Nationaler
Diskriminierungs- &
Rassismusmonitor

NaDiRa Report 2023

Racism and its Symptoms

Report by the German National Monitoring of Discrimination and Racism

German Centre for Integration and
Migration Research (DeZIM)

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What is the German National Monitoring of Discrimination and Racism (NaDiRa)?

The German National Monitoring of Discrimination and Racism (NaDiRa) is intended to constantly provide reliable statements regarding the causes, extent and consequences of discrimination and racism in Germany on the basis of various sources of data. Effective measures against racism are to be developed based on this. Until now, the data available regarding racism in Germany has been incomplete. Despite international obligations, there are insufficient regular representative surveys regarding racism and its effects on society and on those potentially affected by racism and discrimination.

For the first time in Germany, the NaDiRa makes it possible to identify potential societal developments and trends regarding racism and discrimination. Representative surveys are a key component of this monitoring. They are complemented by qualitative studies, experiments and analyses of consultancy data, legal and political documents, and media reports.

The results of the NaDiRa studies and appropriate recommendations for action are published regularly in reports. These are aimed at political decision-makers and at civil society and the broader public. Regular monitoring reports are planned to discuss racism in specific spheres in more depth. In preparation for long-term racism monitoring, a total of 34 exploratory studies with various thematic focuses were published between 2020 and 2021, the results of which have already been published for the most part. A significant milestone was the publication of the initial study *Racist Realities. How does Germany deal with racism?* in May 2022.

This monitoring report follows on from the initial study. It addresses the experiences of people in Germany regarding discrimination and racism. In the process, it considers both the perspectives of the population as a whole and those of the people directly affected by racism. The focus is on the topic of **health and healthcare**. The COVID-19 pandemic showed clearly that healthcare is not guaranteed equally for all. The distribution of resources and polarising discussions in the public sphere reflected social conditions that revealed dynamics beyond just new forms of opposition between groups. Racist sentiments also became obvious, even leading to violence, particularly in the case of racism towards Asian people. In light of this, this report illustrates both subjective experiences of discrimination and racism, and structural obstacles in society. Furthermore, the report maps out racist knowledge bases and stereotyping in healthcare.

The NaDiRa: Background and political relevance

In July 2020, the German Bundestag – the national parliament of the Federal Republic of Germany – provided, for the first time, resources to establish the German National Monitoring of Discrimination and Racism at the German Centre for Integration and Migration Research (DeZIM).

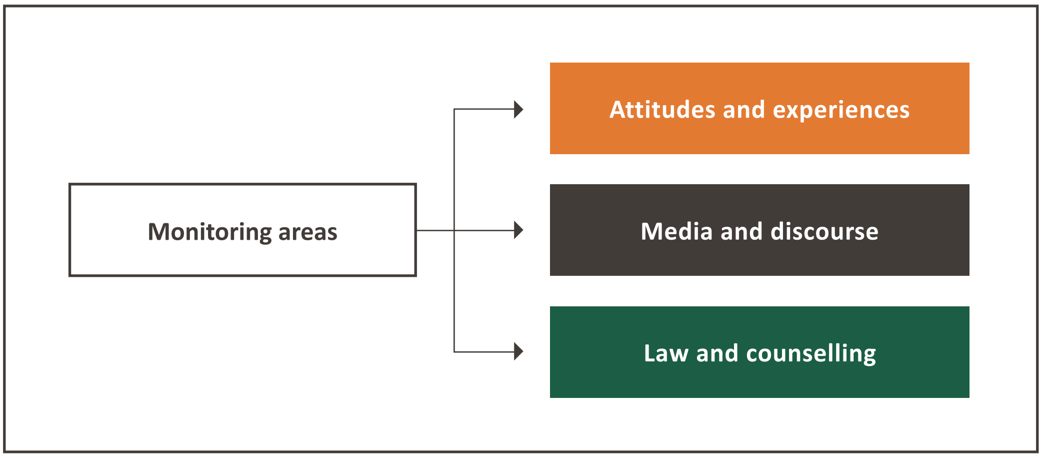
Between German reunification and 2020, at least 200 people were murdered with racist motives in Germany. A series of anti-immigrant, racist and antisemitic murders between 2000 and 2020 in Germany (NSU 2000–2007, Kassel 2019, Halle 2019, Hanau 2020) as well as George Floyd's murder by the police in the USA – which also triggered a widespread movement in Germany protesting against racist violence – led to the establishment in March 2020 by the then federal government of a cabinet committee to combat right-wing extremism and racism.

The cabinet committee's catalogue of measures included supporting 'long-term funding of monitoring of racism and anti-discrimination, with a perspective to transferral into the institutional funding of the DeZIM Institute' (Presse- und Informationsamt der Bundesregierung [Press and Information Office of the Federal Government] 2020: 7). The responsibility for this measure lies with the German Federal Ministry for Family Affairs, Senior Citizens, Women and Youth (BMFSFJ), which funds the DeZIM as a research institution with a departmental character. The current federal government, formed at the end of 2021, very clearly addresses the fight against racism in its coalition agreement: here, the coalition parties once again supported establishing the Monitoring of Racism permanently.

Focuses of the NaDiRa

The NaDiRa examines three areas in order to systematically record the causes, extent and consequences of racism, and to map them over time.

Figure 1. Monitoring areas



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Attitudes and experiences – both of the general public and of those affected

In a Germany-wide, randomised panel study, approximately 13,000 people – including members of racially labelled groups – were regularly surveyed on their individual attitudes regarding racist prejudices, experiences of discrimination and racism, and their subjective perceptions and the reality of their lives. The NaDiRa Online Access Panel (NaDiRa.panel) makes it possible both to obtain representative results as a snapshot and to record short- and long-term trends over time.

Media and discourse

Longitudinal analyses of media data (such as national newspapers) are used to conduct quantitative and qualitative investigations regarding how racism is addressed in public discourse and media reports, as well as which changes can be seen over time. Furthermore, available social media data are evaluated for various target groups to describe the mobilisation and dynamics of racist discourse.

Law and counselling

Political documents, laws, regulations and other relevant sources are examined to research how courts handle racism. This process includes reconstructing how racism as a prejudice, a knowledge base and an implicit legal practice can lead to discrimination in the German legal system. This contrasts with a systematic examination of consulting structures that advise victims of racist violence and people affected by discrimination, support them socially, and empower them regarding legal enforcement.

Regularly rotating focuses: ‘Health’, ‘Housing’, ‘Education’ and ‘Work’

In the population surveys and in further studies, the focus is placed alternately on the central spheres of health, housing, education and work. The objective is to make statements on how and with what consequences racism affects these areas. In the long term, indicators are to be developed for these central spheres in order to identify structural discrimination and inequalities and to analyse them in in-depth studies.

➔ The NaDiRa's approach: Research design and civil society participation

The NaDiRa combines various fields of research: social attitude research, sociopsychological and experimental prejudice research, ethnic discrimination research, and economic discrimination research. The combination of different methodological approaches enables qualitatively extensive, validated, and statistically robust data collection. The NaDiRa continuously provides new study results and makes a relevant contribution to the incipient institutionalisation of German-language research into racism and discrimination.

Alongside scientific, theoretical expertise and empirical data integrity, the accompanying process in civil society is of vital importance to the NaDiRa's recording of discrimination and racism. The process ensures that the perspectives of individuals affected by racism are taken into account. This includes representatives of communities affected by racism, initiatives, organisations, and associations. In order to guarantee high quality control, the research questions and methods are regularly presented to and reflected upon with renowned scientific experts.

Summary of key results

I. Experiences of discrimination are generally widespread: large sections of the population in Germany report that they have experienced it. However, these vary in type, frequency, between different groups, and depending on discrimination characteristics and social spaces.

1. Overt discrimination affects Black people the most, from the groups examined here. For example, almost one in five Black women (19%) stated that they experience threats or harassment repeatedly (several times a year or more often); for Black men, this number was 18%. For Asian men, it was 12%, and 13% for Asian women. For Muslim men and women, the percentages were 13% and 14% respectively. Among non-racially labelled women, this figure was 11%, and it was only 6% of men. Experiences of subtle discrimination are more frequent overall, and the differences between racially labelled and non-racially labelled people are even more pronounced. Black people also have these experiences more frequently. For example, 37% of all Black men stated that they are regularly met with fear. This is four times as frequently as is the case for non-racially labelled men (9%). One in five Black women (20%) stated that they were repeatedly met with fear, in comparison to approximately one in thirty non-racially labelled women (4%). Among Muslim men, more than one in four (28%) stated that they are repeatedly met with fear. For Muslim women, this number is 15%. In comparison, one in five Asian men (20%) stated that they have had this experience, while for Asian women, this is one in ten (10%).

2. Discrimination characteristics: Discrimination is experienced for various reasons: for example, people are discriminated against because of age, disability or chronic illness ***(ability)***; a lack of German language skills, migration status, a name that does not sound German, religious affiliation, skin colour ***(‘race’)***; gender or sexual orientation ***(gender)***; or because of social class affiliation, income or lack of employment ***(class)***.

Racially labelled people trace their experiences of discrimination mainly to racism and less to sexism and classism. The following information relates to those who reported having experienced discrimination. While 68% of Black men named their skin colour as the reason for the discrimination, this number was only 6% for gender, and 20% for income. Among Black women, 61% named their skin colour as the reason for discrimination, 25% stated it was their gender, and 15% linked it to their income. Among Muslim men, 54% indicated that their religion was the main reason for the discrimination, 63% stated that it was because of their country of origin, while gender was only mentioned by 4% and income by 14%. 24% of Muslims stated that it was linked to their skin colour. Among Muslim women, on the other hand, 61% named their religion as the most frequently mentioned reason, followed by their country of origin (56%), their name (37%) and their own knowledge of German (32%). Gender was mentioned by 21%. Among Asian men, too, country of origin (58%), language (38%) and skin colour (32%) represented more frequent reasons for experiences of discrimination and racism than gender (4%) and income (10%). Among Asian women, the main reasons for discrimination were considered country of origin (60%) and knowledge of German (45%). Gender (30%), age (18%) and income (13%) were also cited as reasons. Gender, age and weight were the three most commonly named discrimination characteristics for non-racially labelled women. For these women, 58% of discrimination experiences were ascribed to their gender, 38% to their age and 19% to their weight. Language and religion are negligible with regard to experiences of discrimination for this group. <u>Age, weight and income were the three most common discrimination characteristics for non-racially labelled men.</u> 42% of men with no racial markings gave their age as a reason for discrimination, 19% their weight and 17% their income. Lack of employment was only mentioned by 4%.

<u>3. Social spaces:</u> People experience (racist) discrimination in various social spaces. This can be in public spaces generally, such as in the street or on public transport, or in one’s free time, like when entering clubs or gyms, as well as when in contact with banks and public authorities such as the police. Patients may also experience discrimination or racism in the field of healthcare, for example in hospitals or doctors’ practices. B<u>lack people experience (racist) discrimination disproportionately in public and by the police.</u> One in every two Black people reports experiencing discrimination and racism in public. Two in five Black men (41%) stated that they had often experienced (racist) discrimination from the police. A third of Black women reported the same (34%). <u>Muslims experience discrimination particularly often in contact with public authorities, the police and in healthcare.</u>

More than a third of Muslim men (39%) reported frequent experiences of discrimination and racism by the police, 51% by public authorities and 36% in healthcare. Among Muslim women, 46% reported that it was not uncommon for them to experience discrimination from authorities. The proportion who had these experiences when in contact with the police was 25%, and 35% in healthcare. Asian people reported experiencing discrimination and/or racism primarily from authorities and in public. Almost 40% of Asian men and women reported frequent experiences of discrimination and/or racism from public authorities. In public spaces, this applied to 36% of Asian men and 43% of Asian women.

II. People regularly experience discrimination and racism in healthcare – this also applies to non-racially labelled people.

1. Women more frequently reported having had negative experiences in the field of healthcare. For example, over two-thirds of Muslim women reported having been treated ‘unfairly or worse than others’ by doctors or other medical personnel. 35% even reported that they regularly experienced this, i.e. ‘very frequently’, ‘frequently’ or ‘sometimes’. 61%

of non-racially labelled women reported experiencing unfair and worse treatment than others. Of these, 26% regularly experienced this. More than two-thirds of Black women (67%) reported having been treated unfairly or worse than others in the healthcare sector. Of these Black women, 39% regularly experienced this. Among Asian women, 61% reported having experienced unfair and poor treatment in healthcare, 29% of these regularly. 60% of Black men also reported having experienced discrimination in healthcare, 25% of these regularly.

2. Representative data shows that experiencing discrimination has consequences for the doctor-patient relationship and for healthcare as a whole. More than one in three people from racially labelled groups reported having changed their doctor because their complaints were not taken seriously (34%). Among non-racially labelled people, this was reported by just below one in four people (24%). This affects women in particular. Muslim (39%) and Asian women (37%) more frequently find that their complaints are not taken seriously. Among non-racially labelled women, this figure was around 29%. Racially labelled men are also affected. Muslim (27%) and Asian men (25%) reported more often than non-racially labelled men (19%) that their complaints were not taken seriously. ‘Morbus mediterraneus’ – the racist assumption that ‘southerners’, above all those from Italy, the Mediterranean region or the Balkans, are particularly sensitive to pain – therefore applies to all racially labelled groups and would be better described as ‘Morbus aliorum’. Beyond just the group of racially labelled people, there is evidently also a tendency to assume that all patients – except non-racially labelled men – are exaggerating their pain. In addition, people avoid visiting the doctor when they fear experiencing discrimination there. For example, one in seven Black women (14%) reported having delayed or avoided medical treatment in the last 12 months due to fear of being taken less seriously or treated worse than others. One in eight Muslim (13%) and Asian women (13%) also reported having delayed treatment for this reason. Among Black men, this figure was one in twelve (8%), and the figures were similar for Muslim (7%) and Asian men (7%). For non-racially labelled men, around one in thirty people (4%) had delayed or avoided treatment for fear of discrimination.

3. Access to healthcare is also limited by appointment allocation in medical practices, which was proven with an experiment. The probability of men and women with a name that is common in Nigeria or Turkey receiving a positive answer to their appointment request is clearly and significantly lower than for men and women with a name that is widespread in Germany. These differences appear to be the most pronounced for appointments with psychotherapists.

4. Qualitative and participative findings show that racist knowledge bases are also present in healthcare and can have diagnostic consequences. An overrepresentation of racially labelled groups in connection with derogatory depictions can be found in teaching materials. For example, these groups are linked to 'excessive consumption of alcohol and drugs' or 'increased risk of sexually transmitted diseases'. Black women report being hypersexualised in healthcare. Consequently, tests for sexually transmitted diseases or HIV infections are often offered to Black women. Women who appear Muslim report being denied any independent sexuality. Accordingly, they reported that medical staff did not see any reason to provide certain healthcare services (for example, STD testing) to Muslim women.

III. Discrimination and racism also indirectly damage society as a whole.

1. Experiencing (racist) discrimination damages the general and mental well-being of those affected. Frequent experiences of discrimination are linked to an increased likelihood of anxiety disorders or symptoms of depression. At the same time, access to healthcare is restricted for these people, meaning that they are directly affected by constraints and deficits that can be traced back to discrimination and racism. Alongside the individuals affected, (racist) discrimination can also affect society as a whole, for example through increased healthcare costs and work absences.

2. On average, people affected by racism actually trust institutions more than those not affected by racism. Differences are only negligible regarding the police and the judicial system. However: a loss of trust is linked to experiences of (racist) discrimination. This means that concrete experiences of racist discrimination, independent of discrimination context and characteristics, may be accompanied by a serious loss of trust in concrete institutional sectors.

The report at a glance: Summaries of the chapters

➔ *Representatively surveyed (NaDiRa.panel) and experimentally proven*

I. GENERAL EXPERIENCES OF DISCRIMINATION AND RACISM IN GERMANY

- **Experiences of discrimination are widespread in Germany and happen to racially labelled people disproportionately often:** People who self-identify as Black, Muslim or Asian report experiencing both subtle and overt discrimination far more frequently than non-racially labelled people. Men tend to report experiencing more discrimination than women. Black people report more frequent experiences of discrimination in all situations discussed. In the majority of cases, racially labelled people ascribe their experiences to characteristics that label them racially, such as skin colour, religion, or knowledge of German.

- **Experiences of discrimination vary depending on social spaces:** (Racist) discrimination is experienced differently depending on the area of society. According to the reports, Black people's experiences of discrimination mostly occur when dealing with the police as well as in public and during their leisure time. Muslims report experiencing most (racist) discrimination from public authorities.

- **Lower trust in institutions is linked to increased experiences of discrimination and racism:** Overall, racially labelled people have higher confidence in institutions in Germany than non-racially labelled people. Additionally, the perceived trust of these groups in healthcare – despite their negative experiences – is far more resilient than that of non-racially labelled people. In comparison to people who have not experienced discrimination, however, individuals who had already experienced unequal treatment in the relevant institutions far less frequently reported that they tend to trust these institutions.

II.1 RACISM, DISCRIMINATION AND HEALTH: INITIAL EMPIRICAL FINDINGS FROM THE NADIRA.PANEL

- **Self-perceived health status deteriorates with increased experience of discrimination and racism:** On average, those who report not experiencing racism and discrimination regard their health as good (3.0 on the health scale). Those who frequently experience racism and discrimination regard their health as rather average (<2.5 on the health scale).

- **This affects Muslim women in particular:** In comparison to non-racially labelled men, Muslim women consistently regard their health status as worse. Even after taking social demographics and experiences of discrimination into account, Muslim women – compared with non-racially labelled men – are at a slight disadvantage.

- **Experiences of racism and psychological distress are linked:** When people experience discrimination and racism, those affected have increased symptoms of anxiety disorders and depressive disorders, particularly if they experience this regularly. In comparison to non-racially labelled people, Muslim and Asian people in particular have a higher probability (on average approximately 10 percentage points) of showing moderate or serious symptoms of depression and anxiety disorders.

II.2 NAME-BASED DISCRIMINATION WHEN ACCESSING HEALTHCARE: A GERMANY-WIDE FIELD EXPERIMENT

- **Discrimination takes place during appointment allocation based on name:** Patients with names that are particularly widespread in Turkey and Nigeria are discriminated against in the allocation of appointments at the practices of registered doctors and psychotherapists – despite identically worded requests for appointments. In comparison to individuals with a name common in Germany, men and women with these names receive positive answers less frequently. This discriminatory treatment during the allocation of appointments runs counter to the medical oath to treat people seeking help equally.

- **No discrimination by paediatricians:** During the allocation of appointments in paediatric care, children are treated equally. No evidence was found of name-based discrimination at paediatric practices.

- **Preferential treatment of patients with private insurance and doctorates:** Patients with private (as opposed to statutory) insurance and doctorates (compared to without doctorates) receive preferential treatment in the allocation of appointments. Patients with names common in Turkey and Nigeria, however, benefit from this preferential treatment less than patients with names common in Germany.

II.3 EXPERIENCES OF RACISM AND DISCRIMINATION IN HEALTHCARE

- **Making use of healthcare is delayed due to fear of discrimination:** Differences were seen regarding the timing of taking advantage of healthcare services. Those affected by racism reported more often than those not affected that they visited doctors later or not at all. This applied particularly to women who were vulnerable to racism.

- **The attempt to find psychotherapy is abandoned more quickly:** One in three racially labelled people has already given up attempting to obtain a psychotherapy appointment. For people who are not affected by racism, this figure was just under one in five. Among those who frequently experience discrimination in healthcare, this effect is particularly notable: among Black, Muslim and Asian people, more than half reported having abandoned their search for a place in therapy. The general shortages in psychotherapy services therefore affects racially labelled people in particular.

- **Complaints are not taken seriously:** Many people have had the experience in healthcare of their complaints not being taken seriously. Here, gender-specific differences become apparent. When compared to men, women reported more frequently that they had already had to change their doctor for this reason. This was particularly true for women affected by racism. For men, in comparison, racially labelled men reported more often that their complaints about medical treatment were not taken seriously.

- **‘Morbus aliorum’ – the illness of the ‘others’:** When complaints and pain are not taken seriously, this can lead to misdiagnoses. In this regard, the findings revealed that the non-racially labelled man is considered the norm. Compared to this, the racist stereotype of hypersensitivity to pain is attributed to all other groups. Both women – whether racially labelled or not – and racially labelled men reported significantly more frequently that their complaints were not taken seriously and that it was implied that they were exaggerating their complaints. In medicine, this racist assumption is referred to with the terms ‘Morbus mediterraneus’, ‘Morbus balkan’ or ‘Mamma mia syndrome’. There is therefore an implication that ‘southerners’ – above all people from Italy, the Mediterranean region or the Balkans

– are too sensitive. Our findings prove that this stereotype affects far more people. Of all groups, women in particular are in danger of receiving inadequate medical care as a consequence.

➔ *Researched participatively*

II.4 COMMUNITY VIEWS OF RACISM IN HEALTHCARE – A COMMUNITY-BASED PARTICIPATORY STUDY

- **Muslim and Black people experience inequality through othering:** Study participants reported being situated as intrinsically 'other' through stereotyping in interactions with medical practices and hospitals. They were also categorised as not belonging and different, as well as being downgraded. This can result in disadvantages – for example, through delays and discrimination in treatment as well as misjudgement of symptoms. A loss of trust in the healthcare system and a deterioration in the health of those affected was documented, possibly as a consequence.

- **Othering appears differently with respect to Black people and people who appear to be Muslim:** In healthcare, othering can lead to different forms of discrimination. For Black and Muslim participants in the study, it was implied that they were either overly sensitive or insensitive to pain, or that they were either hypersexualised or did not have any self-determined sexuality, which can lead to various forms of discrimination.

- **Silencing hinders thematisation of racism:** Repeated experiences of othering, invalidation and ignorance can lead to study participants being indirectly silenced or falling silent of their own accord due to fear of consequences.

- **The human right to health is legally limited for asylum seekers:** Structural differences happen for study participants who are seeking asylum. Refugees report that the legal necessity for treatment certificates from social welfare offices leads to delay or even prevention of medical treatment for ill people and that people who are not medical professionals decide whether medical treatment is necessary. In addition, the limitation of healthcare services for asylum seekers, based on the Asylum Seekers' Benefits Act, applies and leads to certain health-related services not being accepted for some study participants.

➔ *Canon of knowledge questioned*

II.5 RACISM IN MEDICAL TRAINING: A PARTICIPATIVE AND EXPLORATIVE ANALYSIS

- **Underrepresentation of racially labelled patient groups in teaching:** In medical teaching materials and in teaching itself, racially labelled groups are mostly systematically not taken into account. For example, people with dark skin types appear extremely rarely in dermatological and other teaching material. Furthermore, colonial medical backgrounds are hidden in many cases.

- **Racially labelled patient groups as a deviation from the norm:** If racially labelled groups are taken into account in medical teaching materials and teaching, they are often located as beyond supposed Western or German norms and values. In the process, very varied groups are generalised as ‘exotic’, ‘different’ or ‘particularly challenging’. At the same time, they are stereotyped through specific attributions and often linked to particular clinical pictures (e.g. HIV or tuberculosis) or behavioural patterns (e.g. consumption of alcohol or drugs).

- **Medicine’s self-image hinders reflections on racism:** When studying medicine, a normative self-image of the medical profession is promoted, which is established as dissociated from a stereotyped and exotified ‘other’ or ‘foreign’. Neither racially labelled patients nor medical students and doctors fit into this image. In addition, self-designation and societal expectations of doctors’ neutrality present a barrier to examining racism critically. As a phenomenon that is not endorsed by society, racism is diametrically opposed to the demands of humanistic neutrality, and is therefore a taboo and is ignored.

- **Institutional structures perpetuate racist conditions:** Medical care is often influenced by staff shortages, a lack of time, a heavy workload and rigid hierarchies. These factors can contribute to perpetuating and reinforcing racism.

➔ Racism, discrimination, racist discrimination: A brief explanation of terms

The terms 'racism', 'discrimination' and 'racist discrimination' overlap but are not equivalent.

In essence, racism is understood as an ideology as well as a discursive and social practice in which people are (1) classified into different groups on the basis of physical characteristics (categorisation), to which (2) generalised, absolute and unchangeable properties are assigned based on 'origin' (generalisation and racialisation), which are (3) evaluated and (to the advantage of the own group) linked to social ranks (hierarchisation), with which (4) unequal treatment and societal structures of power and dominance are reproduced and justified (legitimisation) (see DeZIM 2022: 16–17; see also the section What is racism? Understanding concepts and functioning principles).

Discrimination refers to disadvantageous treatment of people or groups. Not all forms of discrimination can be traced back to racism. Legally, discrimination is understood by means of so-called discrimination characteristics. In particular, these include: gender, 'race', disabilities and religion. Often, discrimination takes place at various intersections – i.e., due to several characteristics which intertwine. Here, we refer to intersectionality (see Crenshaw 1989). The legal background is the specific prohibition of discrimination in Article 3, Paragraph 3 of the German Constitution, and the General Equal Treatment Act (AGG) based on European legal specifications. Discrimination as a societal phenomenon extends beyond legally recognised forms. For example, in the social sciences, but also on the level of state anti-discrimination, further dimensions of discrimination are taken into account, for example social stratification (as a question of class), gender identity and sexual orientation.

Racist discrimination, alongside sexist or age-based discrimination, for example, constitutes a concrete type of discrimination. It is a practice of disadvantageous treatment of people or groups originating in racist differentiation and can occur intentionally or unintentionally. Against the background of the societal aspiration to equal opportunities and equal access to resources, racist discrimination, unlike racism, is legally prohibited. In social sciences,

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it represents an indicator for empirical recording of the extent and consequences of racism. This recording takes place on an individual level through observing interpersonal experiences, for example in institutions or other societal contexts.

➔ Terminology and language

As German-language racism research has been seldom institutionalised thus far, well-founded basic research remains pending. In addition, racism research observes a complex analysis phenomenon, which includes a broad field of theoretical and empirical approaches, meaning there are no clearly defined technical terms yet. In an international comparison, there are already further developed terms and terminology, which are taken into account and discussed here and which are reflected in German-language knowledge production. In the initial study *Racist Realities* (2022), the terms 'racialised' and 'non-racialised' were used for the descriptions of different positions in racist relationships. In the context of theoretical reflections, the following terminology has been adapted and will continue to be developed further regularly:

Racially labelled – non-racially labelled
(Focus: processuality)

Affected by racism – not affected by racism
(Context: perspectives of individuals affected)

At risk of racism – not at risk of racism
(Context: safety)

Vulnerable to racism – not vulnerable to racism
(Context: psychosocial issues)

Racism puts people at risk: Foreword

Racism is not a fringe phenomenon in Germany, but rather affects a large part of the population both directly and indirectly. The findings of our initial study *Racist Realities. How does Germany deal with racism?* (2022) showed that an overwhelming majority of the German population recognises this and does not dismiss racism as a marginal phenomenon. On the contrary: 90% of the population in Germany consider racism to be a problem. 58% of those potentially affected by racism have experienced racism at least once in their lives. If the experiences of related people and indirect experiences of racism – i.e., observed experiences or those that were explained directly – are included, only a third of the population reports not yet having come into contact with racism.

This monitoring report follows up on the findings from the initial study and provides new results on the topic of discrimination and racism in Germany. Experiences of discrimination and racism are still widespread; according to our results, they occur particularly often in the provision of healthcare. For this reason, special attention will be paid to the topic of health and healthcare in this report. In the process, the perspectives of those potentially affected by racism will be taken into account. With the representative surveys of the NaDiRa.panel, it can be proven that, in addition to the consequences for those affected – which may be dangerous to health – racism has negative implications for trust in state institutions and healthcare. This means that racism has a potential destabilising effect on institutions.

Racism and its consequences for society

In 2023, our socio-political present is challenged by multiple crises including war, pandemics, climate catastrophes and refugee movement. Consequences include inflation and increasing socioeconomic inequality. Here, discriminatory stereotypes and racist knowledge bases offer many people a repertoire of seeming explanations to reduce the complex social and economic crises down to apparently clear and straightforward answers. The COVID-19 pandemic illustrated that certain groups of the population were more severely affected by racism during this period than others. At the same time, alongside hitherto barely mentioned racism against Asian people in Germany (see Plaga 2020; Priebe 2020; Suda & Köhler 2024), an increase in antisemitic conspiracy theories (see Berek 2021) was observed. Russia's invasion of Ukraine also strengthened racism dynamics in society, as prejudices and stereotypes against particular racially labelled or national groups were expressed (see Panagiotidis & Petersen 2023) and/or hierarchical rankings between different groups of refugees were postulated (see Pallokat & Poth 2022). The consequences of global climate change may also advance racist dynamics, as they contribute to further aggravating existing social and economic inequalities (see Ituen & Hey 2021; Quent, Richter & Salheiser 2022).

Crises can therefore lead to increasing inequality and conflicts regarding the allocation of resources. A longing for an ‘intact’ past is often linked here to notions of a time that was ostensibly still homogeneous. The crises of the present are thereby directly related to the figure of the ‘other’. To effectively counteract these processes of open erosion of solidarity and reinforcement of racist agitation, it is necessary to uncover established racist knowledge structures in systems of prejudice and to recognise their effects on practices in the relevant institutions. In this way, it is possible to identify the necessary starting points for measures to tackle racism.

Racism jeopardises democracy

When groups that are affected by racism in a society are excluded due to systematic discrimination in their day-to-day lives and within different institutions, this also leads to a loss of trust and, with it, problems of legitimacy for democracies (see Wintermantel 2020: 27). The normalisation of racist ideologies and practices therefore not only poses a risk to the social participation and physical safety of those affected, but has also developed into a threat to the Federal Republic of Germany’s plural democracy that must be taken seriously. This was also emphasised by Frank-Walter Steinmeier, the Federal President when, as part of the International Week Against Racism in 2021, he stated that racism was a ‘problem’ in Germany as it jeopardised ‘living freely alongside one another, the peaceful diversity of cultures, religions and beliefs, our democracy’ (Der Bundespräsident 2021). Alongside the damage caused by racism to racially labelled groups of people, it therefore also threatens the democratic composition of the Federal Republic of Germany and poses a fundamental political challenge. Here, the central question is that of what role racism can play in destabilising a liberal democratic system and in a potential development towards illiberal democracies (see Vormann & Weinman 2020). In addition, alongside these democratic theoretical aspects, there is a current question regarding a symbolic or moral dilution of society, as well as economic and foreign-policy effects that may stem from racism.

Racism jeopardises the economy

Alongside the negative implications for trust in democratic structures and institutions, it is also already possible to observe economic consequences for German society. Calculations by the Institute for Employment Research (IAB) of the Federal Employment Agency predict a shortfall of approximately 7,000,000 employees in the German economy by the year 2025. This shortfall will need to be compensated for, in large part through the immigration of skilled workers (see Institut für Arbeitsmarkt- und Berufsforschung [IAB] 2021). German society is already dependent on foreign workers (see Grabka & Göbler 2020; Loscher, Kolb & Schork 2023) in various segments of the employment market. The policy statement regarding 'fair immigration' of nursing staff between Germany and Brazil that was signed by the Federal Minister of Labour, Hubertus Heil, and his Brazilian counterpart, Luiz Marinho, in June 2023 demonstrates that the nursing sector is particularly affected by this (see Bundesministerium für Arbeit und Soziales [Federal Ministry of Labour and Social Affairs] 2023; Pütz et al. 2019). In comparison to the recruitment of employees in the previous century, however, altered dynamics can be observed that are linked to employees' mobility options and professional qualifications in the context of globalised competitive markets. In particular, racially labelled people with a higher socioeconomic status sometimes have the opportunity not to have to submit to employment conditions and living conditions linked to racism in their careers. Two-thirds of highly qualified skilled workers from third countries report having experienced racism and discrimination in Germany. These experiences with racism, unfriendliness and coldness combine with other factors to contribute to employees migrating elsewhere or lead to Germany appearing less attractive to skilled workers from abroad (particularly from outside Europe) (see Boockmann et al. 2022; OECD 2023). If people affected by racism do not encounter the right conditions to want to work and live in Germany long-term, racism and discrimination will therefore also have the capacity to weaken the country's economic prosperity.

Racism jeopardises Germany's international reputation

Since its symbolic readmission into the international community after the Second World War, Germany's international reputation has been dependent on complying with international agreements and treaties. These are international obligations regarding human rights, which have promoted and continue to require increasing awareness of racism and discrimination in Germany. As a member of the United Nations (UN), Germany is bound by the Universal Declaration of Human Rights and the human rights treaties ratified by the Federal Government. The Federal Republic of Germany has been a contracting member state of the *International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)* since 16 May 1969. The agreement obliges the Federal Government to protect those affected by discrimination and to take measures that contribute to equal rights. As a contracting member state, the Federal Republic of Germany must ensure that state authorities do not discriminate against any people or groups of people. The central question here is the definition of 'racial discrimination'[1] in Article 1, Paragraph 1 ICERD, which includes both direct and indirect discrimination. Accordingly, not only actions with an inherent intention are considered racist discrimination, but also rules that are neutrally formulated but have a discriminatory effect on people or groups of people with the characteristics recognised in Article 1

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[1] For discussion of the term 'race', see FN 6.

ICERD (see Bundesministerium der Justiz und für Verbraucherschutz [Federal Ministry of Justice and Consumer Protection] 2017: 6–7). The ICERD also includes a complaint procedure that makes it possible for individuals affected by discrimination to take a case to the Committee on the Elimination of Racial Discrimination after exhausting their means of legal redress domestically if they believe that their country has acted contrary to the agreement and thereby violated human rights. The Federal Republic of Germany is therefore obliged to protect its population (see ibid.: 16–18). The CERD also formulates recommendations to contracting member states in its 'Concluding Remarks' within its periodic reporting process, which must be responded to by the member states. On 15 May 2015, the committee made unequivocally clear that there was a great need for action and a backlog of accumulated needs in Germany. Here, there was criticism of the insufficient data regarding the situation of individual groups of the population and minorities in the population. The committee believes, however, that this data is necessary to obtain insights regarding social inequalities and the situation of minorities, and to uncover discrimination (see Committee on the Elimination of Racial Discrimination [CERD] 2015: 2–3).

Furthermore, the Programme of Action of the World Conference Against Racism in Durban in 2001 and the Programme of Activities of the International Decade for People of African Descent, which is taking place from 2015 to 2024, oblige UN member states to collect statistical data. The Federal Government has recognised the decade called for by the UN and established a coordinating office to implement it in 2022. This also includes an advisory board that Black[2] organisations and scientists contribute to. Not for the first time, Germany has been urgently advised to initiate extensive investigations. For years, the Federal Government has been responding to these by stating that, for reasons of historical responsibility, it does not wish to collect 'any demographic statistical data and socioeconomic data based on ethnicity since the end of the Second World War' (Bundesministerium des Innern und für Heimat [Federal Ministry of the Interior and Community] 2023). The CERD therefore suggests collecting appropriate data regarding other characteristics, such as native language, predominant language spoken and other characteristics surveyed on a voluntary basis. In the Programme of Activities of the International Decade for People of African Descent, it was also recommended that countries should break down statistical data in accordance with domestic legislation – maintaining the right to privacy and the principle of self-identification (see United Nations 2014). The European Commission against Racism and Intolerance (ECRI), which was established within the Council of Europe, also suggested realising national surveys regarding the experiences and perceptions of racism from the point of view of those potentially affected on 16 March 1998 in its General Policy Recommendation No. 4 (see European Commission against Racism and Intolerance [ECRI] 1998).

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[2] 'Black' is a political self-designation that attempts to describe a specific societal position and collective experience that is affected by racism. To emphasise that 'Black' does not refer to an individual position but to a societal one and to the experiences shared by those in this position through experiences of racism against Black people, the term is written with a capital B (see German National Monitoring of Discrimination and Racism 2023: 371).

Racism becomes the subject of political measures

Based on international obligations, the Federal Government has increasingly begun to establish additional measures to combat racist discrimination in Germany. These activities serve the national implementation of international stipulations.[3] An important milestone here was the development of the 'National Action Plan Against Racism' (2008). However, this was heavily criticised by civil society, among other aspects due to insufficient analysis and description of racism in Germany, a lack of participation of civil society, and a lack of orientation for activities (see Follmar-Otto & Cremer 2009; Netz gegen Rassismus 2009). For the updated and extended edition of the 'National Action Plan' (2017), civil society formulated specifications in which an excessive focus on right-wing extremism and subsequent curtailing of the term 'racism' in Germany were discussed as problems (see Netz gegen Rassismus 2016; see also the section The civil society process accompanying the NaDiRa). After the racist and antisemitic attacks in Halle and Hanau and the Black Lives Matter protests around the world, the previous Federal Government established a cabinet committee to combat right-wing extremism and racism in 2020. This committee produced a catalogue of 89 measures, including the intention to increase research into racism and right-wing extremism, and to institutionalise it in the academic landscape. During this process, two funding guidelines by the Federal Ministry of Education and Research are of central importance, which put the establishment of research projects and junior groups in these topic areas into effect as a pillar of the package of measures (see Bundesministerium für Bildung und Forschung [Federal Ministry of Education and Research] 2021a, 2021b). Attached to the DeZIM Institute, Prof. Dr. Andreas Zick's knowledge network on research into right-wing extremism (DeZIM Research Community) and Dr. Noa K. Ha's knowledge network on racism research (DeZIM Institute) have been proposed and approved.

Additionally, in recent years the first commissioners have been appointed and relevant bodies of experts created and institutionalised at a federal level. The 'Independent Antisemitism Expert Group' (2009, 2015) and the 'Federal Government Commissioner for Jewish Life and the Fight against Antisemitism' (2018, Felix Klein) were followed by the 'Independent Antigypsyism Commission' (2019) and the appointment of the first 'Federal Government Commissioner against Antigypsyism and for the Lives of Sinti and Roma in Germany' (2022, Mehmet Daimagüler), the creation of the offices of an 'Independent Federal Anti-Discrimination Commissioner' (2022, Ferda Ataman) and of a 'Federal Government Commissioner for Anti-Racism' (2022, Reem Alabali-Radovan), as well as most recently the 'Anti-racism Expert Board' (2023). An 'Independent Islamophobia Expert Group' (2020) was also created, and it presented its final report *Islamophobia – a German Summary*. The federal

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[3] A detailed description of this and other measures can be found in the status report Racism in Germany (2023) of the Commissioner for Migration, Refugees and Integration and for Antiracism.

programme ‘Live Democracy!’ is also of central importance to the field of antiracism. Since 2015, it has been extensively promoting model projects from civil society at the communal, state and federal levels, as well as via competence centres and networks. The programme makes an important contribution to racism prevention, in addition to its diversity initiatives and commitment against antisemitism, homophobia and transphobia, Islamophobia and hostility towards Muslims, racism against Black people, and antigypsyism. Its goal is to protect basic democratic principles such as equality, the rule of law, and social participation. An Act on the Support of Democracy (DFördG) is currently being developed for sustainable structural implementation.

Racism generates resistance

The Federal Republic of Germany has been influenced by a history of racist violence. The pogrom-like attacks of the post-reunification period in the early 1990s (in particular in Hoyerswerde, Rostock-Lichtenhagen, Mölln and Solingen) point to a violent process of becoming a nation, which took place with the aid of racist exclusions (see Behrends, Lindenberger & Poutrus 2003; Perinelli 2022: 22–23; Poutrus 2004, 2009, 2019). Following this phase, described as ‘the baseball-bat years’ (see Bangel 2022), the self-exposure of the National Socialist Underground (NSU) in 2011 in particular uncovered a structural safety concern for migrant, migrantised and racially labelled people in Germany (see Thuringian State Parliament 2019). This was followed by further attacks which continue into the present: the threats of the NSU 2.0, the murder of CDU politician Walter Lübcke in 2019, the antisemitic and racist attack on a synagogue and civilians in Halle in the same year, and the racist murders in Hanau in 2020.

This right-wing and racist violence is countered by antiracist mobilisation, which explicitly names racism and demands better protection for those affected. Triggered by migrant and antiracist groups and organisations, the topics of institutional racism have been publicly discussed in Germany, at the very latest since the exposure of the NSU (see Dengler & Foroutan 2017). The attacks in Hanau and Halle were followed by widespread expressions of solidarity with the victims. Additional impulses were provided by national and international mobilisations within the worldwide Black Lives Matter movements (see Zajak et al. 2021). The starting point for structured organisation against racism, however, took place in the 1980s. Here, alongside anti-fascist networks, associations of those affected were particularly important. In 1985/1986, ‘ADEFRA – Afro-German Women’ (later ‘ADEFRA – Black Women in Germany’) and the ‘ISD –Black Germans Initiative’ were founded. These groups offered a space for Black people in East and West Germany to come together, discuss racism, and mutually support each other to handle racism in their day-to-day lives. Other groups also formed against experiences of everyday racism. For example, the ‘Antifa Gençlik’ was founded at the end of the 1980s in Berlin as an anti-fascist self-organisation of migrants who attempted to protect people from right-wing extremist violence. Shortly afterwards, the refugee self-organization ‘The Voice’ emerged in Jena to address questions of refugee movements, human rights and racism in East Germany. It currently operates across Germany. From 1998 onwards, ‘Kanak Attak’, an association of various people, particularly individuals with a background of immigration, attempted to put the topic of racism on the political agenda. The group states: ‘Our common position consists of an attack against the ‘Kanakisation’[4] of specific groups of people through racist ascriptions with all its social, legal and political consequences’ (Kanak Attak 1998). Since the 1990s, the terms ‘person of colour’ and ‘people of Colour’ (PoC) have also become established as self-designations in order to strike back against racist ascriptions (see Ha 2023).

All the developments above make it clear that there is a need for a scientific analysis of racism. In this context, the German National Monitoring of Discrimination and Racism provides continuous data and recommendations for action to counteract racism both protectively and preventatively, thereby contributing to safeguarding democracy in a changing society.

Introduction to the report: Focus on health

Health is a human right[5] and represents an existential aspect of life. Racism is costly not only for the economy and labour market, but also for other social domains including health and healthcare. Furthermore, a higher burden of disease due to more difficult living conditions for certain groups, as well as shortcomings in access to and quality of care, can be linked to significant societal consequences. In the first instance, health implications or increased prevalence of illness due to racist conditions themselves must be viewed as a ‘price’ that is not ethically acceptable. In addition, it has profound consequences for society itself: inequality with regard to quality of life, prevalence of illness, exposure to risks and healthcare can be viewed equally as a precursor to and consequence of societal polarisation. Furthermore, the social relationships between members of society (horizontal) as well as between members of society and institutions (vertical), and thereby the feeling of social affiliation of certain groups, can be negatively affected by unequal access to care and treatment quality. This feeling of social belonging as well as trust in society and its institutions are considered core components of societal cohesion (see Schiefer & van der Noll 2017). It is therefore necessary to note that racism and its consequences can trigger or intensify health risks. The general societal losses in welfare due to discrimination and racism are already well-known (see Becker 1995).

