

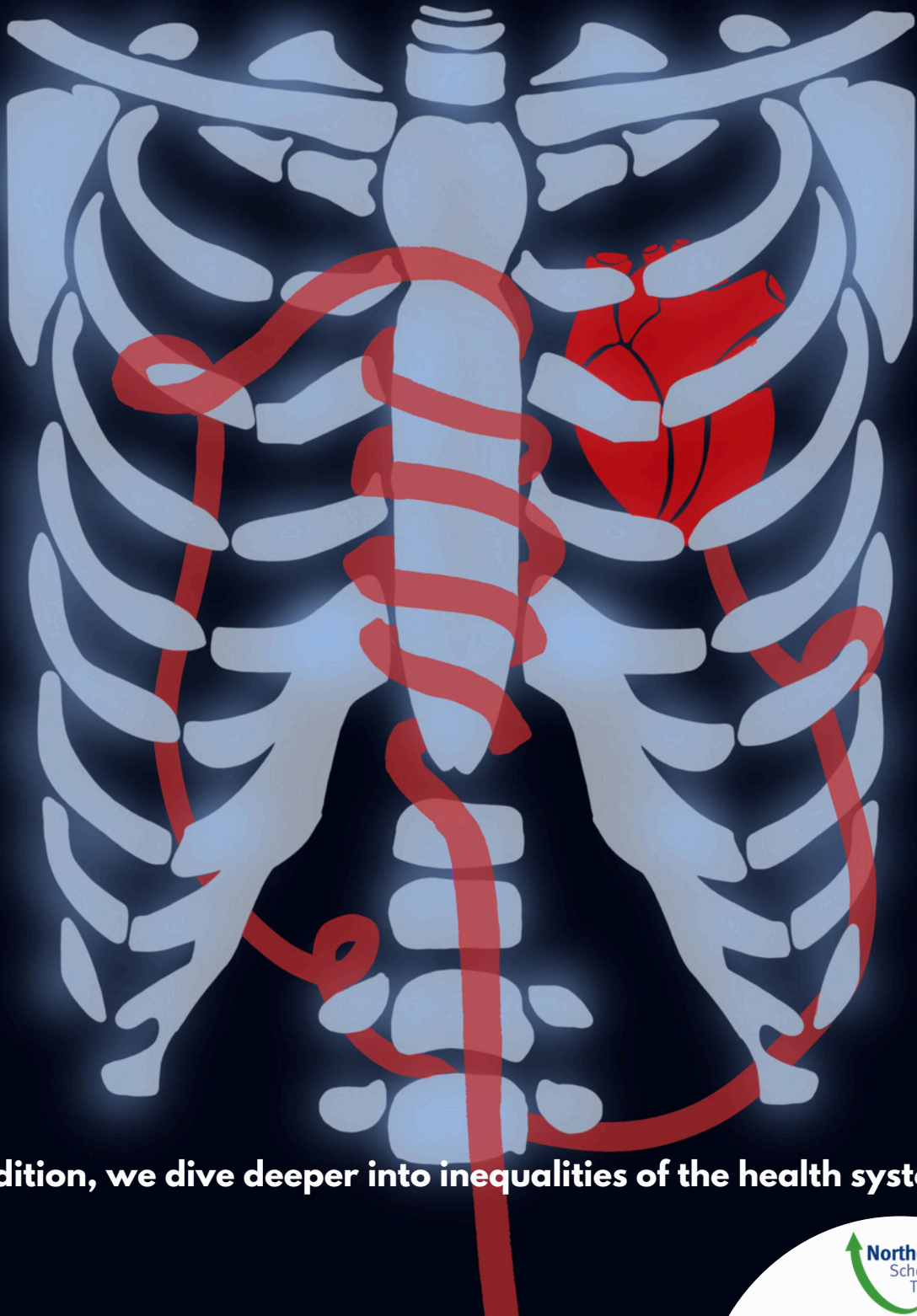


# BRI Journal

APRIL 2026

VOL 4. ISSUE N°2

A fascinating dive into the research carried out by students in the Baltic Research Institute at Liverpool Life Sciences UTC and the Studio School, located in Liverpool's Baltic Triangle



"Our Biology Binds Us" -Art Work  
by: James Forrest  
(Year 12 Graphics Student)

In this edition, we dive deeper into inequalities of the health system.



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Baltic Research Institute



Liverpool Life Sciences UTC **THE STUDIO**



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# In this issue

<b>Meet the Editorial Team / Foreword</b>	<b>3</b>
<b><u>Original Research Articles</u></b>	
<b>Class, Choices, and Consequences: How Social Inequality Shapes Health Risks</b>	<b>4-5</b>
<b>An Insight into the Healthcare Inequalities Surrounding Menopause</b>	<b>6-7</b>
<b>Age Inequalities in Dentistry</b>	<b>8-9</b>
<b>Impact of Homelessness on Healthcare</b>	<b>10-11</b>
<b>From Romantic Illness to Stigmatised Disease: Tuberculosis and the Inequality of Medical Perception</b>	<b>12-13</b>
<b>The Deadly Consequences of Inequality in Healthcare: Medical Negligence due to Ethnicity</b>	<b>14-15</b>
<b>Class and the Distribution of Adequate Hospitals around the UK</b>	<b>16-18</b>
<b>Word Search</b>	<b>19</b>
<b>Next Edition, Acknowledgements and Links</b>	<b>20</b>

# Meet the editorial team...

## Foreword from the editorial team

This is the Easter 2026 Edition of the Baltic Research Journal. In preparation for British Science Week, our team researched and wrote articles examining the factors that hinder our healthcare system, including inequalities around Age, Gender, Race, and more.

