

Higher rates of obesity can be observed for Hispanics and Blacks in the U.S. and Blacks in England, with the differences being larger in the United States. (Martinson, 2010) A survey in England also found that second generation Chinese and Indian immigrants were at higher risk of obesity than the first generation, and obesity rates in other ethnic groups as well, such as Bangladeshi, and Black African, converge to the ratio of the majority White population. In the US, immigrants have higher obesity rates than the native-born population. (Smith et al., 2012)

II.2.2. Cardiovascular Diseases, Diabetes, Mortality

In both the U.S. and England Blacks have higher rates of hypertension than Whites, while the difference is not significant for Hispanics in the former, and Asians in the latter country. Moreover, Blacks are also at higher risk of getting a stroke than Whites in the U.S. Overall, disparities in cardiovascular diseases show a heterogeneity across racial subgroups and countries, and vary by gender, and the absence of a racial difference might be a result of inequalities in life expectancy and survival, which favor the White population. (Martinson, 2010)

Racial/ethnic disparities are of the greatest extent in diabetes. Hispanics and Blacks in the U.S., as well as Blacks and especially Asians in England are more likely to have diabetes compared to their white counterparts (Martinson, 2010), which can be a result or aggravation of the inequalities in child health described above (Martinson et al., 2012).

Differences in morbidity and mortality according to race and ethnicity are also prevalent in both countries. As mentioned before, there are inequalities in life expectancy, but these reflect heterogeneity among racial/ethnic subgroups. In the UK, generally Pakistani and Bangladeshi people are most disadvantaged, but Caribbeans and Indians also have worse health than Chinese or Whites. In the U.S., Hispanics and Asians have the lowest mortality rates, followed by Whites, while non-Hispanic Blacks and Native Americans the highest. (Nazroo, 2003)

III. Explanations for Racial Inequalities in Health and Healthcare

III.1. Characteristics of the Healthcare Systems

The healthcare systems of the United States and the United Kingdom are very different from each other. As the characteristics of the healthcare system might influence certain health outcomes, it is important to consider these differences when comparing the two countries. Inequalities in insurances, access to healthcare, or receiving diagnosis can all lead to racially/ethnically differentiated health outcomes. (Martinson, 2010)

III.1.1. Healthcare in the United States

In the United States there is no universal healthcare: the system “is a mix of public and private, for-profit and nonprofit insurers and health care providers”. (Commonwealth Fund) In 2018, around 92 percent of the population was insured, while more than 8 percent of the population, being 27.5 million people did not have an insurance (Commonwealth Fund). “50 percent more Blacks than Whites are uninsured, while three times as many Hispanics are uninsured as compared to Whites.” (Martinson, 2010) Nevertheless, the ratio of uninsured has decreased in recent years. 67 percent of U.S. citizens is insured privately, and most of them through their employers. Two public insurance programs are also available since 1965. Medicare provides universal access to healthcare for elderly population age 65 or above, as well as for those under age 65 who have long-term disabilities or end-stage renal disease. This insurance includes hospital and medical insurance, and prescription drug coverage depending on the program one chooses. Medicaid ensures services for low-income families, blind, and disabled people, pregnant women, and children under age 18, but eligibility differs across states. Children’s Health Insurance Program was introduced in 1997 for those children whose families fall out of Medicaid eligibility, but still cannot pay for a private insurance, its details also vary by state. The Affordable Care Act, enacted in 2010, requires people to be insured, and made expansions and allowances that facilitate obtaining an insurance. (Commonwealth Fund)

Public insurance programs are funded by federal taxes and individual premiums. The insurance programs cover a different range of services, with Medicare being the less expanded, and Medicaid and private insurance including more services, however these can vary a lot according to states and companies. Cost-sharing and out-of-pocket spending are still significant, which puts a financial burden on many people, but some safety net programs exist for uninsured and low-income people. There are racial/ethnic inequalities in health care quality: “African

Americans, American Indians, Alaska Natives, Native Hawaiians, and Pacific Islanders, as well as Hispanics and Asian Americans often receive worse care than whites”, but there are a number of federal agencies that are charged with reducing these inequalities. (Commonwealth Fund) Some studies indicate that health insurance status is primary determinants of racial and ethnic inequalities in health (Nazroo et al., 2009; veterans), for example, “Hispanics in the US are very likely to be uninsured” (Martinson, 2010).

III.1.2. Healthcare in the United Kingdom

“The United Kingdom has a national health service (NHS) with access based on clinical need, and not ability to pay. All individuals, irrespective of their nationality or immigration status, are eligible to access primary, emergency and compulsory psychiatric care, free of charge. Coverage for secondary care services, however, is only available for those who are ordinarily resident. [...] Private medical insurance is usually used to finance a few select services not offered by the NHS or to access NHS-covered services more quickly.” (Anderson et al., 2022) About 10.5 percent of the population pays for an additional private insurance, mostly by four main insurers. The NHS provides a wide range of services: several items for free, and significantly subsidizes others. For example, the young and elderly population, as well as low-income people and pregnant women do not have to pay for prescription drugs. (Thorlby, n.d.)

Although, it is only ordinary residents who are eligible to all NHS care, nonresidents with a European Health Insurance Card can also benefit from the NHS. Other non-Europeans or immigrants without documents can only access emergency treatment. The NHS Constitution declares “the right to access care without discrimination”. (Thorlby, n.d.) Health legislation is the task of the Parliament, and the hospitals and providers of NHS are owned by the government. The system is mostly funded by general taxes, and national insurance. As in the United States, there are some state agencies in the UK too that are responsible for reducing inequalities and report on the progressions. Each of the four countries of the United Kingdom have their own National Health Service, but their main characteristics, including universality, are the same. (Thorlby, n.d.)

III.1.3. Access to Healthcare

The accessibility of healthcare for immigrants is significantly different in the two countries. In the UK, immigrants who become residents are also eligible to the NHS, and

asylees are provided minimum benefits as well, while in the U.S. “they are excluded from means-tested public benefits for five years”. (Martinson et al., 2017) The availability healthcare can be essential when examining health outcomes of different ethnic and racial groups, as the services people have access to, such as diagnosis, medication, screenings, can influence their health. Based on the results of their study, Martinson et al. (2017) suggest that access to health services plays a role in the nativity differences in low birthweight. For example, in England maternal services are available to immigrant women as well. (Choi – Martinson, 2017)

In the U.S., the type of health insurance determines which services one has access to, which contributes to inequalities in health. For example, there is evidence that “the outcomes for the management of diabetes in the UK match those for the insured population in the USA and that both of these groups have considerably better outcomes than the uninsured USA population.” (Nazroo et al., 2009) Based on previous findings Nazroo et al. (2009) also say that the NHS ensures greater equality in health-related issues for different ethnic groups than the US healthcare system. However, for several health outcomes, such as BMI trajectories (Martinson et al., 2015), the racial/ethnic inequalities are of approximately the same magnitude in England as in the US (Martinson, 2010). We must note that differences in health outcomes can also be a result of the characteristics of the sending countries, for example in the case of immigrants of South Asian origin being more likely to have low birthweight infants. (Martinson et al., 2017)

III.2. Influencing Factors Related to the Immigration Process

The direction and amplitude of the relationship between country of origin and the discussed health outcomes varies across racial and ethnic groups, as well as across countries and time. In the following sections I present some explanations that are related to the characteristic of the immigration process, such as the immigrant health paradox of selectivity, admission criteria in host countries, overall population health in origin countries, and access to healthcare services in host countries. (Martinson et al., 2017)

III.2.1. History of Immigration

Both the UK and the U.S. have traditionally been countries of immigration; however, many differences can be found in the composition and number of immigrants. In the U.S., most immigrants come from Latin America, particularly from Mexico from mid-20th century, and Asia, mainly from China, India, and the Philippines. Immigrants in the UK primarily have Afro-

Caribbean, Indian, Pakistani, and Bangladeshi origins and mostly came in the post World War II era. (Martinson et al., 2017)

Many Black people in the U.S. have been residing there since their ancestors arrived as slaves. (Nazroo, 2003) Black people of Caribbean origin on the other hand “arrived in England after World War II as labor migrants” (Nazroo et al., 2007). Blacks in the US are often in a lower socioeconomic status than Whites; “a long history of institutional racism and discrimination”, as Nazroo (2003) puts it, have contributed to these inequalities. The UK also has a colonial history, and postwar ethnic minority migrants had and still have to face racism and discrimination. (Nazroo, 2003) In contrast to this, Caribbeans who migrated to the U.S. in the same era might have taken advantage of the civil rights movement and therefore are in a better socioeconomic situation than those who migrated to England where they encountered a rather hostile environment. (Nazroo et al., 2007)

III.2.2. Admission Criteria

Overall, immigrants – non-UK-born residents – constitute almost 17% of the population of England and Wales percent, being 10 017 964 people according to 2021 Census data, while over 46 million immigrants in the United States make up almost 14% of the total population as ACS 2022 data shows. The admission criteria for immigrants vary across countries; these criteria influence immigrants’ selectivity, contributing to a different composition of immigrants in each country. According to Martinson et al. (2017) “until the early 1960s, Britain permitted virtually unrestricted immigration from its colonies”, which resulted in a high ratio of Indian and Pakistani immigrants. However, from early 1990s significant restrictions were implemented favoring skilled migrants over family members. In contrast to this, two-thirds of legal U.S. immigrants come with regard to family relations, primarily in the case of Mexicans, although employment-based visas are common here as well, particularly for people from China, India, the Philippines and Vietnam. However, the way in which this selectivity affects different health outcomes, like low birthweight is not always straightforward. (Martinson et al., 2017)