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[4] For an explanation of the term see https://en.wikipedia.org/wiki/Kanake.

[5] The right to health is enshrined in Article 25 of the General Declaration of Human Rights (United Nations 1948) as well as Article 12 of the International Covenant on Economic, Social and Cultural Rights (United Nations General Assembly 1967). According to Article 12, Clause 1 of the Social Covenant, the states party to the covenant recognise every human’s right to enjoy the highest attainable standard of physical and mental health. Germany ratified the Social Covenant in 1973.

The main focus of this report is justified by the above aspects, which became particularly apparent during the COVID-19 crisis. The pandemic once again demonstrated health's fundamental role in our society and its cohesion, and how these risks affect various groups of the population differently. Differences dependent on socioeconomic status or educational background, for example, are factors that potentially overlap with racist conditions and the corresponding unequal distributions in the context of health and healthcare. Studies have shown that racially labelled groups worldwide were particularly affected by the consequences of the COVID-19 crisis. This applies both with regard to housing, living or working conditions and the associated fundamental health constitutions and risk exposure, as well as with regard to access to adequate prevention and care (see Akbulut et al. 2020; Kajikhina et al. 2023; Kollender & Nimer 2020; Penning & Razum 2021). This report will follow up on this and will employ multiple methods to examine the connection between racism and health or healthcare in a targeted way.

Focus on the perspectives of individuals affected

When it was established, one of the tasks given to the German National Monitoring of Discrimination and Racism was the political brief of taking the perspectives of those affected by racism in particular into account during research. This was a reaction by the Federal Government to demands from civil society, which above all were put forward by migrant and antiracist initiatives and organisations, which had been pressing for the collection of data and regular monitoring for years. Accordingly, this report focuses on people vulnerable to racism: criticism of racism in the healthcare system as well as the effects of racism on the health of racially labelled people play a central role in various communities' demands (see e.g. Aikins et al. 2021; CLAIM 2023). The findings presented in this report regarding the relationship between racism and health (see Chapter II.1) illustrate the relevance of the perspectives of individuals affected in research regarding the (unequal) distribution of societal goods and resources. It only becomes possible to describe the correlations between the subjective sense of well-being and experiences of racism through the perspectives of people vulnerable to racism. In addition, experiences of everyday racism reported by those affected and the contexts in which these take place (see Section I) can be viewed as an indicator of the forms and extent of racism in society.

Political action prioritizing equal rights, equality of treatment, and finally equal opportunities for all members of society should therefore take the perspectives and experiences of people affected by racism into account. However, to date these have only been inadequately analysed in Germany. In the central repeat surveys – such as the Microcensus, the SOEP, NEPS, ALLBUS or DEAS – subjective experiences of discrimination, for example, are only recorded in a highly fragmentary manner (see Baumann, Egenberger & Supik 2019). Research has already indicated that the recording and investigation of people's intentions when discriminating (racist knowledge bases) are insufficient to analyse discrimination and racism adequately, however. It is also necessary to consider the effects that these have on those affected (see Nadal et al. 2014). With this in mind, the perspectives and voices of people who are particularly negatively affected by discrimination and racism provide essential contributions to a more precise description of the underlying mechanisms and causes. The NaDiRa's investigations therefore focus on these perspectives and strive to gradually close the relevant gaps in research. In the NaDiRa.panel sampling for this report, particular emphasis was placed on the perspectives of three specific groups that are currently especially relevant for the investigation of racist realities in Germany: Black, Muslim and Asian people. This selection is motivated by historical and current racist discourse in Germany (for more on the selection of the groups, see the section The NaDiRa.panel data).

Structure and contents

This monitoring report presents findings on experiences of discrimination and racism from the survey of the population and those affected on the basis of the NaDiRa.panel (see chapter Research approach and methodology), as well as on research carried out within the NaDiRa since 2021 with the focus on health. Here, the consequences for those affected and for society were considered above all. Beginning with an introduction and an explanation of the theoretical starting point, the report is then divided into two sections:

Part I. General experiences of discrimination and racism: In this section, current findings are presented from the repeat survey of the population and people affected (NaDiRa.panel), which is set up as long-term monitoring. In doing so, findings are provided regarding the initial situation in general and the question of how, where and to what extent the population in Germany experiences discrimination and racism.

For this purpose, groups, discrimination characteristics and contexts are investigated more closely. This section also discusses the connection between (racist) discrimination and the loss of trust in state institutions.

Part II. Focus on racism and health: This in-depth section, consisting of multiple methods, delivers the monitoring results of the NaDiRa.panel on health as well as analysis from qualitative-explorative, participative and experimental research projects at the NaDiRa. It contains five different areas and dimensions that the NaDiRa investigates. First, the results of the NaDiRa.panel regarding health are presented, which examine the connection between racism and the health of those affected, as well as inequality in healthcare (Chapter II.1) and experiences of racism in healthcare (Chapter II.3) via quantitative surveys within the survey of the population. Furthermore, an experimental study is presented concerning a correspondence test of name-based inequality when accessing healthcare (Chapter II.2). Following on from this, two qualitative and explorative-participative studies are presented that consider community perspectives of racism in healthcare (Chapter II.4) and on racist knowledge bases and practices in medical training (Chapter II.5).

These main parts of the report are followed by Recommendations for action for politicians, stakeholders in healthcare, and the relevant training contexts, which are derived from research and literature, plus a Conclusion and an Outlook.

Preliminary historical and theoretical considerations

There is a societal consensus in Germany that racism is to be rejected and is morally reprehensible. At the same time, within both society and science, there is widespread disagreement concerning what is understood as racism (see Hund 2012). Racism continues to lead to violence against many people in Germany, as well as limiting democratic participation. Racist exclusion relates to characteristics which are imagined to be biologically or culturally inherited. These include skin colour, appearance, origin, pronunciation, the wearing of religious head coverings or other religious practices, for example. Therefore, despite being a social construct, racism is powerful. This starting situation results in the urgent need for contentual and analytical discussion regarding the concept of racism as well as ‘Rasse’/‘race’ as an analytical category.[6]

Both terms are conceptualized differently in the international and German-language research landscape, as well as in laypeople’s understanding of them. There is no consistent and generally recognised definition of racism. It is expressed differently (see Hall 2000) depending on the historical, chronological, cultural and societal context, so empirical research into racism has to tailor its concepts concretely to the research topic in question. Racism’s various manifestations and dynamics are difficult to research adequately without flexibility regarding terms (see Scherschel 2015). In order to do justice to the real lives and vulnerabilities of racially labelled people and simultaneously the structural dimensions of racist realities, a broad understanding of racism is required, as well as the objectification of the debate (see Sinanoğlu & Polat 2023). Only in this way is it possible to find a well-founded discussion and appropriate ways of dealing with racism through politics. In light of the range of theoretical work and work on terms, we explain below how the NaDiRa research team approaches the phenomenon of racism analytically.

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[6] There is a persistent debate concerning the term ‘Rasse’ in the German-language research landscape. There is currently no consensus regarding whether ‘Rasse’ can be used productively as an analytical category for critical racism research. The debate focuses on the history of genocide and the associated connotations of the term ‘Rasse’ (see Barskanmaz 2011; Hund 2016; Tsianos 2020). Many researchers therefore suggest a linguistic differentiation between ‘Rasse’ and ‘race’: ‘It would be […] helpful […], if in German – at least in research – the term ‘race’ could be agreed upon to denote the social constructs that are in effect within racist contexts/systems and on which these are based, or which occur during the racialisation process. ‘Rasse’ would then only be used to denote the phantasm of a natural category.’ (Alexopoulou 2023b). Based on critical reflection and civil rights struggles in the USA in the last century, the English term ‘race’ has therefore undergone a shift in meaning and is now understood by the majority as a social construct (see Bellu, Bellu & Tsianos 2023: 57). A similar process has not yet taken place for the German term ‘Rasse’, but it has recently been slowly starting to progress (see for example Barskanmaz & Samour 2020). As the NaDiRa initial study Racist Realities showed, the concept of the existence of human ‘races’ is still widespread in Germany and is shared by one in two people (see DeZIM 2022: 43–44).

What is racism? – Understanding concepts and functioning principles

Following on from international research, the investigations and surveys carried out by the NaDiRa serve as building blocks for the empirically saturated creation of theories. Many relevant theories of racism use the conceptual foundation presented by Philomena Essed (1992) over 30 years ago:

> *'Racism is an ideology, a structure and a process by which certain groups are viewed as essentially different and inferior "races" or ethnic groups on the basis of actual or attributed biological or cultural properties. Subsequently, these differences serve as an explanation for excluding members of these groups from access to material and non-material resources'* (ibid.: 375).

Contrary to a narrow understanding, racism can also occur when not (exclusively) biologistically motivated and can lead to overt violence. Racism must be understood as a form of socialisation that is registered as historically accrued knowledge in our institutions as well as in societal structures and standards[7] and thereby (re-)produces social inequalities. Racism significantly influences everyday cohabitation with a view to participation opportunities and has to be explored with regard to its dynamics and versatility. This is why we speak about 'historical-specific racism' (Hall 1994: 127), which is linked to its own racist images and practices, and which arose from specific historical geographical contexts. Specific forms of racism are particularly noteworthy, such as racism against Black people, racism against Muslims, racism against Slavic people, racism against Asian people, and racism against Roma and Sinti people (see DeZIM 2022: 20–23). Whether antisemitism should be understood as a variant of racism or instead describes an independent phenomenon remains disputed in research (see Cousin & Fine 2012; Goldenbogen & Kleinmann 2021; Katz & Taylor 1988; Klug 2014).

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[7] A norm corresponds to a generally recognised social rule. As the product of a social negotiation process, norms create expectations both with regard to one's own behaviour and that of other actors. In this way, they produce a 'normal case' or a 'norm model' i.e. behaviour or conditions that correspond to these norms. Norms and normal cases, however, often only describe the average or the majority of a society. People, lifestyles and experiences that exist outside such a framework are not taken into account – they fall outside the norm. In this sense, norms can have discriminatory effects (see Klimke et al. 2020).

➔ Levels of analysis in racism

In order to analyse the mechanisms of the (re)production of racism, the research carried out by the NaDiRa takes into account the intertwining of different levels of racism. For this purpose, an analytical distinction is made between the interpersonal, institutional and structural levels. Empirically, racism is characterised by the intertwining of these levels, meaning that it can also operate unnoticed via institutional anchoring (see Rommelspacher 2009 or, specifically for the health sector, Nazroo, Bhui & Rhodes 2020). The institutional level acts as a hinge between individual and structural racism.

Individual racism (also known as interpersonal racism) is based on attitudes and racist actions that occur in personal interactions in everyday life (see Bonilla-Silva 1997; Krieger 2020). It can be expressed openly or subtly and experienced by racially labelled persons in the form of brute force or everyday microaggressions (see Pierce 1970; Spanierman & Clark 2023). It also includes internalised racism, where racist beliefs are internalised by the very individuals affected by racism (see Pyke 2010). In research, individual racism is typically recorded by self-reports, which directly record the experiences of racism or discrimination against racially labelled persons. At the same time, the survey of individual experiences of racism includes the attitudes and racist behaviour of the population as a whole. This can also be done using experimental study designs.

Institutional racism is produced in the structures and processes of social institutions (see Barskanmaz 2019). It operates through supposedly neutral norms, bureaucratic structures and laws that disadvantage certain groups and leads to the ongoing reproduction of racist conditions (see Elias & Paradies 2021). It is not exclusively maintained by explicitly racist policies and racist intentions, but by established functioning principles and distribution of resources and access to them. Analysing racism in institutions requires an understanding of the respective historical and cultural contexts.

In the context of the critical legal and social reappraisal of the National Socialist Underground (NSU), the debate on institutional racism in Germany has experienced a strong upswing and is often negotiated following the definition of the British Macpherson Report (see Dengler & Foroutan 2017). According to the report, institutional

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racism is seen as a collective failure to adequately protect people vulnerable to racism and to recognise and deal with racist acts as such in the aftermath too (see Macpherson 1999). For Germany, in-depth reappraisals have been carried out regarding educational institutions (see Gomolla & Radtke 2009; Heinemann & Mecheril 2016; Karakayalı & Heller 2022). Research on other areas such as the police (see Hunold & Singelnstein 2022b), the employment market (see Ette et al. 2020; Hieronymus et al. 2010; Scherr, Janz & Müller 2015) or the healthcare system (see the section State of research: Racism, health and healthcare**) are still in the early stages.**

Structural racism affects the entire social system (e.g. legal concepts, political structures and economic conditions) and refers to discrimination, disadvantage and exclusion (see Benokraitis & Feagin 1977; Rommelspacher 2009) in various areas such as education, employment, healthcare or criminal justice. It encompasses the intertwined institutions of society, but goes beyond the sum of the individual parts, as it also makes their historical and cultural conditions analytically visible. When analysing structural racism, the interaction of social processes in relation to social inequalities is considered and questioned as to how they are brought about and maintained (see Bailey et al. 2017; Bonilla-Silva 1997; Bruce-Jones 2017). Consequently, structural racism focuses on established inequalities in the totality of social processes and includes both individual and institutional racism.

Racist knowledge, racialisation and racism

As a socialisation process, racism is closely linked to the era of European colonialism and the simultaneous establishment of academic ‘racial research’, which laid the epistemological foundations for dividing people into different groups (‘races’) (see Arthur de Gobineau and Charles Darwin). A supposedly natural boundary was drawn between humans and ‘non-humans’ who were yet to be civilised; this boundary led to the conception and construction of European’s’ ‘superiority’ (see Hund 2007). The production of racist knowledge about different regions of the world, such as the ‘Orient’, also served as a looking glass based on which Europe could portray itself as rational and civilised (see Fanon 2002; Hund 2007; Osterhammel 1998; Said 2014).

Racist knowledge arises in a process that research describes as racialisation (see Goldberg 2003; Terkessidis 2004). It is a constitutive element of racism – as an intertwining of racialisation, knowledge and concrete power relations in society – and from a historical perspective has been productive and subject to change at the latest since modernity and colonialism (see Goldberg 2006, for pre-modernity see Heng 2018; Isaac 2004). The concept describes different people's identification and subsequent devaluation as homogeneous groups. This is a mutually constitutive process of racist knowledge and the concrete (power) structures in which this knowledge can arise and circulate. Here, the construction of supposed 'races' is of central importance, going hand in hand with a genealogical concept of the inheritance of biological and social dimensions (see Bellu, Bellu & Tsianos 2023: 76–79). The sociologist and racism researcher Robert Miles describes this construction as the process of 'race-making' (Miles 1992: 23), in which individuals are sorted according to specific 'races' on a purely ideological basis and collectivised under powerful conditions (see ibid.: 22; but also Banton 1977). Mark Terkessidis (2004: 98) describes this procedure as a 'primal form of the naturalisation of differences'. In doing so, it is not imperative that the distinguishing features can be transferred to the individual; rather, they function as 'signifiers' (Hall 2000). This applies in particular to signifiers linked to biology and need not actually refer to firmly established biological or genetic foundations. However, they are usually reproduced as biologically anchored and therefore understood as 'natural'. The various characteristics that are used for this purpose and represent the building blocks of racist knowledge are subject to historical change. Roughly speaking, four established categories of morpho-physiological, sociological, symbolic or mental and imaginary characteristics can be distinguished (see Guillaumin 1991: 167). To this day there is disagreement in research as to whether racialisation can only be spoken of when individuals and the groups constructed from them are evaluated negatively. Some researchers consider merely the differentiation as the basis for group formation to be implicitly linked to value judgements. Others consider explicit stereotyping to be necessary in order to be able to appropriately analyse the respective process as racialisation (see Terkessidis 2004).

Racism without 'races' and neo-racism

Since the 1990s, research has described new forms of racism in Western societies, which are theorised under the term 'racism without races' or neo-racism (see Back & Solomos 2020; Balibar & Wallerstein 1990; Hall 1989). Beyond older biologistic notions of 'race', 'culture' and 'ethnicity'[8] become the dominant signifiers of differentiation. In their practices, neo-racist actors are therefore reacting to discursive shifts within Europe following the increasing problematisation of racist persecution policies under

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[8] Ethnicity describes a collective identity that is created through self-attributions and attributions to others based on socio-cultural characteristics such as religion, language and traditions (see Barth 1969: 10; Feischmidt 2016; IDA e. V.). Stuart Hall (1994: 16) points out that ethnicity 'is produced at a certain point in time by circumstances'.

National Socialism. Active and decidedly biologistic references to the category of ‘race’ were considered frowned-upon from the early 1970s at the latest and were increasingly sanctioned in the public and political sphere. The concepts of ‘culture’ and ‘ethnicity’, both which have their roots in ethnology (see Barth 1969; Beer 2012; Wimer 2013) and sociology (see Weber 2013), offered alternative reference frameworks for collectively homogenising individuals and providing them with specific natures and properties. Furthermore, they made it possible to intertwine a homogenising collectivisation with territorial imaginaries (see Terkessidis 1998). In particular, the amalgamation of citizenship and ethnic affiliation in Germany is based on such notions of an ‘original presence on the territory’ (Radtke 1998: 81). Ethnic groups or cultural groups can therefore be conceptualised as autochthonous or excluded from an imagined European space.

Without ‘culture’ and ‘ethnicity’ being equated with ‘race’, the former can in some cases be used as a substitute for ‘race’ due to their conceptual vagueness (see Sökefeld 2007). The fact that they are also used in this way becomes apparent in Thilo Sarrazin’s use of language in his neo-racist writings, for example.[9] Even beyond such clearly racist representations, though, ethnicity in particular can be used flexibly as a ‘myth of actual origin and belonging’ (Battaglia 2000: 188) for social differentiation processes (see Polat 2013: 209; Mecheril et al. 2010). Sociological migration research and sometimes also research on racism, for instance, operate analytically with this conceptual tool, often bypassing ‘race’ as an analytical category and thus racism as an analytical perspective (see Diehm, Kuhn & Machold 2010: 78; Nohl & Ofner 2010: 239). Such an approach becomes particularly problematic when the constructive character of ethnicity is lost in an essentialist approach (see Mecheril, Scherschel & Schrödter 2003) – as such, an approach does not equate to a dissociation from racist thinking.

Whenever ‘ethnicity’, ‘ethnic group’ or ‘culture’ are used in an essentialist way, it is necessary to reflect on the use of the term and its (neo-)racist logics and implications. Such an approach is aligned to research literature that points out how biologistic and culture-bound variants of racism are mutually intertwined. Both the historical category of ‘race’ with recourse to cultural concepts and the currently dominant categories of ‘culture’/‘ethnicity’, for instance, operate with biologistic assumptions on the supposedly hereditary nature of specific groups (see Balibar 1993; Hund 2007; for an exemplary analysis, see Bracke & Hernández Aguilar 2020). Other attempts to avoid the concept of racism and instead use historically less charged categories such as ‘Fremdenhass’ or ‘Ausländerfeindlichkeit’ – both translating ‘xenophobia’ – also appear to be less effective for a contemporary analysis of racism (see Alexopoulou 2023a: 24–25; Sinanoğlu & Polat 2023: 8–9).

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[9] In an interview about his book *Germany Abolishes Itself*, Sarrazin himself states: ‘At some point when the book was already far advanced, the publisher told me I should replace the word “race” with “ethnicity” throughout. And that’s what I did. I didn't care at all.’ (Broder & Sarrazin 2010)

In particular, analytical perspectives on racism as neo-racism have been further developed on an international basis in the meantime and deal with the different forms of racism in Western societies, whose liberal-democratic self-image is at odds with the racism found there (see Bonilla-Silva 2022; Lentin 2015). In this context, it is important to give more focus to different socio-psychological and socio-structural causes. This also includes analysing the logics and connections between different structures of power inequality and dominance. For example, racialisation processes intersect with other modes of subjectivation and relationships of oppression. Such interactions with categories such as class, gender or religion are commonly described as 'intersectionality'. Stemming from Black feminist knowledge traditions in the USA (see Combahee River Collective 1987) and initially primarily brought up as a legal concept for the better understanding of loopholes in anti-discrimination law (see Crenshaw 1988, 1989), intersectionality has undergone a 'disciplinary, methodological and institutional journey' (Traußneck 2023: 118). Accordingly, a critical examination using the current modes of appropriation of the term prevails at present (see Haider 2018; Nash 2019; Roldán Mendívil & Sarbo 2022; Traußneck 2023). Intersectionality constitutes an important perspective for analysing the data presented in this report to focus on the intertwining of racist experiences with other forms of discrimination. Today's social reality in Germany, too, requires such an intersectional, context- and time-bound analysis of racism and the institutions and structures through which it is (re-)produced.

(Neo-)racism and national citizenship

As for the feeling of affiliation in Germany, there are shifts that define affiliation through a national, ethnic and cultural understanding of being German (see Mecheril 2002). Following the constitutional constitution of the Federal Republic of Germany, 'citizenship' has the formal function of a central legal-political characteristic of affiliation. Until the reform of German citizenship law in the years 1999/2000, *ius sanguinis* (principle of descent) prevailed, according to which family descent still determined the status of formal legal membership to the German state. Assumptions about the natural connection between nationality and ethnic affiliation underpinned this practice (see Brubaker 1994; Heckmann 1992: 56). However, descent continues to play a significant role even after the reform of citizenship law and the introduction of the *ius soli* (principle of birth), as the definition of a 'people' alone demonstrates in German discussions about affiliation (see Alexopoulou 2019).

Concepts of descent also influence the informal dimensions of social affiliation. In the present day, for example, knowledge about 'others' or 'non-Germans' is circulating that is fed by conceptions of German and non-German living environments and habits (see El-Tayeb 2016). This expresses itself, for example, in the permanent debate on integration that is directed at all those who are categorised as non-German based on constructed characteristics of difference, such as outward appearance or name (see

Battaglia 2007; Bojadžijev 2012). Alongside national, ethnic, cultural or religiously coded categories, being German is therefore no longer merely negotiated as congruent with formal citizenship, but is extended to aspects of the living environment and biographical experiences (see Polat & Wienand 2014). This development materialises, for example, in the production and use of the category 'people with a migration background', which replaced the term 'foreigner'[10] in the course of the reformed citizenship law, but at the same time continued to label specific German citizens. The establishment of the category 'people with a migration background' therefore created a new basis for continuing to address, depict and record ancestry and ethnic affiliations under the umbrella of diversity and plurality (see Fachkommission Integrationsfähigkeit 2020: 218–227). Linked to this are sociological concepts of a mainstream society of Germans that, following a logic of descent is conceived of as *white*[11] and secular Christian (see Doughan & Tzuberi 2018), or nowadays sometimes also as Judaeo-Christian (see Schüler-Springorum 2018).

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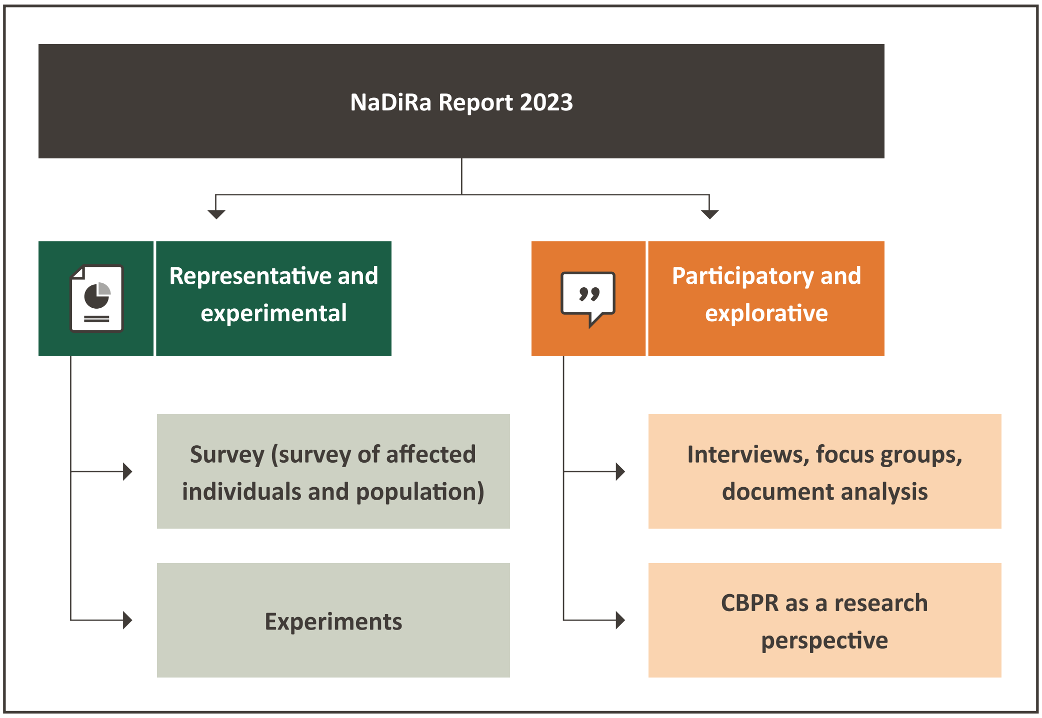
[10] In legal terms, this refers to people with a citizenship other than that of the country where they are currently resident. In Germany, these are any people without German citizenship. In the German context, the term is also used as an evasive term with racist connotations for people who have German citizenship but are denied a German origin or life centred on Germany.

[11] In quantitative social research, the term *white* appeared in Germany for the first time in the early 1960s (see Aich 1963). At the time, it was used to describe German society as a differentiation in the context of data collection on foreign students. In this sense, *white* and *whiteness* do not refer to physical markers, but a socio-politically position of power, and they are often written in lower case and italics (see Eggers et al. 2020). In the NaDiRa quantitative surveys, *whiteness* is not explicitly surveyed, but is approximated by asking about the migration background. In representative surveys, a self-image as 'German without a migration background' (with no further details) therefore corresponds most closely to the social position that is not racially labelled (see the chapter Research approach and methodology).

Research approach and methodology

The NaDiRa works with a multi-method and interdisciplinary research design. In this combination, the interlocking of the various research perspectives as well as the multi-method and interdisciplinary research approach of the NaDiRa represent a novelty in the systematic, quantitative and qualitative recording of racism in Germany. Both quantitative surveys of the population and affected persons (see info box Sample of affected individuals) and other methods of empirical social research are used. For example, the NaDiRa goes beyond a survey of attitudes and prejudices within the population as a whole. By pursuing a longitudinal analysis of racism, the NaDiRa extends previous research on racist discrimination and individual dimensions of social exclusion in Germany. The core element is monitoring.

Figure 2. The NaDiRa's multi-method approach



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Methodology icons

These two icons indicate how the data was collected and findings produced. The icons are used throughout the report to help the reader identify the character of various results at a glance and to provide better orientation: The data sheet with the pie chart symbolises quantitative findings from surveys or experiments. These findings are representative and can therefore be generalised.

On the other hand, the speech bubble with the inverted commas refers to studies where a participative and explorative approach was applied. Sections labelled with a speech bubble icon show the perspectives of the study participants or provide initial insights into specific data sets.

The report's multi-method approach

The results presented in this report with regard to experiences of discrimination and racism in general, as well as some of the findings relating specifically to the healthcare sector, are based on the analyses of the NaDiRa.panel (see section The NaDiRa.panel data). Contexts in which healthcare services can be accessed and used, attitudes towards healthcare institutions, experiences of racism when using healthcare services and individuals' self-reported health situation were examined on a broad scale by carrying out a representative survey across the population and affected individuals, supplemented by a field experiment. In addition, qualitative studies provide in-depth insights into processes and (subliminal) mechanisms such as othering, silencing or racialisation, as well as institutional aspects such as hierarchies or organisational work processes. Against this background, the qualitative studies act as a fundamental supplement to the quantitative surveys. They also contribute to the (further) development of items for measurements in surveys and experiments as well as to a more holistic interpretation of the results. The connecting lines and intertwining between interpersonal, institutional and structural discrimination in particular can be examined in greater detail using the multi-method approach. The qualitative methods and approaches, such as the community-based participative approach (Chapter II.4), focus groups and interviews (Chapters II.4 and II.5) as well as document and image analyses (Chapter II.5), and the experiment (Chapter II.2) are explained in more detail in the respective chapters. The NaDiRa.panel survey's collection of data from and analysis of affected individuals and the population are set out below, as they play a central role in the analyses in the various chapters (I.1 and II.1).

➔ Sample of affected individuals

When drawing up this report, the NaDiRa.panel focussed on three groups in particular, which were selected based on the following aspects:

Black, African and African Diaspora individuals have been living in Germany since the colonial period at the latest and have since self-organised to oppose racist policies and exclusion (see El-Tayeb 2001; Martin 2004). Today, society not only looks back critically on the history of German colonialism and in particular the genocide committed by the German Empire against Herero and Nama people (1904–1908) in what is now Namibia. A few years ago, the German government also officially recognised these atrocities as genocide. This not only raises questions about reparations for historical injustice, but also about the protection of Black people in the present day. The *Afrozensus*, the first nationwide but non-representative survey of Black, African and African Diaspora individuals in Germany, provides an insight into the diversity of today's Black community and their experiences with racism against Black people (see Aikins et al. 2021). It became clear that the respondents taking part in the study tended to have little trust in political institutions in Germany (governments of the German states, federal government, federal parliament). The situation is different with regard to German rule of law, which is largely trusted (see ibid.: 257, 255). The authors of the *Afrozensus* called for more in-depth research to shed light on the connection between people's own experiences of racism and their judgement of state institutions (see ibid.: 255). This is where the NaDiRa surveys come in (see Chapter I). Data on racist attitudes as well as antipathy, sympathy or ambivalence towards Black people in Germany were collected for the first time in 2021 in the *Mitte-Studie* (see Zick & Küpper 2021: 150–158). It became clear that around one in ten of those surveyed agreed with subtle attributions of inferiority in relation to Black people (see ibid.: 151). Although the majority rejected overt, biologistically justified racism, negative attitudes towards Black people were closely linked to assumptions about socially established privileges and therefore

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to a failure to recognise Black people's rights (see ibid.: 151, 155, 158). A connection between negative attitudes against Black people and prejudice against Muslims was also established (see ibid.: 156).

Muslims or people perceived as such currently make up the largest group of immigrants in Germany, accounting for a good 6% of German society as a whole (see Pfündel, Stichs & Tanis 2021: 37). The majority of these people originate from Turkey and Syria, although many of the Muslims of Syrian origin only immigrated to Germany in recent years (see ibid: 38). Especially since the reform of German citizenship law in 1999/2000, immigrants and their descendants, previously primarily considered according to national or ethnic categories, have increasingly been addressed as a religious collective in Germany's public sphere and politics. This shift was not only reflected in corresponding self-descriptions as Muslims (see Spielhaus 2011), but also contributed to the consolidation of widespread racism towards Muslims in society, as well as a politicisation of Islamic studies (see Amir-Moazami 2018; Attia 2009; Shooman 2014). The 2021 *Mitte-Studie* shows that between one-fifth and one-third of respondents harbour negative attitudes towards Muslims and believe that there are too many of them living in Germany (see Zick & Küpper 2021: 187). Other surveys show that Muslims' social advancement is extensively rejected in Germany and is expressed by more than a third of the population (see Zick & Krott 2021: 26). Around half of those surveyed in the 2020 Leipzig Authoritarianism Study even stated that the presence of Muslim people in Germany made them feel alienated (see Decker & Brähler 2020: 64). As early as 2010, Thilo Sarrazin legitimised and promoted the devaluation of Muslims in Germany in his neo-racist writings by drawing up a delimiting comparison between Muslims and Asian people.

For a long time, discourses on racism in Germany saw **Asian people** – or individuals perceived as such – as 'model migrants' who have been treated primarily as a 'model minority' since the late 2000s. The precedent for this was provided by representative surveys from the field of educational science (see Hartlep & Bui 2020). In this context, the strong educational performance of the children of Vietnamese immigrants in Germany – recorded and presented for the first time in the OECD's Programme for International Student Assessment (**PISA**) – are particularly noteworthy. Following on from racist attributions

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originating from the period when German colonialism extended to the region known then as the ‘South Seas’, these findings contributed to attesting to the successful social advancement of Asian people in Germany (see Suda & Köhler 2024). This common narrative, however, masks racism against Asian people, small numbers of whom had already been living in Germany since the turn of the twentieth century or who immigrated or fled to Germany after the Second World War (see Ha 2021). The latter of these groups in particular was the focus of terror and racist violence in the 1990s. The pogrom-like attacks on a dormitory for Vietnamese contract workers in the ‘Sunflower House’ in Rostock-Lichtenhagen in 1992 are stark evidence of this (see Ha 2012; Prenzel 2015; Verein Bildung & Publizistik 2022). These anti-Asian attitudes then resurged again and transformed with the advent of the COVID-19 pandemic. In this context, it was possible to observe a culturalisation of COVID-19 as the ‘Chinese virus’, with its roots in the colonial concept of a ‘yellow peril’, which had first appeared in the context of the German colony in China, people who were considered ‘Chinese’ or ‘Asian’ started to be subjected to increasing attacks (see Suda & Köhler 2024). Since then, racism towards Asian people has also become a widespread topic in public discourse and academia in Germany.

The NaDiRa.panel data

Sampling procedure and data collection

The recruitment drive, known as Wave 0 (W0), was carried out on behalf of the German Centre for Integration and Migration Research (DeZIM) by the infas Institute of Applied Social Science. The population for the panel survey of the German National Discrimination and Racism Monitoring (NaDiRa.panel) comprises individuals with and without migration backgrounds aged between 18 and 70[12] and living in Germany. The survey’s special focus groups were people with migration backgrounds originating in Africa (not including northern Africa), eastern and southeastern Asia, and Turkey or other Muslim-majority countries (including northern Africa). Data collection was based on randomly drawing from registers of residents, although this was designed disproportionately so that communities with a higher proportion of the above target

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[12] The years of birth here are between 1951 and 2004.

groups were taken into account more. Communities were split into two drawing structures before the sample was drawn. This classification was made using information regarding migration proportions on a municipal level, specifically regarding people from eastern Asia and Africa (not including northern Africa). The communities that were among the top 40% of all communities with regard to the proportions of these two groups therefore formed their own category in the draw. In this way, it was possible to increase the percentage of sample points that show a relatively high proportion of people from eastern Asia and Africa (not including northern Africa) from 20% to 50%. For data collection, 250 sample points were drawn at random from the register of residents for each drawing structure. It was possible to carry out a disproportionate drawing on a municipal level, and it was also possible to achieve 'oversampling' by relying on name-based (onomastic) pre-qualification of all the addresses delivered when selecting participants. This meant that people whose names were highly likely to form part of the target groups named above were more likely to form part of the sample.

The sample is therefore characterised by the fact that particularly relevant target groups were recorded disproportionately, meaning that sufficiently high case numbers are available to make differentiated description and analyses of the relevant living situations possible.

The residents' registration offices were able to provide a total of 893,715 addresses, of which 75,375 were written to. The letters, sent by post, included an invitation to the survey, our study as a paper questionnaire, and a five-euro incentive. The participants were informed of the possibility of filling out the survey online. The W0 survey was therefore carried out as a combination of the PAPI *(paper and pencil interview)* and CAWI (computer-aided web interview) method. While the PAPI survey was only available in German, the CAWI survey could be filled out in Arabic, French, English, Mandarin, Turkish, Vietnamese or German.

The field phase started on 24 June 2022 and ended on 21 November 2022.[13] Overall, 21,418 interviews were carried out within this timeframe (10,006 PAPI and 11,412 CAWI), which is equivalent to a response rate of 28.5%. 13,624 of the individuals surveyed (63.6%) consented to their address being saved at the end of the survey so that they could participate in the NaDiRa.panel again (see Ruland et al. 2023).

Onomastic pre-classification

After the Second World War, Germany deliberately chose not to gather information that recorded people or groups in racial categories for official statistics (see Juang et al.

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[13] Before the field phase began, a quantitative pre-test of the online survey was carried out between 8 April 2002 and 12 April 2022, n = 35 (see Ruland et al. 2023).

2021). As a result of this, there is no direct selection basis in the data of the residents' registration offices that could be used to address specifically racially labelled groups when sampling. For this reason, the NaDiRa.panel applied the approximation method of onomastics (see Humpert & Schneiderheinze 2000).[14] With the onomastic method (name-based method), the names of the individuals selected were used to extrapolate a possible regional or linguistic area of origin. This method is now a common procedure in the practice of social-science surveys in order to achieve overrepresentation of minority groups with migration backgrounds (see Liebau, Humpert & Schneiderheinze 2018; Salentin 2014).

However, the method does not represent a definitive classification of people into the relevant groups – it is a pure sampling pre-classification that significantly raises the probability of selecting people who then have the relevant targeted countries of origin. In the NaDiRa.panel's W0 recruitment drive, the names provided by the residents' registration offices were classified into five sub-groups: people with a (family) migration background a) from Turkey b) from Muslim-majority regions of origin (including northern Africa) c) from eastern and southeastern Asia d) from sub-Saharan Africa and e) all others. Field control of the survey was then designed in a way that ensured that a sufficient number of interviews – determined in advance – was carried out for each of these five sub-groups (see Ruland et al. 2023).[15]

Design and deficit weighting

Various methods (see above) were employed to give particular consideration to people with a migration background from Africa (not including northern Africa), eastern and southeastern Asia, and Turkey or other Muslim-majority countries (including northern Africa) in our sample. In order to make general statements about the population (the population of the Federal Republic of Germany) that are as representative as possible, it is therefore essential to incorporate the different selection probabilities when evaluating the data. In these cases, we use a weighting factor provided by infas called 'deficit weighting'. This not only takes onomastic pre-classification and the disproportionate selection from the registers of residents into account, but also deficits regarding the selection of communities and on an individual level. Central characteristics can also be adjusted through weighting[16] (Ruland et al. 2023: 29–31).

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[14] This was carried out by Humpert & Schneiderheinze GbR (see Ruland et al. 2023).

[15] The recording process used therefore ensured that samples were drawn randomly within the subgroups. The case numbers realised within the individual onomastic groups are shown in Table 2.

[16] Gender, age group, highest school-leaving qualification, employment status, household size, state, BIK community-size class, migration background; The BIK regions and the territorial interlacing system are a regional segmentation system running throughout Germany.

Categorisation dimensions in the NaDiRa.panel

Quantitative empirical racism research often focuses on analyses of groups and group differences. This is generally not unproblematic, as group boundaries are ultimately unclear and fluid.[17] In light of this, there is a risk that groups – and therefore group boundaries – are defined and recorded artificially to some extent, and only then as a result manifest themselves in reality (see Brubaker 2002; Wimmer 2008; Zuberi 2000). This should always be considered when handling the topic concretely and interpreting findings. Nonetheless, certain categorisations are necessary in order to recognise group-specific structures of inequality and be able to statistically investigate them at all.

In this context, the question of which type of categorisation is suitable has been discussed intensively and contentiously (see Supik 2022; Will 2022). Groupings based on generations and countries of origin are particularly widespread in integration research. The first section considers the relevant design possibilities regarding the NaDiRa.panel. Particularly in order to depict racist experiences and structures, internal and external attributions are increasingly being discussed and demanded as alternatives (see Supik 2022). The second section discusses the associated arguments and implementation within the NaDiRa.panel. Finally, the handling of the various categories in this report is presented and discussed.

Countries of origin

In order to record the migration backgrounds of the families of those survey, not only was the respondents' own country of birth recorded in the NaDiRa.panel, but also those of their parents and grandparents. This made it possible to identify a respondent's country of origin up to the third generation. In some cases, with complex migration backgrounds (different countries of birth in the family tree), this proved far from trivial and required some decisions regarding prioritising classification. In line with Dollmann, Jacob and Kalter (2014), this was dealt with as follows:

Initially, the grandparent level is decisive. If at least one grandparent was not born in Germany, the country of origin is determined by an overall view of the countries of birth of all four of a respondent's grandparents: If the grandparents have different countries of birth outside of Germany, majority rule applies to these. Accordingly, the respondent's country of origin is determined to be the grandparents' country of birth that occurs most frequently. If there is no clear 'majority country', the maternal line takes priority. If all of the respondent's grandparents were born in Germany, the parents' countries of birth are considered. As with the grandparents, both the majority

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[17] This is illustrated, for example, by the algorithm explained in the last section regarding determination of country of origin, which includes decisions that could also be made differently.

rule and the priority rule apply. This means that the respondent's country of origin is determined by the country of origin of parents born abroad if both parents originate from the same country. If the parents have different countries of birth, the reference used to determine the respondent's country of origin is the mother's country of birth. If one parent was born in Germany and one abroad, the country of birth of the parent born abroad is always the deciding factor when determining the respondent's country of origin.

Finally, for individuals who do not have a migration background – i.e. where the respondent's own country of birth, as well as that of their parents and grandparents, is Germany – their country of origin was considered to be Germany.

The ten most common respondent countries of origin ascertained according to this system are shown below (Table 1).

Table 1. The ten most common countries of origin (absolute numbers and percentages)

Country of origin	Number of respondents
1. Germany	6,171 (28.8%)
2. Turkey	2,168 (10.1%)
3. China	1,255 (5.9%)
4. Syria[18]	1,150 (5.4%)
5. Poland	900 (4.2%)
6. Vietnam	852 (4.0%)
7. India	845 (4.0%)
8. Iran	384 (1.8%)
9. Afghanistan	342 (1.6%)
10. Nigeria	305 (1.4%)

Example: For 6,171 (28.8%) of all respondents, Germany was identified as their country of origin because these people had no personal or family history of immigration. **Source:** NaDiRa.panel, Wave 0 (unweighted); own calculations.

Precision of the onomastic pre-classification in the NaDiRa.panel

Countries of origin can be used to examine the extent to which overrepresentation of the target groups using onomastic pre-classification was successful. Comparison shows that onomastic methods are suitable for addressing the envisaged groups to an extent

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[18] These are likely to be mostly individuals and their family members who immigrated to Germany as a result of the Syrian Civil War.

sufficient for the NaDiRa.panel sampling (Table 2). For example, among the 4,422 respondents with a name which can be associated with a Muslim-dominated country, 80.2% did indeed have one of these countries as their country of origin. Conversely, 94.4% of the 3,755 respondents with a Muslim country of origin were also part of the associated category in the onomastic pre-classification.

