Racism in health and health care in Europe: where does the Netherlands stand?

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Racial discrimination is a sensitive and difficult topic. The lack of systematic evidence of racism in many European countries leads to an automatic assumption that racism does not play a role in society. Where evidence exists, there is reluctance to acknowledge the reality of discrimination.

Bhøpal touched on this sensitive topic and emphasised that if discrimination is left unchecked, the economic, social, scientific and political circumstances that allowed Hitler’s policies to flourish could return. To most well-meaning people in Europe, the notion of history repeating itself will make very uncomfortable reading. However, recent experiences, including the Srebrenica massacre, the increasing popularity of the right-wing political parties exacerbated by islamophobia, and the social tensions in a number of European countries clearly support this depressing notion.

Racism in health and health care

Inequalities in health and health care of ethnic minority groups are evident in many countries. These inequalities are the result of a complex, inextricably linked set of factors, of which racism might be one of the elements. Indeed, evidence suggests that experiences of racial harassment and discrimination is central to the lives of many minority groups and these contribute to ethnic inequalities in health.

Tackling the issue of racism in health is often fraught with difficulties. It becomes unthinkable by health professionals that such an ugly word could be directed at the very professionals that should be protecting equality in health. However, histories such as the notorious Tuskegee Syphilis Study, where many African-Americans with syphilis were deliberately denied treatment, illustrate that health professionals are not immune to racism. (http://www.infoplease.com/spot/bhmtuskegee1.html)

References
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doi:10.1093/eurpub/clm039
Bhopal’s plea that it is time to take racism in health and welfare services seriously needs to be heeded. Tackling racism in health care is a major challenge. However, regardless of the difficulties of this challenge, equity, the core principle of health care in many European countries is something precious to be cherished and fought for.

**The Dutch perspective**

Tolerance is a source of Dutch pride. The Netherlands was the first European Member State to pass a comprehensive anti-discrimination law. The Equal Treatment Act (Algemene wet gelijke behandeling) has been in force since 1994. However, the recent Social and Cultural Planning Office of the Netherlands report shows that discrimination and negative portrayal of ethnic minorities is a problem and is one of the reasons for their unfavourable position in the job market. (http://www scp.nl/publicaties/boeken/9037702376.shtml). The recent change in political climate makes it imperative to be aware of discrimination in all sectors of society including health care.

**Racism in health and health care in the Netherlands**

Although discrimination may affect health and is a problem in health services in some European countries, this has not yet been assessed in the Netherlands. The questions that naturally arise are: does (in)direct racism exist in Dutch health services? And if so, what role does (in)direct racism play in ethnic inequalities in health? What is being done to prevent racism in the health arena? For the first and second questions, we simply do not know the answers because of a lack of systematic evidence in this field. Empirical studies are obviously needed to answer these questions. Krieger, one of the prominent researchers on this topic has described different approaches of studying health consequences of discrimination. For example, the extent to which discrimination in the health services can explain differences in treatment between groups or the extent to which discrimination in the job market or in a public setting can explain health differences such as hypertension at the population-level. For the latter, there are measures in place such as anti-discrimination legislation. However, legislation alone is not a sufficient measure to prevent discrimination in health care. Health professionals may lack confidence and skills in meeting the needs of ethnic minority groups. Although the vast majority of health professionals find prejudice morally abhorrent, they may not recognise manifestations of racial/ethnic prejudice and stereotyping in their own behavior. A range of measures on various levels are therefore needed, for example, training of health professionals and equal opportunities programmes. Recent initiatives to integrate cultural competency training into the medical curriculum (Een arts van de wereld) and ‘interculturalisation’ of mental health services are good examples of what can be done to prevent discrimination in health services. These initiatives need to be evaluated, and extended to other healthcare services if effective.

In sum, the time is right to take discrimination in health and welfare services more seriously in Europe. This will requires investments in information gathering especially in countries with limited information such as the Netherlands. Such information will allow investigators to determine whether racism exists in the health services, and if so, its role in ethnic inequalities in health. It will also help to develop the capacity to tackle discrimination more effectively.

**Acknowledgements**

We thank Professor Johan Mackenbach and Drs A. de Jonge for providing helpful comments on an earlier draft.

**References**