III.2.3. The Immigrant Health Paradox

When examining low birthweight among immigrant and native infants we could see that the former were less likely to be low birthweight than the latter, and in the U.S. being an immigrant has a protective impact against obesity in adulthood as well. (Martinson et al., 2012) There is an overall pattern that “immigrants tend to exhibit better health than natives despite

immigrants' more disadvantaged socioeconomic status". (Florian et al., 2021). This is due to the positive health selectivity of immigrants: they are those who choose to and are able to leave their home country. Therefore, they often have better education, are younger, have a better physical and mental health, and are in a better financial situation than their native counterparts who stay. The selection might continue during the migration process later as well: some of them might return or do not reach their destination because of the unforeseen difficulties that emerge, for example if their health worsens. Moreover, admission criteria often include health-related points, such as the necessity of a health examination. (Constant, 2017)

However, general health is most often estimated by self-report, which might lead to certain biases when examining the more positive health outcomes of immigrants. They might report better health than reality due to language difficulties, for example if they do not understand the diseases they should report; they may only report very serious illnesses and conditions due to cultural norms; they might fear not being allowed in the country if they report certain issues; or they may not be aware of some of their health problems due to lack of diagnosis. (Constant, 2017) In addition to this, there are other factors that challenge the immigrant health paradox. For instance, studies are mixed about whether immigrant status is protective against body weight-related health outcomes, such as BMI trajectories. (Martinson et al., 2012) Furthermore, different immigrant generations might vary in their health: there is a higher probability for second generation immigrants to be in a better economic status, and they also have less traditional ethnic identities, which might affect their health-related behaviors as well. (Nazroo, 2003) Immigrants' health might also be overestimated if we consider neoclassical theory, which suggests that those who do not succeed are more likely to return home. Being unsuccessful might be a result of several factors, but one is definitely socioeconomic status that correlates with health. Therefore, an additional positive selection applies on those who stay for the longer-term. As an example, Mexican immigrants who stay in the US are healthier than those who return. (Constant, 2017)

III.2.4. Values, Norms, Habits

The better health conditions of immigrants can also be attributed to certain values, norms, and practices in their home countries. For example, some cultures and religions, such as Muslimism, prohibit alcohol consumption or smoking, or diets in some sending countries, contain more fish, fruits, and vegetables, while natives might consume more unhealthy food. (Constant, 2017) As an example, Hispanics and Blacks in the U.S., and Blacks in England have

higher rates of obesity, but the magnitude of inequality between Blacks and Whites in the U.S. is higher than in England, which may be a result different diets, Blacks in England being more likely to be immigrants and thus embracing healthier diets. (Martinson, 2010) On the other hand, poorer immigrants may adopt more unhealthy practices, such as eating more high-calorie food because they were not able to do so in their country of origin due to availability or affordability issues. (Constant, 2017) Parents behaviors not only impact their own health, but that of their children as well. Immigrant mothers tend to consume less alcohol and smoke less than native-born parents, which practices are related to better birth outcomes. (Florian et al., 2021)

III.2.5. Unhealthy Assimilation or Regression to the Mean

Despite the immigrant health paradox that is perceptible when immigrants arrive in the host country, their “health declines with time in the new country and converges to that of natives; sometimes, it may even become worse than the health of natives”. (Constant, 2017) Usually, two explanations are formulated when researchers try to account for this deterioration. The first explanation is “unhealthy assimilation”, meaning that immigrants adopt the worse health practices of natives. The longer they stay in the host country, the more similar they become to the natives (Martinson et al., 2012), which mostly means taking up unhealthy behaviors, like drinking, smoking, drug use, diets high in fat, as well as less physical activity. According to the second explanation, as they spend more time in the host country immigrants’ health status simply regresses to the mean of the whole of the population, which is thought to be a natural process. (Florian et al., 2021) With regard to child health, these theories also imply that the children of mothers who arrived in the U.S. or England more recently will benefit more from their immigrant status than those who have been staying in the host country for a longer time. (Martinson et al., 2012)

Further explanations can also be listed that can account for the decline of immigrants’ health. They might be increasingly exposed to certain risks, which lead to “a growing cumulative health burden” (Florian et al., 2021), for instance, worse living conditions, worse employment opportunities or other socioeconomic factors. (Florian et al., 2021) Furthermore, leaving one’s home and moving to another country, familiarizing oneself with the new conditions, overcoming challenges of the migration process, which can impose social and psychological instability, and significant stress for immigrants (Constant, 2017) that ultimately affect their health outcomes. The price affect mentioned before, when immigrants consume less

healthy food because they were not able to buy it in their sending countries, can also contribute to health decline. (Constant, 2017)

III.3. The Role of Socioeconomic Status

Social and economic factors influence disparities in health outcomes; however, the extent of their explanatory force is still contested by researchers. Some studies suggest that the impact of socioeconomic inequalities is negligible. Several others claim that the cultural and genetic factors are at least as important as socioeconomic status. Nevertheless, even more scholars have found evidence that a large part of racial and ethnic disparities in health can be explained by socioeconomic inequalities among minorities. (Nazroo, 2003)

Education is a socioeconomic indicator that most often impacts several life outcomes. According to Florian et al. (2021): “Education constitutes a crucial determinant of health by providing knowledge to improve health status, and indirectly by enhancing socioeconomic resources and promoting better health practices.” A higher level of education usually correlates with better health outcomes. (Florian et al., 2021) Income is the other most used socioeconomic indicator, and it may affect health outcomes as well. For example, an increasing income results in a decrease in mortality rates, and better self-reported general health. (Nazroo, 2003) Whites are usually in a better economic situation than other racial groups in the US and in England too. (Nazroo et al., 2007) Racial/ethnic inequalities can be found according to employment as well. (Nazroo, 2003) Immigrants often form a vulnerable group in many developed countries, being in a lower socioeconomic status than native-born people (Florian et al., 2021), who are often better educated and employed at higher rates (Choi – Martinson, 2017). In the US, even within occupational groups, Black people tend to earn less than Whites. (Nazroo, 2003) Immigrants in both the U.S. and the UK were found to be low skilled and socioeconomically disadvantaged with regard to education and income levels. (Martinson et al., 2015) Therefore, controlling for socioeconomic variables usually reduces the health risk ratios for racial/ethnic minorities in both of these countries. (Nazroo, 2003)

Socioeconomic status in early childhood can impact later health trajectories, which then influences the health outcomes of the next generation as well. Moreover, the effects of socioeconomic disadvantages can also accumulate over the lifetime. (Nazroo, 2003) Low birthweight, child nutrition, and other parental practices, for instance, are related to social, economic, and cultural conditions, which then lead to a higher risk of diabetes, cardiovascular,

or respiratory diseases. (Nazroo, 2003; Florian et al., 2021) However, for some other health outcomes the impact of socioeconomic status is not straightforward, like in the case of overweight. Higher income might allow buying high-quality food and better possibilities for physical activity. In contrast, higher income might also lead to excessive consumption of high-calorie foods, especially for immigrants whose sending countries did not provide a large variety of these products. In the US, immigrant children whose parents are better educated and have higher income are more likely to be obese. Similarly, in England low socioeconomic status appears to be protective against overweight for foreign-born non-white minorities. (Martinson et al., 2012)

The impacts of socioeconomic status may vary according to different health outcomes and age groups, as well as by gender. It does not explain all the racial/ethnic inequalities in health but has an impact on outcomes in both the United States and England. (Martinson, 2010) Understanding the impacts of socioeconomic status on these disparities is complex; results may vary significantly across different groups, we must consider a person's racial/ethnic identity, whether one is native-or foreign born, and the intersections of these characteristics. Taking everything into account, we can say that including social and economic factors in research focusing on racial and ethnic inequalities in health is important because racial and ethnic minority groups do not face the same disadvantages, therefore, we can only get a full understanding of these inequalities if we consider the impact of differences in socioeconomic status. (Nazroo, 2003)

III.4. The Effects of Racism and Discrimination

“Minority groups generally find it difficult to overcome inequalities in wealth, partly because of racially discriminating actions and policies.” (Bhopal, 2007) Immigrants experiencing discrimination is also a contributing factor to losing the initial health advantage they tend to have. (Florian et al., 2021) In a US study, 1 in 8 Blacks who participated in the survey have experienced racial discrimination during their lifetime. In the UK, according to the Fourth National Survey of Ethnic Minorities, 80 percent of the respondents had similar experiences during the preceding year. For many minority groups racial harassment and discrimination are ordinary. (Nazroo, 2003) Racial discrimination and xenophobic attitudes further increases minorities vulnerability and the stress they experience, which “take a toll on their health”. (Constant, 2007) Several studies from the U.S. and the UK found evidence that such mechanisms are in progress and racism and poor health strongly and positively correlate

with each other. (Bhopal, 2007) For instance, in the U.S., those who suffered racial harassment were found to be more likely to experience hypertension, psychological distress, or poorer general health, and similar impacts were observed in the UK as well. Racism also impacts the socioeconomic disadvantages that minorities face, which is eventually related to health too. (Nazroo, 2003)

Moreover, racial and ethnic minorities often receive less quality health care; some surveys suggest that health professionals do not have the skills and confidence they would need to cater for ethnic minority groups. The reasons for this inappropriate treatment may vary from racial prejudice to discriminative practices in shortlisting, and the policies in place also prioritize the ethnic majority's needs. (Bhopal, 2007) In conclusion, to tackle the ethnic disparities in health it is essential to understand the underlying racist and discriminative attitudes and behaviors as much on an individual as on an institutional level in healthcare racial harassment and discrimination are linked to worse health outcomes regardless of socioeconomic status. (Nazroo, 2003) As Williams et al. (1994) indicate "the macrosocial factors and racism are the basic causes of racial differences in health. The risk factors and resources are the surface causes, the current intervening mechanisms. These may change, but as long as the basic causes remain operative, the modification of surface causes alone will only lead to the emergence of new intervening mechanisms to maintain the same outcome." (Nazroo, 2003)