Table 2. Onomastic groups and grouping according to actual countries of origin (absolute numbers and percentages)

	Subgroups by country of origin						
Onomastic groups	Muslim background	Turkish background	Eastern and south-eastern Asian background	Sub-Saharan background	Other background	No migration background	Total
Muslim	3545 →80.2% ↓94.4%	66 →1.5% ↓3.0%	90 →2.0% ↓2.2%	88 →2.0% ↓6.0%	513 →11.6% ↓13.6%	120 →2.7% ↓1.9%	4,422
Turkey	57 →2.4% ↓1.5%	2,089 →86.6% ↓96.4%	3 →0.1% ↓0.1%	4 →0.2% ↓0.3%	177 →7.3% ↓4.7%	82 →3.4% ↓1.3%	2,412
Eastern and south-eastern Asia	72 →1.7% ↓1.9%	3 →0.1% ↓0.1%	3,910 →90.6% ↓96.4%	14 →0.3% ↓0.9%	250 →5.8% ↓6.6%	66 →1.5% ↓1.1%	4,315
Sub-Sahara	29 →1.9% ↓0.8%	1 →0.1% ↓0.1%	12 →0.8% ↓0.3%	1,346 →86.1% ↓91.3%	123 →7.9% ↓3.3%	52 →3.3% ↓0.8%	1,563
No target group	52 →0.6% ↓ 1.4%	9 →0.1% ↓0.4%	43 →0.5% ↓1.1%	22 →0.3% ↓1.5%	2,705 →31.2% ↓71.8%	585 →67.4% ↓94.8%	8,682
Total	3,755	2,168	4,058	1,474	3,768	6,171	21,394

Example: Of the total of 2,089 respondents who were assigned to 'Turkey' via the onomastication procedure, 86.6% stated that they belonged to the 'Turkish background' subgroup. Conversely, 96.4% of all respondents with a 'Turkish background' are in the 'Turkey' onomastic group. **Note:** The figure shows the number of respondents who have a certain combination of onomastic group and country of origin group as well as the corresponding row percentages (→) and column percentages (↓). **Source:** NaDiRa.panel, Wave 0 (unweighted), own calculations.

Pre-classification was even more precise for the other groups. For the 'Eastern and southeastern Asia' group, the overlap between the onomastic pre-classification and the countries of origin was highest, at 90.6% and 96.4%. As can be seen, alongside the false positive cases (respondents are onomastically assigned to one target group, but do not in fact belong to it), there are also false negative cases (respondents are not assigned to a target group onomastically, but in fact belong to it). Overall, the comparison in Table 2 illustrates that people's names can be a helpful indicator for overrepresentation of target groups. At the same time, there are no complete overlaps between name-based assignment of origin (onomastics) and the countries of origin after the countries of birth. While onomastics is suitable for sampling, it cannot be used as a basis for categorisation for the evaluation of the data.

Generational status

The countries of birth of those surveyed, alongside the countries of birth of their parents and grandparents, can be used to determine both the country of origin and the generational status. This opens up the potential of deeper analysis in comparison to a simple differentiation between people 'with/without a migration background' in the categorisation. In general, the following generations can be specified:[19]

1st generation: Respondents were assigned to the 1st generation if they were born abroad and therefore immigrated to Germany themselves. The origins of parents and grandparents are still potentially significant here.[20]

2nd generation: The 2nd generation includes people who were born in Germany but have at least one parent born abroad.

3rd generation: This category includes all respondents whose own country of birth, as well as that of both parents, was Germany, but who have at least one grandparent born abroad.

No migration background: Respondents were identified as not having a migration background if they, their parents and all grandparents were born in Germany, meaning that – up to the third generation – they do not have a migration background.

Overall, the respondents of the NaDiRa.panel are distributed as follows across these four categories (Table 3). Through oversampling of the target groups, approximately two-thirds of the sample have a migration background. Most strongly represented,

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[19] The concept of 'migration backgrounds' implemented in the NaDiRa.panel therefore differs from the operationalisation of migration backgrounds by the Federal Statistical Office, which is based on parents being born with a citizenship other than German. Information regarding grandparents is also not taken into account in the Federal Statistical Office's operationalisation. For this reason, a comparison of our sample with the population regarding country of origin and generational status is only possible to a limited extent.

[20] Here, it must be noted that a small number (n = 55) of respondents were born abroad – probably while their parents were abroad for an extended period of time – but both of whose parents and all four grandparents were born in Germany.

at approximately 49%, were the first-generation group; i.e. people who were born in another country and immigrated to Germany. This information may be of interest when classifying the results, as the first generation often obtained their school or university certificates abroad and only acquired German-language skills as adults.

Table 3. Generational status (absolute numbers and percentages)

Generational status	Number of respondents (%)
1st generation	9,618 (48.5%)
2nd generation	3,473 (17.5%)
3rd generation	942 (4.8%)
No migration background	5,814 (29.3%)

Example: 48.5% of respondents stated that they were born abroad and therefore belong to the first generation of migrants. **Source:** NaDiRa.panel, Wave 0 (unweighted); own calculations.

In general, it can be useful for certain questions to subdivide generational status more precisely, for example according to the age at which respondents immigrated (see Dollmann, Jacob & Kalter 2014; Kalter & Heath 2018; Olczyk, Will & Kristen 2014). In principle, it is possible to classify generational status in more detail using data from the NaDiRa.panel. For the sake of clarity, the general classification is reported here.

Categorisations and groupings on the basis of countries of origin and generations (as above) are particularly widespread and have proven effective to date. Above all, these concepts have the advantage of depicting 'objective' characteristics and as such are, for example, relatively easy to compare between different contexts or over time. However, a disadvantage of this approach is that categories such as country of origin often only capture an extremely imprecise impression of the central characteristics on which racist disadvantages are based. Within these differentiation dimensions, there can therefore be significant heterogeneity regarding characteristics – such as skin colour, religion or ethnicity. If only the country of origin or generational status are considered, it is consequently not possible to sufficiently map out central structures of inequality. This applies in particular to younger generations, whose family history of immigration by parents and grandparents can often be extremely complex.

Internal and external attributions

Particularly in countries with large indigenous minorities or minorities associated with colonial histories – such as the USA or the UK – self-identification is common as a category in statistical recording in order to take the particular societal situation into account. In practice – as can be seen using the example of the British census – respondents are asked which ethnic group they feel they belong to. Here, they can select several identities that do not cancel each other out and that can also be expanded upon with an open response (see Aikins & Supik 2018).[21]

In order to counter the disadvantages of ‘objective criteria’ as previously described, such as country of origin or generational status, and therefore to be able to more appropriately record each minority and group’s risk of suffering discrimination, self-attributions are also increasingly being discussed in German-speaking contexts as an alternative (see Supik 2022). Ideally, it has been suggested that self-identification should be expanded on with a question regarding perceived external attributions. Here, it is seen as an advantage that the subjective self-declaration and subjectively perceived external attributions are not to be understood as fixed categories but rather as dynamic ones, which remain sensitive to both chronological and spatial fluctuations (see Aikins & Supik 2018).

Accordingly, internal attributions are based on a subjective process associated with self-positioning, which is influenced by experiences in daily life and cultural upbringing over the course of a person’s lifetime. With internal attributions, individuals can depict and reflect the complexity and diversity of their identity. Consequently, as previously suggested, self-identification is not a fixed or static cognitive component of an individual’s self-conception, but rather a profound process with regard to groups, which can develop and change over time (see Kinket & Verkuyten 1997).

External attributions, in contrast, relate to processes by which a person is ascribed an identity on the basis of external factors such as their physical appearance, perceived origin, or societal norms. These classifications are made externally, independently of actual affiliation with a group or the associated self-definition (see Appiah 2000). While internal attributions relate to an internal dimension of identity, external attributions refer to an external dimension of identity, i.e. how a person is designated and classified by others (see Stephan & Stephan 2000).

However, when using subjectively assessed internal and external attributions, a potential ‘endogeneity problem’ should always be taken into account. A fundamental question is raised here: is membership of a group the grounds for certain racist experiences, or are the racist experiences the grounds for stronger or weaker identification with a group?

In the NaDiRa.panel, respondents have the chance to assign themselves to one or several groups. The concrete wording in the questionnaire is: ‘People can feel they belong to various groups. How do you feel? Please indicate all groups that you feel you belong to.’

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[21] The US census, for example, has asked the question ‘What is your race?’ since 2010.

Here, the following groups were provided to select from:[22] ‘Asian people’, ‘Jewish people’, ‘Muslim people’, ‘Sinti or Roma’, ‘eastern European people’ and ‘Black people’. Respondents could identify themselves as ‘German with a migration background’ and ‘German without a migration background’ (see also chapter Preliminary historical theoretical considerations). An open question was also included that allowed respondents to describe their self-identification in their own words.

Regardless of their self-identification, respondents in the NaDiRa.panel were also able to specify one or more of these group memberships regarding their perceived external attributions: ‘Independently of which groups you feel you truly belong to, other people may sometimes nonetheless perceive you to be a member of certain groups. Please indicate all groups that other people often associate you with.’

Recording these two dimensions takes into account the fact that perceived external attributions do not necessarily match an individual’s internal attribution, and vice versa.

Regarding the relationships between the different categorisations

Quantitative racism research fundamentally aims to deal with the question of which categorisations are suitable and preferable in order to depict experiences of racism. Discussions of categorisations (see Will 2022) often give the impression that there might be some optimal solution that should be found and established as a new standard. In our opinion, the solution is to recognise that the individual possibilities for categorisation have different or complementary advantages and disadvantages, and should be juxtaposed rather than set against each other. It is precisely their interrelationships that can provide an insight into how robust certain findings are, but also promote understanding of the underlying processes and mechanisms if there are fundamental divergences. Alongside theoretical conceptual considerations, the technical feasibility of surveys also plays an important role in considerations. While most people do not have any difficulty remembering their own country of birth and that of their parents, the question of internal and external attributions can pose a challenge for some as the concepts do not necessarily form a part of public discourse and often have a less significant presence in day-to-day life. Depending on categorisation, this fact can be exhibited by different item non-response rates and can lead to falsifications.

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[22] The focus on the six groups named was based on the fact that these were relevant in recent years in the context of specific forms of racism in Germany. Prejudice and racism against Jews, Sinti and Roma people, Muslims and Black people are therefore particularly virulent phenomena that have ultimately found appropriate political recognition and attention thanks to years of work by the groups affected and their communities (see Bundesregierung 2017). In addition, in Germany during the COVID-19 pandemic, there was a revival of racism against Asian people, which was already particularly present in the 1990s (Rostock-Lichtenhagen). Furthermore, in connection with Russia’s invasion of Ukraine, repeated hostility against people and communities of Russian origin can be observed recently, representing a form of racism towards Slavic people that has a long history in Germany (see DeZIM 2022: 23).

The NaDiRa.panel was designed so that differentiations and categorisations, both regarding country of origin and regarding internal and perceived external attributions, are possible (see above). In order not to overload the report, the analyses are only presented with self-identifications used as a basis for categorisation. We will provide the remaining analyses as additional accompanying material online for those interested in learning more.

Here, some technical information should be provided that should be taken into account when using the categorisation by self-identification. Among other aspects, this is related to the possibility of providing multiple responses. If respondents indicated that they belonged to several groups, they were accordingly entered into calculations several times as investigation units.[23] Furthermore, in general only those who did not indicate more than a total of three identities were taken into account for the analysis groups.[24] Moreover, we focus primarily on the three racially labelled groups for the subsequent comparison between groups: Muslim people, Asian people and Black people. These three groups are overrepresented in our sample selection, above all due to the onomastic pre-classification. With regard to self-identification, this selection also guarantees a sufficiently high number of respondents to make it possible to carry out differentiated considerations of further differentiation characteristics, such as gender or level of education. Unfortunately, due to the low case numbers, this is not possible for the other self-identifications provided – ‘Jewish people’, ‘Sinti or Roma’ and ‘eastern European people’. However, they are included in the analyses in other places, when racially labelled people are discussed as a whole. A special role is played by the categories of ‘German with a migration background’ and ‘German without a migration background’. They are limited to those who gave this category as their only identity. The specification serves to form the relevant comparison groups with people who did not identify with any of the racially labelled groups. In the analyses, these are then shown as a reference for the racially labelled groups.

In Table 4, the left-hand column first shows which analysis groups the respondents can be split into in line with their self-identification and how many of them can be assigned to the individual categories. The middle column shows the extent to which the respondents’ internal attribution corresponds to their perceived external attribution. In the right-hand column, the three most common countries of origin are listed for each analysis group.

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[23] In order to take this fact into account and to prevent potential falsification of the confidence interval, as a rule ‘cluster-robust standard errors’ (Cameron & Miller 2015) are estimated in the analyses.

[24] After thorough technical checks during which both the closed and open responses regarding self-identification, perceived external attributions and country of birth of respondents, their parents and their grandparents were used as cross-validation, there is evidence that individuals who responded with more than three answers to the question (‘People can feel they belong to various groups. How do you feel? Please indicate all groups which you feel you belong to’) seem to have understood the question incorrectly as asking about a kind of emotional attachment to these groups. From this threshold of more than three responses onwards, indications of self-identification tallied strikingly less often with the individual countries of birth indicated within the family or with perceived external attributions.

Table 4 shows that those who identify themselves as ‘Asian’ formed the largest racially labelled group with 4,039 cases. 80.2% of these respondents indicated that they were also perceived as ‘Asian’ by others. The three most common countries of origin for this group are China (27.5%), Vietnam (17.3%) and India (10.8%). With 3,981 respondents, the second largest group was the ‘Muslim’ group. Here, there was a smaller overlap with perceived external attributions (67.9%). For this group, the three most common countries of origin were Turkey (32.4%), Syria (17.2%) and Morocco (5.0%). Although the definition precluded assigning people in the group of ‘German with a migration background’ (n = 1,506) a racially labelled group, and they cannot be clearly identified by means of external characteristics (52.8% overlap with perceived external attributions), a higher weight of Muslim-majority countries can be identified.

Overall, the numbers show that self-identification is certainly plausible with regard to country of origin and corresponds well to this ‘objective’ categorisation. This connection is considered again more closely in Table 5.

Table 4. Internal attribution, perceived external attribution and countries of origin

Internal attribution	Overlap with perceived external attribution	Countries of origin (Top 3)
Asian (n = 4,039)	80.2%	1. China (27.5%) 2. Vietnam (17.3%) 3. India (10.8%)
Muslim (n = 3,891)	67.9%	1. Turkey (32.4%) 2. Syria (17.2%) 3. Morocco (5.0%)
Black (n = 1,262)	68.5%	1. Nigeria (16.2%) 2. Ghana (10.1%) 3. Eritrea (10.0%)
German with MB (n = 1,506)	52.8%	1. Turkey (21.9%) 2. Iran (7.6%) 3. Syria (6.7%)
German without MB (n = 5,602)	67.9%	1. Germany (75.4%) 2. Poland (7.8%) 3. Czech Republic (1.6%)

Example: Among the 4,039 respondents who identified themselves as Asian, 80.2% reported that they were also perceived as Asian by others. **Note:** Numbers refer to respondents who did not indicate more than three identities. Migration background is abbreviated as ‘MB’ here. **Source:** NaDiRa.panel, Wave 0 (unweighted), own calculations.

The relationship between internal attribution and country of origin is shown in Table 5. In the group of people who identified themselves as Muslim, 1,943 respondents (49.9%) indicated that they also came from a Muslim-majority country of origin. A significant proportion (32.4%) came from Turkey. If only these two groups are considered, there was an overlap of over 80%. Furthermore, it is plausible that those who identify as Muslim also come from Muslim-majority countries in southeastern Asia (e.g. Indonesia, Bangladesh, Malaysia) or the sub-Saharan region (e.g. Senegal, Somalia, Mali), meaning that the overlap between internal attribution and country of origin in this group can increase to 90%.

Conversely, 64.4% of those from Muslim-majority countries of origin selected 'Muslim' as their internal attribution, although here there were further relevant percentages distributed across the groups of 'Asian' (15.7%) and 'German with a migration background' (14.6%). A similarly good cross-validity was also shown for the other groups. There was a particularly strong overlap between internal attribution and country of origin for people who had 'no migration background'. Analogously to their country of origin, Germany, 96% of this group reported their internal attribution as 'German without a migration background'.

Table 5. Internal attribution and countries of origin (divided into groups)

Subgroups by country of origin							
Internal attribution	Muslim background	Turkish background	Eastern and southeastern Asian background	Sub-Saharan background	Other background	No MB	Total
Muslim	1,943 →49.9% ↓64.4%	1,259 →32.4% ↓69.1%	113 →2.9% ↓3.2%	211 →5.4% ↓16.0%	316 →8.1% ↓14.4%	49 →1.3% ↓1.1%	3,891
Black	73 →5.8% ↓2.4%	13 →1.0% ↓0.7%	69 →5.5% ↓1.9%	987 →78.2% ↓ 74.9%	82 →6.5% ↓3.7%	38 →3.0% ↓0.9%	1,262
Asian	475 →11.8% ↓15.7%	164 →4.1% ↓9.0%	3,123 →77.3% ↓87.9%	32 →0.8% ↓2.4%	194 →4.8% ↓8.9%	51 →1.3% ↓1.2%	4,039
German with MB	440 →29.2% ↓14.6%	329 →21.9% ↓18.1%	198 →13.2% ↓5.6%	72 →4.8% ↓5.5%	430 →2.5% ↓19.7%	37 →28.6% ↓0.8%	1,506
German without MB	87 →0.6% ↓2.9%	57 →0.1% ↓3.1%	50 →0.5% ↓1.4%	16 →0.3% ↓1.2%	1,166 →31.2% ↓53.3%	4,226 →67.4% ↓96.0%	5,602
Total	3,018	1,822	3,553	1,318	2,188	4,401	16,300

Example: Of the 3,891 respondents who identify as Muslim, 49.9% have a migration background from Muslim countries of origin. Conversely, 64.4% of all respondents with a 'Muslim background' chose the self-attribution 'Muslim'. **Note:** Figures refer to respondents who did not state more than three identities. Migration background is abbreviated here as 'MB'. The table shows the number of respondents with a specific combination of self-attribution and country of origin group, as well as the corresponding row percentages (→) and column percentages (↓). **Source:** NaDiRa.panel, Wave 0 (unweighted); own calculations.

Sociodemographic characteristics of the sample and the groups

The racist experiences and discriminations described in this report are related to the different living situations in which the respondents in the individual groups find themselves. This is particularly true with regard to the questions regarding health situations and healthcare, which empirically are strongly linked to age and gender, but also to level of education (see the section State of research: Racism, health and healthcare). When interpreting the results, it must thus be taken into consideration that individual groups are differently comprised in this regard. In order to obtain an impression of this, a brief overview of the social demographics of the people in the NaDiRa sample and in the different groups is also provided here.

In the NaDiRa.panel, in addition to the option of assigning oneself to the gender female or male, respondents also have the option of selecting the category ‘non-binary’. Furthermore, respondents can indicate their refusal to provide a gender identity using a separate category. The respondents also have the choice of assigning themselves an individual category besides those previously mentioned (‘female’, ‘male’ and ‘non-binary’) with an open response. Overall, the sample consisted of 8,090 women (51.0%) and 7,725 men (48.7%). 39 cases (0.3%) categorised themselves as non-binary, 99 refused gender-based classification and 41 people provided an open response. Thus, only 179 cases (1.1%) fell outside the binary gender categories, which makes separate consideration of this group impossible due to the low number of cases.

The average age of respondents was 45.7 years (standard deviation: 12.0). The age range was from 18 to 71 years old. Differentiated by age group, the two age groups of ‘55 to 64 years old’ (22.6%) and ‘25 to 34 years old’ (19.3%) were the most strongly represented groups by numbers. Respondents in the youngest age group (18 to 24 years old, 9.5%) and in the oldest age group (65 to 71 years old, 12.9%), meanwhile, formed the two smallest age groups.

Table 6. **Sociodemographic characteristics of the NaDiRa.panel sample and the groups**

	Total	Muslim	Black	Asian	German with MB	German without MB	Racially labelled overall
Gender n	15,863	3,824	1,232	3,957	1,471	5,552	8,840
Men	48.7%	52.7%	55.8%	48.8%	49.6%	48.4%	49.8%
Women	51.0%	47.0%	43.7%	50.9%	50.2%	51.5%	49.6%
Non-binary	0.3%	0.3%	0.5%	1.3%	0.2%	0.2%	0.6%
Age group n	15,858	3,814	1,238	3,964	1,473	5,539	8,846
18–24 years	9.5%	16.5%	14.8%	12.3%	11.1%	8.6%	12.4%
25–34 years	19.3%	28.9%	29.4%	29.6%	19.4%	17.6%	25.3%
35–44 years	18.6%	23.5%	20.5%	21.5%	21.9%	17.2%	22.5%
45–54 years	17.2%	18.5%	14.7%	14.2%	19.7%	16.7%	17.8%
55–64 years	22.6%	9.1%	11.3%	12.5%	16.7%	25.6%	13.7%
65–71 years	12.9%	3.6%	9.3%	9.9%	11.2%	14.3%	8.4%
Education n	15,848	3,762	1,225	3,966	1,477	5,581	8,790
Low level of education	15.0%	29.4%	21.9%	17.9%	12.1%	5.1%	19.0%
Intermediate level of education	42.6%	43.9%	47.8%	36.2%	49.3%	53.0%	44.5%
High level of education	42.4%	26.7%	30.3%	45.9%	38.6%	41.9%	36.5%

Example: In the overall sample, 22.6% are aged between 55 and 64. Note: Numbers refer to respondents who did not state more than three identities. Migration background is abbreviated as 'MB' here. **Source:** NaDiRa.panel, Wave 0 (shares in %, weighted); own calculations.

In the NaDiRa.panel, information regarding education can be classified according to the International Standard Classification of Education (see Bundesministerium für Bildung und Forschung 2011). We split the education categories into 'low level of education' (ISCED 1[25] to 2[26]), 'intermediate level of education' (ISCED 3[27] to 4[28]) and 'high level of education' (ISCED 5[29] to 8[30]). Compared with the distribution of education in Germany (see Statistisches Bundesamt [Federal Statistical Office] 2020), a high level of education of the respondents in the NaDiRa.panel can be identified. In our sample, highly educated people with a degree are particularly frequently represented, whereas people with a low level of education are represented disproportionately rarely (15.2%). Among other factors, this circumstance could be traced back to the overrepresentation (oversampling) of people from eastern and southeastern Asia (see above), who have significantly higher educational qualifications compared to the average population in Germany (see Baas 2021; Kreienbrink 2014).

In Table 6, the characteristics just described are also listed for the various groups (internal attribution). When comparing the individual racially labelled groups with the group 'German without a migration background', it is initially striking that the gender ratios differ. While in the group 'German without a migration background', similarly to the Asian group, the proportion of women is higher, men form the majority in the Muslim group and the group of Black people. As for age distribution, it can be seen that the group 'German without a migration background' has a significantly higher proportion of the older age groups (55 to 64 years old and 65 to 71 years old) in comparison to the other groups, while the youngest age group (18 to 25 years old) is comparatively poorly represented here. When considering education, there is an extremely low proportion of people with a 'low level of education' in the group 'German without a migration background'. This has an effect on the significantly higher proportion of people with intermediate education. The proportion of highly educated people is significantly highest in the Asian group, at 45.9%.

As described above, these differences in sociodemographic characteristics may play a role in the circumstances examined in the report. In many places, therefore, more complex, multivariate analysis procedures are used: this makes it possible to consider differences between the groups in the analyses, independently of the differences in sociodemographic characteristics.

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[25] Primary level: e.g. primary school, comprehensive school (Years 1 to 4)

[26] Lower secondary level: e.g. lower secondary school, secondary schools

[27] Secondary level II: e.g. upper secondary schools (senior level), specialised upper secondary schools – two-year (without prior vocational training), vocational, plus business or technical upper secondary schools, vocational schools (dual system) – initial training

[28] Post-secondary non-tertiary education: e.g. evening upper secondary schools, late-entrance upper secondary schools

[29] Short tertiary education programme: e.g. master craftsman training (only very short preparatory courses, up to less than 880 hours)

[30] Doctorate

The civil society process accompanying the NaDiRa

The civil society monitoring process is one of the NaDiRa's methodological approaches for involving civil society organisations and communities affected by racism. The aim is to take their perspectives and knowledge into account in planning and implementing research projects and to ensure critical monitoring. The NaDiRa therefore supports the development towards participative research. The participation of civil society actors in the NaDiRa is based on four premises:

Firstly, civil-society organisations and movements are of particular importance in policy-making. They are crucial actors in the democratic process and help ensure that the concerns of different population groups are taken into account in political decisions. Given the central role of civil society in a democracy, their participation is an important prerequisite for shaping decision-making processes and measures that take different perspectives and needs into account. For science, the participation of civil society actors in the context of racism and discrimination is also a relevant principle in research ethics. On the one hand, it is important to recognise that there has always been and continues to be knowledge production outside of established research institutions. On the other hand, it is important to critically scrutinise the perception of science as an objective and neutral entity. In particular, the role of science in the creation and maintenance of racial ideologies and racist structures must be reflected upon time and again. This also applies to the fact that science generated and legitimised violence against racially labelled groups during the colonial period and the Nazi era. Research therefore bears a degree of historical responsibility for the communities that research is conducted on and with (see Aikins et al. 2021: 33–34).

Secondly, there is a consensus that civil-society organisations are important actors in the fight against racism and discrimination (see European Commission 2020: 19). The importance of their participation in the development, organisation, implementation, evaluation and monitoring of measures aimed at combating racism and discrimination has been recognised in various international, regional and national declarations and plans. These include the 'Declaration' and the 'Programme of Action' of the World Conference against Racism in Durban (see United Nations 2001), the German Federal Government's 'National Action Plan against Racism' of the (see Bundesregierung [Federal Government] 2017), the 'EU Anti-Racism Action Plan' (see European Commission 2020) and the 'Catalogue of Measures of the Cabinet Committee of the Federal Government to Combat Right-Wing Extremism and Racism' (see Presse- und Informationsamt der Bundesregierung 2020). At the World Conference in 2001, the international community recognised that the primary responsibility for combating racism and discrimination lies with the states and therefore decided that the states should develop national action plans against racism and involve non-governmental organisations in designing, implementing and evaluating policies and programmes (see United Nations 2001: No. 99). Furthermore, international law guarantees a right to participation in public affairs (see Art. 21 UDHR, Art. 25 ICCPR and Art. 5 ICERD). Article

2 of the ‘Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities’ (1992) recognises that individuals belonging to minorities have the right to full participation in cultural, religious, social, economic and public life. They also have the right to effectively participate in decisions taken at a national and, where appropriate, regional level that affect the minority to which they belong or the regions in which they live. The ‘International Convention on the Elimination of All Forms of Racial Discrimination’ also includes participation rights (see Art. 5 ICERD). For the specialised human-rights committees, working groups and special rapporteurs in the UN Human Rights Council, consultation with representatives of civil society is standard practice.[31]

Thirdly, civil-society organisations and communities themselves call for participation in implementing measures to combat racism. Although the Durban Declaration and Programme of Action were passed in 2001, Germany only adopted the first ‘National Action Plan against Racism’, which is based on it, in 2008. Civil society criticised the fact that there was no participative process. It was also criticised that the plan was not action-orientated and failed to formulate measures that took the situation of affected groups into account (see Follmar-Otto & Cremer 2009). A new edition of the ‘National Action Plan against Racism’ was drawn up in 2017. This was preceded by a consultation with civil society organisations and representatives of various communities. In its ‘Anti-Racism Agenda 2025’, the Federal Conference of Migrant Organisations called for the participation of civil-society organisations in the planning and implementation of measures for combating racism.[32]

Fourthly, academic institutions play a decisive role in making racism visible and combating it and, to fulfil this role, must work together with communities and civil-society organisations. The Durban Programme of Action sets explicit requirements for academic institutions, intended to ensure that the concepts and methods of data collection and analysis are improved, that research work is promoted, that experiences and successful approaches are exchanged, and that support measures are developed in these areas. In addition, they are to help develop indicators for progress as well as for the participation of individuals and groups of individuals affected by racism and discrimination (see United Nations 2001: No. 93). Furthermore, policies and programmes should ‘take into account the priorities identified by individuals or groups of individuals who are victims of or exposed to racism, racist discrimination, xenophobia and related intolerance’ (United Nations 2001: No. 94). These requirements make it clear that the participation of communities as early as the planning phase of research projects is an important prerequisite.

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[31] During its visit to Germany in 2017, the UN Working Group on the Concerns of People of African Descent conducted a nationwide consultation with Black, African and African Diaspora people. The consultation meetings, which took the form of town halls and discussions, were organised by the communities themselves. The Working Group summarised the contributions in its country report (see Human Rights Council 2017).

[32] The results of these consultation processes include, for example, the Afrozensus or the Catalogue of Demands for the Equality of People of African Descent in Berlin implemented by the Diversifying Matters team of Generation ADEFRA e. V. (see Auma, Kinder & Piesche 2019).

Organisation of the civil-society process accompanying the NaDiRa

Based on these four premises, NaDiRa believes that decisions in the context of racism and discrimination – both directly and indirectly – have an impact on racially labelled groups and must for one be transparent for the groups affected. For another, it is important to create an opportunity to participate in these decisions. In order to be able to adopt the perspective of the people affected, it is therefore important that research projects are supported by civil society. Apart from integrating knowledge from the communities, civil society's support enables critical reflection on the research questions and results. And, last but not least, exchange with civil-society actors is crucial for deciding on which research priorities are to be pursued.

The participation of civil-society organisations also serves to ensure quality, as the collection of data on experiences of racism and discrimination involves sensitive data. Given the misuse of group-related data during the Nazi era, communities' interests require special consideration. Their perspectives are also important when creating questionnaires and interpreting research results. In this context, ethical requirements apply with regard to the participation of individuals affected by racism and discrimination, which are taken into account in the design of the NaDiRa. If communities' participation is not ensured, there is a risk that research will be conducted that excludes the perspectives of the affected persons and – in the worst case – causes harm.

Civil-society actors affected by racism and dedicated to combating racism coined the slogan 'Nothing about us without us'. In accordance with this demand, the NaDiRa is guaranteed to be implemented with the participation of affected groups. Simply making assumptions about the interests and needs of the groups is not enough. Framework conditions and formats must be created that guarantee effective participation so that the affected groups have the opportunity to express their opinions in a self-determined way and help actively shape the research.

Participation formats

The NaDiRa has created various participation formats that pursue the realisation of the aforementioned requirements. The civil-society monitoring process ensures that an expert group made up of civil society representatives engages in continuous dialogue with the researchers. In an initial phase, migrant organisations, Diaspora organisations, newly founded German organisations, and organisations/institutions that focus on the topic of (anti-)racism became members of the expert group. On the one hand, this is intended to ensure critical monitoring of actors working on various racist phenomena and, on the other hand, to establish a connection to community-based knowledge. Participation is open to all organisations, initiatives and individuals interested. It is possible to register via the DeZIM website. In the future, the expert group will be expanded to include further organisations, such as trade unions and charities, which will be selected in consultation with the members of the expert group. The aim of the dialogue between the expert group and NaDiRa is to feed the topics and issues discussed in NaDiRa back into the various communities and therefore create scope for discussion. In addition, the expert group examines whether the research questions are relevant for the affected persons, whether the research results are able to support practical work and whether there are other topics that should be placed on the research agenda.

The various participation formats and topic-related exchange rounds with researchers are intended as offers to organisations interested in contributing their expertise to the NaDiRa. Expert group meetings are held internally with the expert group and the NaDiRa team. The aim of these is to involve the communities through working meetings in which – among other things – questionnaires, the development of research questions, and methodological and research ethics issues are specifically worked on. Based on this, the expert group advised the NaDiRa team in the preparation of this report and played an important role in the quantitative surveys and interpreting the results. Two expert group meetings are held each year.

In addition to setting up the civil-society expert group, the NaDiRa implements formats aiming at the expertise of civil-society organisations before, during and after decision-making phases. Consultation workshops are organised for this purpose. The workshops are used to initiate selective, thematically focused exchanges with civil-society organisations and focus on specific NaDiRa issues as well as the organisations' need for advice.

I.

General experiences of discrimination and racism in Germany

This part of the monitoring report presents the subjective experiences of discrimination and racism experienced by people in their everyday lives. It specifically analyses the extent to which NaDiRa.panel respondents report these experiences and the contexts in which they experience them. Particular focus is placed on the connection between the subjective experience of discrimination and racism and the trust placed in institutions in Germany.

For example, people experience discrimination due to their gender, ethnic origin, migration or refugee status, sexuality, disability, age or racialising characteristics (see Collins & Bilge 2020). They are therefore treated unequally or disadvantaged on the basis of these (ascribed) social categories. The various forms of discrimination are created and maintained by historically determined relations of power structures in society. They are reflected in structural, institutional and individual discrimination and can therefore have an impact on the everyday reality of the lives of certain groups. Racism in the form of racist discrimination is considered a special variant of discrimination. The concept of discrimination used here is explicitly not a formal legal one, even though some experiences may be relevant under criminal law or within the meaning of the General Equal Treatment Act (AGG). Instead, we use a broader, sociological concept of discrimination (see the info box Racism, discrimination, racist discrimination: A brief explanation of terms).

This report focuses on the perspective of the people affected. It should be noted that the NaDiRa.panel recorded subjective experiences of discrimination and racism. These describe perceived realities. Research tells us that the perception and reporting of experiences of discrimination and racism can be biased. Such biases may give rise to interpretations (see Kaiser & Major 2006). On the one hand, people can perceive experiences that are not necessarily discrimination as discriminatory. In this case, the extent of experiences of discrimination and racism would be overestimated (vigilance bias, see Williams 2016). People who have neither had clear experiences of discrimination and racism in their own lives nor belong to a group that has historically been systematically affected by these negative experiences enter a kind of state of vigilance or alarm. They want to protect themselves from the threat of further experiences of discrimination and racism by raising their level of alert. As a result, situations can be over-interpreted if the protective mechanism kicks in at the slightest hint of unequal treatment. On the other hand, there are people who tend to perceive experiences less frequently as experiences of discrimination and racism, even though they are in fact experiences of discrimination and racism (minimisation bias, see Kaiser & Major 2006). This describes a strategy for dealing with stressful situations. By denying that they have experienced discrimination and racism, they avoid the associated negative consequences. For example, they may avoid a confrontation with the situation experienced in order to protect themselves from psychological stress. However, reinterpreting other people's experiences can also result in a biased perception of experiences of discrimination and racism. If other people believe that the person affected has not experienced unequal treatment, then the person affected may give greater credence to this assessment than to their own perception. The current state of research does not yet provide any clear findings on the circumstances under which people tend to increasingly describe experiences as discrimination or racism or, on the other hand, not to name them as such. There remains an enormous need for research in this area, both in Germany and in an international context. In the following, it is therefore important to consider these possible biases in both directions.

Despite the limitations of a survey based on respondents' subjective assessments, the representative data collected in the NaDiRa.panel is highly relevant for research into the extent of experiences of racism and discrimination in Germany. The large number of more than 20,000 people surveyed as part of the recruitment wave, for example, allows for group comparisons, which can be used to show that certain experiences are particularly prevalent in certain groups and therefore cannot be reduced to individual cases (see Aikins et al. 2021). As various studies have already shown, experiences of racism can have far-reaching consequences for the affected persons. This report focuses in particular on the health consequences of experiences of racism (see Section II. Focus: Racism and health; see also Braveman et al. 2022; Lazaridou et al. 2022). As Aikins et al. (2021) show in their study on the everyday realities of Black, African and African Diaspora people in Germany, the prevalence of racism in society and the associated anticipated experiences also cause the people affected to actively avoid certain situations (such as contact with the police and security personnel, public offices and authorities, but they also avoid the housing market and the public and leisure sphere). This means that the subjective interpretation of situations as discriminatory or racist is associated with real and at times restrictive consequences.

Some disadvantages resulting from discrimination and racism can only be identified when analytically considering which social categories coincide and interact. The intersectional approach (see Crenshaw 1989) recognises that people are not only defined by individual characteristics or identities, but that these different dimensions are intertwined. This report focuses primarily on the interaction between racialising characteristics and gender. Previous research has shown that racial stereotypes and prejudices are often gender-specific. Black people, for instance, are predominantly stereotyped with characteristics that society considers typically masculine, while Asian people are stereotyped with characteristics that are considered typically feminine (see Schug, Alt & Klauer 2015; Schug et al. 2017). In the American context, Black women are often depicted in a sexualised way (see Collins 1990), while Black men are criminalised (see Essed 1992; Krieger 2000). Similarly, Muslim men in Germany are regularly described as aggressive and as 'oppressors of women'; Muslim women, on the other hand, are considered oppressed (see Attia 2009).

This chapter has been prepared based on the data collected as part of the NaDiRa. panel recruitment drive (W0). The survey was conducted between June and November 2022. Based on a random selection from the population registers of German municipalities, 75,375 people were invited to take part in the survey. Of these, 21,418 actually took part (response rate = 28.4%). The sample is characterised by the fact that racially labelled individuals were overproportionately invited to take part in the survey based on onomastic (name-based) pre-qualification (for more details, see the section The NaDiRa.panel data). Firstly, the chapter provides an overview of the racially labelled individuals’ experiences of discrimination compared with non-racially labelled individuals’ experiences in day-to-day life in Germany (Chapter I.1). In the next step, the specific characteristics of discrimination indicated by the affected individuals as possible triggers for their experiences (Section I.1.1) were analysed. This is followed by a chapter on the social spaces where discrimination and racism are experienced (Section I.1.2). Section I.1.3 then investigates the connections between experiences of discrimination in institutional contexts and trust in these institutions, followed by a conclusion (Section I.1.4).

The following presentation of the results primarily focuses on comparing two socio-demographic categories: firstly, differences are discussed according to the respondents’ self-identification, which served as the basis for categorising them into racialised and non-racialised groups. Here, respondents were asked to categorise themselves into the groups to which they feel they belong (e.g. Asian people, Muslim people, Black people, German people with or without a migration background). Secondly, differences were tracked along gender lines. For the underlying analyses, other socio-demographic categories – such as the respondents’ educational qualifications – were also taken into account, but these were not discussed further.

1.

The extent of experiences of discrimination in day-to-day life

Racism pervades various levels of society. Alongside structural and institutional racism, which racially labelled people encounter in the form of laws and border regimes, these groups are also confronted with their fellow human beings' racist attitudes and actions in interpersonal relations (see info box Levels of analysis in racism). On this individual level, racially labelled people are currently encountering increasingly subtle forms of racism. Hamidou-Schmidt and Elis (2023) trace this back to an overall decrease in societal acceptance of overt racist attitudes. However, there is a seamless transition between experiences of subtle and overt racism. In literature, microaggressions are conceptualised as part of experiences of discrimination (see Zhang, Gereke & Baldassarri 2022). Although there is as yet no established standardised definition of microaggressions (see Lilienfeld 2017), various characteristics can be identified. They may occur both verbally and non-verbally (e.g. via body language) or paraverbally (e.g. a raised voice). They can also denote both intentional and non-intentional behaviour patterns, which are largely normalised in society and are consequently viewed as acceptable (see Jones et al. 2016). Precisely because discrimination and racism are frequently understood via the perpetrator's intentions, it is often disputed that these subtle experiences are actually felt by the individuals affected. Accordingly, in subtle experiences of discrimination and racism, there is potential ambiguity that can be traced back to conflicts regarding interpretation. Experiences of overt discrimination, however, often denote aggressive patterns of behaviour towards people who are openly and intentionally insulted, harassed, threatened or physically attacked, often with explicit reference to discrimination characteristics (see ibid.).

The 'Everyday Discrimination Scale' was developed in the USA to record experiences of subtle and overt discrimination, which are still widespread in society today (see Williams et al. 1997). This scale is often used during medical and sociopsychological examinations (see e.g. Bastos et al. 2010; Lawrence et al. 2022). In the NaDiRa.panel recruitment drive, the Everyday Discrimination Scale was used to measure experiences of subtle and overt discrimination. For this purpose, respondents were asked to indicate how often certain things happened to them in their day-to-day lives. To answer this question, they received a list with descriptions of seven situations, for each of which they could indicate the frequency of their experiences. Some of the situations (first to fourth statement) could be categorised as experiences of subtle discrimination, and some (fifth to seventh statement) could be categorised as experiences of overt discrimination. Concretely, the situation descriptions were:

- **Experiences of subtle discrimination**
  - 'You receive worse service than others'
  - 'You are treated with less respect than others'
  - 'Someone behaves as if they were not taking you seriously'
  - 'Someone behaves as if they were afraid of you'

- **Experiences of overt discrimination**
  - 'You are threatened/harassed'

- ‘You are abused/insulted’
- ‘You are physically attacked’

These experiences of discrimination were recorded using a scale with six levels ranging from ‘daily’ to ‘at least once a week’, ‘at least once a month’, ‘several times a year’, ‘rarely’ and ‘never’. The answers were used to create two indexes that each encompassed all experiences of subtle and overt racism. The scale of the index for subtle experiences ranged from 0 to 20 points, and that for overt experiences from 0 to 15 points. The values represented the frequency of experiences: the higher the value, the more frequently the situation was experienced.

Experiences of discrimination are part of day-to-day life for many people

Although the General Equal Treatment Act (AGG) forbids discrimination on the basis of age, gender, sexual identity, disabilities and chronic illnesses as well as for racist reasons or due to religion or ideology regarding access to supplies of goods and services as well as in the employment market, experiences of discrimination are part of day-to-day life for many people in Germany (see Wieland & Kober 2023). Wieland and Kober demonstrate that the subjective perception of being affected by discrimination, including for racist reasons, has even significantly increased since 2008.[33] Below, the data from the NaDiRa.panel is used initially to generally discuss the experiences of all people living in Germany between 18 and 70 years old, whereby we differentiate between experiences of overt and subtle racism. In the second step, experiences of discrimination are considered in a more differentiated way, distinguishing between non-racially labelled and (various) racially labelled groups as well as by respondents’ gender.

If all the experiences of unequal treatment recorded using the Everyday Discrimination Scale are taken into consideration, only 12.4% of respondents reported never having experienced any of the seven situations described. Conversely, this result therefore means that the remaining 87.6% have experienced at least one of the experiences of discrimination recorded by the scale in their day-to-day lives. If only the racially labelled groups are considered, this number is even greater at approximately 90%.

