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THE COST OF RACISM

How ethnic health inequalities are standing in the way of growth

The new Labour government has made growth the centrepiece of its policy platform for this parliament, confident that economic growth is the route to prosperity, better public services and, ultimately, a healthier and happier nation. Achieving this vision, however, will mean confronting a significant barrier to growth – the effect of racism on the health and wellbeing of the population. This briefing explores the extent to which health inequity is costing our country money, not only in direct costs to the NHS, but also to the economy more broadly. It also identifies a dearth of analysis of the broad economic costs of racism in health and makes the argument for a new study on the cost of racism, pointing the way towards a fairer and more efficient healthcare system.

Evidence of health inequity and differences in health care experiences between different ethnic groups is well documented. According to data from England, we know that Black, Asian, and minority ethnic communities are more likely to die in childbirth than White British women, that Black men are more likely than White men to be sectioned under the Mental

Health Act, and that Black and Asian communities routinely report worse experiences of accessing health care.[1] We also know that these issues are deeply institutional, with ethnic minority staff within the health service less likely to be filling senior posts, and more likely to experience discrimination and harassment.[2]

At a deeper level, racism is embedded in **policies, governance structures,** and **cultural norms.**

The causes of these differences are complex, interconnected, and associated with factors such as differences in income, employment, housing, and other factors, not least racism. Racial discrimination not only affects the underlying causes of people's health and illness – their life chances, access to education, income and so on – but also their access to health care and treatment.

Racism can also influence the way a person is treated in hospital or bias the decision-making of medical professionals. At a deeper level, racism is embedded in policies, governance structures, and cultural norms. Deeper still, racism influences how funding is distributed, how and by whom research is carried out, and the design and manufacture of essential medical devices, diagnostic processes, and treatments.

The moral case for tackling the health inequalities that arise from discrimination is unarguable, but it is not the only case to be made. Another way of measuring the cost of racism, and one which further underlines the ethical imperative to tackle racism and its impacts on individuals, is an economic approach to estimating the monetary cost to individuals, the NHS, and the economic life of society in general. Such an approach would be similar to "cost of illness" or "burden of disease" studies.

Using such approaches, it becomes possible to describe and quantify the wide-ranging costs associated with racism. This could include the direct costs of treatment, the indirect costs of reduced productivity, and the more intangible, hard-to-measure costs to individuals who experience work-related stress or mental health burdens due to discrimination. This approach can drive home the point

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that failing to tackle racism has an immense economic cost, while also underscoring the savings that could be made by addressing these inequities.

As we explore the cost of racism within the UK context, it becomes clear that a dual focus on both the human and financial impacts of racial health disparities is essential. While the ethical imperative for change is clear, framing these disparities in economic terms can help further bolster the argument for urgent and meaningful interventions. The rest of this paper will begin to outline what such a cost of illness study could look like, drawing on previous research and laying the groundwork for future analyses that will drive real change in both policy and practice.

CALCULATING THE COST OF RACISM

Calculating the monetary cost of racism is not a simple matter. The impacts of racism are so deeply embedded in the health and care system that it touches almost everything we do. For example, we know that Black men are more likely to access mental health services in acute crisis, requiring more intensive and potentially more costly treatment and care. If these individuals accessed care earlier, could the cost be reduced? Would precision medicine be more effective if genetic biobanks were more representative of the national population? How much money could the system save in employment tribunals if workers were not experiencing racism and discrimination? In our work on race inequity, nearly every thread we follow leads to inefficiency and cost. A health system that fails to serve its population in a timely and equitable way will always lead to waste.

The **cost of illness (COI) study** is a long-established tool in health economics. It describes an approach that attempts to 'identify and measure all the costs of a particular disease, including the direct, indirect, and intangible dimensions'.[3] These studies are designed to find the cost – to a healthcare service or to society as a whole - of a particular disease, and therefore articulate the potential savings of treating that disease. COI studies can be useful tools in identifying appropriate policy focus, and in prioritising and directing research funding towards priorities that promise the greatest future return for the system.