III.5. Policy Implications

Racial and ethnic inequalities in various health outcomes, such as child overweight or obesity, differ across minority groups, therefore, a deeper understanding of these factors is necessary to create the appropriate public health and policy interventions. (Martinson et al., 2012) Services and policies are mostly based on the needs of the majority population. (Bhopal, 2007) A more profound examination of immigrant health trajectories would make it possible to tackle health inequalities by race and ethnicity (Constant, 2017) with interventions that are more targeted to minority children and adults (Martinson et al., 2015). Such policies could ensure quality treatment for minorities and might impede the health deterioration of immigrants. Several domains of policies could impact the disparities in health from public through health to fiscal and education policies. (Constant, 2017) Health professionals and staff in healthcare institutions should be trained and educated about minorities' specific needs and characteristics,

such as culture, religion, or living circumstances, in order to provide them quality treatment. It is also desirable to employ more people from ethnic minority groups who can become role models and provide insight into racial/ethnic minorities situation. (Bhopal, 2007)

The findings indicating that inequalities already exist from early childhood, preventive interventions in this period, for example in childcare or schools, could be beneficial for later health outcomes of minority people, such as reducing the probability of overweight or obesity. (Martinson et al., 2015) Overall, the most important fact to consider when studying health inequalities and creating policies is the heterogeneity of racial and ethnic minority groups. (Martinson et al., 2015) These disparities demand “greater academic attention”, particularly in Europe (Bhopal, 2007), but since inequalities persist in both examined countries, more studies and interventions are needed on both sides of the Atlantic.

IV. Analysis

In order to locate the statements about racial inequalities in health and health care in a broader national context and to compare the situation in the U.S. and the UK, I analyzed OECD data on different health-related indicators available for both countries in the past 20-30 years (OECD data was not always available for the same periods for the U.S. and the UK). These data provide an insight into the differences in body weight-related health problems, health expenditure, and insurance rates between the examined countries. For the United Kingdom (England and Wales) 2021 Census and for the United States ACS 2022 data further illustrate the context in which racial inequalities persist, and corroborate the correlation of socioeconomic status, namely education with an important health-related indicator, health insurance. The figures I created based on these data make the diverse types of differences and inequalities visible.

IV.1. OECD Data Comparing the United States and the United Kingdom

Regarding low birthweight infants in the percentage of live births, we can see an opposing trend for the two countries. From 1990 until 2002 the percentage of low birthweight babies was increasing in both countries, and the difference between the two values was moving between 0,2-0,5%. However, while in the United States it continued to increase, in the United Kingdom a slight decrease started and continued until 2021. Therefore, the difference between the two countries grew to 2,1% in 2021 as depicted on Figure 1.

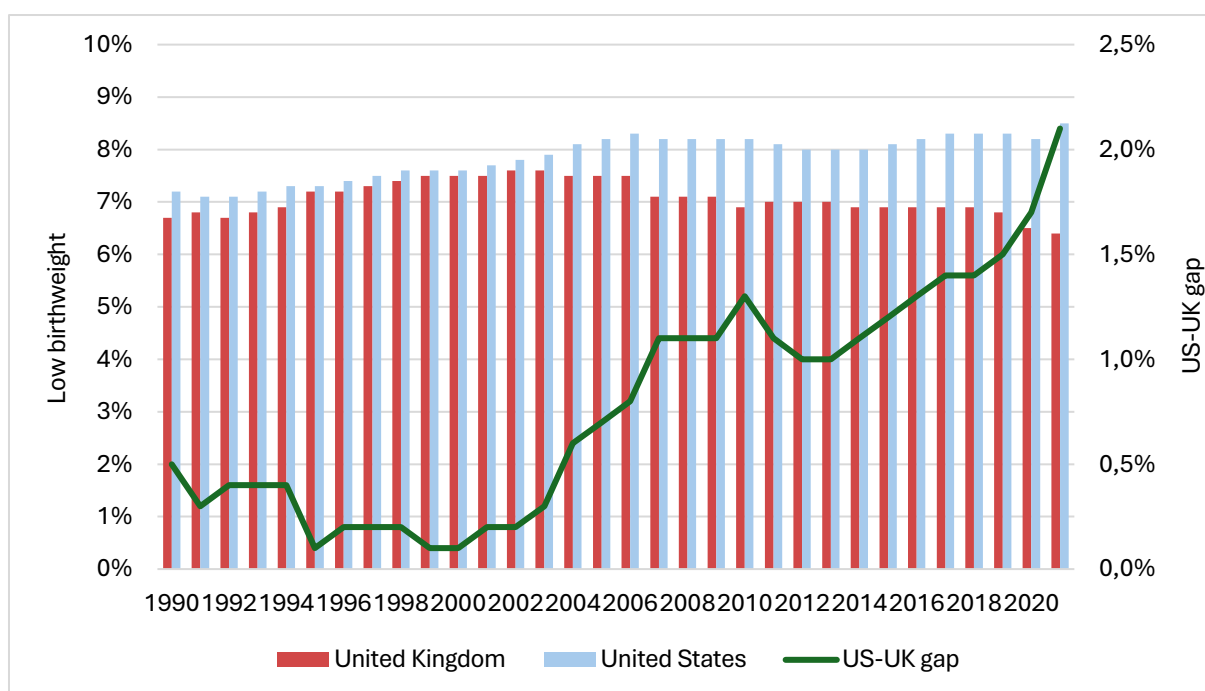


Figure 1. Low birthweight in the percentage of live births in the UK and the U.S., 1990-2021
Source: OECD Data Explorer – Health

In the United Kingdom, the share of population who are overweight or obese has been moving between 60-63% with only small changes from 2000 to 2018. In the United States, this same share has been increasing during this period from 64,5% to 73,1%. Consequently, the ratio of overweight or obese people was always higher in the U.S. than in the UK in the examined period and the gap between the two countries continued to increase.

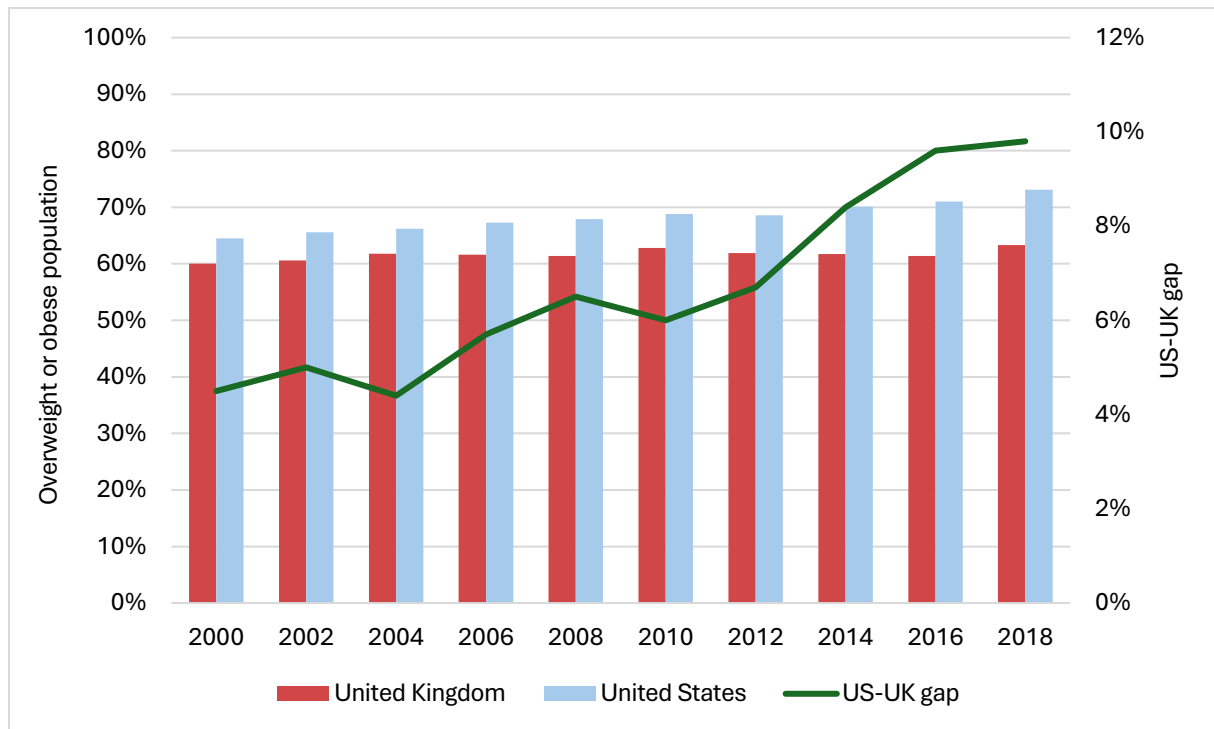


Figure 2. Share of population who are overweight or obese (measured) in the UK and the U.S., 2000-2018

Source: OECD Data Explorer – Health

Since the UK has a universal healthcare system, the percentage of the publicly or voluntarily insured population is 100%. On the contrary, this ratio in the United States has never reached its potential maximum. As it can be seen on the graph, there has been a fluctuation of the ratio of those who have a public or primary voluntary health insurance. From 1997 (OECD data for the United States was only available from 1997) to 2008 the value was slightly moving around 85%, then as a consequence of the economic crisis, it decreased to 81.3%, leaving almost one fifth of the population uninsured. From 2010, the ratio of those having an insurance started to increase again; this was the year of the implementation of the Affordable Care Act of President Obama, which aimed to ameliorate the situation of those most in need (Davis et al., 2011). However, a more significant increase has been observable only in the past 10 years, with the percentage of uninsured population falling under 10%.