As will be shown later, the values for racially labelled and non-racially labelled groups diverge appreciably when the frequency of these experiences is taken into account. It is striking that this value is even significantly above the value measured by Wieland and Kober (2023) for a period of twelve months (52%). This can be explained by the fact that no time period was specified for the experiences of discrimination recorded in the

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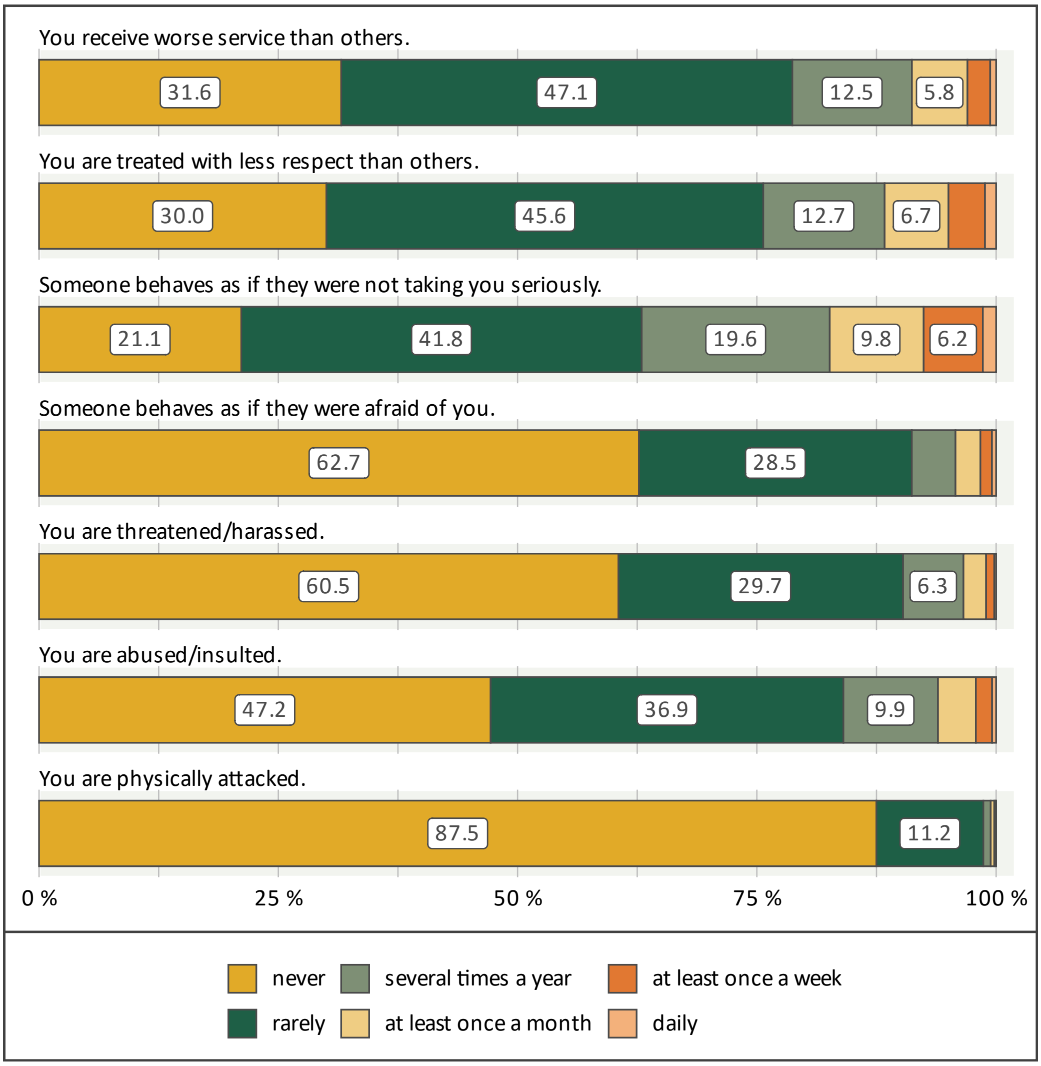
[33] While 6% of respondents stated that they had experienced discrimination for racist reasons in 2008, the proportion was 13% in 2022 (Wieland & Kober 2023).

NaDiRa.panel's recruitment drive,[34] in which the dimension recorded by Wieland and Kober was expanded with a further dimension: all experiences of discrimination up to the point of the survey. The result illustrates once more the extent of discriminatory experiences in Germany.

Figure 3. **Experiences of discrimination in day-to-day life (proportions in per cent)**



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Example: 6.3% of respondents reported that they were threatened/harassed several times a year. **Source:** NaDiRa.panel, Wave 0 (weighted), own calculations. N = 20,613; 20,619; 20,547; 20,545; 20,587; 20,593; 20,564. Proportions under 5% are not shown.

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[34] Wave 0 – which this study is based on – represents the NaDiRa panel's recruitment drive. In this wave, no time limit was set regarding the enquiry as to experiences of discrimination. Respondents were therefore asked to state whether they had ever experienced discrimination. The NaDiRa.panel surveys take place at regular intervals and always include the questions on experiences of discrimination presented in this chapter. From Wave 1 onwards, experiences since the previous survey will therefore be subject to a time limit. This will allow more precise statements to be made regarding the timing and development of experiences of discrimination when analysing follow-up surveys.

The experiences of subtle and overt discrimination are presented individually in Figure 3. Here, it can be seen that experiences of discrimination are widespread among all participants. Receiving worse service, being treated with less respect, and not being taken seriously are examples of subtle unequal treatment that a large majority of respondents had experienced. For example, more than two-thirds of respondents (approximately 68%) reported having received worse service than others. In comparison, not being taken seriously is the form of discrimination that occurs the most frequently. Only 21.1% of respondents had never been in this situation, whereas almost 8% were confronted with this daily or weekly.

Generally speaking, however, respondents reported experiencing overt discrimination less frequently. As the data shows, this is nevertheless not a peripheral phenomenon. A substantial proportion of the population is regularly subjected to overt discrimination such as aggressive behaviour: almost half of respondents had been abused or insulted. Of these, 6% reported that they even experienced this daily or weekly. Just over a third (39.5%) state that they have been threatened or harassed, while 12.5% of respondents have even experienced physical attacks.

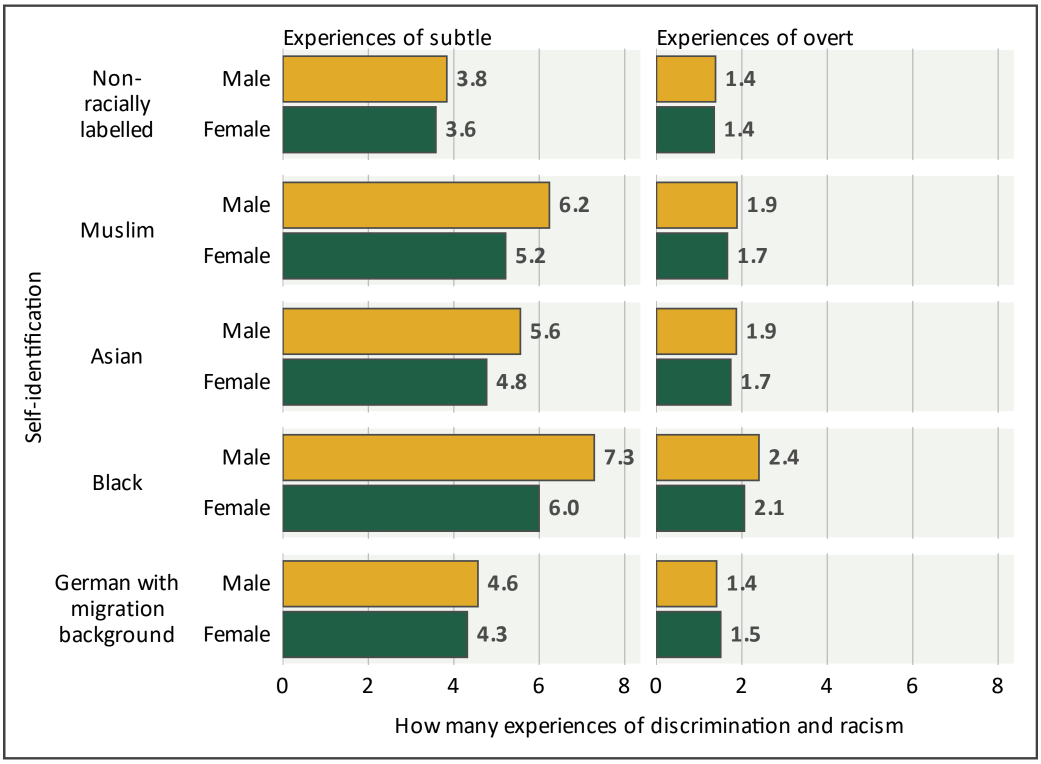
Respondents report more frequent experiences of subtle discrimination than of overt discrimination.

1.1 Racially labelled persons are more frequently affected by experiences of discrimination

Figure 4 shows the group-specific averages of both summated indexes. The averages are shown separately for men and women and for all racially labelled groups considered by the NaDiRa.panel. Figure 4 can therefore be interpreted from two perspectives. Firstly, from the perspective of racialisation by comparing the various groups with each other, and secondly from the perspective of gender by comparing the results for women and men.

On average, all racially labelled groups experience significantly more subtle and overt unequal treatment than the group that identified themselves as German without a migration background. The differences are always statistically significant. For subtle experiences, it can be shown that Black people have the highest average value for both genders and are therefore subjected to experiences of subtle discrimination most frequently. For overt experiences, we also see the highest average for Black people. The figures for the Asian and Muslim groups are almost identical.

Figure 4. **Experiences of subtle and overt discrimination by group affiliation and gender (averages)**



Example: Male respondents who identified as Black have an average value of 7.3 on the scale for experiences of subtle discrimination. This means that they experience subtle discrimination comparatively frequently. **Source:** NaDiRa.panel, Wave 0 (weighted), own calculations. N = 15,740, 15,716

If the gender differences within individual groups are considered, it is striking that, on average, women report less frequent experiences of both subtle and overt discrimination than men. These gender-based differences are always statistically significant for subtle experiences. For overt experiences, however, there are only significant differences between Muslim men and women. Below, both a situation of subtle discrimination and one of overt discrimination are considered in more detail.

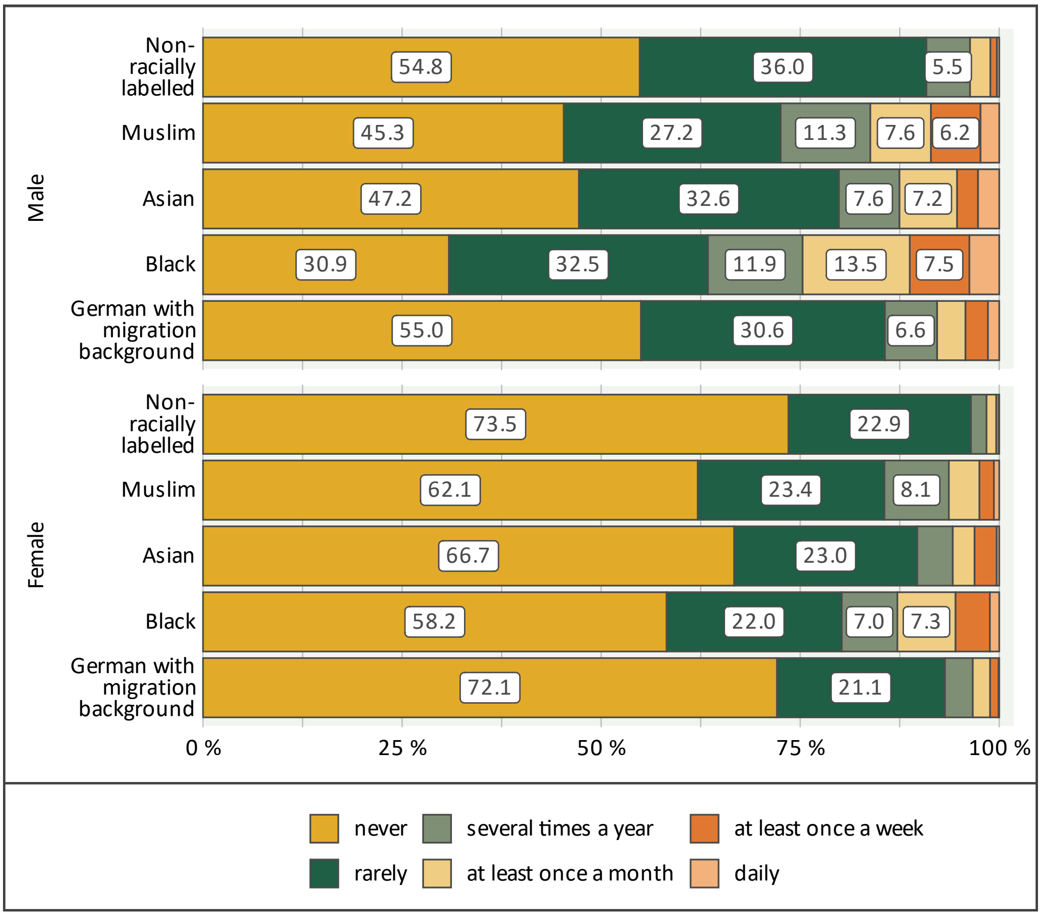
Across all groups, women report less frequent experiences of discrimination than men.

Men are more frequently met with fear

Figure 5 shows the frequency with which men and women report that they are met with fear in their day-to-day lives. Regardless of how they self-identify, men experience this significantly more frequently than women. If the group differences are taken into account, it can be seen that 36.6% of Black men experience this situation several times a year. This proportion is lower for Muslim (27.5%) and Asian (20.2%) men but is still significantly higher than for the non-racially labelled group (9.2%). While roughly at least half of men in all other groups have never experienced this situation of discrimination, this applies to less than a third of the Black men surveyed as part of the NaDiRa.panel. Compared with non-racially labelled men, these results are always statistically significant (with the exception of Germans with a migration background).

Although the proportions are lower for women compared with men, here it is also Black women in particular who are repeatedly met with fear (19.8%). Similar values can be seen for Muslim and Asian women – 14.5% and 19.3% respectively – which is below that for Black women but still significantly above that for non-racially labelled women (3.6%). The proportion of those who have never been met with fear is highest for non-racially labelled women at 73.5%. For racially labelled women, this only applies to a smaller extent (58.2% for Black women, 62.1% for Muslim women, 66.7% for Asian women).

Figure 5. **'Someone behaved as if they were afraid of you' by group affiliation and gender (proportions in per cent)**



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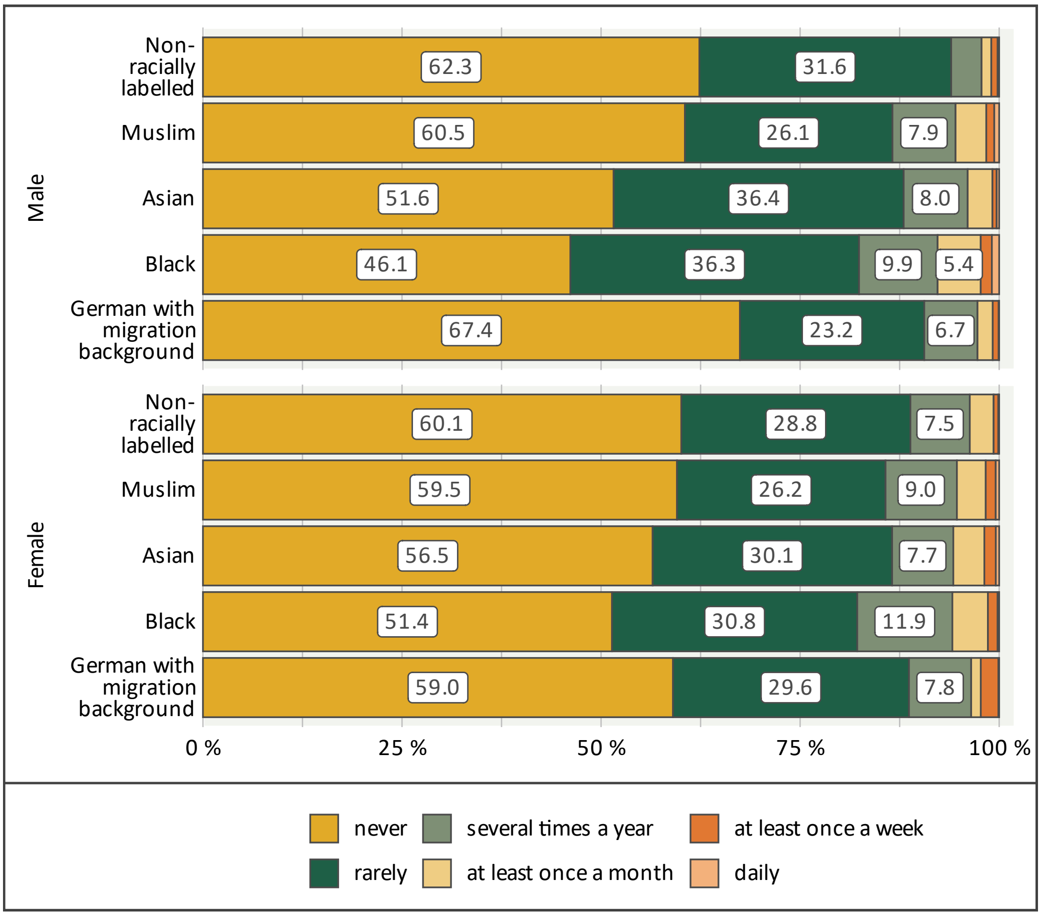
Example: 7.3% of the women surveyed who identify as Black state that they are met with fear at least once a month.
Source: NaDiRa.panel, Wave 0 (weighted), own calculations. N = 7,583, 8,034. Proportions under 5% are not shown.

These results can be linked to the respective characteristics of racism towards Black, Muslim and Asian people, which can only be briefly outlined here: all three types of racism share a projection of potential 'danger'. Influenced by racist colonial images, Black people are often criminalised and portrayed as aggressive (see Hamann 2015; Kilomba 2021; Steyerl & Gutiérrez Rodríguez 2012). As has been demonstrated by research primarily from the USA, in this respect Black women specifically are subjected to diverse stereotypes that, among other aspects, portray them as particularly aggressive (see Ashley 2014; Collins 1986; Griffin 2012). Muslim men, conversely, are often seen as a security risk in public spaces, in particular regarding the immigration of individuals perceived as Muslims (see Amir-Moazami 2018; Bigo 2013; Meyer, K. 2020; Yılmaz-Günay & Klinger 2014). Racist projections towards Asians differ in that in Germany, as in other places, people perceived as Asian are treated as 'model migrants' (model minority) (see Hartlep & Bui 2020; Li & Nicholson 2021). Above all during the COVID-19 pandemic, individuals perceived as (East) Asian became the focus of racist narratives concerning hygiene. Although racism towards Asians also existed before the outbreak of Covid-19 (see Leutner 2022), people perceived as Asian were particularly viewed as a health risk during this time (see He et al. 2020; Köhler & Suda 2023; Zhou 2022).

The way in which this fear is articulated and mobilised is therefore based on historical continuities and developments. Although these fears are articulated in a group-specific manner, they are linked to similar consequences for affected persons: distrust and fear are an expression of and an integral part of widespread racism in Germany.

Subtle discrimination is also experienced more frequently by Black people: 36.6% of all Black men reported that they are met with fear several times a year. This is four times as often as for non-racially labelled men (9.2%). One in five Black women (19.8%) reported that they are frequently met with fear. For the non-racially labelled women, this only applied to one in thirty (3.6%).

Figure 6. 'You are threatened/harassed' by group affiliation and gender (proportions in per cent)



Example: 9.9% of the men surveyed who identify as Black state that they are threatened or harassed several times a year.
Source: NaDiRa.panel, Wave 0 (weighted), own calculations. N = 7,602, 8,066. Proportions under 5% are not shown.

Figure 6 shows the frequency with which men and women in the various groups, differentiated by self-identification, reported having been threatened or harassed. In contrast to the previous example, shown in Figure 5, this is an overt form of discrimination. Here too, it is striking that Black people are particularly affected by this experience. 48.6% of Black women and 53.9% of Black men who were surveyed in the NaDiRa.panel recruitment drive have been threatened or harassed in their day-to-day life. When compared with other groups, Asian men (48.4%) and women (43.5%) also reported particularly frequently that they had experienced threats or harassment. For Muslim men and women, the relevant value was approximately 40%.

Men who identified themselves as German with a migration background reported the least frequent experiences of threats and harassment in their day-to-day lives (32.6%). Non-racially labelled men (37.7%) and women (39.9%) experienced this overt form of racism less frequently than Black, Muslim and Asian people.

Racially labelled women and men were threatened or harassed more frequently than non-racially labelled women and men.

Racialised characteristics are often named as causes of discrimination

Those respondents who had reported at least one experience of discrimination were subsequently asked which (ascribed) characteristics were the decisive factors for this in their opinion. This is therefore also a subjective interpretation of experiences.

In order to be able to capture different levels of racist discrimination, five characteristics were selected that covered biological, cultural and religious dimensions. For seven further discrimination characteristics that were collated, the characteristics named in the General Equal Treatment Act (AGG) served as orientation. Additional characteristics were also included, such as income or unemployment. Overall, the respondents could select all the characteristics that applied from the following list:

- 'Because others do not perceive me as German'
- 'Because of my German language skills'
- 'Because of my skin colour'
- 'Because of my religion'
- 'Because of my name'
- 'Because of my sexual orientation'
- 'Because of my gender'
- 'Because of a disability or chronic illness'
- 'Because of my weight'
- 'Because of my age'
- 'Because of my low income'
- 'Because of unemployment'

Tables 7 and 8 summarise which discrimination characteristics people perceive to be the cause of their experiences in day-to-day life. When interpreting the tables, it must be taken into account that only the average values are listed for the groups shown. This, for example, is the reason for overall low average values for sexual orientation being named as a discrimination characteristic. If this figure is considered for non-heterosexual people, the results are significantly higher (approximately 41% for men and 26% for women). Similarly, further analysis regarding age shows that principally young people (between 18 and 24 years old) and older people (above 55 years old) indicated their age as being a relevant discrimination characteristic.

When considering discrimination characteristics, there are significant differences between racially labelled and non-racially labelled groups, as well as within the racially labelled groups between men and women.

For non-racially labelled men, age (approximately 42%) is most commonly described as relevant to their experiences of discrimination. Weight (19%) and income (17%) are named in second and third place. Interestingly, in this group the proportion of those who did not know which characteristics had led to their being discriminated against was the highest (14%). Among the racially labelled groups, in contrast, the discrimination characteristics reported were above all those which indicated racist discrimination. Almost two-thirds of Muslim and Asian men (approximately 63% and 58% respectively), for example, reported having experienced discrimination because they were not perceived as German. Among Black men, this proportion was approximately 53%, but was exceeded by experiences of discrimination because of skin colour (approximately 68%). For racially labelled men, racialised characteristics such as language, name or religion were also named in second and third place – alongside skin colour and not being perceived as German.

Across all groups, men only reported having been discriminated against because of their gender to a small extent (in each case under 7%) (Table 7). In contrast, women reported having experienced discrimination because of their gender in 21% to 58% of cases (Table 8). Among women, there were significant differences depending on how they self-identified. Non-racially labelled women most frequently named gender as a discrimination characteristic. For them, age was in second place at 38%. As with men, very young and older women show the highest figures here. Weight (19%) and income (10%) follow in third and fourth place. Responses from racially labelled women display many similarities to those from racially labelled men here. For example, Black women most frequently named their skin colour (61%) as the cause of their experiences of discrimination, followed by not being perceived as German (47%). Muslim women most frequently attributed their experiences of discrimination to their religion (61%), followed by not being perceived as German (56%). The latter reason was named most often by Asian women, followed by their German language skills (45%).

Overall, it can thus be concluded that racially labelled women and men see the cause of the discrimination against them in their day-to-day lives above all in the characteristics that suggest racist discrimination.

Table 7. **Distribution of discrimination characteristics for men**

	Non-racially labelled	Muslim	Asian	Black	German with MB
Not being perceived as German	3.5%	63.2%	57.7%	53.0%	43.5%
German language skills	1.8%	32.6%	38.1%	34.0%	17.8%
Name	5.7%	44.3%	27.6%	27.1%	28.2%
Religion	3.7%	53.8%	21.0%	12.9%	11.5%
Skin colour	2.6%	24.3%	31.8%	68.2%	10.5%
Age	42.3%	5.9%	15.2%	17.2%	17.5%
Gender	6.6%	4.2%	3.6%	5.8%	5.6%
Sexual orientation	4.4%	1.4%	1.6%	2.2%	2.7%
Weight	18.8%	5.0%	10.1%	5.0%	8.9%
Chronic disease	10.3%	3.9%	4.6%	8.2%	6.0%
Income	16.7%	13.5%	10.5%	20.3%	14.1%
Unemployment	4.4%	7.0%	6.7%	7.0%	2.6%
Don’t know	13.8%	0.9%	3.6%	5.4%	5.5%

Example: Of the men who identify as Asian, 57.7% state that they were discriminated against because they were perceived as not being German. **Source:** NaDiRa.panel, wave 0 (weighted/unweighted), own calculations. N = 5,885

Table 8. Distribution of discrimination characteristics for women

	Non-racially labelled	Muslim	Asian	Black	German with MB
Not being perceived as German	1.2%	56.3%	59.7%	47.0%	38.3%
German language skills	1.0%	31.8%	44.5%	23.6%	20.3%
Name	2.3%	36.7%	26.5%	17.4%	24.1%
Religion	1.7%	61.4%	22.2%	10.8%	6.8%
Skin colour	0.7%	13.4%	28.8%	61.1%	6.0%
Age	37.8%	12.5%	17.9%	18.7%	20.9%
Gender	58.3%	21.1%	29.9%	24.8%	43.4%
Sexual orientation	2.5%	1.5%	2.9%	3.4%	3.4%
Weight	19.2%	9.9%	10.8%	21.7%	10.1%
Chronic disease	8.4%	4.0%	4.5%	9.0%	7.5%
Income	10.1%	10.0%	12.7%	14.5%	7.8%
Unemployment	2.1%	5.6%	8.0%	14.6%	1.5%
Don’t know	3.6%	0.6%	0.4%	0.2%	3.0%

Example: 61.1% of women who self-identify as Black reported that they were discriminated against because of their skin colour. **Source:** NaDiRa.panel, Wave 0 (weighted/unweighted), own calculations. N = 6,433

1.2 Experiences of discrimination and racism in various contexts

Next, we will shift the focus to the contexts in which the NaDiRa.panel respondents had experienced which can be analysed as (racist) discrimination. the NaDiRa.panel enquired how often – in their own view – respondents had been treated unfairly or worse than others in different situations. Overall, six different areas[35] were addressed:

- ‘During contact with the police’
- ‘During contact with public offices or authorities’ (e.g. residents’ registration office, immigration authorities, job centre)
- ‘In public’ (e.g. in the street, on public transport, when shopping)

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[35] The areas surveyed in the NaDiRa.panel vary slightly between survey waves. While the field of health was surveyed in the recruitment drive (Wave 0) – which forms the data basis for this report – the media context was included in Wave 1. In further follow-up surveys, more explicit questions will also be asked about the contexts of work, housing and education.

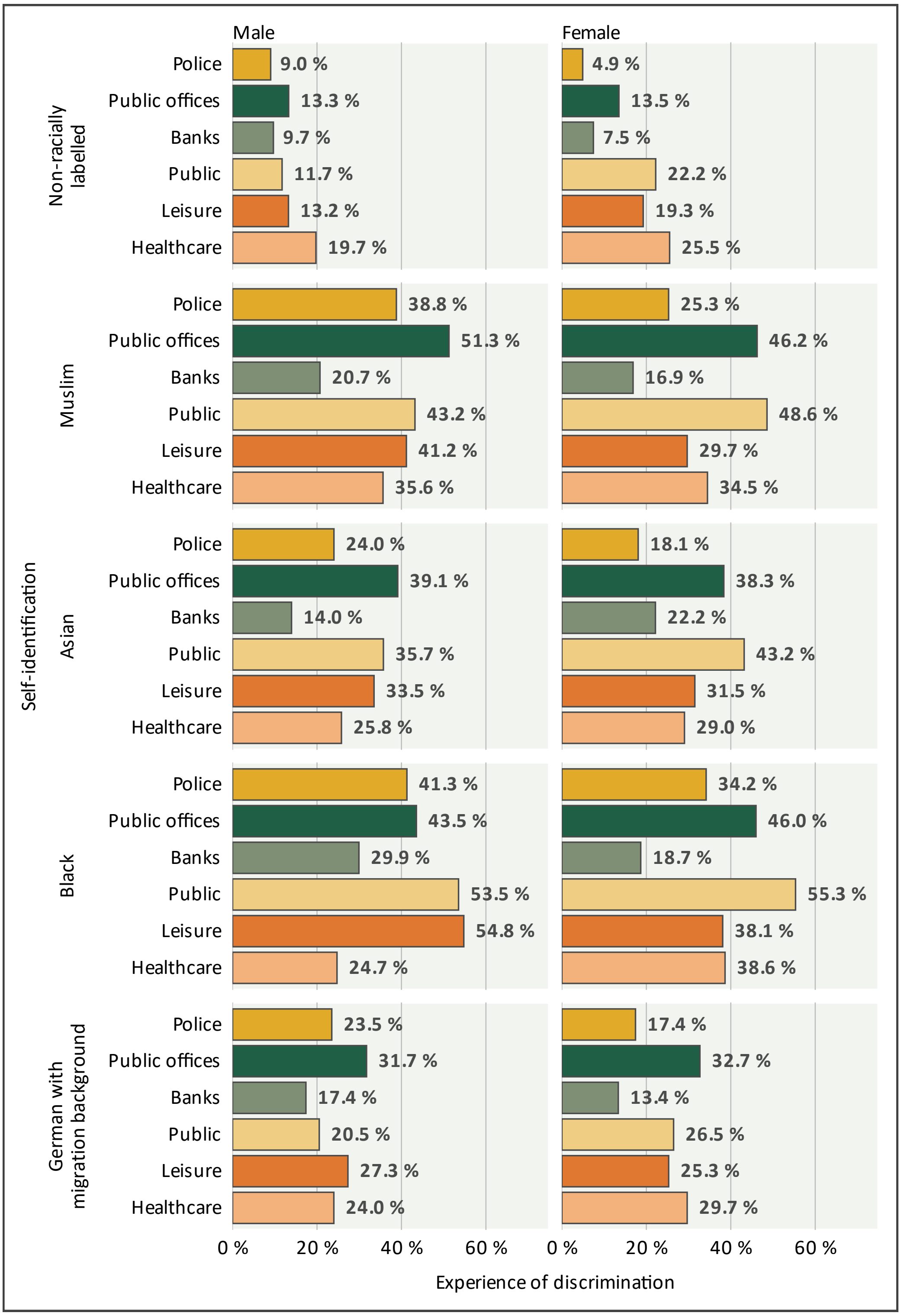
- ‘During contact with banks’ (e.g. when opening an account or taking out a loan)
- ‘In your free time’ (e.g. in associations, in restaurants, in nightclubs)
- ‘In the healthcare field’ (e.g. during contact with a doctor, non-medical personnel such as the receptionist or in the hospital)

Here, respondents could answer ‘very frequently’, ‘frequently’, ‘sometimes’, ‘rarely’ and ‘never’ or state that they ‘had never been in this situation’. Figure 7 aggregates the answer categories of ‘very frequently’, ‘frequently’ and ‘sometimes’ in order to depict the percentage of respondents who experience discrimination relatively often in one of the situations listed above. For this reason, only the cases in which respondents actually had points of contact with the relevant contexts were taken into account. For example, those who reported never having been in the situation ‘Contact with the police’ were not considered here. The figure therefore allows (group-specific) statements regarding how many of those who have been in such a situation also experienced discrimination in this situation. However, due to the structure of the survey, no statements can be made regarding whether the reported situations of unfair or worse treatment were experienced during direct personal interaction or, for example, in written correspondence. Figure 7 shows a summary of the relevant answers sorted according to these areas, by gender, and for the five different racially labelled and non-racially labelled groups.

Analysis shows that the question of which racially labelled group and which gender experience more or less discrimination does indeed depend on contextual conditions. As people frequent each area to a different extent in their day-to-day lives, however, a direct comparison of numbers between these areas is limited. Nonetheless, there are indications of the locations and institutions at which the respondents experienced (racist) discrimination. Furthermore, above all it is interesting to investigate whether and to what extent the pattern changes with regard to gender and groups. It becomes clear that experiences perceived as discriminatory in certain contexts for certain groups of people tend to be perceived more or less virulently.

During contact with the police, for example, there are significant differences between racially labelled and non-racially labelled respondents, as well as between genders. Initially, it can be stated that racially labelled groups experience significantly more discrimination during contact with the police than non-racially labelled groups. Across all groups, men are more affected by contact with the police than women. Here, men are more affected than women during contact with the police across all groups. However, women from all racially labelled groups report more experiences of discrimination (at least 17%) than non-racially labelled men (9%). Black men (41.3%) and women (34.2%), as well as Muslim men (38.8%) and women (25.3%) particularly frequently report having been discriminated against during contact with the police ‘very frequently’, ‘frequently’ or ‘sometimes’.

Figure 7. Experiences of discrimination in various contexts, differentiated by self-identification, sorted into men and women (in per cent)



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Example: 46.2% of female respondents who identify as Muslim state that they have experienced discrimination when in contact with public offices or authorities. **Source:** NaDiRa OAP, Wave 0 (weighted), own calculations. N = 8,407–12,508

Black and Muslim people are discriminated against disproportionately often when in contact with the police. 41.3% of Black men experience discrimination by the police, as well as 38.8% of Muslim men. A third of Black women (34.2%) and approximately a quarter of Muslim women (25.3%) report the same.

Regarding contact with offices or authorities, a generally high prevalence of experiences of discrimination can be seen for racially labelled groups. Almost 40% of people who identified themselves as Asian (men: 39.1%; women: 38.3%) at least ‘sometimes’ experienced worse or more unfair treatment than others in this context. An even higher proportion was seen for Muslims: for the men, more than one in two people (51.3%) had negative experiences with authorities with some regularity (‘sometimes’, ‘frequently’ or ‘very frequently’). For the women, it was almost one in two (46.2%). A similar level of affectedness can be seen among both Black men (43.5%) and Black women (46%). In comparison, the proportion for non-racially groups was slightly over 13% for both genders.

Muslim people experience discrimination particularly often during contact with offices or authorities. More than half of Muslim men report being discriminated against in these situations.

Similar patterns can be seen with regard to contact with banks, although on a significantly lower level. In all racialised and gender combinations, the reported experiences are clearly below the relevant figures for contact with authorities.

In public, racially labelled people’s experiences of discrimination are particularly pronounced. This applies most strongly to Black people. More than half of respondents (men: 53.5%; women: 55.3%) in this group report regularly (‘very frequently’, ‘frequently’ or ‘sometimes’) having had an experience of those recorded by the Everyday Discrimination Scale. The situation for Muslim men and especially women is only marginally better (men: 43.2%; women: 48.6%). Asian people also regularly have negative experiences in public (men: 35.7%; women: 43.2%). Across all groups observed, it is striking that women experience more discrimination in public than men.

Black people are discriminated against in public disproportionately often. One in two Black people reports experiencing discrimination in public.

Experiences of discrimination are also a reality during leisure time, particularly for racially labelled people. Here, there is a reversed gender relationship compared with the public context. In all racially labelled groups, men more frequently report experiencing discrimination than women from the same group. Here, the figures for Black men (54.8%) and Muslim men (41.2%) are the highest.

For the particular area focused on by this report – healthcare – significant experiences of discrimination can also be observed. In the healthcare field, too, the three racially labelled groups are the most strongly affected by perceived unequal treatment and discrimination. For example, more than two-thirds (68.1%) of Muslim women reported that they had been 'treated more unfairly or worse' by doctors or other medical personnel. 34.5% even reported that they regularly had this type of experience, meaning 'very frequently', 'frequently' or 'sometimes'. 61% of non-racially labelled women reported unfair or worse treatment than others. Of these, 25.5% experienced this regularly. More than two-thirds of Black women (67.1%) reported that they had been treated more unfairly and worse than others within the healthcare system, of whom 38.6% had these experiences regularly. Among Asian women, 60.8% reported that they had experienced unfair and poor treatment, 29% of them regularly.

59.7% of Black men reported that they had been discriminated against in the healthcare system, 24.7% of them regularly. The men who identified themselves as German with a migration background also perceived experiencing this situation regularly (24%). However, these figures are below those for Muslim (35.6%), Asian (25.8%) and Black (24.7%) men.

Furthermore, it is interesting that men who self-identified as German without a migration background had the highest figures in the healthcare field compared with other areas of society (19.7%). This could be an indication that discrimination characteristics such as age, class or weight could have a high significance here. With regard to gender, in all groups besides that of Muslim people, women reported more often than men that they had regularly experienced one or more of the situations recorded by the Everyday Discrimination Scale in the healthcare field. This is largely in contrast with the experiences of discrimination in the other fields discussed here, in which men more frequently report more unfair treatment or worse treatment than others.

1.3 Experiences of discrimination and racism and trust in societal institutions

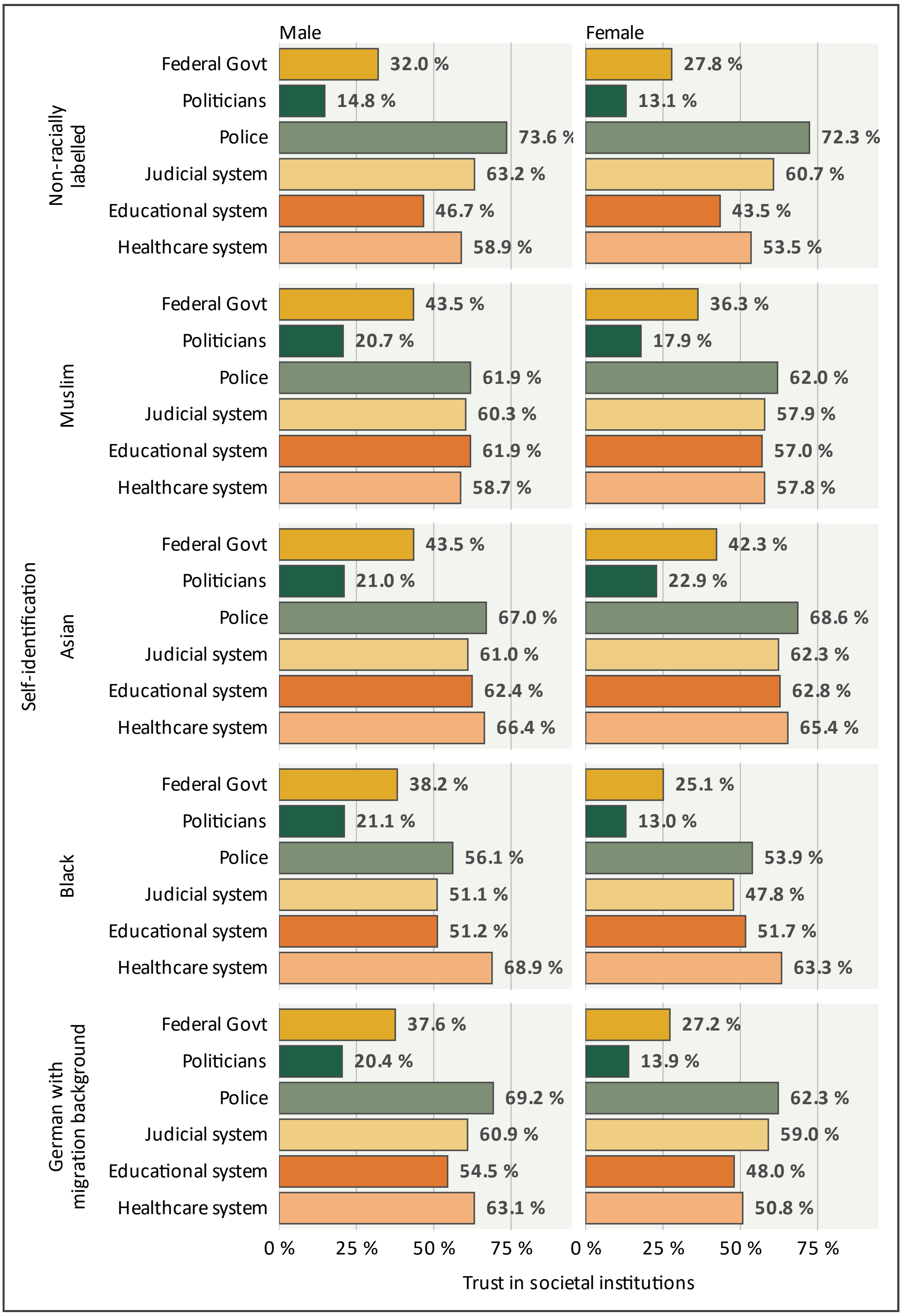
The experiences of discrimination and racism analysed in the previous chapters not only shape the day-to-day lives of those affected, but also affect their attitudes towards the society they live in. International studies have already discussed the trust with which racially labelled groups view societal institutions (see Avery 2006; Doescher et al. 2000; Tyler 2005; van Craen 2013). The NaDiRa.panel investigated the extent to which respondents trusted various societal institutions and authorities. Here, respondents were asked about their trust in:

- The Federal Government
- Politicians
- The police
- The judicial system
- The educational system
- The healthcare system

Respondents were able to express the degree of their trust on a seven-step scale ranging from ‘Fully and completely trust’ (1) via ‘Partially trust’ (4) to ‘Do not trust at all’ (7). Figure 8 shows the proportion of respondents who tended to show trust in each of the six institutions named, i.e. answered 1, 2 or 3. Here, we differentiate between genders and between the groups used in the previous analyses.

The depiction of the respondents’ trust in the various institutional areas (Figure 8) reveals differences between the individual groups and between the genders. With regard to the general trust that respondents have in the Federal Government, it can be initially noted that their trust is at a medium to low level. The level of trust is particularly low in the reference group of non-racially labelled people without a migration background, where only 32% of men and 27.8% of women express a tendency towards trust. This proportion is significantly higher in the three racially labelled groups: both for Muslim and Asian men, it is 43.5%, and 38.2% for Black men. For Muslim (36.3%) and Asian (42.3%) women, too, their trust in the Federal Government is significantly above the level for non-racially labelled women with and without a migration background (27.2% and 27.8% respectively). Only Black women have a lower level of trust (25.1%). In comparison to previous surveys regarding trust in politics and political parties, the results for trust in the Federal Government are therefore higher for all the groups considered in the NaDiRa.panel. For example, they are above the 24% measured by a study from the Bertelsmann Stiftung by Unzicker (2019) in 2018, and in most cases also above the 30% measured in 2017.

Figure 8. Trust in societal institutions, differentiated by self-identification, sorted into men and women (in per cent)



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Example: 14.8% of non-racially labelled men say that they trust politicians in Germany. **Source:** NaDiRa.panel, Wave 0 (weighted), own calculations. N = 16,075–16,215

When considering politicians, it is again striking that respondents' trust in them is overall low: across all groups considered, only one in five people reported that they tend to trust politicians. Among non-racially labelled people, it was only one in seven men (14.8%) or women (13.1%). While the figure for racially labelled men across all groups was relatively constant at between 20.4% and 21.1%, there are larger group-specific differences among racially labelled women: Asian women show above-average trust in politicians with a value of 22.9% overall, while the result for Black women is just as low as that for non-racially labelled women. Analogous to the low levels of trust in politicians established by the NaDiRa.panel, Faus and Storks (2019) also found the lowest levels of trust for political parties in their analysis. In this context, they highlight the relevance of political trust for societal cohesion and note the possibility that low trust could also be accompanied by lower political involvement.