While there are limits to these studies, they can form a helpful tool in policymaking and, at the Observatory, we're interested in whether a similar methodology might be applied to racism itself. Can we estimate the cost of racism to the NHS, to the public purse, and to society more widely? In doing so, can we build upon the already powerful case for a policy focus on eliminating ethnic and racial inequity in healthcare?

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PAST ATTEMPTS TO QUANTIFY THE COST OF INEQUALITIES

Despite the abundance of evidence on racial health disparities, there has been limited work in the UK specifically focused on calculating the economic costs of racism in health. However, several efforts to estimate the broader costs of health inequalities provide useful insights and methodologies that could inform a study on the cost of racism.

Black Report (1980)

One of the earliest and most significant reports on health inequalities in the UK was the Black Report (1980), which highlighted the social determinants of health, particularly focusing on class as a driver of disparities.[4] The report argued that addressing these inequalities would not only lead to better health outcomes but also substantial economic savings for the NHS and wider society. While the Black Report did not specifically address racial disparities, its findings remain relevant in illustrating how structural inequalities, whether based on class or race, can lead to inefficiencies and financial burdens in healthcare systems. The lessons from the Black Report suggest that a similar economic approach could be applied to racial health inequalities, particularly by highlighting how unequal access to healthcare and poorer health outcomes among ethnic minorities contribute to higher overall costs.

Salisbury Centre for Mental Health (2006)

Further evidence of the human cost of racial health inequities can be drawn from a 2022 report on excess deaths in the United States.[5] This analysis revealed that, between 1999 and 2020, 1.63 million excess deaths occurred among Black Americans due to racial health disparities. This equates to 74,090 premature deaths annually, or approximately 203 Black lives lost every day that would not have been lost if racial health inequities were eliminated. These staggering figures paint a clear picture of the devastating human toll of racial disparities. At the same time, they also serve as a powerful illustration of the potential economic costs associated with lives cut short, lost productivity, and the additional healthcare services required as a result of these disparities.

Marmot Review (2010)

Further analyses have sought to quantify specific aspects of health inequities, providing a foundation for understanding the potential economic costs of racial discrimination. For instance, a 2006 study by the Salisbury Centre for Mental Health compared the costs of mental health care pathways for Black and White service users in London.[6] The study found that the average annual cost per Black

Paradies et al (2016)

service user was £6,539, compared to £4,132 for White service users. This disparity was primarily due to Black individuals accessing services later and in more acute states, resulting in higher-intensity and costlier interventions. The study estimated that more equitable care could save approximately £100 million. Although focused on mental health, this analysis highlights the broader issue of delayed or inadequate care among ethnic minority groups, which leads to higher overall costs.

Centre for Health Economics (2016)

Looking beyond the UK, there are international examples that offer valuable perspectives on how to measure the economic impact of racial discrimination. A 2016 study conducted in Australia applied a COI methodology to assess the mental health costs of racial discrimination.[7] The study concluded that racial discrimination resulted in significant economic losses, costing the Australian economy $37.9 billion annually, or roughly 3.02% of its GDP. Although the focus was on mental health, the study demonstrates the potential of applying economic analyses to racial disparities in healthcare. Such methodologies could be adapted for the UK to estimate the financial burden of racial health inequities.

McKinsey Institute for Black Economic Mobility (2019)

In the United States, the McKinsey Institute for Black Economic Mobility published a report in 2019 examining the economic impact of closing the racial wealth gap.[8] Although the report primarily focused on wealth inequality, it emphasised the critical link between health and economic outcomes. Poor health outcomes caused by racial disparities often limit individuals' ability to achieve their full economic potential, thereby perpetuating cycles of inequality. This intersection of health and economic disparity offers a valuable framework for understanding the potential economic benefits of eliminating racial health inequities in the UK.