We look forward to your feedback. Happy Easter and Eid Mubarak from the Baltic Research Team!



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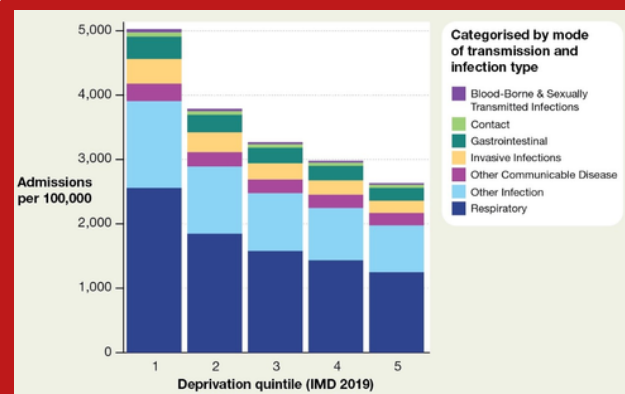
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## *Class, Choices, and Consequences: How Social Inequality Shapes Health Risks*

**Socioeconomic factors can determine health inequalities by shaping the environments and opportunities that dictate behavioural choices. Specifically, low socioeconomic status leads to poor behavioural decisions, leading to chronic disease development and mental health disparities.**

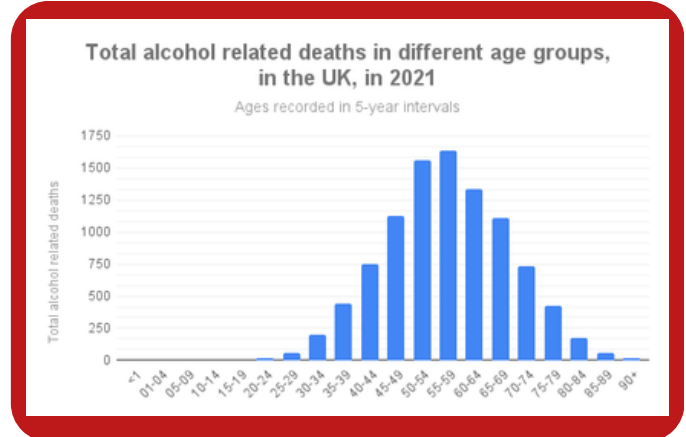
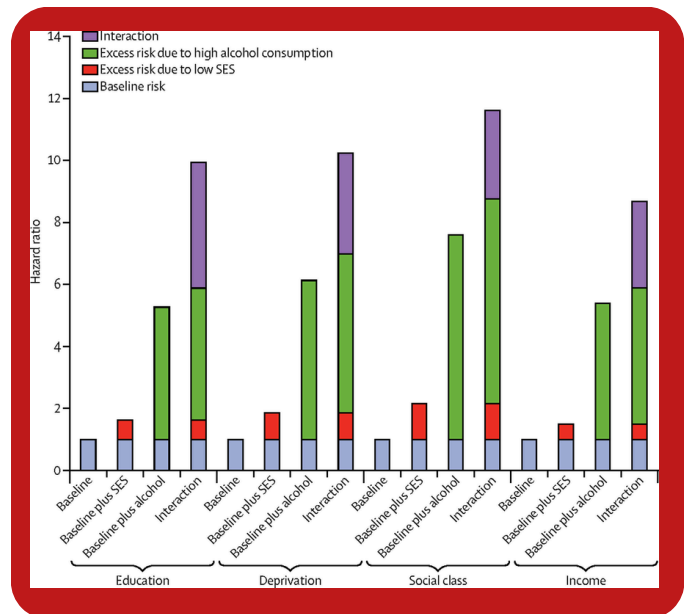
**Low socioeconomic status drives chronic disease developments such as a higher prevalence of cardiovascular diseases, diabetes and cancer. This is due to many reasons, one of which is the fact that these individuals with lower socioeconomic status live in lower-income neighbourhoods that tend to have higher exposure to pollution and crime. According to the Health Protection Report 2025, “In England, those living in the 20% most deprived areas bear the greatest burden, with emergency hospital admission rates due to infectious disease almost twice as high as compared to the least deprived. People from more deprived areas are also disproportionately impacted by radiation, chemical, climate and environmental hazards through their exposure, direct impacts on their health, and the exacerbation of existing health conditions.”**



The report also states that “In England, for the year 1 September 2023 to 31 August 2024, hospital admission rates due to infectious disease and infection were nearly twice as high for people in the 20% most deprived areas (deprivation quintile 1: “IMD1”), as compared to the least deprived (deprivation quintile 5: “IMD5”).” shown by the figure above. This clearly shows how living in a neighbourhood with fewer resources can lead to health risks. People living in these types of neighbourhoods are also exposed to more pollution and a poorer climate compared to people living in less deprived areas. This links heavily to causing them respiratory issues.

This is supported by the report, as it states that respiratory infections had the greatest inequality, with an estimated additional 260,000 admissions due to inequalities associated with deprivation. People living in these areas also tend to smoke more, leading to respiratory issues, cancer, heart disease and other issues. For example, in England, 16% of people in the most deprived areas smoke compared to 5% in the least deprived areas, according to the 'Ash Health Inequalities and Smoking' report. Unemployed individuals are 1.5 times more likely to smoke. Smokers are twice as likely to have a heart attack compared to non-smokers. Smoking causes ~80% of deaths from Chronic Obstructive Pulmonary Disease (COPD). Smoking is one of the leading risk factors for non-communicable diseases because there are over 7,000 chemicals in cigarette smoke, 69 of which are known to be carcinogenic.