The general trend is also seen regarding trust in the educational system, where Asian and Muslim men and women show particularly high levels of trust, with figures around 60%. While the result for Black people is already significantly lower at 51%, the group of non-racially labelled respondents showed a particularly low level of trust here too (men: 46.7%; women: 43.5%).

Regarding the healthcare system, which was viewed with a comparatively high level of trust by respondents overall, non-racially labelled respondents also showed a comparatively low level of trust. Only 58.9% of non-racially labelled men and 53.5% of women from this group reported that they trusted the healthcare system. Similarly low results were seen for Muslim people, which is not surprising given the fact that this group, alongside Black women, reported particularly frequent experiences of discrimination in the healthcare field (see above). However, although Black and Asian people also experience significantly more discrimination than non-racially labelled people, they showed a higher level of trust in the healthcare system than the non-racially labelled group.

Only with regard to the police and the judicial system did non-racially labelled people in the NaDiRa.panel show a comparatively high level of trust. This is particularly evident regarding the police, with a value of 73.6% (non-racially labelled men) and 72.3% (women). While Asian women and men also showed a comparatively high level of trust in the police – 68.6% and 67% respectively – the figures for Muslim women (62%) and men (61.9%) are significantly lower. In Germany, Black people have the lowest level of trust in the police: only 53.9% of Black women and 56.1% of Black men who were surveyed as part of the NaDiRa.panel reported that they trusted the police. This result largely coincides with studies from the US context that found that racially labelled people tend to trust the police less (see. z. B. Frank, Smith & Novak 2005; Weitzer & Tuch 2005). Some studies trace this back to experiences of discrimination by the police, which affect racially labelled people to a particularly high extent, as also shown by the data from the NaDiRa.panel (see Tyler & Wakslak 2004; Weitzer & Tuch 2002). For the European context, Röder and Mühlau (2012), for example, showed that trust in the police for immigrants in the first generation is initially higher compared with people without a migration background, whereas children of immigrants show significantly lower levels of trust. Czymara and Mitchell (2023) also discovered that the level of trust of people who immigrated themselves decreases with increased duration of stay, which they traced back to a negative effect of experiences of discrimination by the police, among other aspects. Taking the future survey waves of the NaDiRa.panel into account, it will be possible to investigate the connection between experiences of (racist) discrimination and trust in the police in a more differentiated way and, taking into account respondents' self-identification, more extensively.

Overall, trust in the judicial system was somewhat more balanced. For example, the proportion of those who trusted in the judicial system among people who identified themselves as German with a migration background, as well as among non-racially labelled, Muslim and Asian people, was between 59% (German women with a migration background) and 63.2% (non-racially labelled men). In contrast, Black men (51.1%) and women (47.8%) showed a significantly lower level of trust in the judicial system. Overall, the data from the NaDiRa.panel confirmed the results found by Faus and Storks (2019) for society as a whole, namely that the institutions that are perceived as political (or here, particularly the group of politicians) are viewed with less trust than the police or the judicial system.

In summary, we can state that racially labelled people tend to have a higher level of trust in German institutions than non-racially labelled people. This is particularly true regarding trust in the Federal Government, the educational system and the healthcare system. Although this may appear to be a surprising finding at first glance, it is not new in the international state of research. For example, studies from the USA show that the disproportionately high level of trust in politics on the part of racially labelled people does not represent an exception: when minorities who are discriminated against perceive that certain structures for societal participation exist, their trust in politics can increase (see Wu, Wilkes & Wilson 2022).

Racially labelled groups tend to have a higher level of trust in Germany's institutions than non-racially labelled people. This is particularly true regarding trust in the Federal Government, the educational system and the healthcare system.

The fact that racially labelled people (in particular Muslim people and Black people) tend to show lower levels of trust than non-racially labelled people towards the police and the judicial system – in contrast to other areas of society – may be linked to indifferent and sometimes dismissive treatment by these institutions towards victims of racial violence as well as unsolved racist murders (see, for example, the handling of the NSU, and the police operation connected to the series of murders in

Hanau). These subjects are often topics of public discourse. This may have a negative impact on the trust of affected persons towards institutions (see Böttger, Lobermeier & Plachta 2014; Herrnkind 2022: 311). The fact that Black people in particular have comparatively low levels of trust with regard to the police corresponds to this group being affected by police violence particularly often and their processing this topic and placing it on the public agenda (see Baumgartner, Epp & Shoub 2018; Böttger, Lobermeier & Plachta 2014; Finkeldey, Dennison & Cui 2023; Herrnkind 2022; Hunold & Singelnstein 2022a; Nix et al. 2017; Thompson 2022; Voigt et al. 2017). International studies explicitly indicate that differences in trust between racially labelled and non-racially labelled people are also related to the differing experiences of discrimination and racism of affected persons (see Brunson 2007; Douds & Wu 2018; Flexon, Lurigio & Greenleaf 2009; Liebkind & Jasinskaja-Lahti 2000; Skogan 2006; Wilkes & Wu 2019).

Particularly for the area of the police, the data from the NaDiRa.panel allows for closer examination, as not only trust was asked about here, but also experiences of worse treatment during contact with the police. As described above, respondents were able to answer the question ‘How often have you been treated more unfairly or worse than others in the following situations? – During contact with the police?’ on a six-step scale. Figure 9 shows the trust of the different groups towards the police, differentiated according to the extent of the respondents’ own experiences of discrimination (‘never’, ‘rarely/sometimes’, ‘frequently/very frequently’).[36] It can be seen that people who have experienced discrimination in contact with the police show significantly lower levels of trust than those who have not experienced this situation. Non-racially labelled people who have never experienced discrimination by the police show a level of trust of 80.8%. With increasing experiences of discrimination, this figure also decreases for non-racially labelled respondents; in the case of rare experiences of discrimination to 46.1%. Only 14.8% of respondents who often experienced discrimination by the police reported trusting this institution.

In the Muslim group, 75.6% of those who had never been discriminated against in contact with the police stated that they trust them. This figure drops to 49% for infrequent experiences of discrimination and to 15.3% for frequent experiences. For Black people, for whom particularly low trust values for the police context were already exhibited in Figure 8, the proportion of those who have not yet experienced discrimination and trust the police is 63.4%, which is significantly lower than the results measured for the other groups. 52% of Black people who state that they have sometimes experienced discrimination by the police say that they tend to trust the police. Their results are therefore similar to those of the other groups. And, if only respondents who have often been discriminated against by the police are considered,

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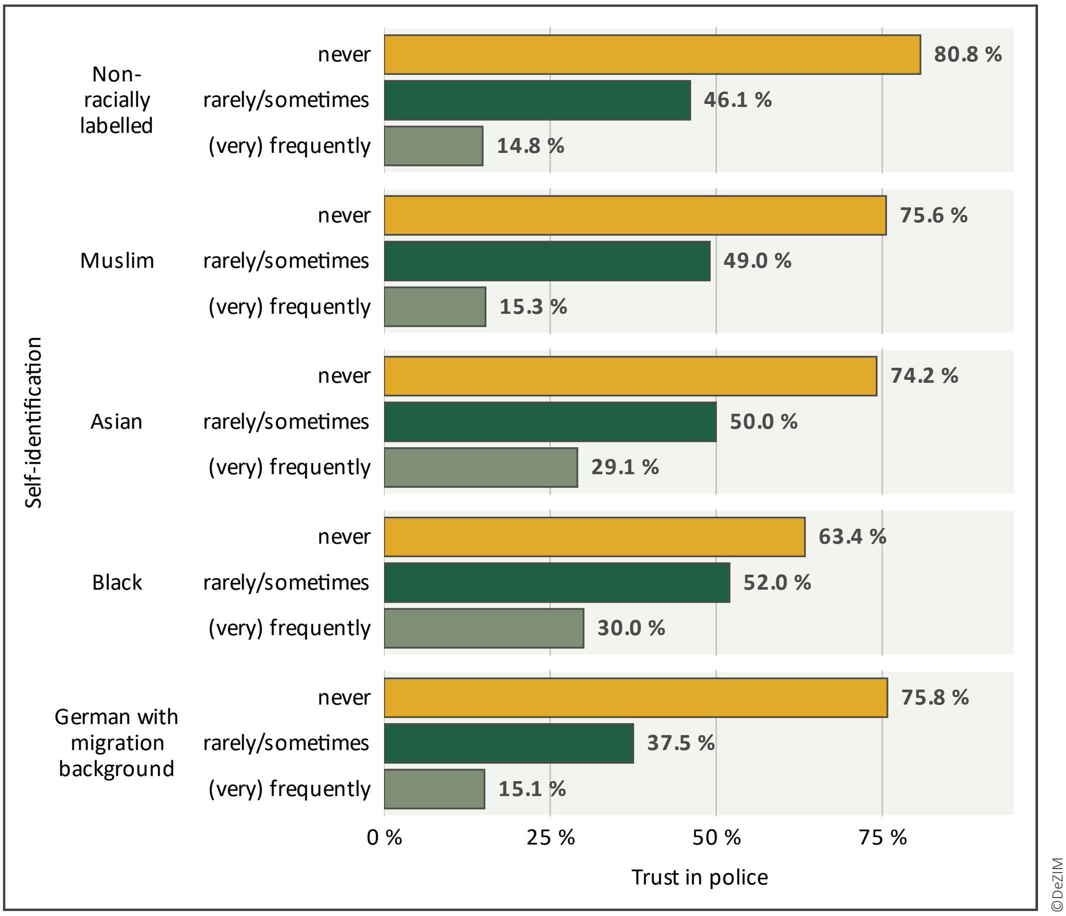
[36] It was not possible to differentiate by gender due to the low number of cases, which is why only figures for the respective overall group are reported here.

the result of 30% is even higher than for the group of Muslims and those not racially labelled, who have often experienced discrimination in contact with the police.

Figure 9. **Trust in the police, differentiated by self-identification and discrimination experienced by the police (proportions in per cent)**



Example: Among the Muslim respondents who had frequently or very frequently experienced discrimination by the police, 15.3% stated that they tended to trust the police. **Source:** NaDiRa.panel, wave 0 (weighted), own calculations. N = 8,567

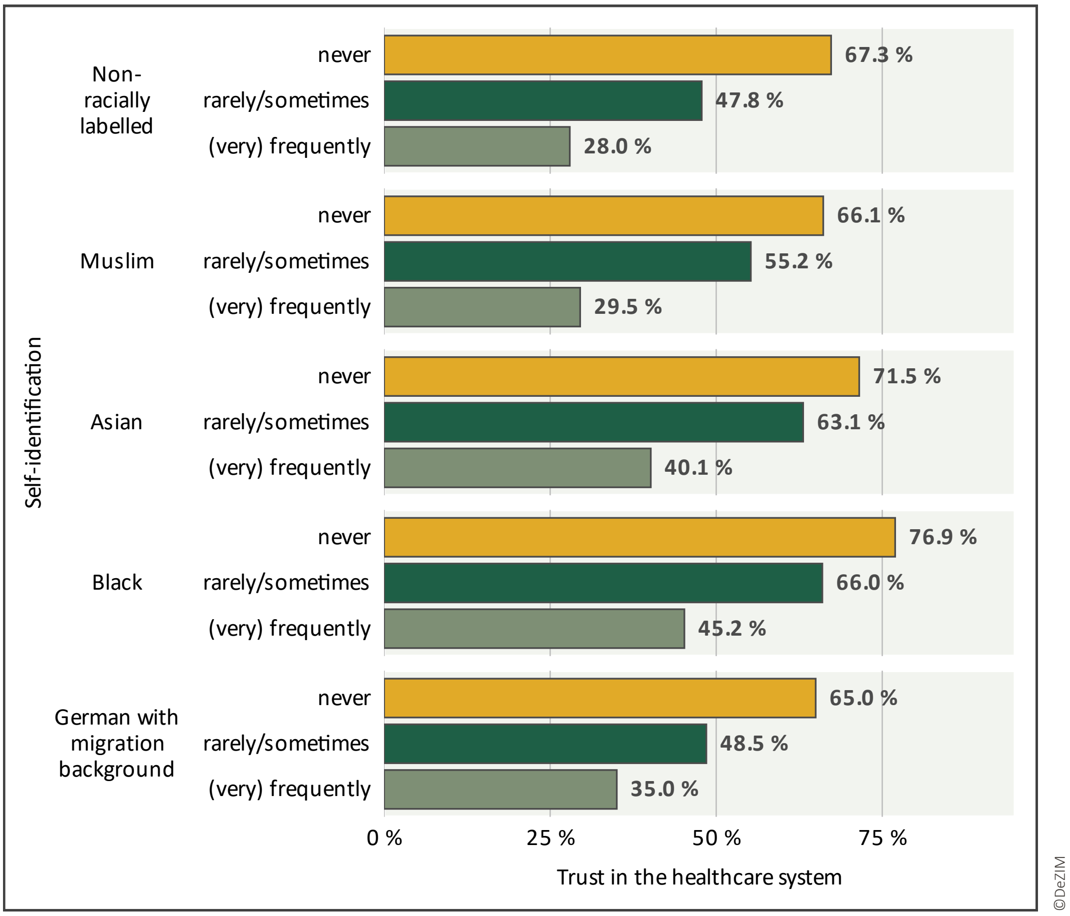
If we differentiate by frequency of experiences of discrimination, a similar pattern can be seen across all the groups considered: those who experience discrimination by the police more often have less trust in them. If there are no experiences of this type, only Black people are still noticeably more sceptical. Just as for Asian people, however, if discrimination is experienced frequently, trust in the police is higher than for the other groups. Overall, the data clearly shows that with regard to the police, there is a strong connection between trust in the institution and specific experiences of racism and discrimination.

Trust in the police is high overall; even racially labelled groups have a high general level of trust. However, experiences of racism and discrimination during contact with the police lead to decreasing levels of trust.

A similar analysis is possible for the field of healthcare, focused on in this report, since context-specific experiences of worse treatment were investigated here too. Figure 10 illustrates various groups' trust in the healthcare system as a function of the frequency of experiences of discrimination in this area. Here, it can be seen across all groups that those who have experienced worse treatment also show significantly lower levels of trust in this area. 66.1% of Muslims who had never experienced discrimination in healthcare stated that they tended to trust the healthcare system. Among those who experienced discrimination rarely or sometimes, the proportion was 55.2%, and among those who frequently experienced discrimination, it was only approximately 30%. This finding can be carried over to both the racially labelled groups and the non-racially labelled group: the more often a person experiences discrimination in the healthcare field, the lower their trust in the healthcare system.

However, it is still striking that, for the same frequency of experiences of discrimination, the racially labelled groups still showed higher levels of trust than the non-racially labelled group. For example, 45.2% of Black people who experienced racism still expressed a tendency to trust the healthcare system frequently or very frequently.

Figure 10. **Trust in the healthcare system, differentiated by self-identification and discrimination experienced in the healthcare field (proportions in per cent)**



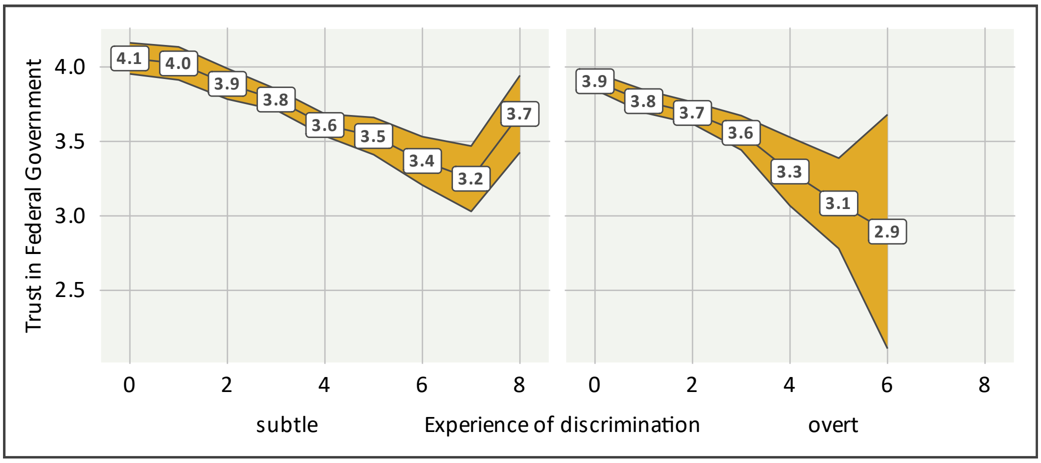
Example: Among Black people who experienced discrimination often or very often in the healthcare field, 45.2% stated that they tended to trust the healthcare system. **Source:** NaDiRa.panel, Wave 0 (weighted), own calculations.
N = 12,695

Groups that are vulnerable to racism enter the healthcare system with a high general level of trust and also have a higher level of resilience against poor experiences. Nevertheless, experiences of discrimination also compromise trust in this area.

The fact that specific experiences of degradation and exclusion within the healthcare field can reduce trust in the healthcare system as a whole is also mirrored by current international data. Experiences of racism – according to most studies – not only reflect negatively on satisfaction with healthcare and the general level of trust in it (see Glover, Sims & Winters 2017; Hamed et al. 2022; Rausch, Hotait & Beigang 2021), but also influence racially labelled people's future contact with the healthcare system (see van Houtven et al. 2005) and complicate cooperation between medical staff and patients (see Kandula et al. 2009).

The two fields analysed here – police and the healthcare system – indicate that context-specific experiences of worse treatment pose a risk to trust in societal institutions. Furthermore, it can be demonstrated that experiences of discrimination are also linked to trust in institutions, independent of context. This can be seen particularly clearly in the example of trust in the Federal Government and the judicial system. Figure 11 and Figure 12 show the average scores for trust in the relevant institution by frequency of experiences of discrimination. Here, we differentiate between overt and subtle forms of discrimination (see above). Respondents' age and level of education are also examined.

Figure 11. **Relationship between experiences of discrimination and racism (subtle, overt) and trust in the Federal Government (averages)**



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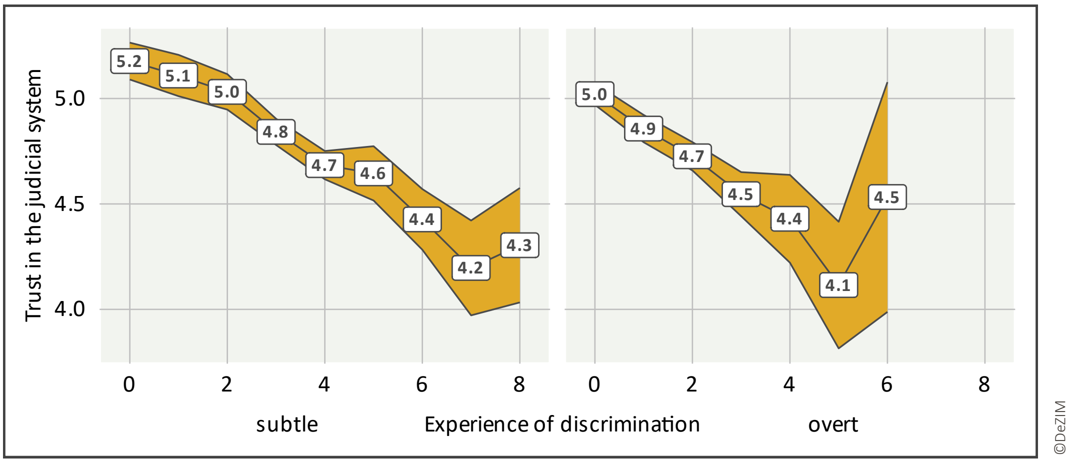
Example: ResponExample: Respondents who had a score of 6 on the scale for overt discrimination and therefore experienced discrimination frequently had an average trust in the Federal Government of 2.9 points. **Source:** NaDiRa. panel, Wave 0 (weighted), cluster robust standard errors, own calculations. Results controlled for age and education level. The yellow bands represent confidence intervals (95%). N = 15,645

Regarding both the Federal Government and the field of the judicial system, it can be seen that, for subtle experiences (e.g. 'Someone behaves as if they were not taking you seriously' and 'You are treated with less respect than others'), trust was somewhat higher than for experiences of overt discrimination (e.g. 'You are threatened/harassed' and 'You are physically attacked'). Experiences of subtle discrimination and racism therefore appear to have less of an effect on trust in the Federal Government and the judicial system than overt experiences. A clear correlation between the frequency of experiences of discrimination and trust in the Federal Government or in the judicial system can also be seen: the more frequently respondents experienced discrimination themselves, the lower their trust in the Federal Government or the judicial system.

Figure 12. **Relationship between experiences of discrimination and racism (subtle, overt) and trust in the judicial system (averages)**



Example: Individuals with a score of 8 on the subtle discrimination index, i.e. who experience subtle discrimination comparatively frequently, show an average score of 4.3 on the scale of trust in the judicial system. **Source:** NaDiRa.panel, Wave 0 (weighted), cluster robust standard errors, own calculations. Results controlled for age and education level. The yellow bands represent confidence intervals (95%). N = 15,567

Experiences of discrimination and racism are also relevant to trust in the Federal Government and the judicial system. As the frequency of experiences of overt and subtle discrimination increases, the overall level of trust in these institutions decreases.

The findings presented above indicate that experiences of racism and discrimination can damage societal trust in institutions. At the same time, the data from the NaDiRa.panel shows that, in principle, racially labelled people have a higher level of trust – except in the police and the judicial system – than non-racially labelled groups. The reduction of (racist) discrimination is therefore imperative to avoid jeopardising and potentially squandering the remarkable trust with which racially labelled people fundamentally view German institutions. As shown by previous studies, distrust in the government not only undermines compliance with social and political rules; in fact, it can promote societal confrontations and polarisation (see Hetherington & Rudolph 2008; Levi & Stoker 2000). A certain level of political trust is an important foundation for a stable democracy (see Zmerli 2016).

1.4 Conclusion

Based on the representative surveys of the NaDiRa.panel, this section of the report provides an initial overview of experiences of discrimination and racism in Germany, which will be further expanded on and differentiated in Section II. In conclusion, the following main results can be noted: general experiences of discrimination are widespread – 87.6% of the population report having had these experiences. Overall, the majority of respondents reported having been treated worse than others. However, a closer look shows that these experiences are by no means evenly distributed throughout the population. They vary with regard to socio-demographic categories as well as characteristics that are perceived by those affected as relevant to discrimination. In addition, there are differences regarding the social contexts in which discrimination is experienced. Overall, experiences of discrimination are accompanied by lower trust in institutions.

Experiences of discrimination vary by social group: When respondents' socio-demographic characteristics are taken into account, it can be seen that racially labelled people report experiencing discrimination far more frequently than non-racially labelled people. This applies both to the seven everyday experiences (subtle and overt discrimination) and to the institutional contexts which were examined. For example, almost all those in the racially labelled groups reported having experienced discrimination (Black people: 95.2%, Asian people: 88.9%, Muslim people 89.9%). For racially labelled groups, discrimination therefore does not constitute a marginal phenomenon. Racially labelled people in Germany experience unequal treatment and discrimination disproportionately often and to a greater extent than non-racially labelled people. Gender differences are also noticeable. For example, racially labelled women report such experiences somewhat less frequently than racially labelled men. Both overt and subtle discrimination are experienced most frequently by Black people. For example, one in two Black women reports having experienced threats or harassment (48.6%). 53.9% of Black men also reported these experiences. 36.6% of all Black men said that they were met with fear several times a year or even more frequently. This is four times more frequently than for non-racially labelled men (9.2%). One in five Black women (19.8%) reported that they are frequently met with fear. In the non-racially labelled group, however, only one in thirty women reported this (3.6%).

Experiences of discrimination are perceived according to various characteristics: Depending on their socio-demographic positioning, those affected perceived different characteristics as being decisive with regard to their experiences of discrimination. Here, examples are age, disability or chronic illness (ability), a lack of German language skills, migration status, name, religious affiliation or skin colour ('race'), sex (gender) or sexual identity, as well as class affiliation, income or unemployment (class). It is particularly informative to consider the contexts of experiences into which racially labelled people categorise their experiences of discrimination. Analysis shows that respondents mostly attribute these to characteristics that indicate racist discrimination. Racially labelled people therefore predominantly attribute their experiences of discrimination to racism and less to sexism and classism. While 68.2% of Black men reported their skin colour as the grounds for discrimination against them, for gender characteristics this value was only 5.8%, and for income only 20.3%. Among Muslim people, 53.8% reported their religion as key characteristics for their experiences against them, and 63.2% mentioned their country of origin, while the characteristics of gender and income were mentioned by 4.2% and 13.5%, respectively. 24.3% of Muslims mentioned their skin colour. For Asian men, their country of origin (57.5%), their knowledge of German (38.1%) and skin colour (31.8%) were also perceived significantly more frequently as relevant to their experiences of discrimination and racism than gender (3.6%) and income (10.5%). For racially labelled women, very similar patterns were seen. Although they mentioned their (assigned) gender as relevant to their experiences of discrimination significantly more frequently than racially labelled men did, they also named racist discrimination characteristics the most frequently by a clear margin. They therefore differed significantly from non-racially labelled women, who most frequently named gender, age and weight as relevant discrimination characteristics. These women attributed almost 58.3% of experiences of discrimination to their gender, 37.8% to their age and 19.2% to their weight. Language and religion were of very little relevance in this group. Age, weight and income are the most frequent discrimination characteristics for non-racially labelled men. 42.3% of non-racially labelled men reported their age as grounds for their discrimination, 18.8% their weight and 16.7% their income. Unemployment was only mentioned by 4.4%. These results clearly show that people perceive and categorise their unequal treatment extremely differently. Thus, the majority of racially labelled people emphasise precisely those characteristics which refer to their racial labelling. With this in mind, it is possible to see the relevance of racism for the perception of people's own day-to-day experiences.

Experiences of discrimination vary depending on social spaces: People experience (racist) discrimination in various social spaces. This can occur generally in 'public', for example in the street or on public transport or in 'leisure time', such as when visiting clubs and gyms. These experiences can also take place during 'contact with banks', 'contact with authorities', 'contact with the police' or 'in the healthcare field', i.e. in hospitals and when visiting doctors. The (racist) discrimination experienced is distributed differently across these observed areas of society depending on the groups. For Black people, reports of discrimination during contact with the police as well as in public and in leisure time dominate. One in two Black people report (racist) discrimination in public. Discrimination by the police is reported by almost half of Black men (41.3%), but a third of Black women also report this (34.2%). The majority of Asian men perceive discrimination in contact with authorities (39.1%), while for Asian women it mainly takes place in public (43.2%). Muslim people most frequently report (racist) discrimination during contact with authorities (51.3%). More than a third of Muslim men (38.8%) reported experiencing discrimination during contact with the police. For Muslim women, the scores were somewhat lower, but are also extremely high at 46.2% and 25.3%, respectively. With the exception of the healthcare field, the scores are higher for men than women across all groups. With regard to healthcare, Black women most frequently report worse treatment (38.6%). In the field of healthcare, experiences of discrimination related to characteristics such as age or weight also seem to be widespread. This is evident in the fact that non-racially labelled people also cite high levels of these experiences in comparison to other areas.

Lower trust in institutions is linked to increased experiences of discrimination and racism: In general, racially labelled people have a higher level of trust in institutions than non-racially labelled people. In all groups, men tend to trust institutions more than women. This applies to trust in the Federal Government, politicians, and the education and healthcare systems. Racially labelled groups view the healthcare system with a particularly high level of trust. Furthermore, these groups' feeling of trust towards healthcare is far more resilient regarding poor experiences than that of non-racially labelled people. For example, 76.9% of Black people who had never experienced discrimination in the healthcare field stated that they tended to trust this field. For those who reported having been discriminated against in the healthcare field often or even very often, this score is 45.2%. For non-racially labelled people, this difference is significantly larger. Therefore, even among those who had never experienced discrimination in the healthcare field, 67.3% reported tending to trust the field. In the case of discrimination being experienced often or very often, this score was as low as 28%. Only the police and the judicial system do not fall into this pattern. General trust in the police is high across all groups. However, here, it is non-racially labelled groups who show a higher level of trust. In general, the findings from the NaDiRa.panel show that perceived trust towards state institutions rapidly decreases across all groups with increased experiences of discrimination and racism. This applies to all areas.

II.

Focus: Racism and health

Healthcare is considered a fundamental human right and is an essential aspect of human existence and social participation. It encompasses an area where people are particularly vulnerable and, in many cases, dependent on help and aid networks. Accordingly, access to healthcare and its quality, as well as medical knowledge and medical practice can, in many cases, be a matter of life or death. At the same time, societal change and social conditions are reflected in healthcare and confront it with various challenges.

Below, the structural challenges of the healthcare system and the connection between racism and health will be discussed initially. After a brief historical summary of the relationship between racism and medicine, the framework of healthcare in Germany will be outlined. Finally, there will be an overview of the state of research regarding racism, health and healthcare. In the first chapter, data from the NaDiRa. panel regarding the relationship between experiences of discrimination or racism and respondents' health will be presented (Chapter II.1). Subsequently, quantitative and qualitative findings show the racist obstacles and exclusions that face racially labelled people when they would like to or need to make use of the healthcare services provided. The first step is a representative field experiment in which name-based discrimination during the allocation of appointments in medical practices was proven (Chapter II.2). This is followed by an examination of experiences of discrimination and racism in healthcare, based on data from the NaDiRa.panel (Chapter II.3). These representative data are supplemented by qualitative enhancements. Chapter II.4 discusses 'Community perspectives of racism in healthcare', and a final chapter discusses racism in medical training (Chapter II.5).

Structural challenges in the healthcare system in Germany

Although the German healthcare system is well-developed and well-equipped by international standards, and access to healthcare is largely safeguarded by law, there are structural problems that can have a negative effect on patient care and the healthcare sector as a whole. These shortcomings can be seen in various areas, but are often linked to economisation in the wider healthcare system (see Manzei & Schmiede 2014). For example, in hospitals, the 'significant financial pressure' […] leads to 'economisation of medical decisions with overprovision, underprovision and misprovision for patients, as well as increasing strain on hospital staff, according to the available empirical studies' (Marckmann 2021: 199). Beyond the context of hospitals – in outpatient care, for example (see Schnee 2014) – the dynamics of economisation and social and demographic change also have an impact. A central problem is the unequal (geographical) distribution of medical services. There is a shortage of medical staff (and the corresponding training opportunities), specialists, healthcare services, practices and hospitals (see Deutsches Ärzteblatt 2022a; van den Berg, Fleßa & Hoffmann 2022), above all but not only in rural areas and structurally weak areas (including in the states of former East Germany). The low density of medical facilities leads to longer waiting times for appointments and treatments and for healthcare that is no longer guaranteed – particularly by specialists such as in paediatric care (especially for chronically ill children, see Wissenschaftliche Dienste des Deutschen Bundestages 2022). Long journeys therefore make it especially difficult for people with limited mobility (e.g. older people or those with disabilities) to access healthcare and lead to social inequality (see Rind, Reime & Weidmann 2022).

A related problem is the general staffing shortage in nursing and to some extent in healthcare as a whole. In hospitals, nursing homes and outpatient facilities, there is a lack of qualified personnel to cover patients' needs (see Deutsches Ärzteblatt 2022b). Economic rationalisation, high pressure workplaces and overworked existing staff all have a negative effect on the quality of treatment or care and on patient safety. The high level of strain on employees may lead to a further shortage of specialists, for example due to changes of profession or staff burnout (see Deutsches Ärzteblatt 2022a; Hans-Böckler-Stiftung 2022).

Shortcomings in the provision of psychotherapy, further intensified by the COVID-19 crisis, are seen not least in longer waiting times (see Bundespsychotherapeutenkammer [Federal Chamber of Psychotherapists] [BPtK] 2021). The recommended maximum waiting time for an initial psychotherapeutic consultation is three weeks. In 2018, the Germany-wide average was 5.7 weeks (see BPtK 2018). In 2019, 'approximately 40% of patients waited at least three to nine months for treatment to commence when a previous psychotherapeutic consultation had established that they had a mental illness and therefore required treatment. This means that almost half of mentally ill people had an unacceptably long wait for necessary treatment' (BPtK 2021). This urgency was recently emphasised by a concept from the Federal Chamber of Psychotherapists, which targeted primarily the reduction of waiting times for psychotherapy in rural and structurally weak areas and within the care of children and young people (see BPtK 2023). The interministerial workgroup 'Health-related effects of COVID-19 on children and young people' also intensively addressed the reduction of waiting times for psychotherapy services and developed proposed solutions (see Interministerielle Arbeitsgruppe [Interministerial working group] 2023).

Racism, health and society

However, health is only taken into account to a limited extent with regard to preventing and promoting health in various fields of society and politics. Above all, the connection between structural living conditions and the population's individual resources is only marginally addressed in this context. Thus, various basic social inequalities with regard to health-related opportunities remain unnoticed (see Gerlinger 2022). The structural problems and racist relationships presented as examples can promote each other.

Even beyond the consequences of economisation and beyond hospital contexts, existing difficulties and problems can reinforce and be reinforced by racist discrimination. It is therefore important to understand the effects and dynamics of racism on the German healthcare system as well as healthcare for those affected, beyond the general challenges. The COVID-19 crisis made clear that social conditions that also play a role in the context of racism are reflected by the distribution of resources and the corresponding debates regarding health and healthcare. Racism creates and reinforces health-related inequalities in our society (see Phelan & Link 2015; Williams, Lawrence & Davis 2019).

Experiences of racism and the associated socio-economic conditions can be the cause of and trigger for states of illness. People who are affected by racism are therefore at greater risk of health burdens and illnesses (see for example Brondolo et al. 2009; Brunnett 2016; Williams & Mohammed 2009). This is particularly dramatic in a context where racist societal circumstances can additionally contribute to healthcare for certain groups of the population not being ‘appropriate, adequate, accessible, affordable and acceptable’ – as stipulated by the UN International Covenant on Economic, Social and Cultural Rights (Wendeborn 2021). This means that racist societal circumstances can restrict healthcare for certain groups of the population. Language, residency status and racist exclusions, such as those due to name or appearance, for example, influence access to the structures and resources of the healthcare system. This differing access to symbolic and material resources can therefore be viewed as a consequence and indicator of societal and thereby also racist circumstances. Progressive economisation and associated structural conditions can lead to an increase in discrimination and racism and can be reinforced by them (see Schödwell et al. 2022). Inequalities in health burdens and healthcare additionally lead to a decrease in perceived sense of belonging and decreased trust in societal institutions (see Schiefer & van der Noll 2017).

Until now, health-related inequalities have been recorded in the context of racism via the categories of ‘migration background’ and ‘citizenship’. The Robert Koch Institute (RKI) indicates in its current health monitoring report that these categories are insufficient for recording health-related inequalities and the varied experiences of racially labelled people in the healthcare system (see Kajikhina et al. 2023). Furthermore, the RKI suggests taking an intersectional perspective as a basis. These two gaps will be addressed by this monitoring report.

Racism and medicine: Historical continuities

Medical and biological knowledge, as well as the corresponding practice, served as a basis for and legitimisation of racist colonial and Nazi policies of oppression and eradication (see for example Bauche 2017; Eckart 1997; Jütte et al. 2011; Weindling 1989). Medical historical research shows how racist ideologies stretched into the medical science of deciding which lives were worth living and which were not. Since the middle of the 19th century, eugenics dealt with the question of selective genetic systems, a bustling transatlantic enterprise, as evidenced by the international eugenics conferences between 1912 and 1932. These conferences dealt with creating 'the perfect human race' and made a science of the racist ideology of human 'races' (see Kühl 2014; Mitchell & Snyder 2003). These knowledge archives continue to have an effect on the categorisation and racialisation of people even today (see Nguyen & Puhlmann 2023: 171).

Since the eighteenth century, the (life) sciences, and medicine with them, contributed to establishing and legitimising racist conditions in society by systematically relaying racist knowledge bases and practices, for example via 'race anthropology' or 'racial theory'. These conditions also reinforced the professionalization and expansion of these fields, for example by granting medical knowledge with particular political relevance (see Bauche 2017; Foucault 2020; Plümecke 2014: 69–71). With its direct connection to people and its scientific practical applications, medical knowledge therefore was and is directly involved in defining body standards.[37] Decidedly racist discourse (including regarding the body), which was significantly based on medical science and life sciences, among other aspects, was therefore able to lead all the more invisibly to the current concepts and normative models (e.g. male patients or light skin tones as a standard), which are used today in various areas of the healthcare system. The medical field thus played a role in 'dissolving the constitutive entanglement of biological and social dimensions via the assertion of a natural difference on the biological side' (Plümecke 2014: 20). The use of the term 'race'[38] – still common today as a biological concept in (international) medical science, but sometimes also in medical training in German (see the Chapter II.5) – is a clear example of this (see Malinowska & Żuradzki 2023). Therefore, a current challenge is to monitor the continuities and the resurgence of racist biological categorizations and essentializations of the human body in present and future developments in the fields of human genetics and technology (see Nguyen & Puhlmann 2023: 171).

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[37] See also FN 7 regarding norms.

[38] Human 'races' in the biological sense do not exist. Science has long since discredited the biologistic concept of 'race'. As a rule, the term is no longer used in Germany, in a departure from the 'racial doctrine' that culminated in the Nazis' 'Nuremberg Race Laws', and is now totally taboo. Nevertheless, the word continues to be used as a legal term in the context of non-discrimination principles, such as in as Article 3(3) of the German Basic Law. In the English-speaking world, there is a tradition of attempting to recast the term 'race' beyond biological concepts. In these contexts, 'race' is seen as indispensable for analysing racist systems of oppression and emancipatory movements. 'Race' and, in particular, racial consciousness, i.e. the process in which people become politically aware of their racialisation and discrimination, can therefore become the basis for practising resistance against racism. See also FN 6 on this.

Framework of healthcare

The areas of the healthcare system[39] are varied and not limited to medicine: they range from political requirements and legislation to the insurance system and public healthcare services to NGOs and counselling facilities. Overall, these areas can be structured within a triangular relationship: *service beneficiaries* (population or patients), *service providers* (e.g. counseling centers, hospitals and doctors) and *service funders* (e.g. the state and health insurance companies). All three facets are considered in various places in the NaDiRa studies, the results of which are presented in this report, although the direct service contexts of medical practices and hospitals are the focus. As health and illness depend on a variety of social and biological factors, the NaDiRa not only examines contexts in the public healthcare system, but also the direct and indirect effects of racism on the health of those affected themselves.

The field of healthcare is influenced by social and even existential dependent relationships, asymmetries of power (e.g. the doctor-patient relationship) and particular vulnerability of service beneficiaries (patients). Particularly in connection with racist discrimination, the aspect of vulnerability is important as racially labelled patients are often doubly vulnerable: potentially affected by racism *and* reliant on adequate care. In some cases, the latter can be a matter of life or death, while it is sometimes a limited resource and must often take place under great time pressure and a high workload on healthcare professionals.

Internationally, inequalities regarding health and healthcare have been being observed for decades in the context of institutional racism (see Jones 2000). In Germany, more in-depth discussions of institutional racism to date have been principally located in the field of educational institutions (e.g. Gomolla & Radtke 2009; Heinemann & Mecheril 2016; Karakayalı & Heller 2022). International public health research provides various models for analysing (institutionalised) racist inequalities in the healthcare system and with regard to health indicators, although mostly with an emphasis on the intertwining of various levels (regarding institutional racism, see also info box Levels of analysis in racism). Thus, for example, Nazroo, Bhui and Rhodes (2020) arrange the levels into structural, institutional and interpersonal racism, while the approach of C. P. Jones (2000) emphasises the connection between interpersonal, institutional and internalised racism. The NaDiRa analyses take all these levels and their intertwining into account in various places in order to examine the mechanisms of the reproduction, legitimisation and perpetuation of racism in healthcare as well as the extent of the connection between experiences of racism and health.

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[39] Here, 'healthcare system' refers to an overarching political field of action that relates to issues of care quality and equity, efficiency, demand planning, training management or innovation development (see BMG 2023). 'Healthcare', on the other hand, refers here to the direct (mostly practical day-to-day,) contexts of healthcare resulting from this, such as healthcare facilities, products and services (e.g. hospitals, medical technology or medical treatments).

State of research: Racism, health and healthcare

The German National Monitoring of Discrimination and Racism examines areas of healthcare on the one hand and, on the other, the direct effects of discrimination and racism on the health of those affected and the resulting group-based inequalities. *Health and healthcare* are also closely linked in society. Here, health in an individualised and pluralistic society is not necessarily based on a universal concept. Research differentiates between the dimensions of ‘objectivity’ (scientific medical approach), ‘subjectivity’ (individual perceptions) and ‘relationality’ (social or biological contextualisation), for example (see Lenk 2011: 68–70). The NaDiRa studies refer to all these aspects in various places and link them to various living conditions and societal conditions. In contrast to health, healthcare refers to concrete contexts such as healthcare facilities, products and services. Together, they only represent an (institutionalised) section of social analysis of health and illness. With this in mind, healthcare constitutes its own scientific research topic. For this reason, it is necessary to differentiate between health and access to and quality of healthcare. The following short outline of the current state of research reflects this distinction.

Racism and health

There are already a series of studies regarding the question of the relationship between racism and health. International papers, which mostly come from the English-speaking world, prove that racism decreases the average life expectancy of those affected, as it can damage both psychological and physical well-being and facilitates unhealthy behaviour patterns, such as smoking and substance abuse (see Arora, Coker & Gillam 2001; Cassidy et al. 2004; Gee et al. 2009; Gee et al. 2006; Nestel 2012; Priest & Williams 2018; Williams, Lawrence & Davis 2019; Gibbons et al. 2010; Hurd et al. 2014). Furthermore, studies indicate that experiences of racism are accompanied by an increased risk of heart disease, high blood pressure and diabetes (see Brondolo et al. 2011; Cuffee, Hargraves & Allison 2012; Dolezsar et al. 2014; Krieger 2014; Wyatt et al. 2003).