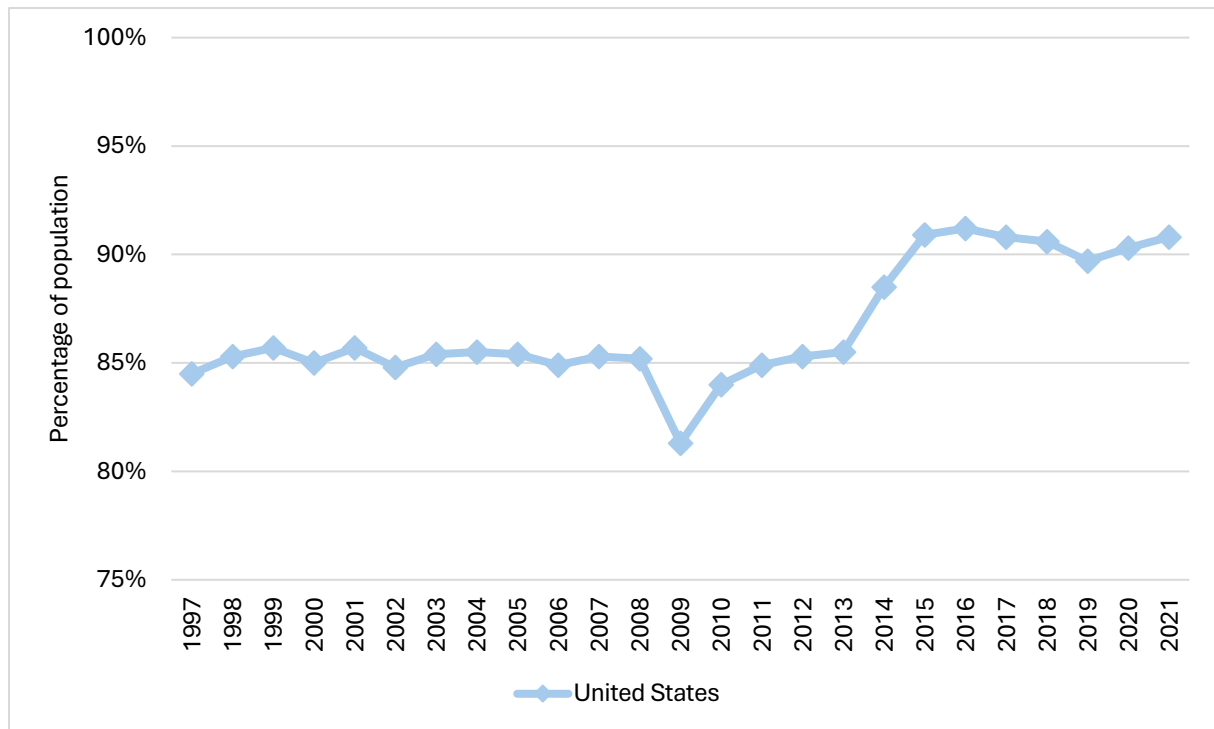


Figure 3. Public and primary voluntary health insurance in the percentage of population in the U.S., 1997-2021

Source: OECD Data Explorer – Health

The United Kingdom has always spent less on healthcare than the United States, which is paradoxical because it is not in line with other health-related indicators. Despite the great expenditures, the healthcare system of the United States does not cater for the whole of its population as even today about 10% of the population does not have an insurance and out-of-pocket payments are very high. Overall, we can see an increasing trend in health expenditure for both countries with a peak during the COVID-19 pandemic when the UK spent more than 12%, while the U.S. almost 19% of GDP on healthcare.

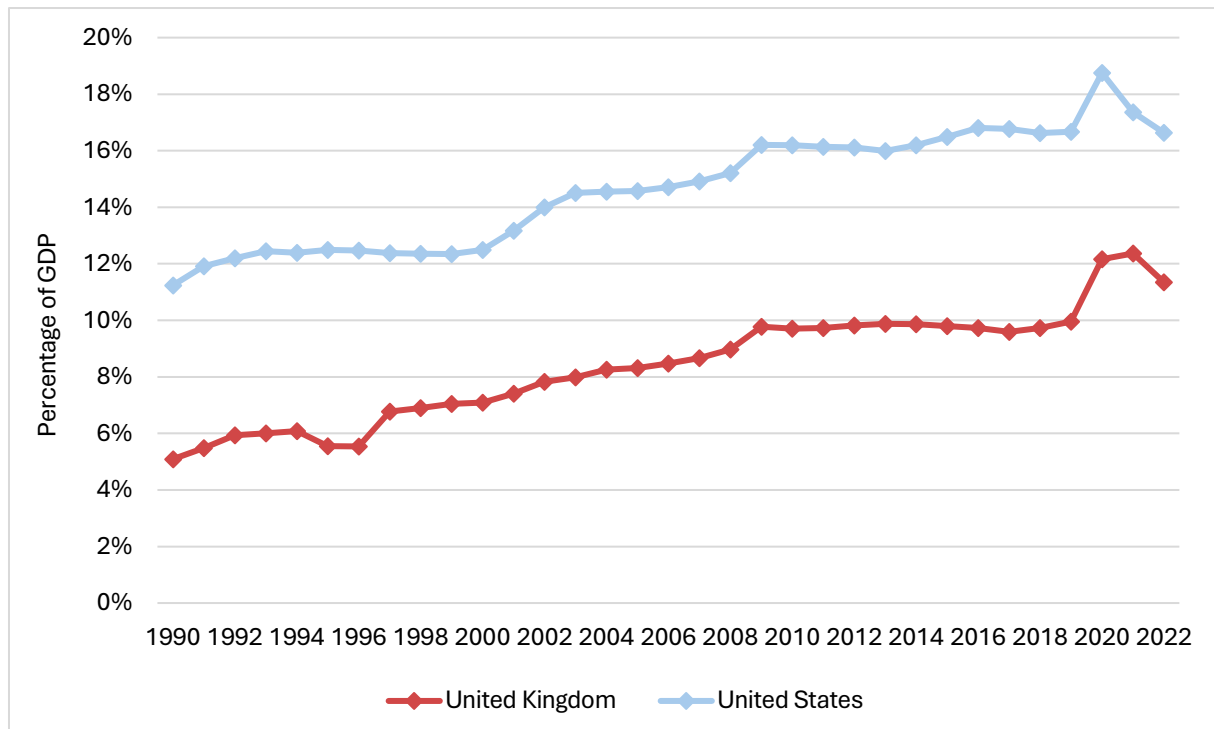


Figure 4. Health expenditure in the percentage of GDP in the UK and the U.S., 1990-2022

Source: OECD Data Explorer – Health

IV.2. United Kingdom 2021 Census Data

2021 Census data used here contain information about England and Wales as the method and pace of processing data varies among UK member states. England and Wales together have an immigrant population of more than 10 million people. Non-UK-born immigrants make up almost 10% of the total population, mostly from the Middle East and Asia, but also from Africa and the Americas and the Caribbean as seen on Figure 5. White race groups are mostly UK- or Europe-born, while the ratio of people born outside of Europe is around 50% among the Asian and Black, and other non-white ethnic group populations, depicted on Figure 6. This is important because several arguments about racial health inequalities refer to differences in certain values, norms, and habits, which might affect non-Europeans to a greater extent (see Constant, 2017; Florian et al., 2021).