Lower socioeconomic status can also lead to individuals being more prone to substance abuse. For example, those in the most socioeconomically deprived decile have 2.23 times the rate of alcohol-specific mortality and 1.53 times the rate of alcohol-related mortality compared to the least deprived decile. Moreover, 56% of people in treatment for crack and/or opiate addiction in England live in the 30% most deprived areas. Issues like these can cause liver cirrhosis, various cancers (mouth, breast, bowel, liver),



Overall, people who have lower socioeconomic status are more likely to suffer from health inequalities due to several factors, such as the area they live in, as more deprived areas expose individuals to a poorer environment, leading to people being at a higher risk of developing diseases and other issues. In addition to this, individuals with a lower socioeconomic status are likely to fall into unhealthy behaviours such as smoking cigarettes, increased alcohol consumption and substance abuse.

## *An Insight into the Healthcare Inequalities Surrounding Menopause*

### What is Menopause?

Menopause is a natural, permanent end to menstruation and fertility, confirmed when a biological woman goes 12 consecutive months without a period. It is triggered by a significant decrease in oestrogen and progesterone.

Common symptoms of the menopause include:

- Anxiety
- Changes in mood – such as low mood or irritability
- Hormonal changes – which can trigger new, or worsen pre-existing, conditions like bipolar disorder, depression, and schizophrenia
- Changes in skin conditions, including dryness or an increase in oiliness and the onset of adult acne
- Difficulty sleeping – resulting in many women feeling tired and irritable during the day
- Discomfort during sex
- Feelings of loss of self, such as emotional numbness and disconnection
- Hot flashes

77% of women are reported to find at least one symptom of the menopause “very difficult”, and 44% wait over a year for treatment; according to Fingertips: Department of Health and Social Care. Treatment includes HRT (hormone replacement therapy), which helps with hot flashes, mood changes, and bone health; and CBT (cognitive behavioural therapy), which helps manage anxiety, low mood, and stress associated with menopause. However, many women are not offered appropriate treatments like HRT, with 23% prescribed antidepressants instead. Furthermore, women of ethnic minorities often find advice irrelevant and face lower access to care.



Examples of medical inequalities due to race include:

Medical staff ignore or dismiss symptoms reported by ethnic minority women, particularly Black women, leading to later diagnoses and worse outcomes.

Prejudiced, often unconscious, beliefs are still present in clinical settings, such as the dangerous myth that Black women have higher pain thresholds or thicker skin, which can lead to inadequate pain management.

Some staff even view “other” minority patients, viewing them as “not like me,” leading to a lack of empathy and a failure to provide tailored, individualised care.

Unmet menopausal needs can have a huge impact on the lives of women, straining relationships, harming mental health, and even forcing some to leave the workforce. This is due to widespread stigma, leaving 25% of women facing difficulties at work, with many facing penalties for sickness or lack of flexibility, despite their symptoms being out of their control.

## Stigma

Results from a US national survey show that over a third of women feel shame due to their menopause-related symptoms (37.4%), and 82.7% reporting feeling stigma associated with such symptoms, despite menopause being a significant biological milestone experienced by approximately half the population. This stigma stems from deep-seated ageism, sexism, and a societal obsession with youth, equating this natural transition with a loss of beauty, fertility, and value. It is therefore often shrouded in silence, with symptoms like hot flashes and mood swings viewed as embarrassing, making women fear being perceived as weak, erratic, or even incapable in the workplace.

## Lack of Research

Historically, medical research has been dominated by male models, leaving the impact of menopause on brain health or disease under-researched. Due to this, there is limited data on how the menopause transition affects long-term ageing and how to treat age-related diseases in women, such as Alzheimer's, cardiovascular, and metabolic diseases, effectively. Studies indicate a severe lack of education on menopause for both women and healthcare professionals. This leaves women unprepared for the physical and emotional changes brought on by menopause, resulting in misdiagnoses, a lack of support for women, and stigma. This knowledge gap leads to higher symptom severity, reduced quality of life, increased workplace disruption, and, due to minimal training for healthcare providers, inadequate medical care. Lack of reliable, accessible information surrounding menopause has also led to millions of women being exploited by a "menopause gold rush" as companies, celebrities and influencers promote expensive, and often ineffective, menopause miracle treatments for their symptoms. Unfortunately, under-research seems to be a recurring theme within the medical world when it comes to women's health. Endometriosis affects 11% of women, yet research funding is

disproportionately low compared to chronic conditions like diabetes or Crohn's disease, which each have a similar prevalence. In 2022, the US National Institutes of Health (NIH) spent just \$16 million for endometriosis research (0.038% of their budget), which equates to roughly \$2 per patient.