Closer to home, there have been efforts to quantify various aspects of health inequality in the UK. Michael Marmot's landmark 2010 study of health inequalities attempted to identify the order of magnitude costs of associated with health inequalities looking at, among other things, direct costs to the NHS, productivity losses, and the financial impact of shifts in disability free life expectancy.[9] Focusing on health inequalities more broadly, as opposed to race, the report attempts to produce a counterfactual assessment of the costs that could be saved if everyone in the country had the same health outcomes as the richest 10% of the population. It estimated that health inequalities lead to productivity losses of £31-33 billion per year; led to lost taxes and higher welfare payments in the region of £20-32 billion; and

Caraballo et al
(2022)

direct costs to the NHS of at least £5.5 billion.[7] As the report accepts, these figures are primarily intended as an illustration to inspire action.

Finally, a 2016 paper from the University of York's Centre for Health Economics, attempts to outline the cost of inequality according to deprivation by looking at disparities in inpatient hospital costs. It concluded that this inequity resulted in costs of around £4.8 billion in 2011/2012.[10] Each of these studies is, in their own way, limited by both the quality of data available, and by the complexity of the question each sets out to ask. Health inequalities do not exist in a vacuum, and such figures will only ever be illustrative. Nevertheless, they provide indicative estimates of the costs of inequality and an approach to estimating the costs of racism in particular.

CURRENT PICTURE

In preparing this briefing, we have conducted a limited and non-systematic literature search to gauge current knowledge on the financial and economic costs of racism and racial discrimination in healthcare. This exercise demonstrated that, while there has been limited work to assess direct costs, the evidence pointing towards indirect costs is substantial. The following section of the paper presents a high-level view of how these costs might be articulated.

POORER HEALTH

It is important first to consider the cost incurred by the underlying burden of poor health experienced by Black, Asian, and minority ethnic communities in England. We know that, across many diseases and conditions, there is greater prevalence of disease in these minoritised communities.[11] This can be seen in higher admission rates for certain ethnic groups, in measures of healthy life expectancy, and in self-reported health.[12, 13, 14] The reasons for these inequalities are complex, driven by a number of societal factors across housing, education, access to green space, disparities in infrastructure, pollution, and many more. Underlying these factors, however, is structural racism and the related inequalities that determine a person's likelihood of experiencing poorer health. This represents one of what Michael Marmot has referred to as 'the causes of the causes' of health inequity.[15, 16]

This dynamic has never been played out more explicitly than during the COVID-19 pandemic, where individuals from ethnic minority communities and members of the health and care workforce were quickly seen to be dying at much higher rates than their White counterparts. At the time, UK policymakers in the government's Race Disparity Unit were quick to stress the fact that 'ethnicity itself was not thought to be a risk factor', an explanation that failed to account for the many ways in which race and racism directly inform other cited risk factors, including working in a front-line job (such as healthcare, transport or hospitality), living in a multi-generational household, or living in a dense urban centre.[17]

As the evidence shows, a higher disease burden leads to higher cost, both in terms of the delivery of care, and in terms of the cost to society of lost working years to conditions such as cardiovascular disease, sickle cell disease, and diabetes. We see extensive inequalities in maternal health, mental health, and other areas that cannot be dismissed as cultural difference or explained away by controlling for other factors. These inequalities affect both men and women and are present across the entire life-course.[18, 19] Each of these points of inequality leads to greater cost and, were we to eradicate this underlying inequality in disease burden, it may be possible to realise savings to the health service.

ACCESS TO HEALTHCARE

Exacerbating inequalities in underlying disease burden is inequality in access to services. With access, cost tends to derive from the lack of timely diagnosis and treatment, where conditions become more acute and therefore more expensive to treat over time. For example, in mental healthcare where some ethnic minority groups, especially Black men, tend to present at the point of more acute crisis. We also see that Black and Asian women and pregnant people, particularly migrants, often have less positive experiences in accessing maternal services, including through maternal mental health screening processes.[20]

Ineffective screening – wherein some communities are underrepresented – present a cost in terms of missed diagnosis and later commencement of treatment. The evidence shows ethnic inequalities in screening across various forms of cancer, cardiovascular disease, mental health and maternity, citing a number of associated factors including cultural beliefs, awareness, and structural racism.[21, 22, 23, 24] The same studies show that more effective and representative screening can reduce healthcare inequalities and, by extension, cost.[25, 26]