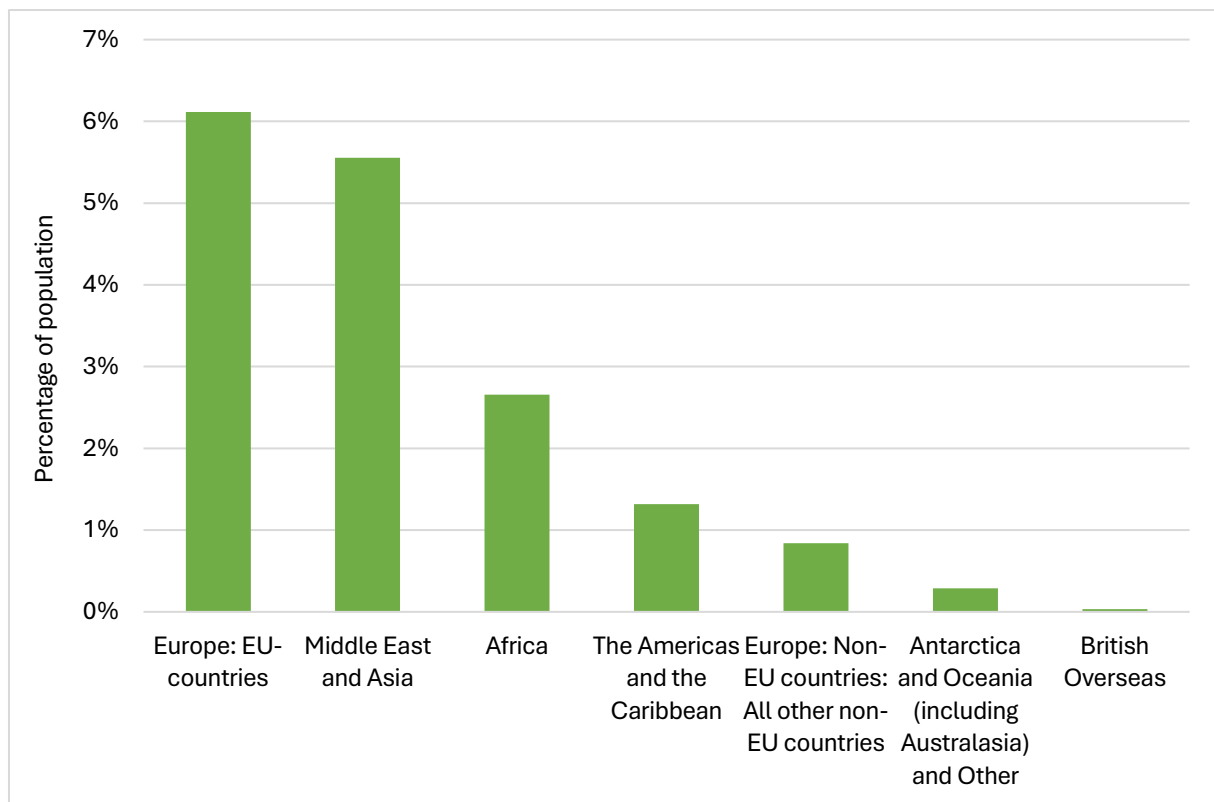


Figure 5. Immigrant population by region of birth in England and Wales, 2021
Source: 2021 Census, United Kingdom

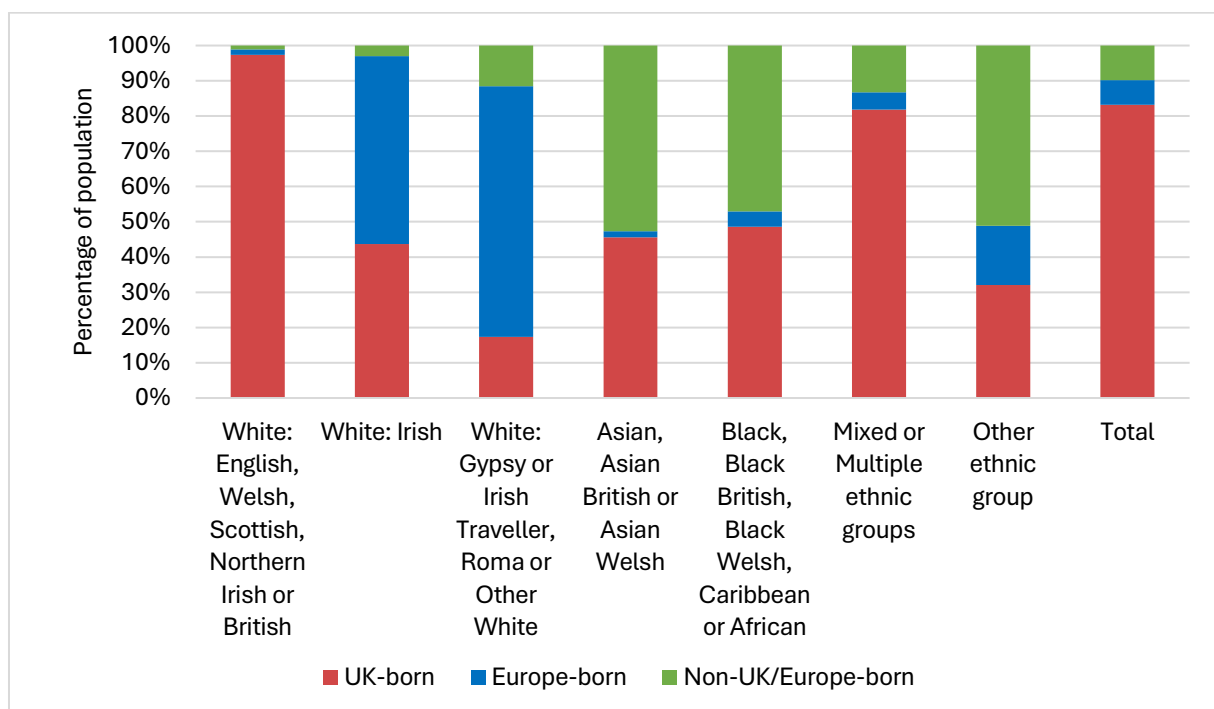


Figure 6. Region of birth by race groups in England and Wales, 2021
Source: 2021 Census, United Kingdom

2021 Census data provide information about general health, whether people reported it to be “good” or “not good” by ethnic groups. Looking at the summarized results, the ratio of

people reporting not good health was largest in the White Irish population, followed by the "White - English, Welsh, Scottish, Northern Irish or British" group according to the 2021 census in England and Wales. However, if we look at the more detailed data by age groups, we can see that this is mostly due to the higher amount of people reporting bad health aged 50 years and above, especially in the 65 years and over age group. On the other hand, in the case of the population that falls into the "Mixed or Multiple ethnic groups" category we can see the opposite of this distribution. A somewhat similar pattern is true for the population in the "Asian, Asian British or Asian Welsh" and the "Other ethnic group" categories as well. The population of the "White: Gypsy or Irish Traveller, Roma or Other White" category, as well as of the "Black, Black British, Black Welsh, Caribbean or African" reported most commonly good health in all age groups. These results might be attributed to life expectancy-related characteristics of the different race groups. In those categories where older age groups' reported health was not good there is a larger number and ratio of older people. In other words, the life expectancy of people of such races is higher, which leads to a greater amount of people with worse health, which is more common for elderly people, while the young people in these groups are still the healthiest. The contrary might stand for race groups where the pattern of general health is the opposite of this, however there is no current data available for life expectancy by ethnic groups. Apart from the White race groups, all other groups have the highest ratio of people reporting not good health in the 16 to 49 years age group as it can be seen in Figure 8.

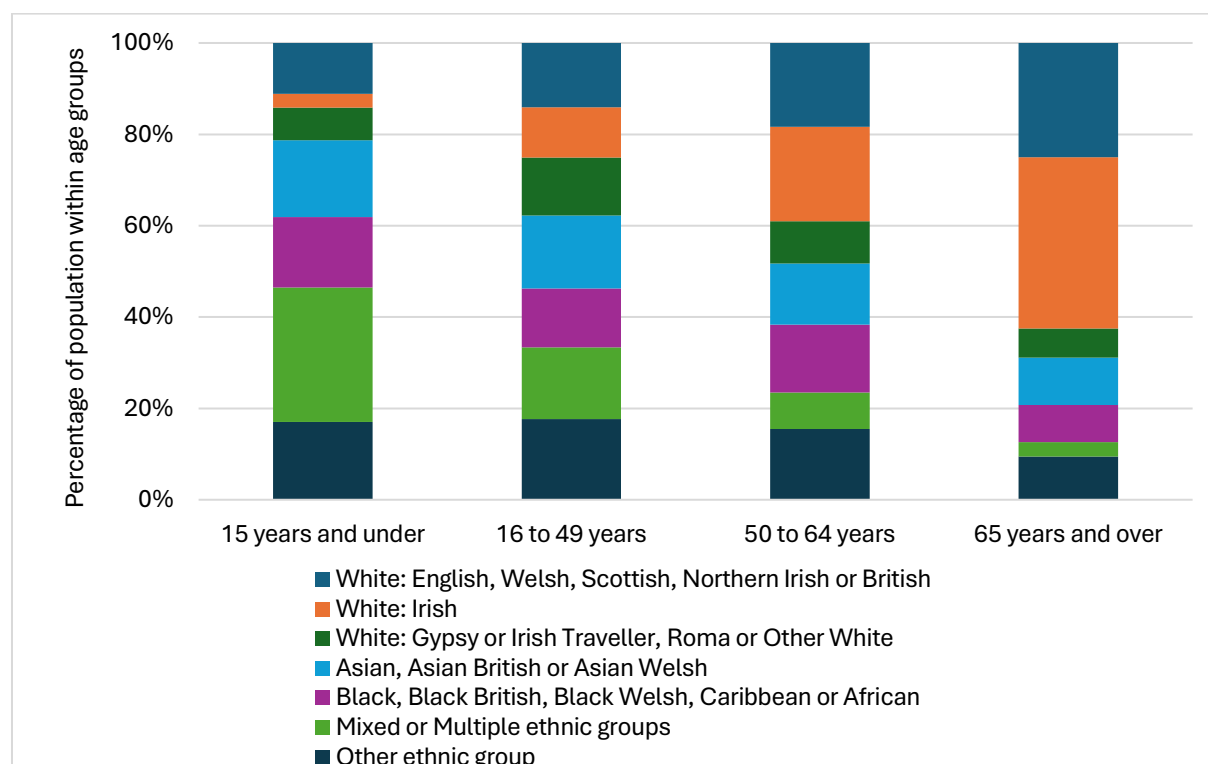


Figure 7. Percentage of population reporting "Not good health" within age groups according to race groups in England and Wales, 2021