In order to portray how racism leads to health inequalities in societies, a distinction between direct and indirect mechanisms has become established in research. Initially, racism has a direct effect on the health of those affected, as racist unequal treatment directly precipitates onto racially labelled people and groups. Those affected internalise racist values and prejudices, which can have serious consequences on their feelings of self-worth and on their mental health (see David, Schroeder & Fernandez 2019; Gale et al. 2020; James 2021; Lazaridou et al. 2022). A further explanatory approach concerns the consequences of increased perceived stress on those affected (see Meyer, I. H. 2003). Long-term exposure to external stress factors (here: experiences of racism) therefore not only leads to feelings of sadness, helplessness and the fear of having to overcome these feelings (see Wilson & Gentzler 2021; Winters 2021); repeated experiences of racism can also trigger hyperactivity of the cardiovascular system (see Geronimus 1992; Geronimus et al. 1996; McEwen & Seeman 1999), which fosters the development of psychological disorders (see Lei et al. 2022). According to approaches based in stress theory, racism therefore represents a decisive risk factor for the occurrence of symptoms of depression (see Madubuko 2011; Schunck, Reiss & Razum 2015), symptoms of anxiety (see Cuevas et al. 2021) and psychosocial stress (feelings of sadness and helplessness) (see Kaholokula et al. 2017).

However, racism not only directly affects the health of those affected as an experience, but also adversely affects them indirectly. Racism is closely linked to the generation and reproduction of socio-economic inequalities that significantly determine the extent of health-related inequalities in society (see Link & Phelan 1995). In other words, racism has the effect of pivotal living conditions and the associated health-related opportunities being based on unequal resource distribution in society. This includes the availability of healthy food, the opportunity to lead a healthy lifestyle, knowledge regarding health, reasonable working and living conditions or access to healthcare, for example (see Ituen & Hey 2021; Morello-Frosch & Lopez 2006; White & Borrell 2011; see also Chapter II.3).

In comparison to research in the USA, the United Kingdom, Australia and New Zealand, world there is still a significant lack of research into racism and health in the German-speaking. This may be due not least to the fact that racism as a term was avoided in research for a long time and has only recently been recognised as an issue for analysis in scientific studies. In Germany, the state of research on the topic area of racism and health exhibits several problems. While there are certainly studies dealing with the living situations of migrants in Germany within health-related migration research, forms of racist discrimination and marginalisation are only used as an aside as explanatory variables, and the research focuses instead on the particular situation of immigrants (see Spallek & Razum 2016). This viewpoint, which is closely linked to the migration process, runs the risk of treating the identified differences too much along the lines of a ‘cultural’ interpretation: health-related differences are therefore principally attributed to ‘cultural’ differences and the associated specific lifestyles and mentalities (see Yeboah 2017). This explanatory approach promotes racist categorisations and threatens to mask existing structures rather than problematising them as factors that are hazardous to health (see Velho 2010). There are now some quantitively oriented papers that attempt to analyse the effects of (racist) discrimination on (subjective) health using the data from the Socio-Economic Panel (SOEP) (see Beigang et al. 2017; Igel, Brähler & Grande 2010).

However, they remain limited, since discrimination and health are both surveyed one-dimensionally, and above all because membership of racially labelled groups cannot be measured adequately via the categories used, namely migration background or the even more vague proxy of (non-German) citizenship (see Bartig et al. 2023).

Although viewpoints regarding the health-related effects of racism have gained importance (see Kluge et al. 2020), there are currently no papers that approach the correlation between racism and health systematically. However, the few existing studies indicate that the findings from the English-speaking world may also be partially reproducible here (e.g., regarding the increased COVID-19 exposure of racially labelled groups; see Kajikhina et al. 2023).

Racism and healthcare

In general, research shows that various institutional structures can have a significant influence on social inequalities in the healthcare system (see Kringos et al. 2013). Inequalities in the population created by racism in healthcare may be expressed in differing access, different usage of health-related measures and facilities, and differing treatment quality (see Elias & Paradies 2021; Jones 2000; Wendeborn 2021). Here, a review carried out in 2022 shows that US research on racism in healthcare is predominant (see Hamed et al. 2022). Anglo-American studies show that racism occurs in various healthcare sectors and is encountered in interactions between various parties (e.g. patients, doctors, nursing staff) (see Bastos, Harnois & Paradies 2018; Mahabir et al. 2021; Mateo & Williams 2021). The majority of these studies reach the conclusion that discrimination in the healthcare system not only contributes to maintaining and reinforcing health-related inequalities (see van Ryn et al. 2011), but also has a long-term influence on how those affected use healthcare services, the level of trust with which they view the healthcare system as a whole, and the patterns in which they interact with healthcare (see Adegbembo, Tomar & Logan 2006; Hall et al. 2015; Maina et al. 2018; van Ryn et al. 2011; Ben et al. 2017; Paradies, Truong & Priest 2014; van Houtven et al. 2005; Williams & Mohammed 2009).

In Europe, and particularly in Germany, there is a fundamental need for research in this regard (see Hamed et al. 2022). The few studies from other European countries, mainly from the United Kingdom and Sweden, show that racism in the healthcare system also represents a problem in these countries (see Hamed et al. 2020, also with regard to Germany; Cortis 2000; Hamed et al. 2022; Kang, C., Tomkow & Farrington 2019). Criticism is also expressed in the review mentioned above: ‘research on racism in the healthcare system is mainly descriptive, atheoretical, uses racial categories uncritically and tends to ignore racialisation processes, making it difficult to conceptualise racism.’ (Hamed et al. 2022)

On the one hand, the findings and connecting lines mentioned above are transferable to the German context to a certain extent (see also Terkessidis 2004 regarding racialisation processes, Bauche 2017 regarding historical (post-)colonial knowledge bases, Gerlach et al. 2008 regarding racist treatment standards), while on the other hand the existing particularities (e.g. regarding institutional healthcare, racially labelled groups or legal and historical references) are largely unresearched. International studies can therefore serve above all as starting points for research questions that approach the relevant idiosyncrasies of the phenomena in Germany empirically and provide evidence.

Isolated research approaches that evolved in recent years indicate a lack of analysis of racism and discrimination in mental healthcare and psychotherapy practice (see Kluge et al. 2020; Sequeira 2015; Velho 2011; Yeboah 2017). Studies that have collected qualitative data regarding Black patients' experiences of racism, patients with 'migration backgrounds', and the perspective of 'white GPs' regarding treatment of these groups of patients provide snapshots of the topic area of racism in healthcare (see Gerlach & Abholz 2009; Gerlach et al. 2012; Gerlach, Becker & Abholz 2008; Gerlach et al. 2008). Those surveyed report a lack of respect and that they are not recognised or accepted as fully adequate dialogue partners but are perceived as 'others' (see Gerlach et al. 2012; Gerlach, Becker & Abholz 2008). On the other hand, for medical staff, contradictory behaviour, degradation, and an expressed sensation of distance with regard to patients (see Gerlach et al. 2008) were observed, as well as ascriptions of collective characteristics (e.g. pain tolerance). These ascriptions may be accompanied by misdiagnoses or delays to treatment (see Aikins et al. 2021; Gerlach, Becker & Abholz 2008; Hamed et al. 2020). Furthermore, the Afrozensus offers an initial survey of anti-Black racism in the healthcare system from the viewpoint of members of the community – namely with regard to the experiences of Black patients and Black healthcare staff (see Aikins et al. 2021).

Other studies focus on discriminatory structural conditions in healthcare to asylum seekers. For example, there are analyses of restrictions to healthcare services due to the Asylum Seekers' Benefits Act (AsylbLG), without explicitly naming racism (see Gottlieb & Schülle 2021). Further analyses conceptualise these restrictions as systematic marginalisation and social exclusion (othering) (see Bozorgmehr & Razum 2015).

Initial findings regarding how economic and organisational structures (e.g. a lack of time and staff shortages) contribute to the reproduction and maintenance of racism in the healthcare sector are provided by a current publication by Schödwell et al. (2022). It points out that 'the economic framework of hospital care, in particular the DRG system, and the lack of cost coverage of language mediation […] (can) reinforce existing structures of discrimination and racism'[40] (ibid.).

As only scarce data is available, the state of quantitative research regarding racism in the healthcare system is sparse. However, isolated studies indicate that there are certainly care inequalities between racially labelled and non-racially labelled people and groups. A study published during the COVID-19 pandemic used official death statistics to show that the probability of dying from a COVID-19 infection was higher for foreigners

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[40] DRG stands for Diagnosis Related Groups and is described by the authors as follows: 'The DRG system is a flat-rate billing system based on diagnosis-related case groups for inpatient hospital treatments'. (Schödwell et al. 2022)

than for people with German citizenship (see Plümecke, Supik & Will 2021). Information is also provided by research on refugees, according to which refugees not only show a high prevalence of symptoms of depression and anxiety, but at the same time make significantly less use of primary healthcare services and GP services (see Biddle et al. 2021). Investigations of the healthcare situation of migrants with health insurance also show that people with a migration background make less use of medical services, although the results vary according to the healthcare areas examined and the migrant subpopulations selected (see Klein & Knesebeck 2018).

The fact that experiences of discrimination in the healthcare system do not represent an exception is documented by initial surveys of those affected (see Beigang et al. 2017), as well as by consultation requests with anti-discrimination authorities in Germany. According to evaluation of the consultancy cases, insults, unfairness, and refusal to provide treatment due to insufficient language skills are among the most frequent examples of discrimination (see Antidiskriminierungsstelle des Bundes [Federal Anti-Discrimination Agency] 2017, 2020). Further studies suggest that experiences of discrimination within medical services are widespread, and come to the conclusion that origin-based experiences of racism restrict willingness to make use of healthcare services and also restrict access to care (see Bermejo et al. 2012; Brzoska et al. 2010; Schwarz et al. 2012).

In summary, it can be stated that there has not yet been systematic research on the extent to which racist knowledge, for example in the form of bias, prejudices and stereotypes, manifests itself in healthcare staff and influences day-to-day actions in healthcare. There is also a lack of studies that consider experiences of racism from the point of view of those affected – taking various forms of racism (e.g. racism against Sinti and Roma, Black, Muslim, Slavic, and Asian people) into account – in the individual healthcare areas of the healthcare system. Overall, there is a need for systematic research regarding the extent to which (institutional) racism obstructs equal access to the healthcare system and adequate healthcare.

1.

Racism, discrimination and health:

Initial empirical findings from the NaDiRa.panel

1.1 Research design: Method and concepts

Initial results from the NaDiRa.panel are presented below to visualise the consequences that experiences of discrimination may have on the health of individuals affected for Germany. As already illustrated by the Robert Koch Institute (see Hövener & Wieler 2023), there is a lack of comprehensive intersectional investigations into health and health-related inequalities in Germany, particularly ones taking racially labelled people into account. For this reason, an initial systematic overview of the state of health of racially labelled and non-racially labelled people is presented here, with the aid of Wave 0 of the NaDiRa.panel (for more on the term 'racially labelled', see info box Terminology and language; for more on classification in the survey, see the chapter Research approach and methodology). Here, a subjective measurement of respondents' own state of health and an established scale for recording symptoms of depression was used. The question of self-assessment of respondents' health (self-related health) has proven to be a good indicator of objective health (see Palladino et al. 2016; Wuorela et al. 2020) and is used in most large health studies as a standard (see Wachtler, Hoebel & Lampert 2019; Moor et al. 2018). Thus, the respondents in the NaDiRa.panel were also asked to assess their **state of health:**

- Respondents were asked to estimate their **state of health** on a five-tier scale that ranged from 'very good' and 'good' to 'average', 'poor' and 'very poor'. This results in scores on the health scale from 0–4, where higher scores signified better health.
- Data on **mental health** was also collected using the established PHQ-4 scale (see Kroenke et al. 2009). This consists of four individual question items, whereby two items record anxiety symptoms (frequency of 'nervousness, anxiousness or stress' and 'not being able to stop or control worrying') and two items record symptoms of depression (frequency of 'low level of interest or enjoyment in activities' and 'low spirits, melancholy or hopelessness') during the previous two weeks. The frequency was also recorded on a five-tier scale with possible answers of 'daily', 'almost every day', 'more than half of the days', 'some days' and 'not at all'. The measurements were processed in a way[41] that made the overall scale for all four items a range from 0 to 12, where increasing scores signified a higher level of symptoms of anxiety and depression.
- **Experiences of discrimination and racism** were recorded using seven different questions describing situations, which were already introduced in Chapter I.1. Here, respondents were asked to state how frequently they experienced the following things in their day-to-day lives:

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[41] The two response categories 'daily' and 'almost every day' were combined into one category.

- ‘You receive worse service than others’
- ‘You are treated with less respect than others’
- ‘Someone behaves as if they were not taking you seriously’
- ‘Someone behaves as if they were afraid of you’
- ‘You are threatened/harassed’
- ‘You are abused/insulted’
- ‘You are physically attacked’

The combined answer categories were: ‘never’, ‘sometimes’ (more rarely/several times a year) and ‘often’ (at least once a month, at least once a week/daily). The relevant answers were brought together for the following analyses, such that they were equivalent to a scale which ranged from 0 to 14. For example, if a respondent answered all seven questions with ‘sometimes’, they were given a score of 7. However, if the respondent answered all questions with ‘often’, they were given the score of 14. Someone who ‘often’ received worse service, for example, was ‘rarely’ met with fear and otherwise did not have any of the experiences listed above would be given a score of 3. A higher score on the scale therefore not only signifies that the person experiences different types of discrimination but also that they have these experiences more frequently.[42] As the statements regarding day-to-day experiences of racism were formulated in an open manner, they can be understood as referring to various forms of discrimination and racism. This investigation therefore not only targets the measurement of racially labelled people’s experiences of discrimination, but also the measurement of gender-based forms of discrimination, for example.

1.2 Self-assessed health

In the initial step, differences in self-assessed health and its connection to experiences of discrimination and racism were examined. Figure 13 provides an overview of the average state of health in the various groups, which were differentiated by self-identification and respondents’ gender. A comparison between non-racially labelled people and those that categorised themselves as belonging to a racially labelled group or described themselves as German with a migration background does not show any statistically significant differences (for more on the use of the concepts of ‘self-identification’ and ‘migration background’, see the chapter Research approach and methodology). Concretely, the average values for all groups were close to 3 points.

Substantively, this means that, on average, all groups assess their general state of health as good. It should be noted here that these are gross scores, i.e. the results refer to group differences without taking further characteristics such as age into account.

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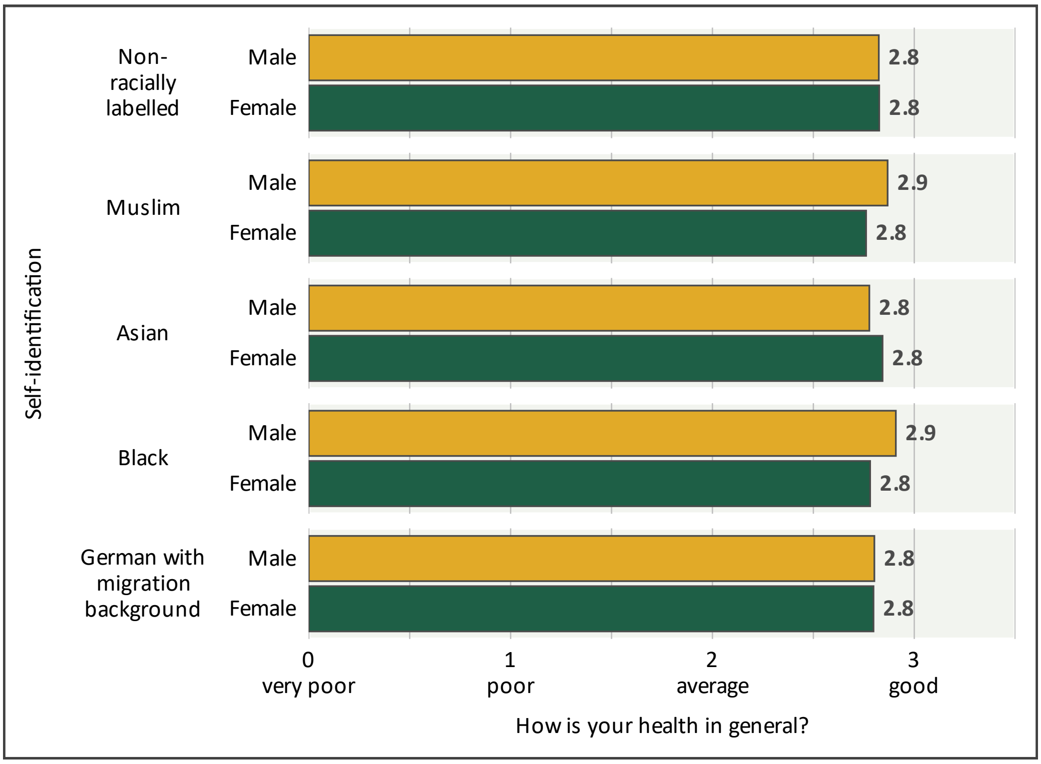
[42] A factor analysis showed that all seven items load on one factor (intrinsic value: 3.05).

Figure 13. **Self-assessed health (0–4), differentiated by self-identification and gender (averages)**



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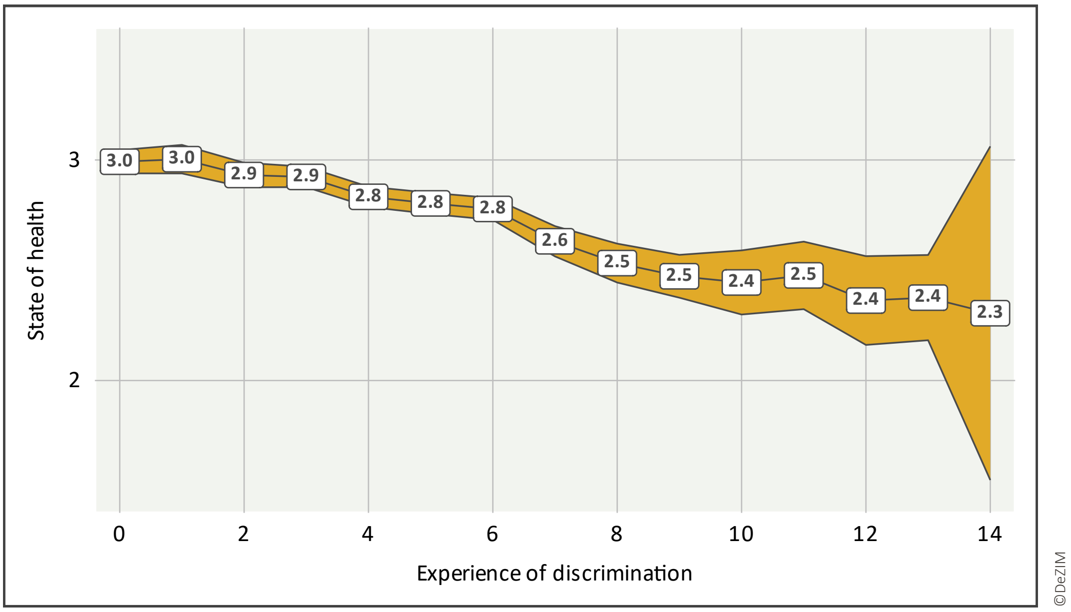
Example: Muslim men give an average score of 2.9 on the self-assessment health scale. **Source:** NaDiRa.panel, Wave 0 (weighted), own calculations. N = 15,721

When assessing respondents' state of health, no differences between groups or genders were shown.

Is it possible to conclude from the result of no differences across groups in general state of health that experiences of discrimination and racism do not have an effect on health? In order to answer this question, the correlation between experiences of discrimination and racism and the general state of health will be considered in the next step. In general, an almost linear relationship can be observed when controlling for age and educational level (Figure 14): with increasing experience of discrimination and racism, the respondents assessed their own health to be worse. For people who reported often being affected by (racist) discrimination in all day-to-day situations enquired about, their self-assessment decreased by almost one point (0.7). These scores reflect a decline from a good state of health when experiencing discrimination and racism rarely or not at all compared to a person who experiences racism and discrimination regularly. This connection can be seen independently of self-identification and gender. This means that all groups surveyed assessed their general state of health as worse the more often they were exposed to situations that they perceived to be discriminatory or racist.

Figure 14. **Relationship between experiences of discrimination and racism and general state of health (averages)**



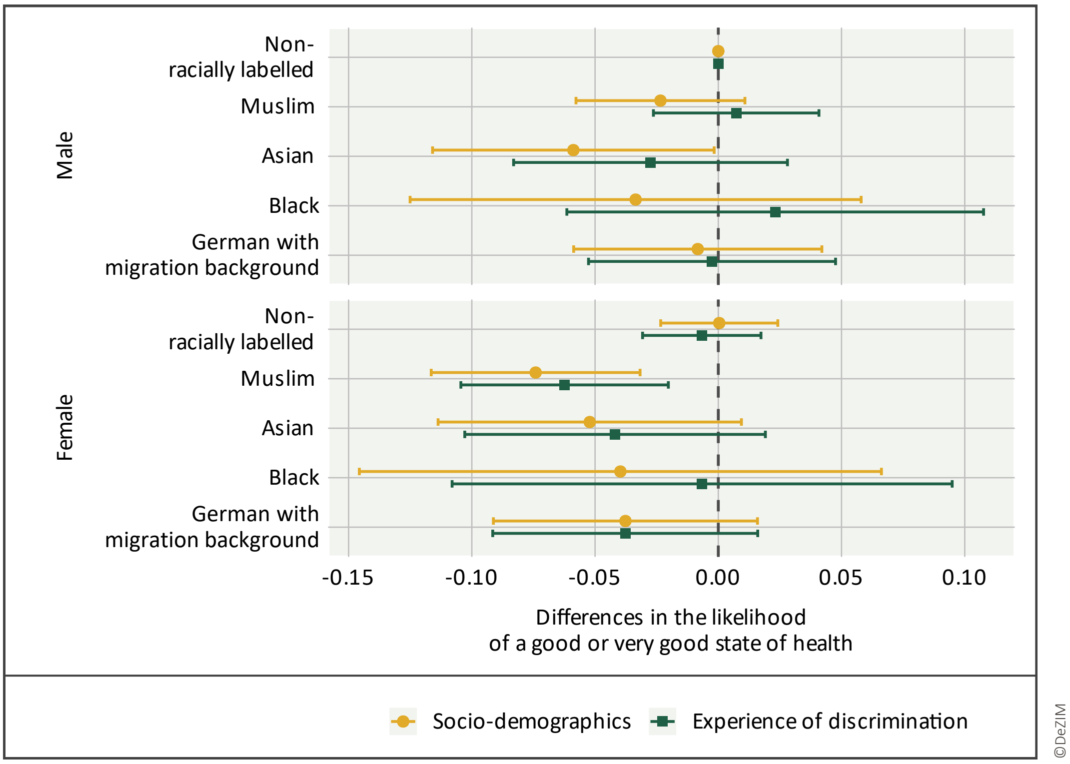
Example: For respondents who scored a 12 on the discrimination index, i.e. who state that they experience discrimination frequently, the average self-assessed state of health is 2.4. **Source:** NaDiRa.panel, Wave 0 (weighted), cluster robust standard errors, own calculations. Results controlled for age and education level. The yellow band represents confidence intervals (95%). N = 15,459

With increasing experience of discrimination and racism, respondents assessed their general state of health as worse.

As a final consideration, the self-assessment of the state of health was converted in a way that made it possible to differentiate between people with good or very good health and those with average, poor or very poor health. Figure 15 therefore shows the likelihood of respondents having good or very good health and also differentiates them according to self-identification and gender. The figure encompasses two analysis models: in the first model, respondents' age and level of education is considered (model: social demographics / yellow dots). The second model also includes experiences of discrimination and racism (model: experiences of discrimination / green dots). In both models, non-racially labelled men form the reference group and are represented by the vertical line at 0.

If differences due to age and level of education are included in the calculations, all groups (with the exception of non-racially labelled women) tend to show a lower likelihood of having good or very good health in comparison to non-racially labelled men. However, this difference is only statistically significant for Asian men, with 6 percentage points, and Muslim women with 7 percentage points. This means that – similarly to the results in Figure 13 – there are no disadvantages for most groups when compared with non-racially labelled men.

Figure 15. Differences in the likelihood of a good or very good state of health broken down by self-identification and gender (in percentage points)



Example: Taking socio-demographic variables into account, Muslim women are 7 percentage points less likely to describe their health as good or very good than men who are not racially labelled. **Source:** NaDiRa.panel, Wave 0 (weighted), cluster robust standard errors, own calculations. The results of the logistic regression are presented as average marginal effects and were corrected using the KHB method. Results controlled for age and education level. The horizontal lines are confidence intervals (95%). N = 15,459

When experiences of discrimination and racism are included in the model, the likelihood of good or very good health increased – this applies especially to racially labelled people. For Asian men, this is even true to the extent that the difference from the reference group is no longer statistically significant. In other words: if there were no differences in the frequency of experiences of discrimination between racially labelled and non-racially labelled people, then some racially labelled groups would even have a better state of health than non-racially labelled groups, although the differences would only be small. Only Muslim women seem to still have a disadvantage of 6 percentage points compared with non-racially labelled men when social demographics and experiences of discrimination and racism are controlled for. If Muslim women are compared with Muslim men, their probability of assessing their state of health as good or very good is still 7 percentage points lower.

In comparison to non-racially labelled men, Muslim women less frequently assess their state of health as being good or very good, when age and experiences of discrimination are taken into account.

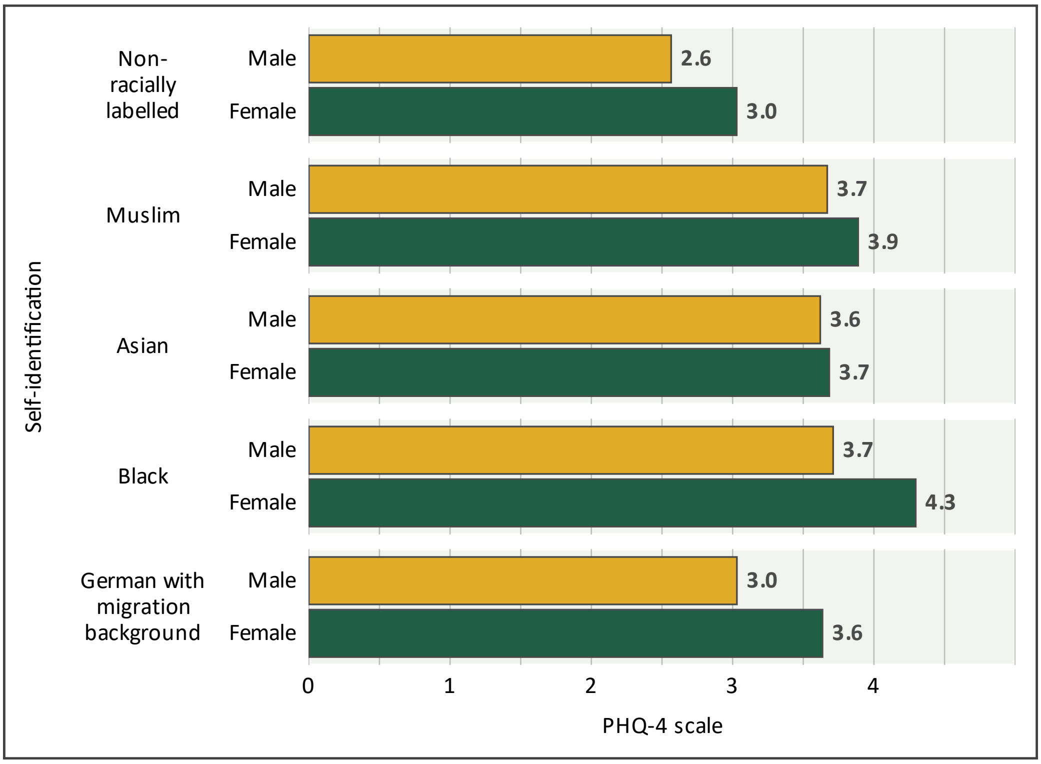
1.3 Mental health: Symptoms of depression

The analysis steps for investigating mental health were carried out in an analogue way to those for the general state of health.

The scores on the PHQ-4 scale can be split into categories for interpretation purposes: scores from 0 to 2 signify normal or no symptoms, scores from 3 to 5 refer to mild symptoms, scores from 6 to 8 signify moderate symptoms, and scores from 9 to 12 refer to serious symptoms of a potential anxiety disorder and depressive illness. In general, when evaluating the findings, it must be taken into account that having symptoms does not necessarily imply an actual anxiety disorder or depressive illness, but can merely be viewed as an indication of this.

When considering the average scores for the groups shown in Figure 16, it is striking that, in some cases, there are significant differences. With 2.6 points, non-racially labelled men show the lowest average scores on the PHQ-4 scale, followed by non-racially labelled women and German men with a migration background (3 points). The highest scores are for Black women (4.3 points) and Muslim women (3.9 points). Although the difference from non-racially labelled men is smaller for all other groups, these are statistically significant differences in all cases. Therefore, although groups on average show mild symptoms of an anxiety disorder or depressive illness, the scores for all groups are higher compared with those for non-racially labelled men.

Figure 16. **Anxiety disorder and symptoms of depression (0–12), differentiated by self-identification and gender (averages)**



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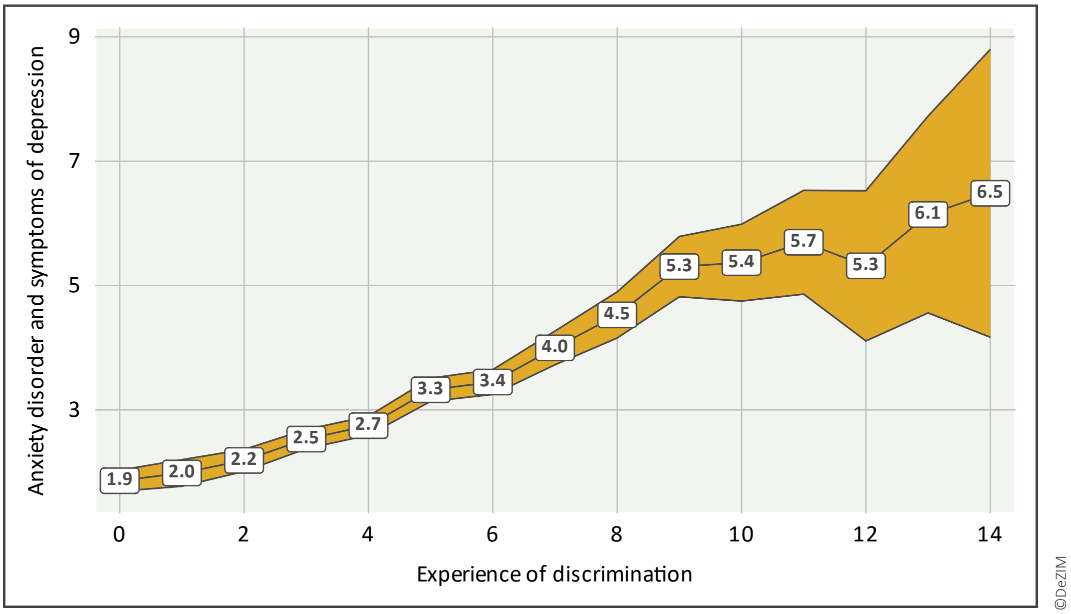
Example: Black women have a score of 4.3 on the PHQ-4 scale, which measures depression and anxiety disorders. **Source:** NaDiRa.panel, Wave 0 (weighted), own calculations. N = 15,768

On average, racially labelled groups and people with a migration background have higher scores on the scale for anxiety disorders and depression. In general, women have higher scores than men.

Figure 17 shows the relationship between experiences of discrimination and racism and the indicators of an anxiety disorder and symptoms of depression. Here too, there is an almost linear relationship: the more respondents experience discrimination and racism, the higher their scores on the PHQ-4 scale. If a person was never confronted with discrimination and racism in the situations presented, this person does not, on average, exhibit any symptoms of anxiety disorders or depressive illness. On the contrary, those who frequently experience unequal treatment in the form of discrimination and racism can be found in the category of moderate symptoms. It can therefore be stated that there is a significant link between experiences of discrimination and racism and symptoms of anxiety disorders or depression.

Figure 17. **Relationship between experiences of discrimination and anxiety and symptoms of depression (averages)**



Example: People who have not experienced any discrimination (0) score an average of 1.9 points on the anxiety scale. Source: NaDiRa.panel, Wave 0 (weighted), cluster robust standard errors, own calculations. Results controlled for age and education level. The yellow band represents confidence intervals (95%). N = 15,505

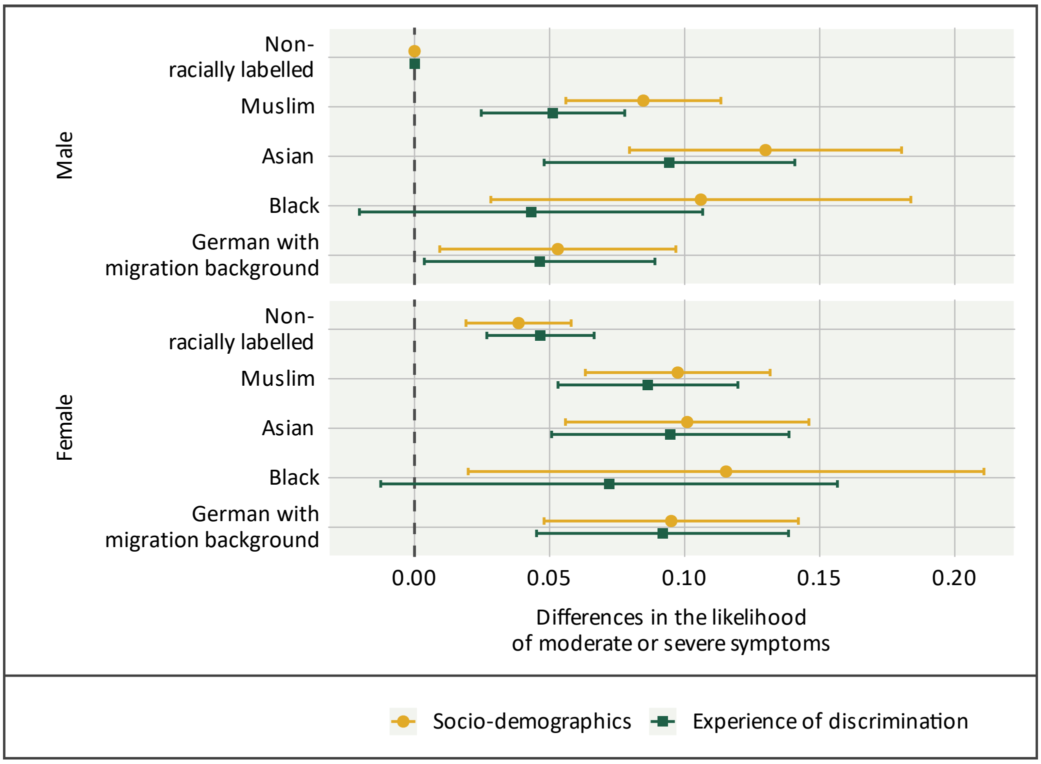
Experiences of discrimination and racism are accompanied by increased symptoms of anxiety disorders and depressive illness, in particular for people who experience these situations regularly.

For a simpler illustration of the results, Figure 18 shows the likelihood of moderate to serious symptoms of anxiety disorders and depression across groups. As in Figure 15, two models are calculated here. Initially, an analysis is carried out that takes age and level of education into account (model: social demographics / yellow dots), and subsequently experiences of discrimination and racism are considered (model: experiences of discrimination / green dots). Non-racially labelled men form the reference group (vertical line at 0).

Asian women and men show an increased average probability of moderate or serious forms of anxiety disorders and symptoms of depression (11 and 13 percentage points, respectively) when compared with non-racially labelled men, as do Black women and men (11 percentage points). For all other groups, this likelihood is also increased to a statistically significant level (on average, a difference of 4 to 10 percentage points from non-racially labelled men).

The change in the second model is particularly noteworthy: when including the frequency of experiences of discrimination and racism, the overall differences from non-racially labelled men are reduced. This model also shows that all racially labelled groups have a higher likelihood of moderate and severe symptoms when compared with non-racially labelled men. However, only the differences between Muslim and Asian men and non-labelled men remain statistically significant.

Figure 18. Differences in the likelihood of moderate or severe symptoms for anxiety disorders and depression by self-identification and gender (in percentage points)



Example: Taking into account the respondents' socio-demographics, Black men are 11 percentage points more likely to have moderate or severe symptoms of anxiety disorder or depression than non-racially labelled men. **Source:** NaDiRa. panel, Wave 0 (weighted), cluster robust standard errors, own calculations. The results of the logistic regression are presented as average marginal effects and were corrected using the KHB method. Results controlled for age and education level. The horizontal lines are confidence intervals (95%). N = 15,505

In comparison with non-racially labelled men, Muslim and Asian people in particular have a higher likelihood of experiencing moderate or severe symptoms of depression and anxiety disorders when the frequency of experiences of racism and discrimination are taken into account.

1.4 Conclusion

This chapter provided an initial overview of health-related inequalities between racially labelled and non-racially labelled people with regard to the subjective assessment of their own health. In summary, the findings show that there are health-related disadvantages for racially labelled people, particularly with regard to mental health, which was measured using an indicator for anxiety disorders and symptoms of depression. For the general state of health, no comparable differences could be seen. Only the group of Muslim women stands out due to a worse average state of health. Possible explanations for this are discussed in the following chapters.

For both health measurements, there is a clear connection to experiences of discrimination and racism. People who are frequently affected run the risk of developing a worse state of general and mental health. However, these analyses are only cross-sectional studies. This means that they only represent statistical snapshots, which should be examined more closely over time or using causal methods. In spite of the limitations, the findings on the basis of the NaDiRa data coincide with the results of international studies. Racism has been identified in literature as an important risk factor for the health of individuals affected (see Phelan & Link 2015; Williams & Mohammed 2009), and in particular the state of research regarding the connection between racism and mental health, for example anxiety disorders and depression, is clearer (see Berger & Sarnyai 2015; Cuevas et al. 2021; Madubuko 2011; Schunck, Reiss & Razum 2015). The findings presented here indicate that in Germany, too, experiences of discrimination and racism are negatively linked to general and mental health. Studies that discuss the biological consequences of marginalisation also draw attention to the separate significance of the frequency of experiences of racism and discrimination (see Epel 2009; Lewis, Cogburn & Williams 2015). Experiences of racism and discrimination ‘get under the skin’ (Krieger 2005) in the sense that repeated exposure to psychosocial stressors (in this case: discrimination) can lead to dysregulation of the nervous system, which adversely affects health in the long term (see McEwen 2012; Seeman et al. 2001).

For the first time in Germany, the data of the NaDiRa.panel offer the opportunity to make statements regarding the state of health of racially labelled people. Furthermore, respondents’ gender plays a role in the analysis in order to make specific inequalities visible. Nevertheless, this is only an initial overview, which is not able to sufficiently record the heterogeneity within the groups. For example, residents’ legal residency status is not taken into account. In particular against the background of the immigration of refugees to Germany since 2013, a person’s experience of displacement is closely linked to their state of health, as well as to their legal access to healthcare. For other groups, too, selection processes and reasons for migration may have an influence on inequality with regard to health indicators and healthcare. The following chapters also provide remarks on the relevance of these aspects.

2.

Name-based discrimination when accessing healthcare: A Germany-wide field experiment

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Ruta Yemane

Not everyone is treated equally in the healthcare system in Germany, as demonstrated by various scientific papers (see Bartig et al. 2021; see also the section State of research: Racism, health and healthcare). Racially labelled people in particular are affected by unequal treatment (see section Framework of healthcare and Chapter II.4). This is in opposition to one of the principles of the Hippocratic Oath (Declaration of Geneva), which is one of the World Medical Association's most important documents and forms an integral part of the professional code for doctors in Germany. It was adopted in 1948 as a consequence of the Second World War and the Nazi policy of extermination, in both of which doctors and medical personnel were substantially involved (see Frewer 2008). The oath states that, among other aspects, 'ethnic origin' and 'race' must not influence medical duties towards patients.[43] Research work regarding discrimination in the healthcare system, however, indicate unequal treatment, for example unfavourable treatment of patients based on socio-economic aspects such as education, income, and insurance status (see Han et al. 2015; Lungen et al. 2008) as well as ascribed ethnic origin or 'race' (see Hamed et al. 2022; LaVeist, Rolley & Diala 2003; Pascoe & Smart Richman 2009).

Correspondence tests are suitable for the identification of discrimination. This refers to special field experiments that are used to investigate discrimination in various spheres of life (e.g. staff selection, during communication with authorities, when accessing day-care centres or schools). In Germany, correspondence tests that investigate discrimination in the employment market using job application documents are the most widespread. Here, potentially relevant characteristics of fictitious applicants are systematically varied, while other characteristics remain constant. The application documents of the fictitious applicants are sent to real companies that are searching for staff. Subsequently, researchers analyse whether applications from women or from people with a migration background, for example, receive a positive response from companies less frequently than other applications (see Veit 2020).

In the healthcare system, such studies are also applicable to investigating discrimination against patients in allocating appointments, i.e. access to healthcare. Here, fictitious patients, whose name and other characteristics are systematically varied, request an appointment in medical practices or clinics, either by telephone or email. The researchers then record whether, when and how the appointment request receives a response. There have been some field experimental studies regarding discrimination owing to 'race' in the USA (see Kugelmass 2016; Leech, Irby-Shasanmi & Mitchell 2019; Shin et al. 2016; Wisniewski & Walker 2020). For European countries, however, there are field experimental studies regarding the role played by socio-economic aspects (Germany: Kuchinke, Sauerland & Wübker 2009; Lungen et al. 2008; Sauerland, Kuchinke & Wübker 2009; Werbeck, Wübker & Ziebarth 2021; Austria: Angerer, Waibel & Stummer 2019; Switzerland: Gottschalk, Mimra & Waibel

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[43] 'I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient.' (Montgomery, Parsa-Parsi & Wiesing 2018)

2020), but there are barely any with a view to name-based or racist discrimination (for ethnic discrimination, see Halla, Kah & Sausgruber 2021).

The field experiment presented here is a correspondence test to measure name-based discrimination of patients during appointment allocation in the practices of established doctors and psychotherapists in Germany (see Mecheril 2002; see also chapter Preliminary historical and theoretical considerations). To this end, we requested appointments in practices across the country, where first names and surnames as well as some other characteristics of the (fictitious) patients were varied at random. In contrast to research work, which records subjective perceptions and experiences via interview or survey data, for example, this field experiment provides causal evidence of unequal treatment.

2.1 Research design: A country-wide field experiment into name-based discrimination against patients

For the experiment, almost 6,800 randomly selected medical practices (general practices, dermatology, paediatrics and radiology) and psychotherapists were contacted in June/July 2022 and between December 2022 and February 2023 to request an appointment for a fictitious person or their children. Each practice was only contacted once. Contact was mainly made via email, which allowed for a high level of standardisation.[44] For the enquiries, fictitious people were created whose names were systematically varied. Names were selected which suggested Turkish and Nigerian (for non-Germans) or German origins, as the names were widespread in the countries in question and among immigrants from these countries and their children.45 In addition, other characteristics were experimentally varied: male or female names, names with or without doctoral degrees (as a signal of level of education and social status), statutory or private insurance, as well as with regard to the reason for the appointment request (acute illness or a routine examination).