## Recent Efforts

It's not all doom and gloom when it comes to menopause; however, with an increase in funding (\$56 million in 2023), the US NIH and other bodies are beginning to prioritise menopause studies. In addition to this, a bill was passed as a part of the Employment Rights Act 2025, enforcing all UK employers of 250 or more to have Menopause Action Plans. These plans involve implementing clear policies, training managers, making workplace adjustments (e.g., temperature control), and fostering an open culture. The bill comes into effect from April 2027 (and voluntarily from April 2026), allowing **hope for further research and support for menopause in the future.**

## Age Inequalities in Dentistry

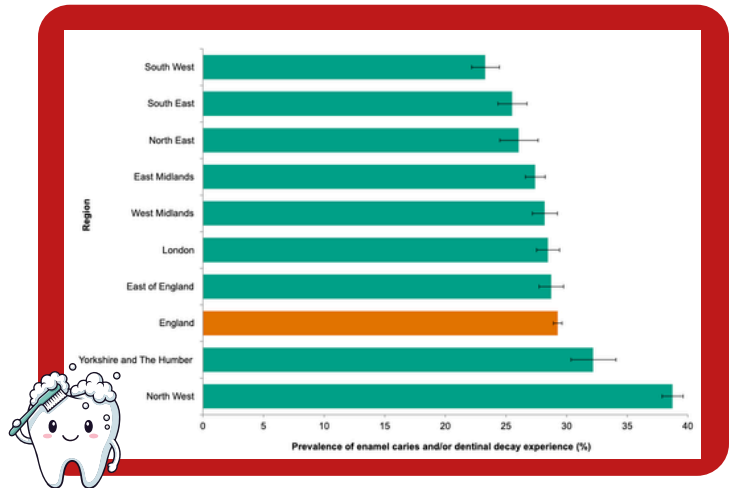
Age has a quiet but powerful influence on how people experience dental care. Most of us grow up thinking the dentist is just a place you visit every six months, but the reality is far different from expected. Different age groups run into different problems, and some people get left behind without anyone really noticing. When you look at dentistry through the lens of age, you see patterns that don't feel accidental at all and are instead inequalities.

### Big Problems, Small Teeth

Dental trouble can start ridiculously early. Tooth decay is still the number-one disease in children, even though it's one of the easiest to prevent. It's strange when you think about it: we know how to stop it, yet thousands of young children end up in hospital every year to have teeth removed under general anaesthetic. That's a huge step for something that shouldn't have reached that point, being potentially extremely traumatic as an experience for them.

A few things that convey this inequality for children:

- They can't book their own appointments, so everything depends on adults remembering
- Parents don't always get clear advice about brushing or fluoride
- Kids' teeth are softer, so sugar hits their teeth harder
- Depending on where you live, getting an NHS dentist can feel like winning a raffle



When a child has toothache, it doesn't just ruin their day. It can mess with sleep, make eating uncomfortable, and even affect how confident they feel at school. People sometimes shrug it off because "they're only baby teeth," but the impact is very real. Young children need the most support, yet the NHS doesn't always reach them early enough.

### Teenagers and Young Adults

Teenagers sit in a weird middle ground. They're not little kids anymore, but they're not fully independent either. This is the age when people start making their own decisions about health, and honestly, the dentist usually drops pretty low on a teenager's priority list.

A few things that get in the way:

- Braces are scarce, so lots of teens who want them don't qualify, and if they do, they may not get them at the optimal age for the best results
- Moving to college or starting work disrupts routines
- Costs start creeping in
- Nothing feels urgent when you're young and healthy

This is also the age when habits stick. Someone who stops going to the dentist at seventeen might not go back for years, and by then the problems are bigger and more expensive. The system doesn't really offer anything tailored to this age group, even though it's a crucial time for long-term oral health.

### Busy Lives, Expensive Teeth

Adults in their 20s to 50s face a different kind of inequality. It's nothing due to biology; it's about their lives getting in the way. Dentistry is partly privatised, so cost becomes a real barrier. Even NHS charges can make people hesitate.

Common reasons adults fall behind include:

- Work hours that clash with appointment times
- Parents putting their kids' needs first
- Dental anxiety that gets worse the longer someone avoids going to the dentist
- And if money is tight, people will wait until something hurts before going

This creates a cycle - delay, the problem gets worse, treatment costs more, and more delay. It's not that adults don't care about their teeth; life just piles up, and dentistry isn't always accessible enough for them to keep up with it.

### The most Overlooked Group

Older adults often have the highest dental needs but the lowest access to care. People are living longer and keeping more of their natural teeth, which is great, but it also means more complicated dental issues later in life.

They face challenges such as:

- Mobility problems that make travelling difficult
- Care homes with little or no dental provision for them
- Memory issues that affect brushing and consent for treatment
- Medications that dry out the mouth and increase decay
- Reduced income after retirement, so even more difficulty in paying for treatment

Poor oral health in older age isn't just uncomfortable - it can lead to infections, difficulty eating, and even serious medical complications. Yet dentistry and general healthcare rarely work together, so oral health often gets pushed aside for older people.

### Why These Gaps Exist

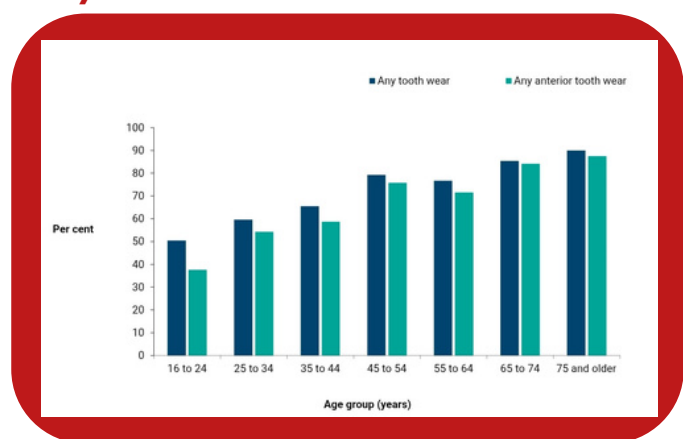
These inequalities don't happen by accident. They come from how dentistry is set up:

- It focuses more on treating the symptoms, not the underlying root cause
  - Access to NHS dentistry varies massively depending on location
  - Dentistry is separate from general healthcare, so it is seen as a lesser priority
  - And policies rarely consider the needs of each age group and their differences
- The result is a system that supports some ages well, others poorly, and almost no one consistently throughout their life.