Source: 2021 Census, United Kingdom

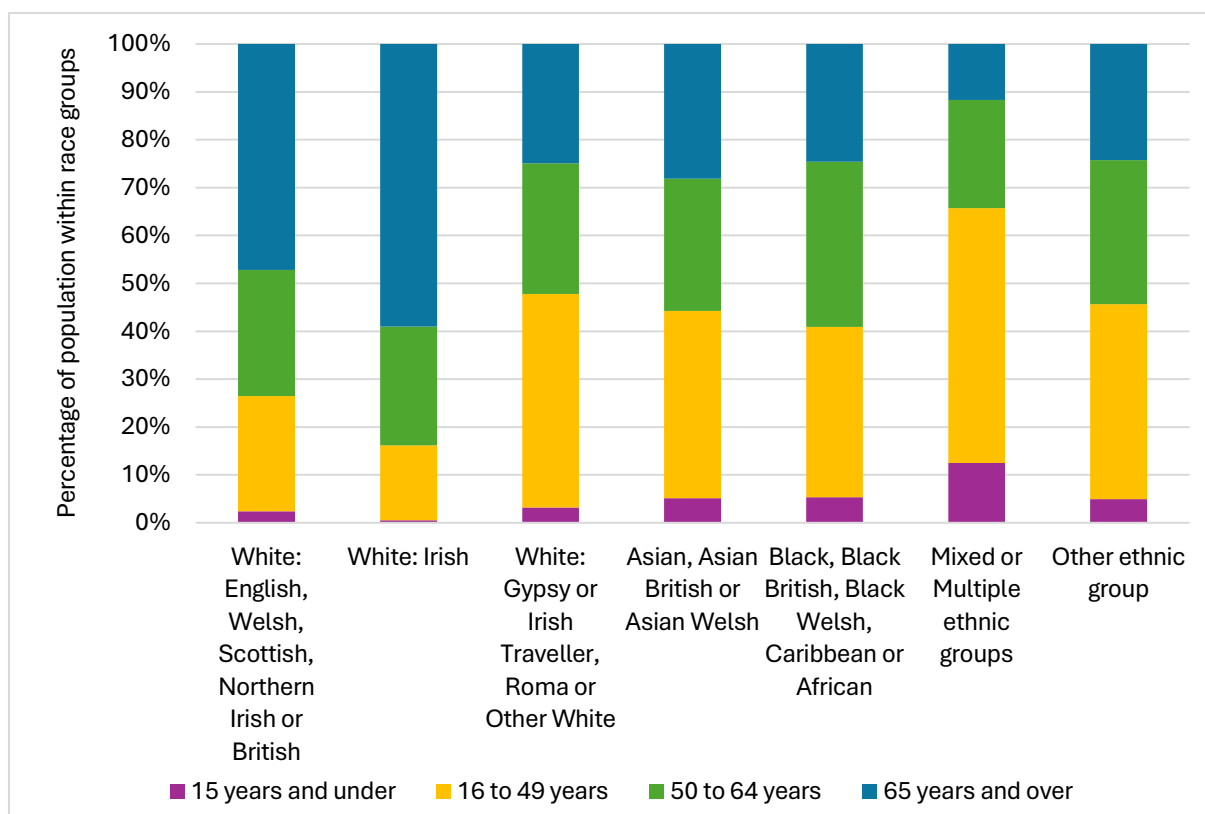


Figure 8. Percentage of population reporting "Not good health" within race groups according to age groups in England and Wales, 2021
Source: 2021 Census, United Kingdom

United States American Community Survey 2022 Data

The American Community Survey (ACS) provides estimates about different characteristics of the United States' population. In the U.S. almost 14% of the population is foreign-born. Among immigrants the largest group is that of Asians. About 44% of the foreign-born population has Hispanic or Latino origins (combined with any other race).

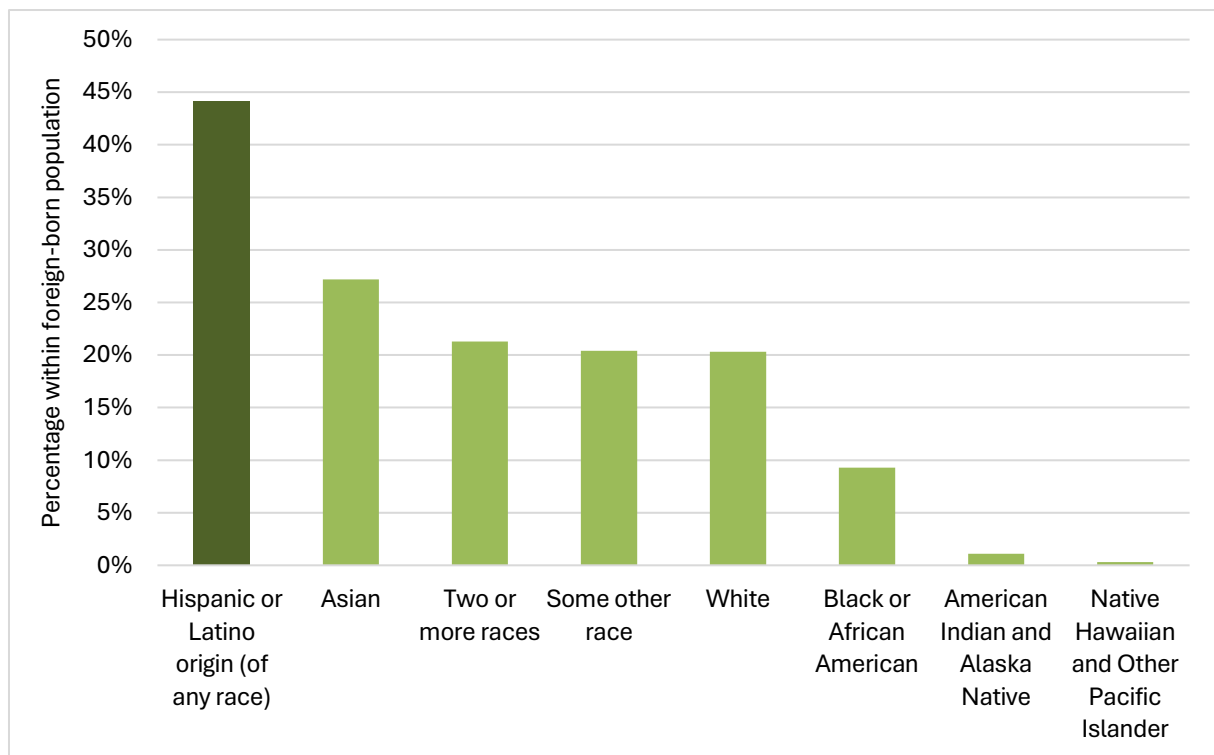


Figure 9. Racial distribution of foreign-born population in the U.S., 2022
Source: American Community Survey 2022

Health insurance is a significant concern for people living in the United States since the healthcare system, in contrast to the United Kingdom, is not universal. Approximately 92% of the total population was insured in 2022, according to the ACS 2022. Insurance rates were highest among Asians, followed by Whites and Blacks or African Americans. The ratio of those uninsured was largest for the "Some other race", the "American Indian and Alaska Native", the "Two or more races", and the "Native Hawaiian and other Pacific Islander" race groups, with 12-19% of the population not being insured. Lacking an insurance was most common in the 26 to 44 years age groups for all races and the least for those aged 65 years and over.

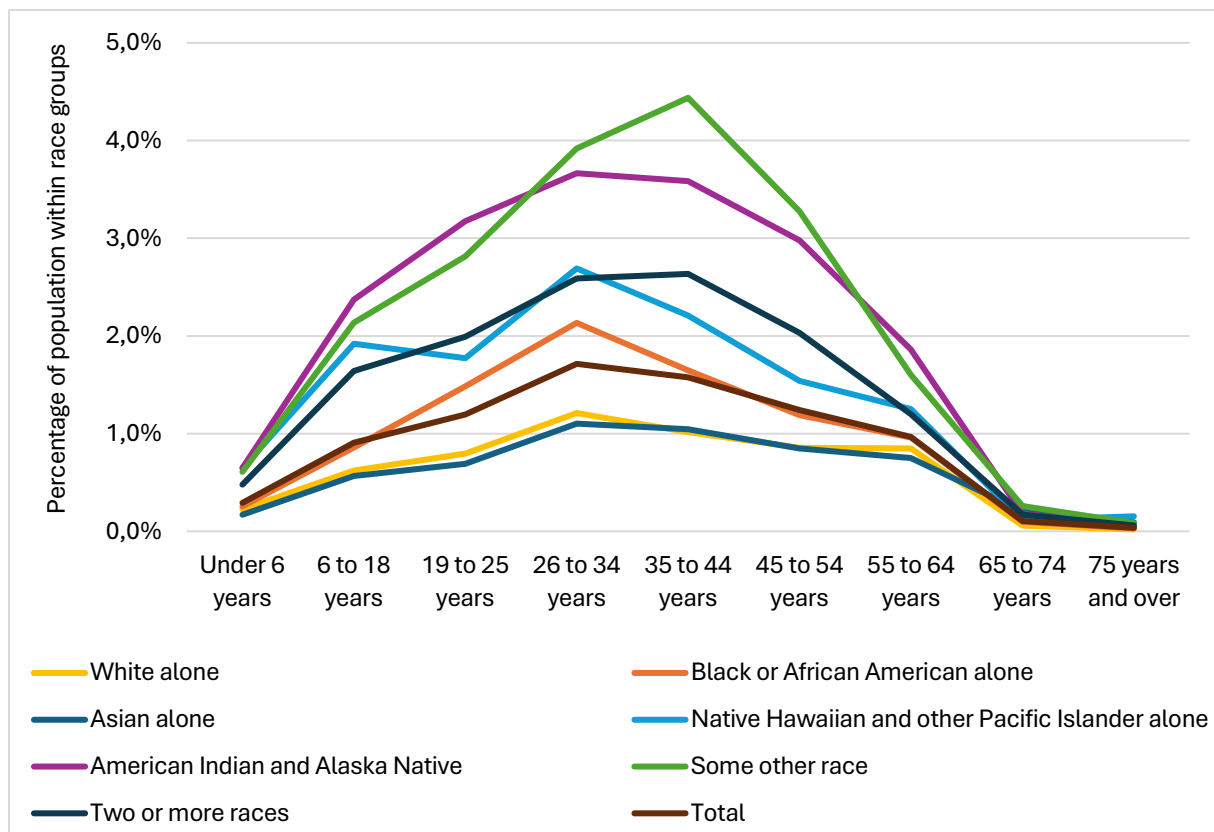


Figure 10. Percentage of uninsured population within race groups according to age groups in the U.S., 2022

Source: American Community Survey 2022

Education is an important indicator of socioeconomic status, and as such it is associated with many of the disparities that exist within a society, including racial inequalities in health and healthcare (see Nazroo, 2003; Choi – Martinson, 2017; Florian et al., 2021). 2022 ACS data shows (Figure 11) that possessing a bachelor's degree or higher is most common for Asians, followed by the White population, while the ratio decreases significantly for other race groups. The percentage of population having at least a bachelor's degree is less than 20% in the "Some other race alone" category, among American Indians and Alaska Natives, and Native Hawaiian and other Pacific Islanders. The ratio of population having less than a high school diploma is the highest in the former two groups, but it is above 10% among Blacks or African Americans, and Asians as well.