The appointment request for a routine examination at a dermatology practice for a privately insured female patient with a name assumed to be Turkish and without a doctorate, for example, read as follows:

---

[44] Audio recordings of appointment requests were only left on the answering machines of medical practices in the first wave of data collection. As this approach was easier to realise and email addresses were commonly available, enquiries were only sent by email in the second wave.

[45] The below names were used based on their prevalence in the following countries: Nigeria, male: Yakubu Bakole, Umar Atanda, Chinwendu Abiola; Nigeria, female: Farida Abayomi, Binta Obafemi, Abike Nkama; Turkry, male: Deniz Özcan, Ali Sahin, Ahmet Özer; Turkey, female: Seda Yildiz, Fatma Öztürk, Elif Yilmaz; Germany, male: Paul Müller, Niklas Hoffmann, Florian Schneider; Germany, female: Laura Schmidt, Jana Fischer, Anna Wagner. Apart from the aspect of prevalence in the relevant countries, names convey further associations and sometimes ambiguities that can lead to limitations. This concerns associations with gender in gender-flexible names (e.g. Deniz), national/ethnic/cultural categorisations (e.g. names that can be associated with both Turkish and Kurdish origins) and name-based social class attribution.

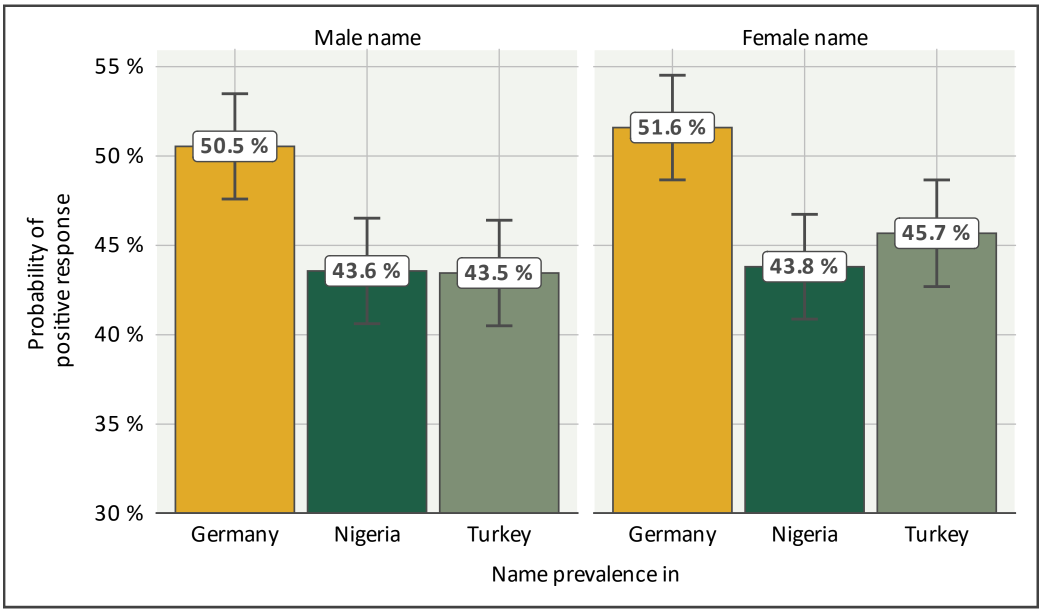
> *‘Subject: Appointment request*
> *Dear Sir or Madam,*
>
> *I would like to make an appointment as a patient in your practice.*
> *I have a large number of moles and would like to have them inspected again.*
> *My health insurance is with Allianz.*
> *I am flexible regarding the time and would appreciate a proposal for an appointment in the near future. I will then promptly confirm the appointment.*
> *Thank you for your answer.*
>
> *Yours faithfully,*
> *Elif Yilmaz’*

2.2 Results

Almost half of the 6,789 appointment requests sent received a positive response (47%); the practices therefore demonstrated their willingness to find an appointment for the fictitious patients. Among these responses, patients with names that were widespread in German received positive answers to their appointment requests significantly more frequently (51%) than patients with names that commonly occur in Turkey (45%) or Nigeria (44%).

Conversely, whether the appointment request came from a woman or a man did not influence the likelihood of receiving a positive response (female names: 47%, male names: 46%). The reason also did not play a significant role: patients with acute symptoms received a positive response in 48% of cases, while this was true of 45% of patients who requested a routine examination. However, there were clear and statistically significant differences for patients who were privately insured (50%) in comparison to those with statutory insurance (43%) and for people with a doctoral degree (49%) in comparison to those without (45%).

Figure 19. Group-related differences in the probability of a positive response by name (in per cent)



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Example: For people who request an appointment with a female name that is common in Nigeria, the probability of receiving a positive response is 43.8%, which is around 8 percentage points lower than for people with a female name that is common in Germany (51.6%). **Note:** The bar chart shows the probability of a positive response to an appointment request for the respective name group. The type of insurance, the indication of a doctorate, the urgency of the symptoms, the type of contact (telephone or email) and the medical speciality are statistically controlled for and kept constant at the level of the respective mean value. The vertical lines are confidence intervals (95%). Own calculations, N = 6,789

Figure 19 represents the differences between the groups with regard to the frequency of a positive response from the practices, split by gender. Here, the factors named above of type of insurance, having a doctoral degree, the urgency of symptoms, type of contact made and the medical speciality field were taken into consideration.

Figure 19 demonstrates that, even when the characteristics of the appointment request remain the same, people with names that are common in Nigeria and Turkey receive positive responses less frequently when compared to people with a name which is widespread in Germany. Whether a woman or man requests an appointment, however, does not have a demonstrable influence on the likelihood of receiving a positive response – and this is true regardless of whether the person has a name common in Germany, Nigeria or Turkey. This study therefore provides clear evidence of name-based discrimination during appointment allocation by doctors and psychotherapists with their own practice due to the migration background suggested by the name, but not due to the gender signalled.

The probability of patients with names widespread in Nigeria or Turkey receiving a positive response to their appointment request is 6 or 8 percentage points lower, respectively, than that for patients with names widespread in Germany. Whether the name is male or female does not play a significant role.

Greater name-based discrimination against patients with a higher socio-economic status

The statistically significant higher probability of a positive response to an appointment request from patients with names widespread in Germany compared with those with names widespread in Turkey or Nigeria mostly persisted when individual sub-groups were considered, such as only those with male names or only patients with acute symptoms. Nevertheless, some of these additional characteristics reinforced the effect of the name (or reduced it). Name-based discrimination against patients with statutory insurance was therefore lower than against privately insured patients. Similar results were seen when comparing fictitious patients with and without doctoral degrees. Name-based discrimination tended to occur more among patients with doctoral degrees.

To some extent, this pattern contradicts expectations that can be derived from statistical discrimination theory according to which information regarding productivity (here: social and socio-economic status) would reduce discrimination (see Guryan & Charles 2013). Nevertheless, in line with statistical discrimination theory, it can also be assumed that the same signals are interpreted differently. Potentially, the pattern found is based on the assumption that doctoral degrees of patients with names which trigger associations with countries other than Germany were possibly obtained abroad and consequently devalued. Similarly, it could be the case that private insurance is interpreted differently for patients with names that are less common in Germany than for those whose names are widespread in Germany (e.g. as an indication of solo self-employment or a small business rather than well-paid employment). These interpretations, however, are hypothetical and accordingly must be investigated more thoroughly in later analyses.

No evidence of name-based discrimination in paediatric practices

In some instances, the results for the various specialisations indicate large differences. Due to the low case numbers, they must be interpreted carefully. However, they offer important indications of where closer investigations would be relevant in the future. Here, two results appear particularly interesting: there are almost no group differences in appointment requests to paediatric practices. When fictitious people request appointments for their children, the name appears to be irrelevant.

A conflicting pattern can be seen with regard to appointments in psychotherapy practices. Here, the group differences are larger. If appointment requests are made by people with names common in Turkey, the probability of receiving a positive answer was approximately 12 percentage points lower than for people with names that were common in Germany. A clear difference of approximately 8 percentage points was also recorded for the group of patients with names widespread in Nigeria. Name-based discrimination therefore also seems to be particularly relevant in psychotherapeutic care.

2.3 Conclusion

Patients with names which are associated with countries other than Germany are discriminated against: Patients with names which are widespread in Turkey or Nigeria are discriminated against during appointment allocation in the practices of doctors and psychotherapists – in spite of identically formulated appointment requests. We were able to prove this discrimination for a country-wide sample of randomly selected practices of general medicine, dermatology, radiology and psychotherapy. Here there were certain indications – albeit only partially statistically secure – that this form of name-based discrimination was particularly pronounced in psychotherapy. This finding contradicts the medical oath to provide equal treatment to patients seeking help.

No significant discrimination in paediatric practices: This study did not, however, find any indications of name-based discrimination against patients in paediatric practices. This finding is unexpected in that there has been a significant scarcity of paediatric services in Germany for several years (see Wissenschaftliche Dienste des Deutschen Bundestages 2022). The document ‘Regarding the scarcity of specialist care in paediatric and adolescent medicine’ (2022), prepared by the Research Services of the Federal Government, describes how doctors are increasingly overworked and an acute risk to services. In particular as a result of the COVID-19 pandemic, it reports, treatment density and costs as well as the numbers of chronic and mental illnesses have significantly increased. This leads to worries on the part of parents and children regarding a secure level of medical treatment due to long waiting times for appointments and long journeys to medical practices (see ibid.). The fact that discrimination dynamics do not also lead to a deterioration of the treatment situation for children of migrants is a welcome finding. Nevertheless, which factors are decisive remains unclear.

Additional research required: While this study is able to causally prove name-based discrimination as a correspondence test, it does not provide information on who is responsible (medical assistants or the doctors and therapists) and why discrimination occurs (e.g. hostility, misgivings, profit expectations, concerns regarding qualification for treatment such as in the case of dermatologists for Black patients, see Holm & Burgdorf 2001). Likewise, it was not possible to clarify within this investigation on the basis of which characteristics and associations the discrimination shown took place. Names can not only be interpreted as an indicator of a supposed migration background. They can also, for example, be seen as signalling racially labelled characteristics, religious affiliation or possible language barriers. It was not possible to record the circumstances leading to a positive or negative response using the investigation design selected here.

Studies with different designs (qualitative or quantitative) that provide findings on the specific forms, dynamics and processes of discrimination are required here, in addition to causal evidence of existing discrimination (see also Chapters II.4 and II.5).

Equal access to healthcare is a valuable commodity in a democratic society and a welfare state such as Germany. If this is not ensured, it can have far-reaching consequences for mental and physical health and life expectancy, in particular for individuals who belong to marginalised groups. Our study shows that patients are discriminated against due to ascriptions of a foreign origin, interlaced with well-being and education.

This chapter presents the initial results of the project ‘Social and ethnic inequalities in health care access’ (funded by the Berlin Social Science Center, WZB). The project receives additional funding from the short studies of the German National Monitoring of Discrimination and Racism (funded by the BMFSFJ).

3.

Experiences of racism and discrimination in healthcare

Access to healthcare free from discrimination and racism is not only a fundamental human right, but also an important indicator of a functioning society based on solidarity. However, a look at the research landscape in Germany shows that there is a void in the study of discrimination and racism in the healthcare system in particular. There is scarcely any knowledge available on the extent and manifestations of discrimination and racism, as well as on how these affect access to and the quality of healthcare (see Braun & Zeeb 2021). In addition to the lack of reliable data, research into discrimination and racism in the context of healthcare is also difficult, as these rarely manifest themselves openly and, in most cases, elude clear identification (see Bonilla-Silva 2009).

Qualitative studies among experts from the field of medical rehabilitation and experience reports from patients have shown, for example, that discrimination and racism in the context of healthcare are often subtle, such as disrespectful treatment by medical staff or the feeling of those experiencing racism that they are not being taken seriously (see Bartig et al. 2021; Brause et al. 2010; Gerlach et al. 2012). Studies indicate that even the fear of being repeatedly discriminated against can lead to poorer health (see Karlsen & Nazroo 2004). When analysing discrimination and racism in the healthcare system, it is therefore essential to include the experiences of those experiencing racism (see also Chapter II.4).

For the first time, the German National Monitoring of Discrimination and Racism is now providing representative data to map the extent as well as the consequences of experiences of discrimination and racism in selected areas of the healthcare system. Due to the composition of the sample (see also the chapter Research approach and methodology), it is possible to identify differences in the provision of healthcare between those affected and not affected by racism. In addition, the various vulnerabilities and multiple disadvantages within racialised groups, for example due to age or gender, can also be identified.

This way, the data provides initial insights into the situation of racially labelled groups in Germany with regard to medical and psychotherapeutic care. The results presented refer to the first panel survey (Wave 0) of the NaDiRa.panel.

On the basis of existing international and national research findings on inequalities in healthcare, discrimination and racism, in particular the following information was collected:

- Information on **utilisation of medical care** (‘Have you received medical treatment, counselling or had an examination/scan/screening in the last 12 months?’)
- Information on **barriers to accessing healthcare** that are faced in particular by people who experience discrimination and racism (‘In the last 12 months, have you delayed or avoided medical treatment

because you feared being taken less seriously or treated worse than other people?')

- Information on utilisation of **psychotherapeutic care** ('Have you visited a psychologist, psychiatrist or psychotherapist in the last 12 months for counselling, examination or treatment?')
- Self-reported information on specific **experiences of discrimination experienced by people in medical treatment situations** (e.g. 'I had to change doctors because my complaints were not taken seriously.')

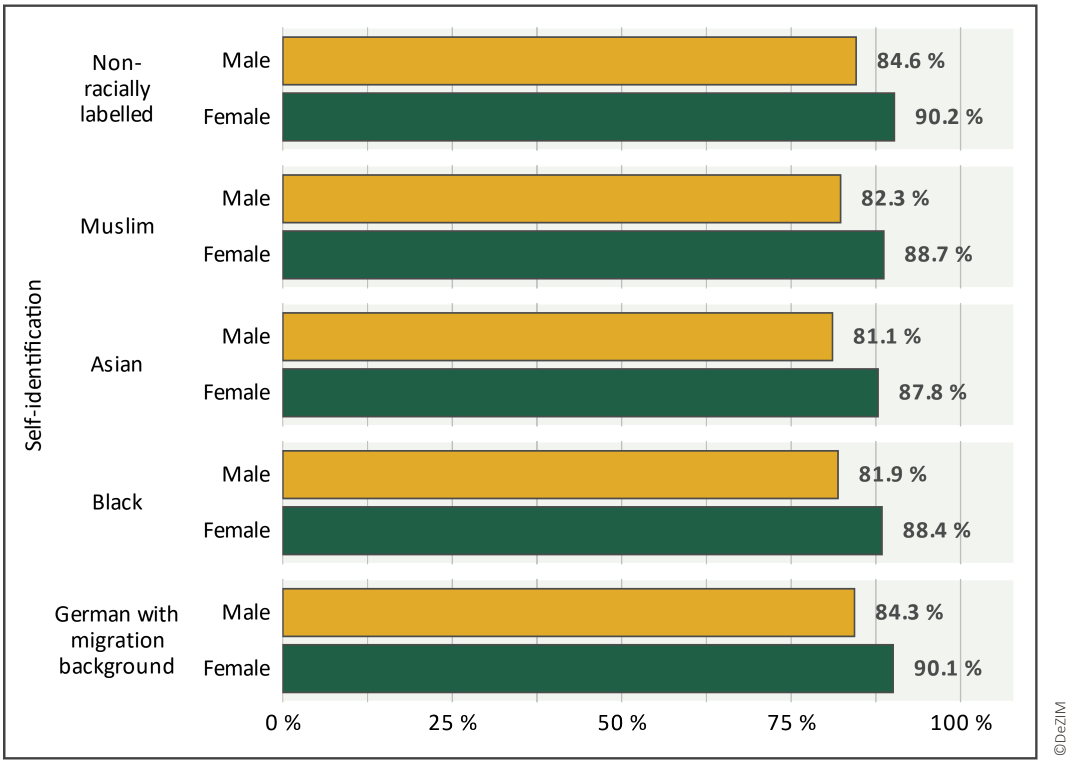
In the following, these focal points are analysed in a differentiated manner according to both self-identification and gender. Considering both group affiliation and gender makes it possible to uncover existing multiple disadvantages in healthcare.

3.1 Utilisation of medical care

In order to provide an overview of the general healthcare situation in Germany, the study participants were first asked whether they had received medical treatment, examinations/scans/screenings or counselling in the last twelve months. The results of the survey show that the majority of the population in Germany utilises medical care: around 87% of respondents stated that they had seen a doctor during the last year.

Figure 20 illustrates that racially labelled people have received treatment slightly less frequently in the last year than non-racially labelled people and Germans with a migration background. Even after monitoring for age, education and gender, the differences from Asian people remain statistically significant compared to non-racially people, but only amount to 3 percentage points. There are, however, gender differences in terms of utilisation of medical care. The proportion of women who have received medical treatment in the last 12 months is around 5 percentage points higher than that of men. These results are therefore in line with previous nationwide studies, according to which around 90% of women and 84% of men in Germany have received outpatient care in the last 12 months (see Romel & Prütz 2017).

Figure 20. **'Have you received medical treatment, an examination/screening/scan or counselling in the last 12 months?', differentiated by self-identification and gender (percentages)**



Example: 88.7% of Muslim women have received a medical consultation, examination or treatment in the last 12 months.
Source: NaDiRa.panel, Wave 0 (weighted), cluster robust standard errors, own calculations. N = 15,580. Results controlled for age and education level.

In all groups, at least 81% of men and 88% of women had seen a doctor in the last twelve months.

Further analyses show a correlation between the use of medical treatment and age: on the one hand, young men are less likely to have seen a doctor in the last year (< 80%), while on the other hand it is mainly older women who have seen a doctor more often in the last twelve months (> 90%). While studies from English-speaking countries indicate a correlation between utilisation of medical care and socio-economic status (see Filc et al. 2014; Frølich et al. 2019; McMaughan, Oloruntoba & Smith 2020), this is not evident in the data available here. This difference can be explained by the fact that the organisational forms of the presented healthcare systems vary greatly from country to country, meaning that financial aspects can fundamentally influence utilisation of medical care. As the healthcare system in Germany – despite its tendency towards economisation (see the introduction of the DRG in 2003) – sets different standards via the general insurance obligation, this finding is not particularly surprising.

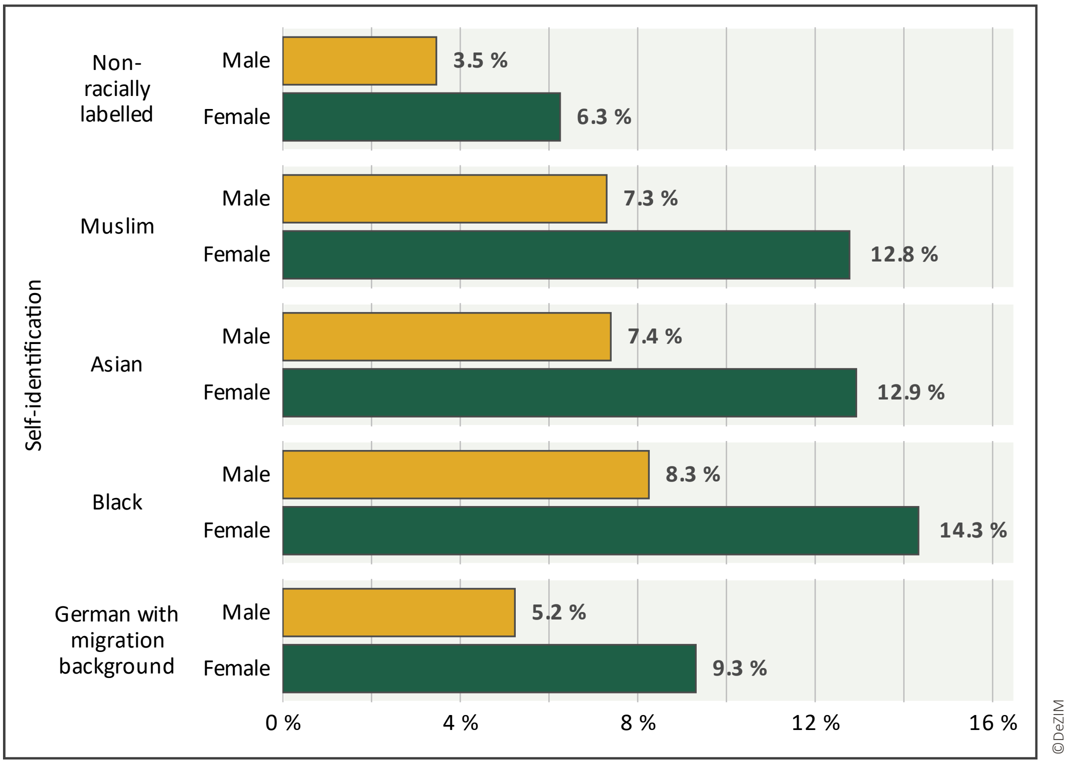
3.2 Not if, but when: Experiences of discrimination delay access to healthcare

The fact that most people in Germany have access to the healthcare system does not guarantee that medical care is provided fairly and that it also reaches those who are particularly dependent on it. This is because, unlike basic access to the healthcare system, the timing of access is crucial for the appropriate treatment of (potential) illnesses, which can result in long-term health damage or even premature death if illnesses are not recognised or treated in time (see Bergeot & Jusot 2022; Müller & Turina 2021; Quintal et al. 2023). International studies indicate that a significant proportion of patients delay or even avoid medical treatment even though they need help (see Vreman et al. 2019). The reasons cited in the literature for such delays or avoidance include income (see Anderson et al. 2021; Apouey & Geoffard 2014; Kim et al. 2017), waiting times for appointments (see Röttger et al. 2016, see also Chapter II.2) or the distance to the nearest medical centre (see Moran et al. 2021). Essentially, it can be established that current research is increasingly focusing on discrimination in order to better understand patients' avoidance behaviour (see Harris, Cormack & Stanley 2019; Horgan et al. 2022; Kitching et al. 2020; Liu, Pabayo & Muennig 2021; Röttger et al. 2016; Zhang, Gereke & Baldassarri 2022). The various study results show that perceived discrimination significantly reduces the willingness to utilise medical services (see Burgess et al. 2008; Hausmann et al. 2008; van Houtven et al. 2005).

Women are more likely to delay or avoid medical treatment

The NaDiRa data can be used to examine the extent to which the anticipation of discrimination is related to the likelihood of avoiding or delaying medical treatment. The participants in this study were therefore asked whether they had delayed or avoided medical treatment in the last twelve months because they feared that they would be taken less seriously or treated less favourably than others. In the group of non-racially labelled people, under 5% affirmed this, while the proportion among racially labelled people was around 10%. With regard to respondents' gender, it should be emphasised that it is mostly women who delay seeking treatment or do not seek treatment at all due to the fear of being discriminated against. At 13%, the proportion of racially labelled women is the highest compared to non-racially labelled women (around 6%), non-racially labelled men (around 4%) and racially labelled men (around 8%).

Figure 21. **Delaying or avoiding medical treatment, by self-identification and gender (shares in per cent)**



Example: 12.9% of Asian women surveyed stated they had delayed or avoided treatment because they feared they would be taken less seriously or treated less favourably than others. **Source:** NaDiRa.panel, Wave 0 (weighted), own calculations. N = 15,537. Results controlled for age and education level.

When broken down by the various racially labelled groups and respondents' gender in Figure 21, the following pattern emerges: in contrast to non-racially labelled men (3.5%), racially labelled men were twice as likely to have delayed treatment in the last twelve months. It should be emphasised that around one in twelve Black men have delayed or avoided medical treatment in the last year (8.3%), whereby the proportions for Muslim (7.3%) and Asian men (7.4%) are similarly high and all differ statistically significantly from the comparison group. The differences in the extent to which a person has delayed or even avoided treatment due to fear of discrimination are even more pronounced when the respective percentages of (racially labelled) women are taken into account: according to this, both non-racially labelled and racially labelled women are more likely to make the decision compared to men, to delay or even avoid medical treatment, whereby the differences between all groups of women and men who are not racially labelled are statistically significant. Moreover, the very high percentages for Black (14.3%), Muslim (12.8%) and Asian (12.9%) women differ statistically significantly from non-racially labelled women (6.3%). It can therefore be concluded that women experience discrimination in the healthcare sector more often than men (see the following analyses on experiences of discrimination).

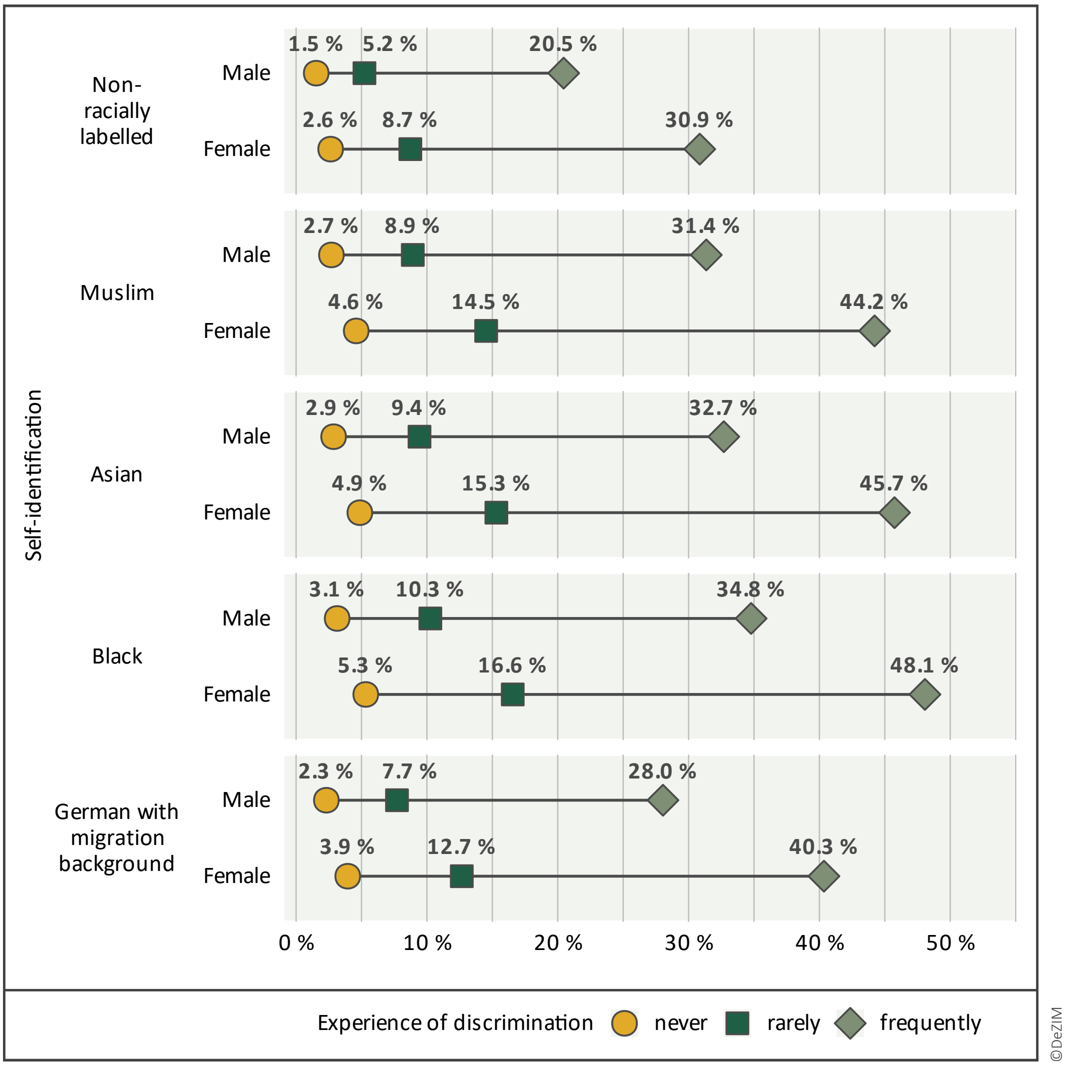
Racially labelled women, in particular, delay or avoid medical treatment due to the fear of not being taken seriously or being treated worse than others.

Correlation between experiencing discrimination and seeking medical treatment

More explicit indications as to which factors cause the delay or avoidance of necessary medical treatment are revealed if we include subjectively perceived discrimination in addition to self-identification and gender. The fact that experiences of discrimination within and outside the healthcare system can reduce the willingness to seek medical services has now been well-documented in several international studies (see Mateo & Williams 2021). Experiences of discrimination and racism, in particular, have not only been shown to reduce patient trust and satisfaction (see Ben et al. 2005; van Houten et al. 2005), but also have a negative impact on how people interact with the healthcare system (see Hausmann et al. 2010; Kandula et al. 2009).

In order to assess subjectively perceived discrimination, the participants in the NaDiRa. panel were asked how often they were treated unfairly or worse than other people (e.g. when in contact with a doctor, non-medical staff such as receptionists, or in hospital). Respondents could choose between ‘I have never been in this situation’, ‘rarely’, ‘sometimes’, ‘frequently’ and ‘very frequently’. The categories ‘very frequently’ and ‘frequently’ as well as ‘sometimes’ and ‘rarely’ were merged, for the following breakdown of the results in Figure 22.

Figure 22. Delaying or avoiding medical treatment, by self-identification, gender and experiences of discrimination in the healthcare system (in per cent)



Example: Among Black women, who often experience discrimination in the health sector, 48.1% state that they have avoided or delayed medical treatment. **Source:** NaDiRa.panel, Wave 0 (weighted), own calculations. N = 12,196. Results controlled for age and education level.

Figure 22 shows a correlation between the frequency of the perceived experience of discrimination and the delay or avoidance of medical treatment: among those who state that they frequently or very frequently experience discrimination in the healthcare system, at least one in five people have delayed or avoided medical treatment in the last year. Taking gender into account, the share is even higher: for example, one in three women who have frequently experienced discrimination in the healthcare system report that they have avoided or delayed necessary treatment. Finally, these analyses also reveal differences between the various groups affected by racism: while one in five non-racially labelled men (21%) report such experiences, it is one in three among Black, Muslim and Asian men (Blacks: 35%, Muslims 31%, Asians: 33%). This pattern can also be found among women, although the overall figures are higher. For example, at least one in three women with frequent experiences of discrimination state that they have delayed or avoided treatment in the last twelve months. Among Black, Muslim and Asian women, almost every second person has had this experience (Blacks: 48%, Muslims 44%, Asians: 46%). For non-racially labelled women, the share is around 31%.

For all groups analysed, the comparison with other socio-demographic characteristics also shows that the likelihood of delaying medical treatment decreases with increasing age and higher education.

Women and men who frequently experience discrimination in the healthcare system are significantly more likely to delay or avoid medical treatment than people who have not experienced discrimination.

These findings illustrate that inequalities in healthcare are not necessarily related to access to the healthcare system. Even if people have received medical treatment within the last twelve months, this does not say anything about the frequency, appropriateness or scheduling of the healthcare service received. However, experiences of discrimination appear to be related to the timing of utilisation of medical care. Even if it is not possible to carry out causal analyses for this here, these findings are in line with the results of international research.

3.3 Psychotherapy

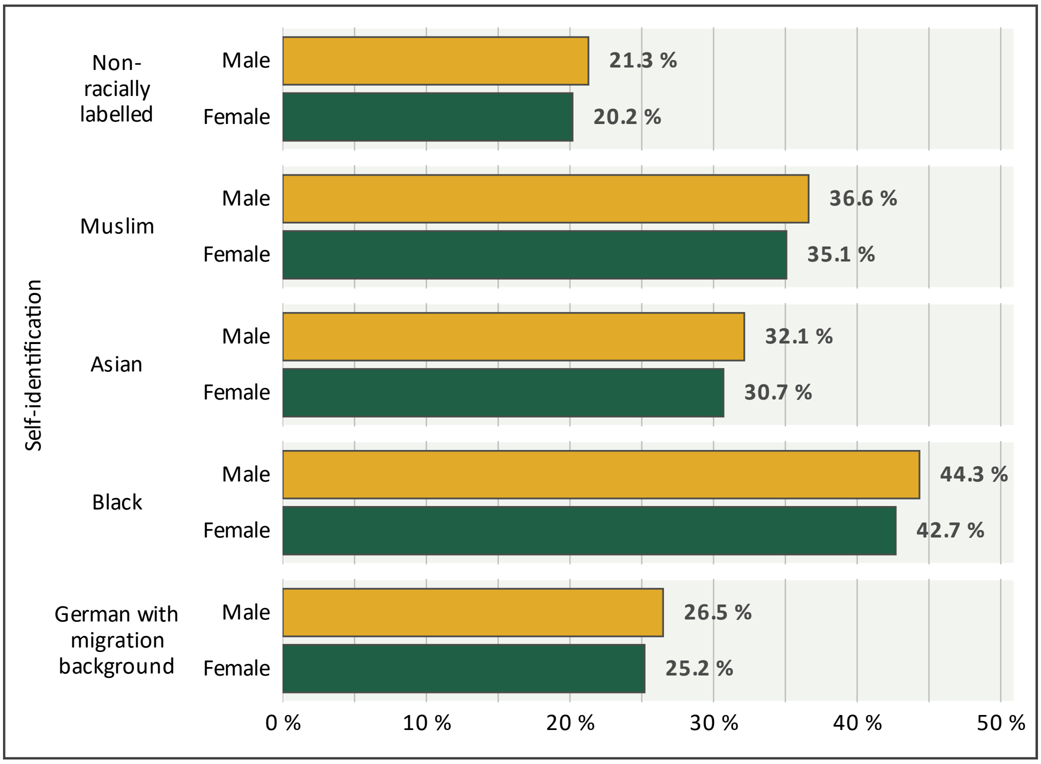
The fact that subjective experiences of discrimination and racism are linked to the willingness to seek medical help can also be illustrated with regard to the psychosocial care situation. The sector of psychotherapeutic, psychiatric and psychological treatment is important because international studies emphasise the direct effects of racism and discrimination on mental health (see Berger & Sarnyai 2015; Lee & Ahn 2011; Paradies et al. 2015; Pieterse et al. 2012; Priest et al. 2014; Williams & Mohammed 2013). It is therefore important for comprehensive healthcare to enable these target groups in particular to receive timely counselling, examinations or treatment.

To outline the extent to which there are differences in psychotherapeutic care between racially labelled and non-labelled people in Germany, the following question was asked in the NaDiRa.panel: ‘When did you last see a psychologist, psychiatrist or psychotherapist for counselling, examinations or treatment?’ Respondents were given the following response options: a) ‘less than 12 months ago’, b) ‘more than 12 months ago’, c) ‘I am still waiting for an appointment’, d) ‘I have given up trying to get an appointment’ and e) ‘I have no need for counselling or treatment’. In order to only include people in the analysis who actually need a psychotherapy appointment, all those who were in psychotherapy more than twelve months ago, are still waiting for an appointment or have no need for treatment were excluded. For better comparability with the previous results, only people who had received psychotherapy in the last twelve months or who had already given up trying to get an appointment were included.

Racially labelled people give up the search for therapy more quickly

Figure 23 shows the proportion of people who have now given up trying to get a psychotherapeutic, psychiatric or psychological appointment. Looking at the racially labelled groups, it becomes apparent that the share of racially labelled people who respond that they have given up trying to find an appointment is at least 10 percentage points higher than for non-racially labelled people. In other words: while around one in five non-racially labelled people (21%) have given up seeking therapy, one in three racially labelled people (35.4%) have done so. Furthermore, in contrast to the previous findings, it should be emphasised that there are no differences between men and women within the individual racially labelled groups. However, it is clear that the share of people who have given up looking for treatment varies between the individual racially labelled groups. People who identify as Black (43%) are the most likely to say that they have given up seeking psychotherapy. This is followed by the Muslim (35%) and Asian (31%) groups. Among those who describe themselves as German with a migration background, around one in four people state that they have given up trying to find an appointment (26%). Furthermore, there are generally no significant differences in level of education when it comes to seeking an appointment, while younger respondents are more willing to end their search prematurely than older respondents.

Figure 23. 'I have given up trying to get a psychotherapy appointment', by self-identification and gender (percentages)



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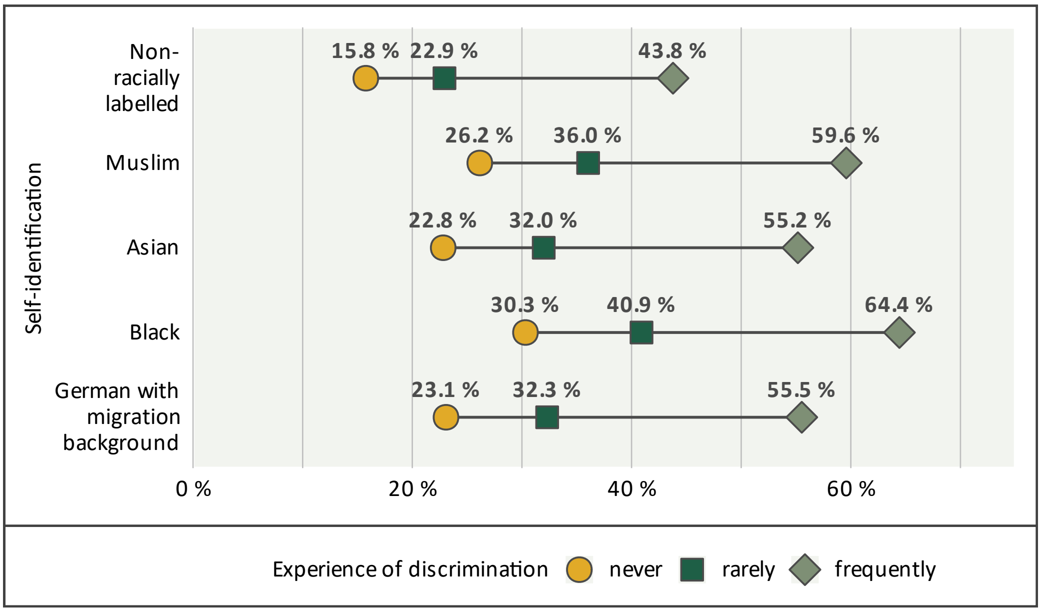
Example: 44.3% of the Black men surveyed stated that they had given up seeking psychotherapy. **Source:** NaDiRa.panel, Wave 0 (weighted), own calculations. N = 2,120. Results controlled for age and education level.

Racially labelled women and men, particularly Black women (43%) and men (44%), are more likely to give up seeking psychotherapy than non-racially labelled people.

The findings provide initial indications that there may be various reasons why people make less use of psychotherapeutic care. In addition to structural conditions, such as the fact that the supply of psychotherapy is lower than the demand, the sometimes significant differences between non-racially labelled and labelled people suggest that other reasons are also important in explaining the gap between utilisation and the search therapy.

Analogous to the previous findings on the avoidance and delay behaviour of racially labelled people, there is a correlation between subjective experiences of discrimination and the decision to seek therapy or not. Figure 24 shows the respective racially labelled groups in relation to gender and self-perceived experiences of discrimination in the health sector. Because the scores for men and women only differ slightly from each other, these results are not differentiated according to gender. The following findings confirm that the frequency of discrimination experienced is (negatively) related to the willingness to seek psychotherapeutic help. While around 44% of non-racially labelled people who often experience discrimination in the healthcare system state that they have given up seeking a psychotherapy appointment, the corresponding figure for racially labelled people is between 55% and 64%. A closer look at the individual groups affected by racism makes it clear that the resignation to give up seeking psychotherapeutic help is particularly pronounced among Black people, who also state that they often experience discrimination in the healthcare system. There, almost two-thirds (64.4%) state that they have given up trying to get a psychotherapy appointment. The proportion is around 60% for Muslims and 55% for Asians.

Figure 24. 'I have given up trying to get a psychotherapy appointment', differentiated by self-identification and experiences of discrimination in the healthcare system (shares in per cent)



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Example: Among Muslim people who frequently experience discrimination in the healthcare sector, 59.6% state that they have given up seeking a psychotherapy appointment. **Source:** NaDiRa.panel, Wave 0 (weighted), own calculations. N = 1,796. Results controlled for age and education level.

More than half of the people who classify themselves as belonging to a racially labelled group or have a migration background are more likely to give up seeking psychotherapy if they have often experienced discrimination in the healthcare system.

The significance of discrimination for access to healthcare and utilisation of psychotherapy services discussed here is doubly relevant for monitoring of racism and discrimination in Germany in depth. Ongoing research confirms that experiences of racism and discrimination act directly as stressors that affect the mental well-being of those affected (see Berger & Sarnyai 2015). Equitable care is therefore essential in order to address these inequalities in (mental) health through suitable therapy programmes. The findings presented here in the NaDiRa.panel indicate that those who have an increased need for psychotherapy due to experiences of racism and discrimination are also those who most frequently abandon their search for an appointment. According to this phenomenon, which has long been described in health science contexts as the *inverse care law* (see Hart 1971; Watt 2018), it is primarily people who are in better health that seek medical care. To a certain extent, this can therefore also be applied to the issue of racism and the thesis of double disadvantage: people who frequently experience racism theoretically have a greater need for (psychotherapy) services, but are less likely to seek treatment. Those who in turn do try to get an appointment can be disadvantaged by discrimination in the allocation of appointments (see also Chapter II.2). Obstacles in the allocation of appointments can contribute to people affected by racism and discrimination giving up their search for therapy more quickly in comparison.

In addition to this imbalance in psychosocial care, therapeutic treatment that is sought in order to deal with experiences of racism and discrimination can also have the opposite effect. It is often overlooked that subtle racism may be occurring in the psychotherapeutic relationship, which can manifest itself both in the downplaying of experiences and in completely avoiding the topic of racism (see Maharaj, Bhatt & Gentile 2021). In addition, racially labelled people’s needs may also be different when seeking therapy. For example, therapists with a similar life situation or language skills may be preferred. It is therefore necessary to investigate the exact reasons for the findings listed here in greater depth.

3.4 Experiences of discrimination in medical treatment

To date, no systematic studies have been carried out in Germany on the extent to which racially labelled people experience unequal treatment in the healthcare sector. Studies, particularly from English-speaking countries, suggest that prejudices, stereotypes and racist behaviour are widespread in healthcare (see Paradies, Truong & Priest 2014; Schouten & Meeuwesen 2006). In order to understand how discrimination is expressed in the healthcare system in the German context, the following section focuses on a specific medical treatment situation. The participants in the NaDiRa.panel were therefore asked ‘whether they have ever had to change doctors because their complaints were not taken seriously'[46] The situation presented in the survey is suitable for analysing racism and discrimination. The aim of such an analysis should be to investigate concrete experiences in terms of whether they are evenly distributed between different social groups or whether they are systematically unequal. Our findings show that these experiences are distributed differently.