### Conclusion.

Age inequalities in dentistry show how much a person's stage of life shapes their oral health. Children face preventable problems, teenagers slip through the cracks, adults juggle cost and time, and older adults are often forgotten. None of this is inevitable; it's the result of how dental care is organised.

A fairer system would support people at every age, not just when they're young or when they're in crisis. Dentistry should adapt to people as they move through life, not expect everyone to fit into the same mould.



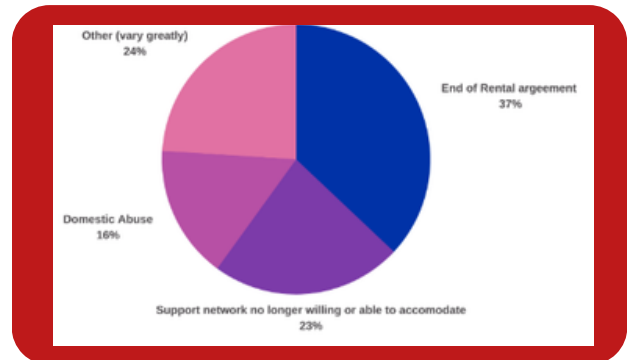
## Impact of Homelessness on Healthcare

In contemporary UK, there is an evident homelessness crisis, with an estimated 382,000 people homeless in England alone. It is continuously on the rise in the UK due to a variety of social and individual factors, from domestic abuse to the end of rental agreements, and can create barriers in different areas of life, such as hygiene, employment, and particularly healthcare.

It is a continuing issue that can and does influence NHS treatment, despite the six core values being centred around patients. Homelessness is directly tied to poorer health outcomes and a lower life expectancy, almost half of that of the average population.



In fact, homeless people are up to 10x more likely to face an early death than those who live in housing. This can be due to a variety of factors, such as poor access to hygiene, drug use, alcoholism (these two factors often tie into homelessness), increased exposure to extreme weather conditions, street violence, etc.



Poorer health outcomes inevitably mean many homeless people have to go to hospital more often, but this comes at a significant cost to the NHS services costing an additional estimated £85 million per year as of 2010, a figure consistently on the rise, primarily as a result of emergency care due to delayed preventive care, as well as the standing fact that many homeless individuals suffer from long term health conditions [requiring regular medical intervention] it is estimated this is an issue for over 41% of homeless people in the UK.

Homelessness is often referred to as a silent killer, as a result, putting people at constant risk, with significantly higher mortality and morbidity rates amongst the homeless population.

Research from healthwatch.co.uk found that those who are homeless have significant problems gaining adequate access to health care, even with the NHS and its free healthcare system in place. This is typically due to a variety of factors.

For example, although it is not legally necessary, some GPs will insist on proof of residency for you to register, and with homeless people not having a fixed address, this can be a barrier, with a study finding that only 31% of those with no fixed address can access GP services. This staggering statistic highlights the inequality in healthcare access for the homeless.

A second factor is the common intolerance for missed appointments amongst GPs, which can be influenced by poor communication methods between practices and homeless individuals due to factors such as low access to charging, not having data or perhaps not having a mobile at all. These two factors alone outline the surface of ways homeless people can experience unequal treatment in healthcare.

Another factor may be due to the internal prejudice of doctors towards those who are homeless. Although not an inadvertent barrier to healthcare, some NHS workers may hold prejudices against homeless people as a result of their own stereotypes or labels they place upon them, or perhaps past experiences. This can be a barrier because prejudgments of these people and a view of them as being less than or inadequate can lead to poorer care in some contexts, even if not explicitly shown. This can be reiterated by the assumption that homeless people have lower literacy rates or understanding.

Despite this, these factors may be systematic and a sign of an institutional error, rather than that of individual doctors; regardless, these factors could be resolved and improve healthcare access for the homeless. For example, the issue of patients being expected to provide proof of residency could be resolved by an increase in NHS (mobile) vans, as they could be used for more regular checkups than GP practices, and would not require permanent registration or proof of residency. Furthermore, an increase in mobile vans could reduce the number of emergency treatments and promote earlier medical intervention, which could decrease costs. Despite this, vans may be expensive to run as a consistent service, and as a result, only provide temporary assistance to health care inequality.



In conclusion, inequality in healthcare treatment is a prevalent social issue despite the UK running a free National Health Service. For the homeless, different factors influence health care treatment, an unfair institutional issue that is hard to resolve until the homelessness crisis in the UK is more recognised and more funding is available. Finally, although homelessness can still cause inequality in the health care system, NHS workers are legally required to notify local housing authorities if a patient is homeless or at risk of becoming homeless (within 56 days). This is a result of the Homelessness Reduction Act 2017, and can benefit those who are homeless by providing them with safe housing. Many homeless people may not be aware of the scheme and personally choose not to go to the NHS, and so not get this opportunity, thus decreasing the effectiveness of this act.