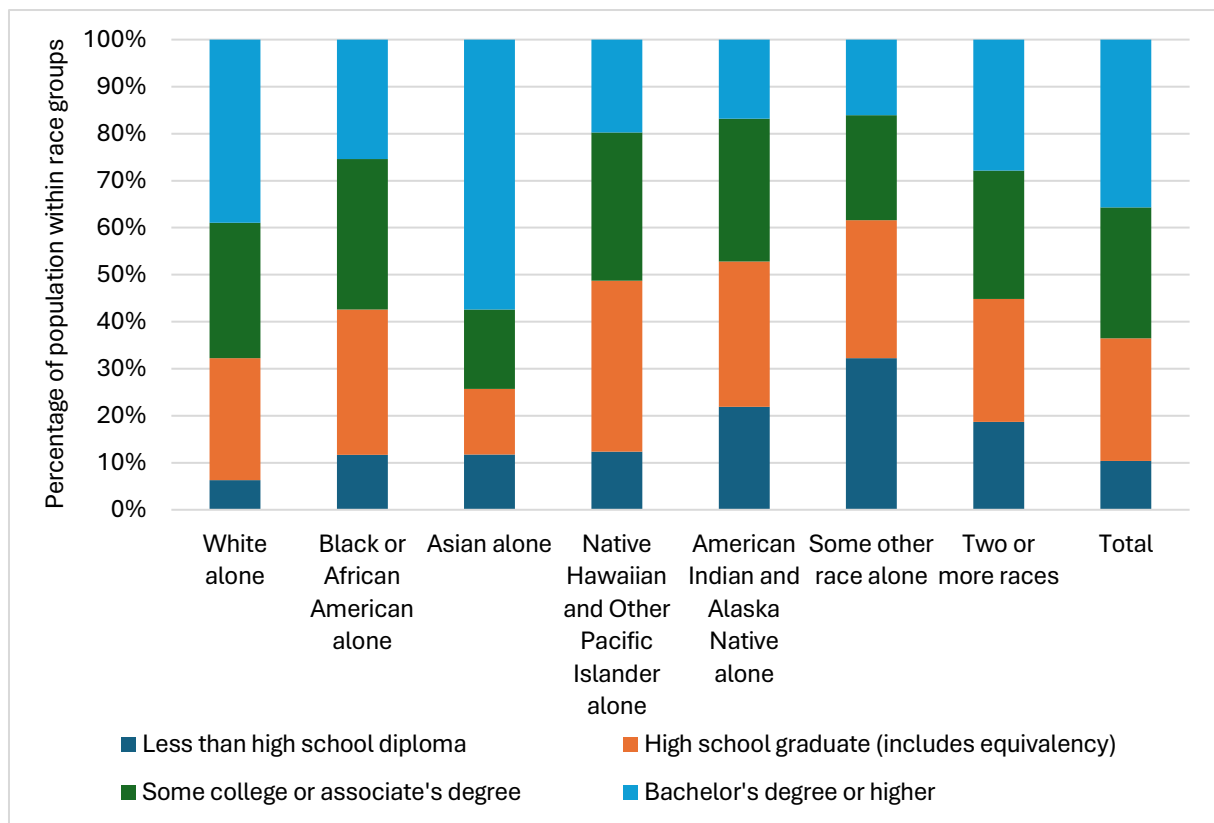
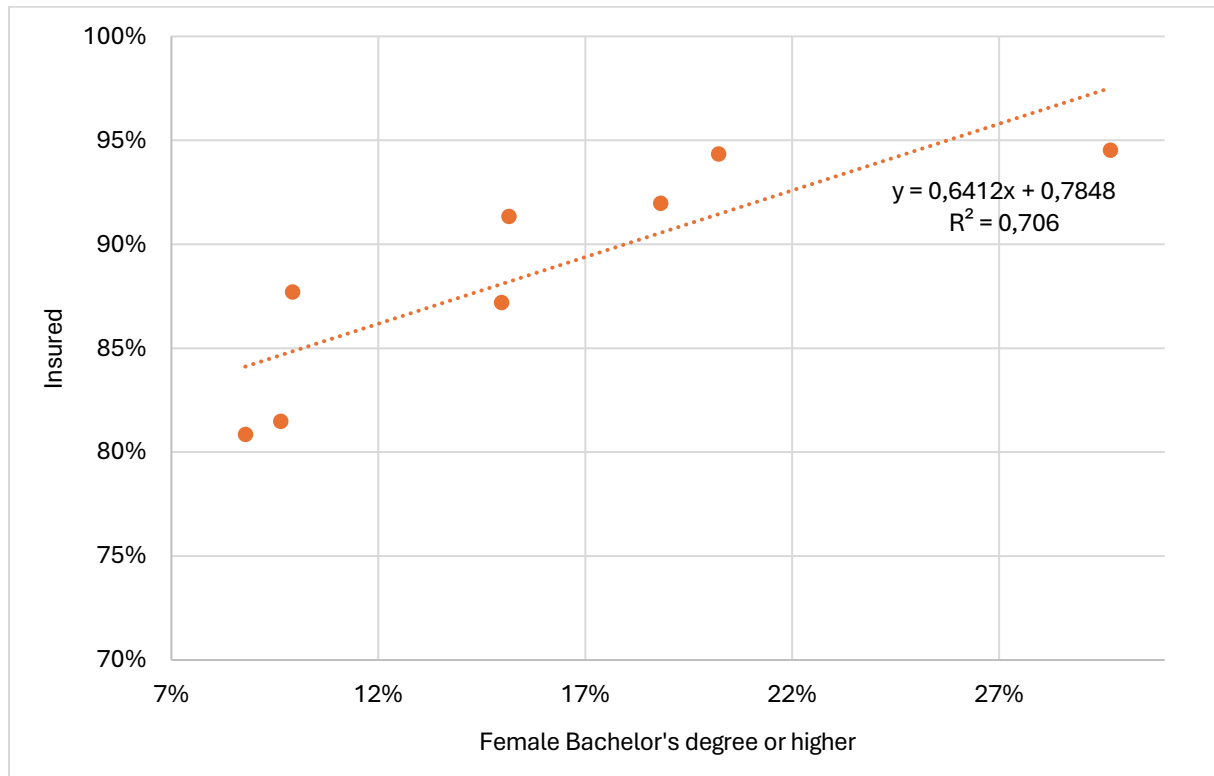


Figure 11. Percentage of population within race groups according to level of education in the U.S., 2022

Source: American Community Survey 2022

When doing a regression analysis to test whether being insured correlates with the level of education, the results show that, indeed, there is a strong positive correlation between being insured and having at least a bachelor's degree. The correlation is even stronger for women, where the value of R^2 is above 0,7, which can be seen in Figure 12.



*Figure 12. Correlation between insurance and education
(Female – Bachelor's degree) in the U.S., 2022
Source: American Community Survey 2022*

There is an even stronger negative correlation between being insured and the level of education being less than high school diploma, which is even more significant for men than women, R^2 being well above 0,7. This can be seen in Figure 13. Given that not having a bachelor's degree and having less than a high school diploma is most prevalent in non-white race groups, they are more affected by the above correlations in a negative way.