Issues in access also extend beyond screening programmes to both primary and secondary care. Evidence suggests that language, culture, population diversity, and institutional attitudes all prove a barrier to primary care access for some ethnic minority communities, creating limitations to reaching what is often considered the 'front door' of healthcare services.[27] These are often exacerbated by practical barriers such as the cost of transport, time off work, and childcare. These limitations in access extend also to elective care, with evidence

showing that, particularly in the post-COVID service, Black, Asian, and ethnic minority individuals tend to remain on waiting lists for longer than the White British population.[28] While inequity in access is present across a majority of minoritised groups, there is also evidence of particularly stark issues in access for migrant groups and for Gypsy, Roma, and Traveller communities.[29]

EXPERIENCE OF TREATMENT AND QUALITY OF CARE

Inequities in experiences of healthcare and the quality of care received not only lead to higher cost in terms of poorer outcomes of care, but also in the burden of complaints, legal action, and the investigation of serious events or near-misses. Evidence shows significant differences of experience for ethnic minority communities. Some stark examples include the provision of pain management drugs, with research showing that patients from racial and ethnic minority groups were less likely to receive prehospital pain medication after traumatic injury than White patients, as well as stark examples of preventable deaths among sickle cell disease patients.[30] We also see that differences in quality of care for different ethnic groups in dementia care, and the treatment of severe mental illness.[31]

A study of emergency hospital admissions shows that admission was especially high among individuals of Bangladeshi, Pakistani, Black African, White other, or other background with up to twofold differences compared with the White British group.[32] The study's authors concluded that these admissions would have been avoidable, but for suboptimal primary care, suggesting that greater investment in delivering high quality care more equitably could have saved a significant amount of money. Similar conclusions have been drawn in international literature, where there's evidence of poorer quality care leading to a higher rate of readmission for ethnic minority patients.[33]

WORKFORCE

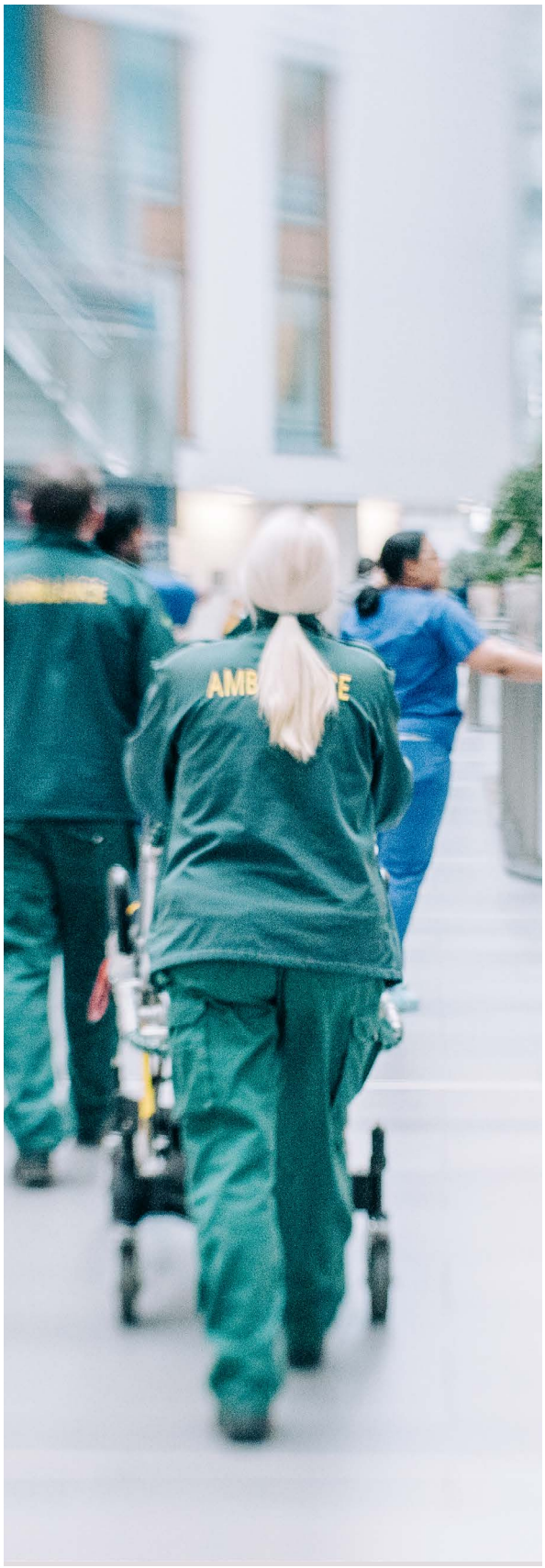
The NHS Workforce Race Equality Standard (WRES) shows that a quarter of staff in the NHS are from a Black, Asian, or ethnic minority background.[34] This figure rises to 41% for the medical and dental workforce. And yet, as explored by the WRES, as well as the British Medical Association, the Nursing and Midwifery Council, the General Medical Council, and others, these workers continue to suffer discrimination and harassment from both patients and colleagues, have worse chances of being promoted and championed in their workplace, and do not feel represented by their leadership.