Table 1: Mean and median age of death for each of the categories

Dataset	Men		Women		People	
	mean age of death	median age of death	mean age of death	median age of death	mean age of death	median age of death
General population	74	77	80	83	77	80
Homeless population <sup>6</sup>	48	47	43	42	47	46

## *From Romantic Illness to Stigmatised Disease: Tuberculosis and the Inequality of Medical Perception*

**Tuberculosis, Beauty, and Stigma: Inequality in the Cultural History of Disease**

Tuberculosis (TB) has long been one of the most significant infectious diseases in human history, yet its social meaning has varied greatly across different societies. In the eighteenth and nineteenth centuries in Europe, tuberculosis, then commonly known as consumption, was often romanticised and associated with beauty, refinement, and sensitivity. In contrast, as tuberculosis spread through colonised regions such as Africa during the nineteenth and twentieth centuries, it increasingly came to be described as a "dirty disease" linked to poverty and poor hygiene. These contrasting perceptions reveal how racial and social inequalities have shaped the cultural interpretation of illness.

In Europe, tuberculosis became embedded within cultural ideals of aesthetic fragility. Symptoms such as pale skin, weight loss, flushed cheeks, and fatigue were interpreted as signs of delicacy rather than illness. Pale complexions were associated with higher social status, reflecting a life free from manual labour and exposure to sunlight. Tuberculosis sufferers were frequently portrayed in literature and art as emotionally sensitive or spiritually elevated individuals. Scholars have described tuberculosis during this period as a "romantic disease", influenced as much by cultural ideas as by medical science (Sontag 1978).

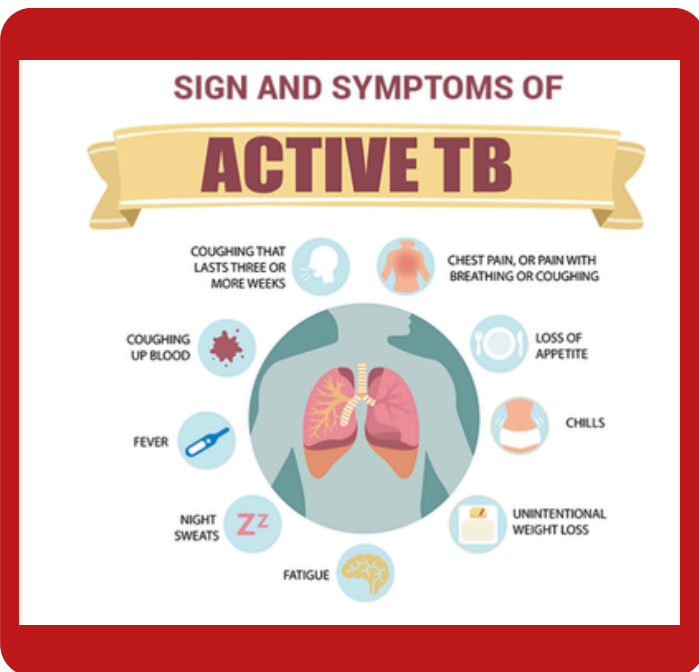


These perceptions were closely connected to class and power. Tuberculosis initially affected urban middle-class and upper-class populations in European cities, groups that influenced cultural production and public discourse. As industrialisation progressed and the disease spread among working-class communities living in overcrowded conditions, tuberculosis became increasingly associated with poverty and social disorder (Porter 1997). The earlier romantic image gradually declined as medical

Science began to recognise tuberculosis as a contagious bacterial disease following Robert Koch's identification of *Mycobacterium tuberculosis* in 1882.

During the colonial period, European interpretations of tuberculosis in Africa reflected significantly different assumptions. Colonial medical authorities frequently portrayed tuberculosis as a disease caused by unsanitary environments and supposedly uncivilised lifestyles.

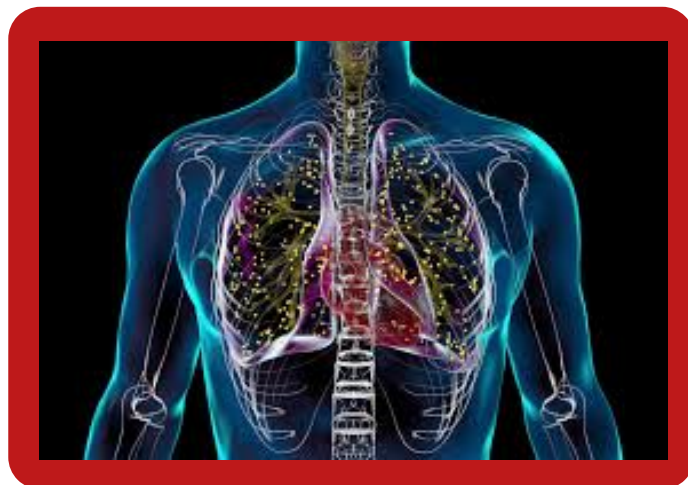
Rather than recognising the structural conditions created by colonial rule, including forced labour systems, population displacement, overcrowded housing, and limited medical infrastructure, European narratives often attributed the disease to the behaviour of colonised populations (Packard 1989). This shift from romanticisation to stigmatisation illustrates the role of inequality in shaping medical narratives. Tuberculosis itself did not change biologically, but the social meanings attached to the disease reflected broader hierarchies of race and class. When tuberculosis affected wealthy Europeans, it was often aestheticised, but when it affected colonised populations, it became framed as evidence of social and moral failure.



Understanding the changing perceptions of tuberculosis provides important insight into the relationship between disease and inequality. The transformation of tuberculosis from a romanticised European illness into a stigmatised "dirty disease" in colonised regions highlights how medical narratives can reinforce social divisions. Addressing global tuberculosis requires not only scientific solutions but also recognition of the historical inequalities that have shaped its impact.