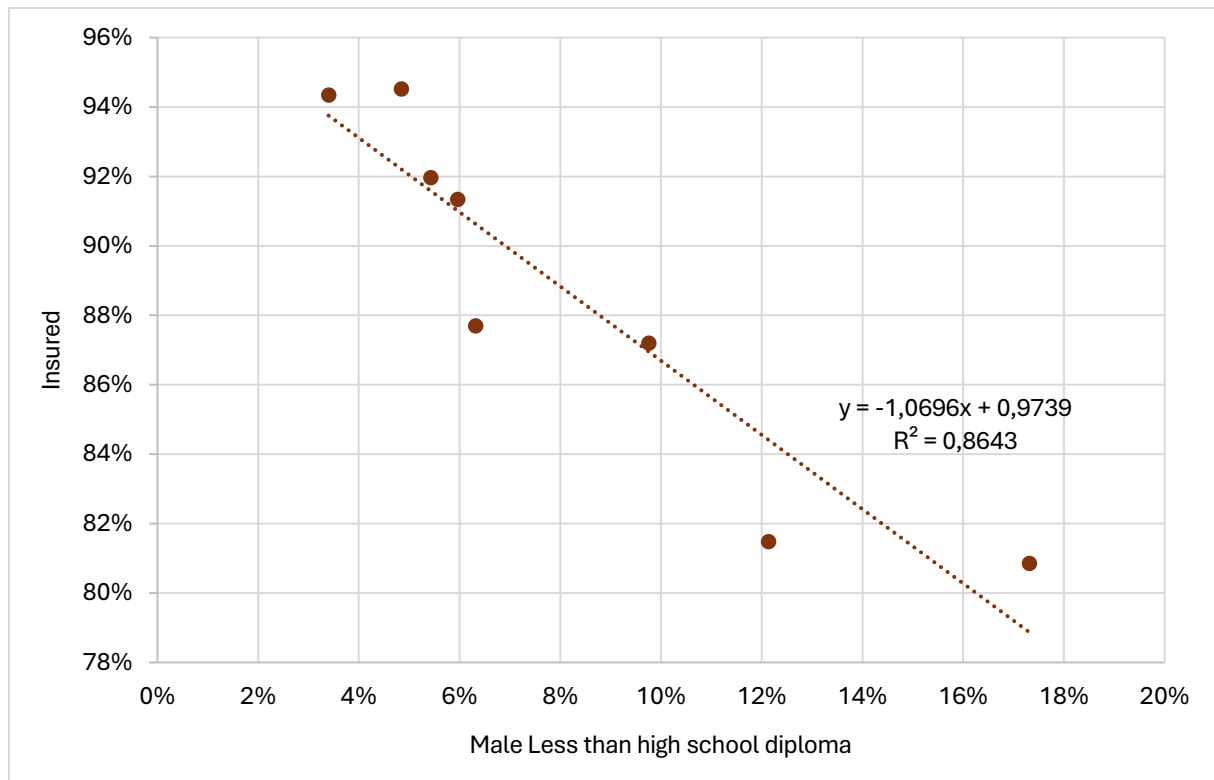


Figure 13. Correlation between insurance and education (Male – Less than high school diploma) in the U.S., 2022
Source: American Community Survey 2022

V. Limitations

This essay provided an insight into racial disparities in body weight-related health outcomes in the U.S. and the UK, and more importantly into different explanations that might account for such inequalities. The analysis of OECD data, 2021 Census data for the UK, and ACS 2022 data for the U.S. highlighted significant differences between the two countries as well as the prevalence of racial inequalities. However, a deeper understanding of the underlying mechanisms exceeds the limits of this writing, and other limitations must be considered as well with regard to the validity and generalizability of the studied literature and data. The examination of racial and ethnic inequalities in health is more frequent in the United States than in the United Kingdom (Nazroo, 2003; Martinson, 2010) and more precise data were available in the former as well. Moreover, data about the United Kingdom only included England and Wales due to the separate processing of census data in each member of the UK. Another limitation is that measurement of race and ethnicity is often problematic, since minority groups and ethnic identities can be very diverse as seen through the analyzed data as well.

The findings of most studies are hardly generalizable. The experiences of different minorities vary across borders and time. (Nazroo et al., 2007) Groups of the same origin might face entirely different obstacles in one country or another; immigrants and native minorities might also have various experiences, and generations also vary according to their socioeconomic status and their identities. To get a broader picture of inequalities data that permit the observation of changes during the lifetime would be indispensable (Nazroo, 2003), including age, cohort, and period effects (Martinson, 2010). The comparison of the U.S. and the UK is restricted by the differences of the surveys used by researchers and the data itself, but also the interpretation of the responses, as some issues might be understood differently in these countries because of the divergent cultures or healthcare structures. (Nazroo et al., 2007) With regard to the studies examining specific health outcomes, the findings are often mixed, and several different theories coexist concerning the reasons of racial disparities, which hinder generalizability.

VI. Conclusion

This paper gave an insight into racial and ethnic inequalities in health and healthcare in the United States and the United Kingdom, through examples of disparities in certain health outcomes and presenting possible explanations for these experiences. A summary of the most prevalent racial/ethnic disparities in body weight-related health outcomes in the U.S. and the UK served as an illustration of the existence of racial inequalities in health and healthcare in general. In both countries infants in racial minority groups were at greater risk of being low birthweight than Whites (Choi – Martinson, 2017) however immigrant status can have a protective effect, but this varies across race groups (Martinson et al., 2017). Studying this birth outcome is important because it can influence the cognitive development of the child and increase the probability of certain health risks. (Choi – Martinson, 2017) In the case of obesity, overweight, and BMI racial inequalities are prevalent in both countries favoring the majority population (Martinson et al., 2012), which are already detectable at early ages and persist in adulthood as well (Martinson et al., 2015). Overall, obesity rates are higher in the United States. Disparities in cardiovascular diseases and mortality show a heterogeneity across racial subgroups and countries and vary by gender in the case of hypertension and diabetes as well with some race groups experiencing worse outcomes, others not. The absence of a racial difference in some outcomes might be a result of inequalities in life expectancy and survival, which favor the White population. (Martinson, 2010)

The synthesis of the literature provided several possible explanations for these unequal experiences of racial minority populations as well as for the differences between the situation in the United States and the United Kingdom. Firstly, characteristics of the healthcare system of the United States and the United Kingdom can impact health. In the U.S., whether someone is insured, and the type of insurance largely determines the range of available services, and immigrants' access to certain services might be restricted, whereas in the UK the NHS provides universal access to healthcare services to residents and Europeans, and some basic services for asylum seekers as well. (Commonwealth Fund; Thorlby, n.d.) The access to healthcare is an important factor in disparities as the treatments people receive, such as diagnosis, medication, screenings, can influence their health. Despite the English healthcare system being universal, the extent of inequalities in some health outcomes is similar to that in the US. (Martinson et al., 2017)

The history of different ethnic groups in the given countries is also an influencing factor and might account for the different health outcomes of minorities of the same origin in one country or another, and the depth of inequalities. (Nazroo, 2003; Nazroo et al., 2007) The divergent admission criteria contributes to different composition and number of immigrants in the U.S. and the UK; some of these restrictions result in a positive selectivity by skills or education. (Martinson et al., 2017) The immigrant health paradox refers to the phenomenon that immigrants perform better in certain health outcomes despite their more disadvantaged socioeconomic status, which can be attributed to the selective nature of migration: those who migrate are often better educated and healthier than those who stay. (Constant, 2017) The values, norms, and habits, of minority people also effect health outcomes. For example, some cultures prohibit alcohol consumption, they might embrace healthier diets, or smoke less. (Martinson, 2010; Constant, 2017) However, several studies suggest that with time, the initial health advantage of immigrants disappears, either because of an unhealthy assimilation – taking up the less healthy habits of the native majority population, such as drinking and smoking –, or due to a simple regression to the mean of the majority. (Martinson et al., 2012) Moreover, they might also face some obstacles when moving to a new country that impact their health with time, like stress, living conditions, or employment opportunities. (Constant, 2017; Florian et al., 2021)

The role socioeconomic status plays in the explanation of racial/ethnic inequalities in health is contested, nevertheless, there is increasing evidence that including factors like

education, income, or employment in analyses reduces the health risks for minorities. (Nazroo, 2003). Racism and discrimination put an additional burden on racial/ethnic minority groups as well, by increasing their vulnerability, and worsening their mental and physical health. (Constant, 2017; Nazroo, 2003) In order to effectively tackle inequalities in health, interventions must be targeted and pay special attention to the heterogeneity of the experiences of different minority groups. As disparities already exist in early childhood, policies that target this period could have a beneficial impact on childhood and adulthood health as well. (Martinson et al., 2015)

Based on these arguments, I conducted an analysis of OECD data, which showed that the United States performed worse in the observed health outcomes, namely low birthweight, and overweight or obesity. Another significant difference between the two countries is that while the UK has a universal healthcare system with everyone being insured, the U.S. still has a tenth of its population uninsured, which is the basis of several health disparities. Both countries have a great proportion of immigrants, who are mostly non-white or have Latino or Hispanic origin in the U.S. In England and Wales all together White race groups reported not good health most frequently. However, when breaking down the result by age groups we can see that the representatives of non-White race groups reporting not good health is more common among younger age groups, while the ratio of population in not good health of White race groups is highest among older age groups. In the United States insurance rates were highest among Asians, followed by Whites and Blacks or African Americans. Being uninsured was most common in the 26 to 44 years age groups for all races, which partly corresponds to the 16 to 49 years age group where non-white population reported not good health the most in England and Wales. Regarding the correlation between education and insurance rates in the U.S., there is a strong positive correlation between being insured and having at least a bachelor's degree, especially among women. Moreover, there is an even stronger negative correlation between being insured and the level of education being less than high school diploma, more significantly for men. Not having a bachelor's degree and having less than a high school diploma is most prevalent in non-white race groups, which corroborates the importance of socioeconomic arguments when analyzing racial inequalities. The results of the data analysis and the regressions are well-illustrated by the figures I created.

Overall, the patterns of racial/ethnic inequalities in health show a complex picture, varying by age, gender and across different minority groups. Such disparities persist in both studied countries, but in several aspects the United States performs worse. Therefore, these inequalities in health and healthcare remain an important issue to be studied and understood by scholars and policy makers so that they can be reduced on both sides of the Atlantic.

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Data sources

OECD Data Explorer: [https://data-explorer.oecd.org/?fs\[0\]=Topic%2C0%7CHealth%23HEA%23&pg=0&fc=Topic&bp=true&snb=47](https://data-explorer.oecd.org/?fs[0]=Topic%2C0%7CHealth%23HEA%23&pg=0&fc=Topic&bp=true&snb=47) Last accessed: 17/04/2024

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