Evidence shows disparities between different ethnic groups in the healthcare workforce in terms of outcomes from COVID-19, and in related areas such as the provision of personal protective equipment, effective risk assessments ahead of placements, and support from employers.[35,36,37] Poorer experiences are not limited to the pandemic response, however, with many studies detailing experiences of racist behaviour in the NHS,

and others highlighting higher rates of stress, burnout, and related mental health issues.[38]

Poorer workplace experiences for ethnic minority workers are not only unjust, but have a **direct impact on staff morale, retention** and **recruitment.**

Poorer workplace experiences for ethnic minority workers are not only unjust, but have a direct impact on staff morale, retention, and recruitment. All of these factors contribute to higher cost through turnover, sick-pay, agency use, and tribunals.



CONCLUSION

This paper represents the start of an essential conversation about the economic cost of racism in healthcare and how it affects the NHS, individuals, and wider society. While the moral case for addressing health inequities remains clear, this discussion has highlighted the pressing financial argument, that failing to address racial disparities not only harms individuals but places a significant economic burden on the healthcare system and the broader economy. We must never lose sight of the human costs of racism, but we must also consider the financial and economic costs if we're to fully remove excuses for inaction.

The evidence presented throughout this paper demonstrates that racial health inequities result in inefficient resource use, greater healthcare costs, and lost economic potential. Drawing from studies like the Black Report (1980) on social determinants of health, we can see that structural inequalities continue to persist and result in significant financial losses. These findings reinforce the need for targeted policy interventions that address the root causes of racial health disparities.

WHAT COMES NEXT?

The next steps must focus on the development of a cost of illness framework that quantifies the economic impacts of racial health disparities in the UK. This framework would involve robust data collection on health outcomes, healthcare access, and the costs associated with preventable illnesses and delayed care. By adapting methodologies like those explored in this briefing, we can create a similar model for the UK. Such a model would allow us to estimate the excess healthcare costs and premature deaths that occur due to racial disparities and provide policymakers with a clearer understanding of the financial stakes involved.

Ultimately, the findings of this study would highlight the significant savings that could be realised by addressing racial health disparities. The inefficiencies caused by systemic racism, from avoidable hospital admissions to workforce discrimination, place unnecessary strain on an already stretched NHS. Addressing these disparities will lead to a healthcare system that is more equitable, efficient, and accessible for all. By shifting resources toward preventing the root causes of racial health inequities, we can improve outcomes and achieve better financial sustainability within the NHS. This cost of illness analysis will be a vital tool in shaping future policy and ensuring that racial health inequities are tackled with the urgency and seriousness they deserve.

FOOTNOTES

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