Today, tuberculosis remains strongly associated with global inequality. The majority of cases occur in low and middle-income countries, where barriers to diagnosis and treatment persist. Although modern medicine recognises tuberculosis as a preventable and treatable bacterial infection, social stigma continues to affect those living with the disease. Historical attitudes toward tuberculosis demonstrate that health inequalities are shaped not only by biology but also by social and political power.



## *The Deadly Consequences of Inequality in Healthcare: Medical Negligence due to Ethnicity*

The National Health Service (NHS) prides itself on upholding the core values it was founded upon, but does it actually refer back to these values in practice? The NHS states on one of its websites that “we make sure nobody is excluded, discriminated against or left behind.” However, personal accounts and health outcome statistics contradict this.

It is no secret that the NHS, like many other public service institutions in the UK, can contain racial bias. Within the NHS, racism can present itself internally, with how staff members treat each other, and externally, with how staff members treat patients, and likewise, with how patients treat staff members. Racism within the NHS can often lead to medical negligence and the misdiagnosis of patients from an ethnic minority, which can lead to fatal healthcare outcomes for these patients.

### Systematic racism in practice:

The NHS was founded in 1948 and was built upon several core values. However, racism within the medical profession dates far before the creation of the NHS. The idea of selective medical treatment for patients based on skin colour is claimed to begin in medical school. The learning resources physicians are taught during this period are built on the foundations of medical textbooks; however, what if this is one of the first places where racism is taught?

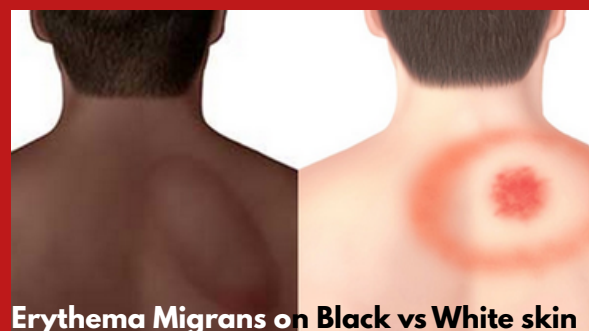
Erythema Migrans is a rash that occurs in over 70% of patients with Lyme Disease, and therefore is a key aspect in the signalling of the beginning of the Disease. However, in nearly all medical textbooks, the rash is depicted on white skin.

Articles from the medical department of Imperial College London use the example of Erythema Migrans to convey the delay.



In the diagnosis of Lyme Disease in black patients. This delay in diagnosis can be caused by physicians having difficulties recognising the rash on non-white skin. Ultimately, a delayed diagnosis leads to a higher risk of patients experiencing long-lasting side effects. The long-term effects of Lyme Disease, if left untreated, include Arthritis, facial palsy, and myocarditis (inflammation of the heart muscle).

As described by the NHS, Lupus (systemic lupus erythematosus) is a long-term condition that causes joint pain, skin rashes and tiredness.’ With no current cure, management of this condition, along with its symptoms, relies heavily on early intervention to prevent the deterioration of health within the diagnosed patient. However, similar to the diagnosis of Lyme Disease, Lupus is also often misdiagnosed or delayed in diagnosis completely when it comes to patients from an ethnic minority.



Erythema Migrans on Black vs White skin

An article from the National Library of Medicine describes black women as being significantly more likely to struggle with Lupus than white women, as racism within other sectors of life, such as housing, socialising, during education, in a public setting or by the police, can cause stress leading to a Lupus flare-up. These factors act as a catalyst when combined with potential medical neglect, leading to a potentially fatal outcome. When undiagnosed or left untreated, Lupus can cause irreversible organ damage, including that of the kidneys, brain and heart, as well as an increased risk of suffering a stroke and infections.

### **Racism Within Obstetrics and Gynaecology:**

The NHS defines a maternal death as ‘the death of a woman during pregnancy or within one year of its end, from causes related to or worsened by the pregnancy’. A BMJ article identified maternal and neonatal healthcare as one of the top five healthcare sub-sectors that are impacted by ethnic inequality.

The problem of racism within Obstetrics and Gynaecology on an international and global scale becomes more complicated during the realisation of how embedded it can be within the medical sub-sector. James Marion Sims (nicknamed the ‘Father of Gynaecology’) is known for his development of a surgical technique to repair vesicovaginal fistula, a severe complication caused during childbirth and pelvic surgeries. As well as this, Sims was chosen to be the American Medical Association’s president, being regarded as one of America’s best surgeons at the time. However, Sims has been criticised for his research; Sims tested the surgical procedure on enslaved black women without their consent, with claims of him taking advantage of black oppression.

In the UK, black women are over three times more likely than white women to suffer a maternal death. With Asian women demonstrating a similar increase in maternal death statistics, it is claimed that there needs to be a rapid change within the NHS. But how can change occur when racism is so deeply rooted in the healthcare we rely on?

Over the course of the last few years, there has been an increase in the number of conversations about the issue of racism within the NHS. But what is the NHS actually doing to combat racism and selective medical treatment based on skin colour?



An NHS provider's article describes trusts as ‘not solely responsible for tackling structural racism’ and instead, takes the approach of tackling the issue of racism awareness within the NH, providing cultural competency training to staff. The article describes the implementation of this, being met with a positive change in language and overall positive feedback. This is a step in the right direction towards the eradication of racial bias within the NH; however, it poses the question: to what extent can things really change without reevaluating the foundations they were built on?

### **Writer's Note:**

**This article was produced and researched for the purpose of drawing attention to the issues experienced by patients and staff from ethnic minorities within the NHS. This article is by no means a condemnation of the steps the NHS is taking to battle racism within the medical treatment it administers. The issues discussed in this article aren't bound to the healthcare system of the United Kingdom, and exist on a global scale, so shouldn't be thought of as an issue only existing in the NHS.**

## *Class and the Distribution of Adequate Hospitals around the UK*

The NHS faces struggles nationally. It's undoubtedly overwhelmed due to factors like COVID-19 that hit the UK in 2020. How did some hospitals perform differently from others? Is privatisation the way to go for an upper-class society?

In the UK, there is a clear North-South divide. We use this to describe the unfair distribution of economic wealth in the UK. An example we can use to describe this is through the distribution of private hospitals. The top hospitals that are private hospitals are in the south of England, specifically in London.

The CQC (Care Quality Commission) ranks all hospitals, care homes, etc., based on multiple aspects of what "good care looks like" and the overall rating is labelled outstanding (best), good, requires improvement and inadequate (worst)

Using CQC (Care Quality Commission) ratings, we can infer whether the North has a lower quality of care in NHS hospitals than the Southern private care centres.

### The Harley Street Clinic: (London)

Safe	Good ●	<a href="#">Medical care (including older people's care)</a>	20 April 2023	Outstanding ●
Effective	Good ●	<a href="#">Services for children &amp; young people</a>	20 April 2023	Good ●
Caring	Outstanding ●	<a href="#">Critical care</a>	4 January 2017	Good ●
Responsive	Good ●	<a href="#">Diagnostic imaging</a>	20 April 2023	Good ●
Well-led	Outstanding ●	<a href="#">Outpatients</a>	20 April 2023	Good ●
		<a href="#">Surgery</a>	20 April 2023	Outstanding ●

### The Wellington Hospital: (London)

<a href="#">Medical care (including older people's care)</a>	13 February 2017	Good ●	Safe	Good ●
<a href="#">Critical care</a>	13 February 2017	Good ●	Effective	Good ●
<a href="#">Outpatients and diagnostic imaging</a>	13 February 2017	Good ●	Caring	Good ●
<a href="#">Surgery</a>	16 June 2023	Outstanding ●	Responsive	Good ●
			Well-led	Good ●

When looking at these examples, you have to take into consideration the economy of London, as this premier global financial hub, meaning it is a city or jurisdiction with a high concentration of international finance, banking, asset management, and trading activities. This is where people have the most money. Think about it, why run a business that nobody can afford the services for? It's pointless!



This shows the distribution of 23 hospitals rated Inadequate by the CQC. Surprisingly, there are more hospitals rated inadequate by the CQC in the South than in the North. However, there is also a higher concentration of private hospitals in the South. Your local hospital has a CQC rating; if you would like to find out, scan the QR code below.



If we compare the NHS internationally, you can see that the performance of care is poor. The trends show that the less affordable (exemplified by the USA) has a better quality of care compared to more affordable healthcare systems. There is an anomaly, however. Australia is very expensive and has poor performance rates.

### Healthcare system overall performance and affordability

I - highest performing and most affordable  
II - lowest performing and least affordable



### Overburdened NHS Pushes More Brits To Go Private

Share of UK respondents that have private health insurance



At least 1,046 UK adults (16-84 y/o) per survey  
Source: Statista Consumer Insights



statista

First and foremost, private healthcare is a business, in which their priority is to maximise profit. On the other hand, the NHS is a publicly funded healthcare system, with its priority being to ensure access to universal healthcare. Despite this, more and more people (about a 10% increase in 3 years) are signing up for private healthcare. According to respondents, their most significant complaint was the long waiting lists, an issue easily mended in 2 different ways.

## Cromwell Hospital: (London)

<a href="#">Medical care (including older people's care)</a>	20 December 2018	Outstanding	Safe	Requires improvement
<a href="#">Services for children &amp; young people</a>	20 December 2018	Good	Effective	Good
<a href="#">Critical care</a>	20 December 2018	Requires improvement	Caring	Good
<a href="#">Diagnostic imaging</a>	20 December 2018	Good	Responsive	Good
<a href="#">Diagnostic and screening services</a>	25 April 2023	Good	Well-led	Good
<a href="#">Outpatients</a>	20 December 2018	Good		

The first, the least feasible, is in which the Treasury acquires and absorbs private hospitals. This would prevent the financial drain that occurred during COVID, in which the NHS paid 26 private companies to provide beds and staff, to a total cost of between 2 and 5 billion.

The arguably more financially practical solution would be to incentivise private healthcare employees to join the NHS. Currently, most private doctors and nurses claim their largest qualm with the NHS is both the pay and the work-life balance. If the NHS received more funding, this would kill two birds with 1 stone. More people hired means better conditions and hours for those who are working, and furthermore, more funding means more private hospital staff would be encouraged to find employment within the NHS.



However, some proponents of NHS privatisation argue that market competition can lead to a drive in both efficiency and an improvement in service quality. Moreover, it could also alleviate pressure on the public system, at a time when NHS waiting lists are at an all-time high. It also provides a high quality of healthcare, despite only doing so for those who can afford it. Lastly, private healthcare tends to have access to more modern equipment, allowing for an exceptional level of service every time.



# WORD SEARCH

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**menopause**

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## In the Next Edition...

Our Student Carys Gauder will write a fascinating article on the censorship women suffer in everyday life, as well as how that affects women personally. As a team, we always work hard to produce the highest quality of work. The next edition will be packed with many amazing research projects produced by our students.

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Happy Easter and Eid Mubarak from all at the Baltic Research Institute

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