To this end, the differences in the groups of racially labelled and non-racially labelled people are considered below. To simplify the presentation of the results for the two questions, the answers 'very frequently', 'frequently', 'sometimes' and 'rarely' were summarised in the category 'Yes, I have experienced this' and compared with those who have never had such an experience.

'Morbus aliorum': Construction of the pain-sensitive 'other'

Overall, more than one in three racially labelled people state that they had to change doctors because their complaints were not taken seriously (34.4%). Among non-racially labelled people, this figure is just under one in four (24.2%). Generally speaking, experiences of discrimination in medical treatment occur frequently in both groups and are associated with consequences for healthcare. The wording chosen shows that dissatisfaction with the medical staff providing treatment was so high that those affected no longer wanted to be treated by them.

Taking gender into account, major differences crystallise between the racially labelled and non-racially labelled groups surveyed. Figure 25 shows that it is women in particular who experience such discrimination in medical treatment: compared with non-racially labelled men (18.7%), the proportion of non-racially labelled women who experience this is around 10 percentage points higher (28.8%). In the group of racially labelled people, the difference between men (25.5%) and women (37.7%) is more than 12 percentage points, although the overall figures are higher than in the reference group of non-racially labelled people.

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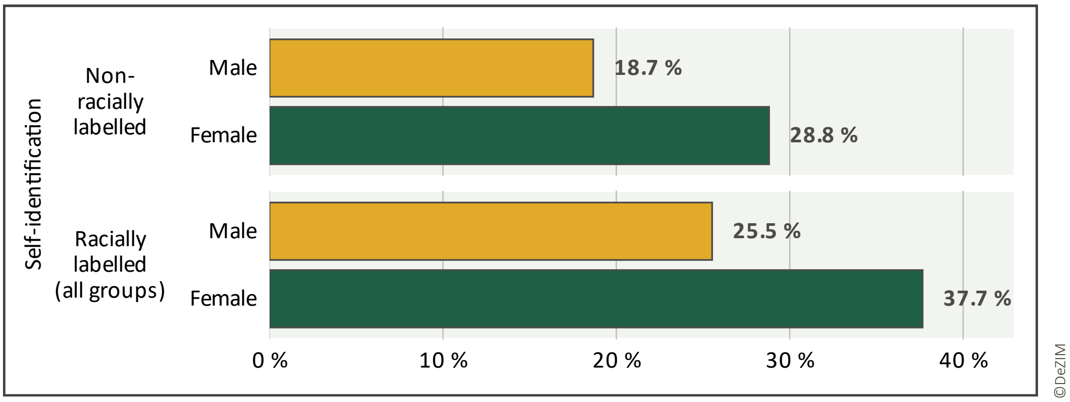
[46] In addition to the question of whether a person 'had to change doctors because their complaints were not taken seriously', they were also asked whether the suspicion that the person was only faking their complaints arose during the medical treatment. Due to the similarity in content of the two questions and the similar results, only the findings from the first question are presented in this sub-chapter.

Figure 25. **'I had to change doctors because my complaints were not taken seriously', differentiated by self-identification and complaints (shares in per cent)**



Example: 37.7% of racially labelled women state that they have already had to change doctors because their complaints were not taken seriously. **Source:** NaDiRa.panel, wave 0 (weighted), own calculations. N = 13,637. Results controlled for age and education level.

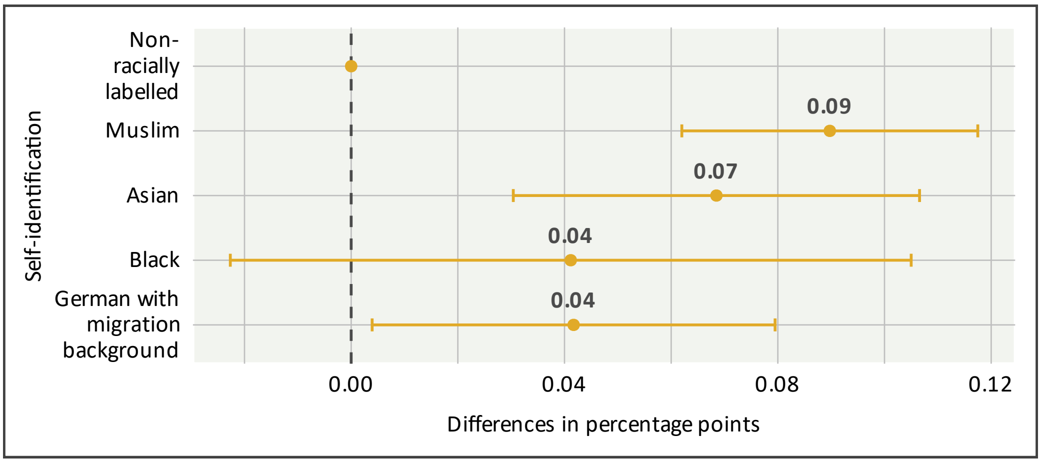
More than one in three racially labelled women have had to change doctors because they felt they were not being taken seriously. The proportion is over a quarter for women who are not racially labelled.

The fact that racially labelled men and women report experiences of discrimination in treatment more frequently is hardly surprising as the findings are broadly consistent with studies on the prevalence of racist prejudices in doctor-patient relationships and medical training (presented clearly in Chapters II.4 and II.5). For example, this includes the pseudo-diagnosis colloquially referred to as 'Morbus mediterraneus', also known as 'Morbus bosporus' or 'Mamma mia syndrome', which can also be considered from the perspective of non-acceptance in medical treatment (see von Eisenhart Rothe 2019; Gast ArbeiterIn 2022; Stary 2019). Predominantly people with roots in the Mediterranean region or assumed as such are mistakenly considered to have an exaggerated and inappropriate perception of pain (see Karger et al. 2017; Mroczynski 2017; see also Chapter II.4). Although this is a fictitious diagnosis or, in other words, a pseudo-diagnosis, it is still subliminally imparted in parts of medical training today (see Bundesvertretung der Medizinstudierenden in Deutschland e. V. 2022). It is particularly worrying that these prejudices are not always perceived and recognised as a problem in informal exchanges between doctors (see Aikins et al. 2021). According to various studies, people working in the healthcare sector sometimes lack awareness of the fact that racist pseudo-diagnoses such as 'Morbus mediterraneus' can have serious consequences on the health of those affected. For example, a qualitative study shows that, although the term 'Morbus mediterraneus' is categorised as racist by the majority of trainee doctors, the pseudo-diagnosis itself is considered a practicable way of classifying patients and clinical symptoms (see Gerhards, Schweda & Weßel 2023; see also Chapter II.5).

The fact that (racially labelled) women, in particular, report more frequently than (non-racially labelled) men that they are not taken seriously in medical treatment indicates that both racism and sexism – as well as the intersectional interaction between them – are central points of reference in understanding unequal treatment in the medical treatment situation. Scientific studies also indicate that women are disadvantaged in treatment, which can have a negative impact on health and well-being (see Heise et al. 2019). For example, studies of coronary heart disease show the problem that women – even with the same symptoms – have their medical history taken differently and receive different drug prescriptions and treatment recommendations than their male peer group (see Bönte et al. 2008; Göring 2022; Schieber et al. 2014). However, it should be noted that forms of discrimination and unequal treatment do not necessarily have to be based on individuals' sexist attitudes (see Kang, S. K. & Kaplan 2019) to result in negative effects. Instead, gender-specific norms represent a complex system that suggests certain thought and behaviour patterns to men and women that society considers 'normal' and 'natural' (see Villa 2014). To examine how these stereotypes are reflected in the health sector, various research studies have already pointed to the medicalisation of the female body that has long been observed historically (see Duden 1987; Schmersahl 1998). Current studies explain how the medical gaze is also orientated towards gender-specific norms: when men enter the consultation room, their attitude towards their medical condition tends to be fact-oriented, while it is assumed that women focus on their emotions and experiences with their illnesses (see Andersson, Salander & Hamberg 2013; Samulowitz et al. 2018). According to socio-psychological theories, the stereotyping of women as 'too emotional' in particular results from the view that women overemphasise, dramatise or even invent their feelings of pain in medical treatment situations compared to men (see Lloyd, Paganini & Brinke 2020).

According to international studies, there is now evidence that stereotypical views about different pain perception also apply to racially labelled minority groups (see Hollingshead et al. 2016). For example, Black people who receive medical treatment in the USA are ascribed a lower perception of pain due to racist ideas about biology (see Hoffman et al. 2016). This often leads to racially labelled people being denied pain medication despite presenting corresponding symptoms (see Schulman et al. 1999). Figure 26 shows that racially labelled people had to change doctor more frequently than non-racially labelled people. Multivariate analyses show that the differences to the comparison group (non-racially labelled people) are statistically significant for the Muslim and Asian groups as well as for people who consider themselves German with a migration background. Muslim people are 9 percentage points more likely to change doctors because their complaints are not taken seriously than people who are not racially labelled. The corresponding figure for Asian people is 7 percentage points.

Figure 26. 'I had to change doctors because my complaints were not taken seriously', according to self-identification (differences in percentage points)



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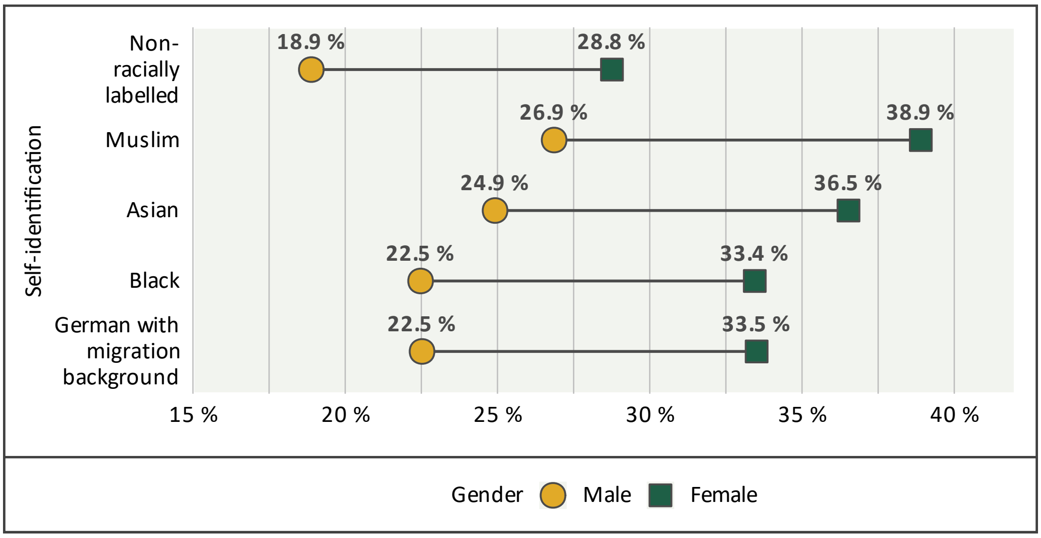
Example: Compared to non-racially labelled people, Muslims are 9 percentage points more likely to change doctors because their complaints are not taken seriously. Source: NaDiRa.panel, Wave 0 (weighted), own calculations. The logistic regression results are presented as average marginal effects (AME). Results controlled for age and education level.

Compared to people who are not racially labelled, Muslims are 9 percentage points more likely to have to change doctor because their complaints are not taken seriously. This difference remains the same when other socio-demographic characteristics (age, education and gender) are taken into account.

A closer intersectional look at the data not only shows the aforementioned link between racist and sexist views in medicine and its practice, but also reveals that non-racially labelled men are considered the norm. Here, gender-specific assumptions with regard to the sensation of pain and racist stereotypes overlap and result in a collective category of pain-sensitive 'others': racially labelled and non-labelled women as well as racially labelled men. Compared to the non-racially labelled male norm, these 'others' more frequently describe the experience of not being taken seriously in medical care. In Figure 27, all of the racially labelled men surveyed have higher values than non-labelled men (18.9 %). Only the differences between Muslim (26.9 %) and Asian men (24.9 %) and non-labelled men are statistically significant. However, the picture becomes even more meaningful if women are also taken into account. Women, including those not racially labelled, report more frequently than men that their pain was not taken seriously and that they therefore had to change doctors. The difference from the men who were not racially labelled is at least 10 percentage points and is statistically significant for all groups of women considered. According to the available data, discrimination in the medical treatment situation affects Muslim and Asian women the most (Muslim: 38.9 %, Asians: 36.5 %) and is 10 percentage points higher than for women who are not racially labelled and around 20 percentage points higher than for men who are not racially labelled.

Figure 27. **'I had to change doctors because my complaints were not taken seriously', according to self-identification and complaints (differences in per cent)**



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Example: 38.9% of Muslim women state that they have had to change doctors because their complaints were not taken seriously. **Source:** NaDiRa.panel, Wave 0 (weighted), own calculations. N = 15,018. Results controlled for age and education level.

Muslim (38.9 %) and Asian women (36.5 %), in particular, have had to change doctors because their complaints were not taken seriously.

Based on our findings, this is probably not primarily an expression of 'Morbus mediterraneus', which relates exclusively to groups from the Mediterranean region. Instead, a practice in medical treatment can be identified that would be better described as a 'Morbus aliorum' – the illness of the 'others'. In addition to various racially labelled groups, this practice also involves the 'opposite sex' deviating from the usual 'male' norm (see de Beauvoir 1951).

3.5 Conclusion

The findings presented in this chapter show that discrimination and racism are expressed in different ways in healthcare.

High but delayed utilisation: Although the majority of racially labelled people were able to seek medical treatment in the last twelve months, the analyses show differences in the timing of medical care utilisation. If we not only analyse the 'whether' but also the 'when' of healthcare, it becomes clear that racially labelled people tend to go to the doctor later or not at all. This is particularly true for racially labelled women, as becomes clear from gender-specific analyses. For example, every second or third racially labelled woman who frequently experiences discrimination in the healthcare system has delayed or avoided treatment in the last year. Among Black, Muslim and Asian women, it can be even every second person. Among racially labelled men, this figure is lower and affects one in three people.

Barriers to seeking psychotherapy treatment: In the previous chapter, it was shown that people with a name that is not common in Germany are particularly discriminated against when requesting appointments at psychotherapy practices (see Chapter II.2). At the same time, this chapter shows that racially labelled people are quicker to give up seeking psychotherapy treatment. One in three racially labelled people who sought access to psychotherapy care abandoned their search for a place in therapy. Among people who are not racially labelled, this figure is just under one in five. This resignation is particularly notable among individuals who frequently experience discrimination in the healthcare system: more than half of Black, Muslim and Asian people state that they have given up looking for a place in therapy. The general short supply of psychotherapy treatment services therefore affects racially labelled people particularly hard. In light of current research on the effects of racism and discrimination on mental health (see Berger & Sarnyai 2015; Lee & Ahn 2011; Paradies et al. 2015; Pieterse et al. 2012; Priest et al. 2014; Williams & Mohammed 2013), it is extremely alarming when the healthcare system fails to provide equal access and adequate services to particularly vulnerable groups.

Quality of treatment depending on racialisation and gender: In addition to the differences in access to and utilisation of medical services between racially labelled and non-racially labelled people, there are also differences in the quality of medical treatment. When receiving medical care, many people find that their complaints are not taken seriously. Here, gender-specific differences become apparent: more than one in three racially labelled women – but also over a quarter of non-labelled women – state that they have had to change doctors because of this. Among men who are not racially labelled, the figure is just under one in five. This experience not only varies according to gender, but also in terms of self-identification with a racially labelled group. Compared to men who are not racially labelled, racially labelled men more often experience discrimination in medical treatment, although the proportions vary depending on which racial group they belong to. Racially labelled women – especially Muslim and Asian women – most frequently report that their complaints were not taken seriously and that they had to change doctors as a result.

‘Morbus aliorum’: Biased diagnoses that can be attributed to ‘Morbus mediterraneus’, ‘Morbus balkan’ or ‘Mamma mia syndrome’ are not limited to racially labelled persons from certain regions of origin, as the terms imply. Instead, in medical practice, the non-racially labelled man emerges as the norm from which all other people, i.e. racially labelled and non-labelled women as well as racially labelled men, deviate. ‘Morbus aliorum’ – the illness of the ‘others’ – describes the fact that it is not only the majority of all racially labelled groups that are at risk of not being taken seriously by doctors and other medical staff due to their pain symptoms. The experiences of discrimination among women who are not racially labelled cannot be captured by the terms used to date either. These ‘othering’ processes (see Chapter II.4) can lead to differences in diagnosing and treating health complaints. The present results show that it is women in particular who are at risk of receiving inadequate medical care across all groups.

4.

Community perspectives regarding racism in healthcare: A community-based participatory study

Tanja Gangarova, Lina Kabangu, Melike Yildiz

While in large parts of the world racism is extensively researched and recognised as a social determinant of health-related inequalities, in Germany there are very few valid studies regarding healthcare-related racism research. Isolated studies that were developed in recent years (see the section State of research: Racism, health and healthcare) provide selective insights and indicate that racist discrimination also has an effect on health in this country and affects the (re)production of access barriers to healthcare. However, what is missing in the existing literature, as well as in the focal point of the scientific and political discourse – with one exception (Aikins et al. 2021) – is the perspectives of the racially labelled communities themselves. This study starts from this systematic void and investigates the following research questions:

- In what way and with what consequences do Black and African people, those belonging to the African diaspora and those labelled Muslim experience racism in healthcare?[47]

The knowledge being sought here relates to health-related forms and dynamics of racism and to the associated effects and consequences. The study focuses on racialisation processes, and therefore follows a current review of racism in the healthcare sector (see Hamed et al. 2022). Here, not only is the way in which the existing conditions are reproduced of interest, but also what opportunities for change exist. This results in a further research question:

- What action is required from the perspective of people who have experience of racism?

In order to capture racism from the perspective of individuals who have experienced it, the study is designed in the form of community-based participatory research (CBPR).[48] Through the equal participation of the people whose living environment and experiences are being researched, CBPR aims to produce knowledge dialogically in every step of the research process. CBPR also focuses on the research process itself, as racism and other processes which lead to societal inequality may also be reproduced in the research collaboration (see Muhammad et al. 2018). This study therefore suggests critical reflection regarding the epistemological preconditions of knowledge production and the establishment of a dynamic culture of ethical (self-)reflection in racism research.

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[47] The study focuses on experiences in medical practices and hospitals. The study takes the perspectives of racially labelled persons themselves and therefore uses these groups' self-descriptions.

[48] In CBPR, communities are understood as persons and/or contexts that are directly affected by the research topic and the expected results (see Horowitz et al. 2009). For example, not only can professional actors in a context (hospital) be involved, but members of the patient groups whose health and experience are at stake, as well as their relatives and interest groups, are also applicable (see von Unger 2012). In addition, community partners should determine who and what a community is themselves and on a project-specific basis – and then have this validated by other community members (see Minkler 2005).

4.1 Research design: Method and concepts

In this section, the research strategy of community-based participatory research (CBPR) and its implementation in this study will be introduced first. In a second step, the theoretical framework of the study results shown will be presented. This is the result of participatory analysis of the data collected and serves as an interpretative blueprint to qualitatively evaluate the empirical material.

Research perspectives: Community-based participatory research (CBPR)

Historically, hegemonial production of knowledge and research practices have significantly contributed to justifying oppression: research was used to legitimise enslavement and colonisation, to deny the humanity of racially labelled communities and to prove *white* people's supposed superiority (see Jackson, Caldwell & Sellers 2012; Savitt 1982; Washington 2008). Robert Koch's medical experiments on Black people in parts of eastern Africa (see Bauche 2017) are just one example of research in German history that took place on a state-led, systematic basis in colonial and Nazi contexts of violence (for Nazism, see Jütte et al. 2011). In the context of these historical developments, an ethical and methodological review of one's own research practice is warranted (see Chilisa, Major & Khudu-Petersen 2017; Siouti et al. 2022; Smith 2022). It is particularly important to critically question the effects of collecting research data without the participation of the researched communities, and instead to produce and share this data jointly (see Egid et al. 2021). For this reason, this study applies the research strategy of community-based participatory research. CBPR in healthcare research requires that representatives of the community whose experiences and health is being researched be involved in developing research questions, collecting data collection, and analysis, as well as in interpreting and evaluating the research results, from the outset and on an equal footing (see Wallerstein 2020). The goal of this is to create new knowledge together, to encourage the empowerment of all those involved and to develop action strategies in order to break down health-related inequalities (see Israel et al. 1998). CBPR as a research strategy also strives to reduce the power imbalance between researchers and the individuals being researched (see Gaventa & Cornwall 2015). Here, the principles of CBPR display a special feature: they include an explicit prompt to critically reflect on power aspects and discrimination with regard to various dimensions (including 'race') in every research phase (see Wallerstein et al. 2018).

CBPR has various advantages, including access to groups, living environments and experiential worlds that are hard to reach via other forms of research, transparency for research-ethical processes, adequate survey instruments, an interpretation of the results that is sensitive to context and diversity, and relevant recommendations for action that can be put into practice successfully (see Minkler 2005). Today, numerous literature reviews show that CBPR can have a positive effect on health outcomes and the transfer of knowledge in marginalised communities (see Drahota et al. 2016; O'Mara-Eves et al. 2015; Ortiz et al. 2020).

The implementation of CBPR in this study

The degree of participation with which CBPR studies can be implemented depends on the resources of those involved and the general conditions of the study in question. In this study, we formed a team of two peer researchers (the co-researchers: Lina Kabangu and Melike Yildiz) and one representative of the research institute (Tanja Gangarova) – the three authors of this article. Peer researchers are participants from the communities being researched. They are therefore involved in a special way: they become partners in the research process, meaning they are involved in researching, making decisions, and realising the project (see Roche, Guta & Flicker 2010). To be able to realise their participation in practical research, the peer researchers were trained in advance in the fields of research ethics and data protection, study design and methodology, focus groups and presentation techniques, data management and participatory data evaluation, and were employed as paid researchers for the duration of the project. The two peer researchers contributed significantly to defining the formulation of the research questions, selecting the individuals taking part in the study, selecting and implementing survey methods, and analysing and processing results. In order to guarantee the methodical quality of the participatory evaluation and assessment, an independent advisory board was convened and continually involved in the research process. The advisory board consisted of three experts (two of which were people of colour) with expertise in the field of migration, racism and participatory health research.

The involvement of 14 study participants – Black people, African people, people belonging to the African diaspora, and people labelled as Muslims – took place through the peer researchers' networks.[49] The team's multilingualism was a crucial resource here. The study participants were chosen to be as diverse as possible, in order to represent a broad spectrum within the community. Characteristics such as gender (seven women, six men, one non-binary person), age (people aged from 19 to 65 years old), various levels of education, origins in different countries (Germany, Turkey, Iran, Morocco, Algeria, Egypt, Uganda, the Congo, Kenya, Cameroon), German citizens, people with various residence documents (refugees, residence permits, illegalised people) as well as residence in different federal states were also taken into account.

The qualitative survey in the form of six focus groups (see Bär et al. 2020) – three focus groups with two subsamples of seven participants – was carried out between April and June 2022. The focus groups were designed to be bilingual (in German and English)

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[49] CBPR requires the establishment of relationships with community partners. To realise an ethical research process within the planned duration of the study, it was decided to initially work with communities to which access had already been established. Further communities will be included in subsequent studies.

and to build on one another, with the aim of achieving comprehensive participation as well as empirical anchoring, and thus proximity to the experience of the interviewees. The topic structure of the guidelines was derived from the initially formulated research questions: a) experiences with barriers and discrimination in healthcare and their consequences, particularly with regard to anti-Black and anti-Muslim racism, b) strategies regarding discrimination and c) recommendations for action from the participants. The six focus groups lasted 90 minutes and were carried out as video conferences due to the COVID-19 pandemic. The leadership was split dialogically between the researcher and the peer researchers (see Krueger & Casey 2015). Audio recordings of the discussions were transcribed and pseudonymised.

The data was evaluated using DEPICT, a participatively designed process for qualitative analysis (see Flicker & Nixon 2015). Through the participation of peer researchers in all stages of evaluation, DEPICT aims to democratise the process. The focus group material was evaluated using the DEPICT concept and MAXQDA software, with inductive and deductive processes complementing each other. The preliminary research results were discussed and interpreted by participants of the focus groups in additional meetings – this then further contributed to the results (see Russo 2020).

The DeZIM Institute’s Ethics Committee[50] voted to classify the study as unobjectionable with regard to research ethics (ID: DI-2022-0003). The study participants were informed in detail, both verbally and in writing, about the aim of the study, the confidential treatment of the research data, and the anonymous and voluntary nature of their participation. The study participants were able to withdraw their involvement at any time. They decided for themselves whether, how and which personal data was permitted to be collected, interpreted and published – in dialogue and in a processual way. A written and verbal declaration of consent was collected from each participant in this regard. Reflections on research ethics took place in all study phases in the form of feedback loops within the core team, with the advisory board and with external supervision.

Theoretical concepts

The central theoretical reference points of this study and its results are the concepts of othering (see Said 1978; Spivak 1985, 1988) and of silencing (see Dotson 2011). While these concepts are applicable in general and to various areas of society, in this study they refer to healthcare.

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[50] The DeZIM Institute’s Ethics Committee is a committee of the DeZIM Institute that examines research projects by DeZIM Institute scientists with regard to their ethical soundness (https://www.dezim-institut.de/institut/ueber-das-dezim/gremien/ethikkommission; last accessed on 6 July 2023).

Othering

The concept of othering, which comes from postcolonial theory, describes a differentiation process whereby an imagined 'we' is discursively created in distinction to the 'others' and 'foreigners'. Here, the 'we' is considered the norm and the 'other' as anomalous, and the two are placed in a hierarchical relationship (see Said 1978). Othering therefore reproduces a lower, inferior position and leads to repression and marginalisation of the supposed 'others' (see Mecheril 2009). Through this binary categorisation, the unequal distribution of privileges and social resources is legitimised and existing power structures are protected (see Riegel 2016). Othering is relevant on various social levels (interpersonal, institutional, structural) and can refer to various social dimensions (ibid.), meaning that different forms of discrimination can intertwine (intersectionality) (see Spivak 1985). Kien Nghi Ha et al. (2007) point out that 'white "normality"' is also anchored in German institutions and structures, and that one-sided speaking conditions are created through othering processes: 'The white norm speaks, judges and remains invisible in this powerful process; the 'others' are discussed, analysed and devalued, thus becoming supposedly mute, ahistorical objects' (Ha, al-Samarai & Mysorka 2007: 10; see also Spivak 1988). This results in the individuals categorised as 'others' not being identified or recognised and heard in their position as being knowledgeable, but are discriminated against and/or silenced.

Hegemonial discourse in postcolonial Western societies continues to be shaped by othering processes. For example, Grove and Zwi (2006) showed how refugees are primarily presented in public discourse in Western host countries as a threat, and that this interlocks with the field of public health. Ethnic categories with which health science knowledge regarding migrants is generated can also create othering effects by transmitting the image of migrants as (potential) 'carriers of disease' (see von Unger, Odukoya & Scott 2016). This also applies to derogatory expressions that are institutionalised in healthcare contexts based on widespread racist assumptions. The so-called Mediterranean syndrome or 'Morbus mediterraneus' (see also Chapter II.3), for example, is a derogatory term for the prejudice that assumes that migrants tend to exaggerate when expressing pain (see Castañeda 2012). Othering is embedded in discourse regarding power and representation (see Akbulut & Razum 2022), which shape social practices and interactions, including in healthcare contexts.

In a qualitative ethnographical study, Johnson et al. (2004) show links between othering and health-related inequality using the example of healthcare for southern Asian women in Canada. They document the framing of diagnostic investigations and treatment by stereotyping patterns of attribution, us-them differentiations, and therefore the construction of the patients as 'others'. Othering processes as a basic pattern of anti-Black racism in German healthcare was proven by Aikins et al. (2021): they show how racist thought patterns and behavioural patterns impede access to medical treatment on a structural and individual level. Alongside the construction of Black patients as 'others', their experiences are constantly devalued and denied, which leads to ‘normalisation of the practice of racism against Black people’ (ibid.: 147). Hamed et al. (2020) analyse patients’ experiences of racism in Sweden, Germany and Portugal as structural violence that negatively influences access to care as well as treatment. In this and other studies regarding the experiences of racism of Black people and patients ‘with a migration background’ in GP care in Germany (see Gerlach et al. 2012; Gerlach, Becker & Abholz 2008), those surveyed report a lack of respect and that they were not identified or recognised as fully fledged participants, but were instead viewed as ‘others’. Contradictory behaviour was shown among medical professionals, as well as devaluation and an expressed sensation of distance to the patients (see Gerlach et al. 2008), and ascriptions of collective characteristics, such as pain tolerance (Gerlach et al. 2012; Aikins et al. 2021; Hamed et al. 2020; see also Chapter II.5) or hypersexuality (Aikins et al. 2021). These ascriptions are often accompanied by misdiagnoses or delays in treatment (Aikins et al. 2021; Hamed et al. 2020; Gerlach, Becker & Abholz 2008). Repeated confrontations with othering in healthcare contexts lead to serious psychological stress and a loss of trust in care structures (see Aikins et al. 2021; Hamed et al. 2020; see also Chapter II.3).

In addition, access to healthcare is particularly restricted for those going through asylum procedures. According to the Asylum Seekers’ Benefits Act (AsylbLG), in the first 18 months of their stay, asylum seekers only have a restricted claim to healthcare services, such as for the treatment of acute illnesses and pain, to support with pregnancy and birth, and for vaccinations (see Gottlieb & Schülle 2021). In seven German states, access to these services is granted via the benefits authorities – this means that staff who are usually not medical experts decide on whether a visit to a doctor’s surgery is necessary (see Lindner 2022). Isolated studies conceptualise these restrictions as part of othering processes in terms of systematic marginalisation and social exclusion (Bozorgmehr & Razum 2015). Little is known regarding how asylum seekers experience their access to healthcare. Although racism is not named explicitly, some studies provide indications of racist discrimination that is expressed in the form of experiences of rejection, delays to treatment, incorrect treatment and language barriers (see Nowak & Hornberg 2022; Spura et al. 2017).

Silencing

Silencing is a concept of postcolonial theory that describes how marginalised groups’ voices are suppressed. Originating from Spivak’s (1988) understanding of epistemic violence, i.e. the intertwining of power and knowledge, the American philosopher Kristie Dotson conceptually develops different variants of silencing processes on a micro-level and shows how these lead to marginalised people not being heard (see Dotson 2011). She uses the term ‘testimonial quieting’ to describe cases in which someone speaking is repeatedly not identified or recognised by their audience as being knowledgeable and is denied their capacity to act, for example due to discriminatory prejudices and stereotypes. During ‘testimonial smothering’, on the other hand, the person speaking silences themselves due to perceived ignorance of their audience, by dissimulating or reducing their speech (see ibid.: 244). With reference to Patricia Hill Collins (2000) and Charles W. Mills (2008), Dotson argues that not listening represents an active practice of ignorance or not wanting to know, which is fundamentally enrolled in the colonial nature of power and knowledge (see ibid.: 242). Both forms of silencing can be triggered by racist microaggressions (see Sue et al. 2007; regarding microaggressions, see also Spanierman & Clark 2023).

Hamed et al. (2020) show how asymmetrical power structures in healthcare prevent patients from disclosing exposure to experiences of othering. Qualitative studies of medical professionals in Sweden and Canada document how experiences of racism in the workplace are not discussed due to fear of the consequences (see Ahlberg et al. 2022; Beagan, Bizzeth & Etowa 2022). Instead, the resulting emotions and feelings are suppressed. The studies suggest that silencing processes can lead to the normalisation of racism in healthcare.

The concepts of othering and silencing are intertwined. However, an analytical separation allows for understanding of the reproduction of racism on different levels. The framework sketched here is intended to serve as a blueprint for interpreting the results presented and to contribute to understanding and integrating them.

4.2 Results

Two mutually linked dynamics prove to be central in the analysis of the data:[51]

- **a.** Being viewed as different and inferior (othering): In a multidimensional process, the study participants were categorised as not belonging and as anomalous, and were thus devalueb.
- **b.** Being reduced to silence (silencing): The study participants were not heard because they were silenced or no longer expressed themselves due to previous bad experiences or fear.

These dynamics are presented by means of the empirical material (interview passages from the focus groups) and categorized theoretically. The data shows that the dynamics described are closely intertwined with each other. For better understanding, they are shown as separate entities. On the one hand, they include the dimensions of health-related practice, as well as those of health-related policies on the other.

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[51] Further dynamics, which were worked out from the experiences of the study participants, will be presented in subsequent publications.

Being viewed as different and inferior (othering)

The experiences described by study participants in healthcare can be described by a process of generating the ‘other’ (constructing otherness). In interactions in healthcare, they were situated as intrinsically ‘other’ (foreign). Their audiences perceived aspects such as name, skin colour, a head scarf, actual or perceived religion, language, dark hair or a beard – known as ‘markers’ – and initially suspected they belonged to a specific group, and therefore had stereotypical attributes.

The following passage from a focus group conversation illustrates how noticing a marker, such as being Black, leads to Black people being de-individualised by medical professionals, homogenised as a group and construed as substantially different, in this example as being insensitive to pain:

> *‘They just don’t realise that we are individuals, everyone is different [...] just because one patient [...] is resistant to pain doesn’t mean that all people who are from Africa don’t experience pain.’ (Paul)*

Furthermore, there is a description of how the process of creating the ‘other’ is dependent on transitory and colonially influenced racist and discursive knowledge bases. Specific projections made onto Black bodies during the colonial period, for example the assumption that Black people were less sensitive to pain (see Bourke 2014). The following passage illustrates how these ideas become linked to assumptions regarding poor healthcare in countries which are economically worse off. This can lead to discrimination:

> *‘In the healthcare system, many people think that Black people can endure a lot of pain, because they come from countries where many are poor and where you don’t have much, where you have to learn to deal with pain, where medical care is really bad anyway, so you can make them wait a long time – like in my case.’ (Lilliane)*

Specific practices for generating ‘others’ in healthcare were portrayed in the focus groups – these vary according to the markers and discourse of knowledge invoked. While Black people are ascribed an insensitivity to pain (see also Gerlach et al. 2012; Aikins et al. 2021), those perceived as Muslim are alleged to be oversensitive to pain (see Castañeda 2012). The study participants who were perceived as Muslim reported that they and their relatives had been refused treatment because their complaints were not taken seriously – with grave consequences. These experiences coincide with the results of the quantitative surveys from the NaDiRa.panel (see Chapter II.3):

> *‘They [A&E at the hospital] said: “No, now don’t make a fuss”. And at some point he absolutely couldn’t breathe. This time they took him to hospital by ambulance. It turned out that he actually had COVID. [...] He*

> *had to be ventilated straight away. [...] He was triple-vaccinated. [...] They even rang the GP to ask whether it was really true or just a fake. At some point the GP rang: "Oh yes, the PCR test was positive". "Thank you. We no longer need that information. He's already in the process of dying."' (Pari)*

Intersectional dynamics are indicated by statements in which a female Black patient was offered an HIV test in the field of gynaecology without having requested it. Behind this is the colonially influenced ascription of hypersexuality to Black people, in this case Black women, and the perception that they are carriers of diseases. This is also referenced in contemporary discourse, as previously shown by other German studies (see Scott, von Unger & Odukoya 2017). Analogously to this, Black study participants report that they were offered HIV tests:

> ❞ *'You go to Frauenarzt [gynaecologist], and they would ask you: 'Have you already done an HIV test?' Only because you are Black, they would test.' (Rose) [English original]*

Various markers lead to different assumptions despite comparable situations: while Black women are hypersexualised in healthcare (see also Aikins et al. 2021), Muslim women are denied independent sexuality – an assumption which at times links to colonial interpretations of the Muslim head covering as a symbol of the oppression of women (see Attia 2014). The following quote shows how a female Muslim participant was automatically categorised as belonging to the group of 'women of a certain culture' – with the assumption that the patient would not be particularly sexually active and that there was thus no reason to carry out the requested healthcare services:

> ❞ *'When I once asked the gynaecologist about an STI test*[52]*, she appeared abashed and told me not to worry too much, that it was rather unlikely for women from my culture. For women from my culture?' (Taslima)*

The quote also implicitly indicates distancing on the doctor's part from a culture that she labels as not hers but as 'other'. Studies by Gerlach et al. (2008) and Johnson et al. (2004) empirically prove this differentiation between a supposed 'own' culture and a supposed 'other' culture (see also Chapter II.5).

Other narratives regarding Muslims also slip into interpersonal communication in healthcare and can illustrate gender-specific influences. One male study participant describes how he, perceived as Muslim, is associated with Islamic terrorists and that this negatively influences the quality of his treatment:

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[52] The abbreviation STI stands for 'sexually transmitted infections'. More information can be found on the website of the WHO: https://www.who.int/health-topics/sexually-transmitted-infections#tab=tab_1.

> *'He prescribed a medication that has some side effects like mental health side effects. "You need to be careful because one of the people in the plane of 9/11 was taking this medication." He was making the association between me and the terrorist instead of saying people can get angry, get depressed, etc., which is written on the Beipackzettel [package slip]. […] This assumption about me resulted in not answering my questions, not giving me the best treatment and the general feeling of not being cared for.' (Ahmad) [English original]*

As was shown throughout the focus groups, which built upon each other, the experiences described do not represent isolated incidents. Instead, the participants noted a repeating pattern:

> *'After the last interview [focus group], I realised that such events, whether in the healthcare system or elsewhere, are not isolated cases. [...] Everyone has something to tell and has apparently experienced something like this more than once.' (Paul)*

The normative processes of creating the 'others' were described as extremely efficacious by the study participants, as expressed by the following passage:

> *'Such cases happen exactly at the moment when you don't expect them [...] when you're at the health authority or go to the doctor's office. [...] in such moments you get a reality check, so to speak [...] you feel uncomfortable and also disrespected, you think to yourself: wow, I'm living my normal everyday life, I've obeyed the law and I'm doing everything [...] but then there are always moments between the lines that bring you back and show you: things are different.' (Paul)*

It appears that, independently of how a person acts, it is not always possible to evade othering processes or to control or influence them.

The creation of the 'others' in health-related politics

The law, in particular the Asylum Seekers' Benefits Act, becomes apparent in the focus groups as a significant setting of labelling as 'different' to the normal case. Study participants report that legal specifications not only complicate access to medical treatment but also legitimise and perpetuate the responsible authorities' marginalisation practice. The following passage illustrates the development, interdependency and reproduction of structural, institutional and interpersonal racism in healthcare:

> *‘There are also structural factors like German laws which are already established and block the access to medication or medical treatment. The person who doesn’t have ‘this and this’ is not allowed to have access to this and this. These laws help the authorities like Ausländerbehörde [Immigration Office] and Sozialamt [Social Security Office] to say “We are acting according to the law”. It is in the law. So, we are not acting discriminatory.‘ (Rose) [English original]*

Statements from participating refugees show how the legal requirement for social welfare offices to assign medical vouchers leads to a delay in or even prevention of medical treatment for ill people. During this process, non-medically qualified personnel make decisions regarding the necessity of such treatment:

> *‘These are horrible moments because I was really sick and I needed my medication. At the end I got the Schein [certificate] but too late, after a week.’ (Aziz) [English original]*

> *‘At the beginning of the asylum procedure, I always had to go to the social welfare office and convince the case worker that I really needed to see a specialist doctor.’ (Peroz)*

Even when staff in the social welfare offices are convinced and the ill person receives a medical voucher, the necessary medical treatment is not guaranteed – even when there is goodwill on the part of the doctors. This is because the restriction to healthcare services for asylum seekers, anchored in the Asylum Seekers’ Benefits Act, determines the options for medical treatment (see Gottlieb & Schülle 2021):

> *‘However, he [the dentist] said that he was not allowed to treat my teeth because I am still in the asylum process and the costs of the treatment are not covered. He is only allowed to remove my teeth.’ (Taslima)*

These statements illustrate the effect which the Asylum Seekers’ Benefits Act has on institutions (social welfare office and medical practices) and their employees: through non-approved or reduced medical services and through inexpert preliminary evaluations. The hierarchisation of access to the healthcare system results from linking the right to health with residency status. This restriction downgrades health from a human right to a civil right (see Ooms, Keygnaert & Hammonds 2019) and contributes to the social exclusion of those affected (see Bozorgmehr & Razum 2015).

Internalisation of othering experiences

Individual or continual experiences with othering and racist discrimination were frequently described by study participants as painful and can have a negative influence on participants' perceived (human) dignity and their self-worth:

> *'I phoned them [...] they gave me an appointment [...] until they asked me for my name [...] and then they said: "Well, the appointment, it's not possible after all. Call at a later date". [...] It was actually quite painful – on the one hand, because then of course I have to wait longer for an appointment, and on the other hand, my name is part of my identity [...] That grates on my dignity, to be honest.' (Hamid)*

For some study participants, these experiences triggered a perception of themselves as 'different' – an example of how racism 'also acts within the dominated subjects' (Hall 1994: 20) and of how othering is internalised. This can cause people to consider themselves inferior (see also Hamed et al. 2020) and to question themselves. Some also try to receive less degrading treatment and thus maintain their self-esteem by modifying their behaviour more heavily in medical practices:

> *'I am asking myself why, and of course this is one of the mental health impacts of discrimination, being sick in healthcare and not feeling cared for. So, that's why you start questioning yourself. Why is this happening? Is something wrong with me? Did I do something wrong or should I do more to present myself in a way that the doctors care about me?' (Ahmad) [English original]*

The experiences described with othering in healthcare are often associated with serious psychological stress for those affected (see also Aikins et al. 2021, see also Chapter II.3). The internalisation of the ascription of being 'different' can in isolated cases also lead to people doubting that they are 'worthy' of receiving good treatment, as the following statement expresses:

> *'As I said, you're not respected and at some point you no longer respect yourself either. Then you say: "Wow, there's no point in going to the doctor, I'd rather stay at home and endure the pain".' (Paul)*

The quote shows that people decide not to visit a doctor out of fear of poor treatment (see also Chapter II.3). This dynamic is examined in more detail below.

Being silenced

Silencing is apparent as an additional dynamic in the experiences described by the study participants. By means of the statements, two interlinked forms of this dynamic can be portrayed: (1) study participants are not identified or recognised by medical staff as knowledgeable subjects with the power to act, for example due to racist prejudices, and are not heard or listened to (‘testimonial quieting’), (2) study participants do not even articulate their concerns because – due to presuppositions based on experience – they assume that their audience will not display an appropriate understanding of their concerns (‘testimonial smothering’). Fear of possible consequences of articulation of their concerns also leads to remaining silent and influences attempts to establish the capacity to act.

Being silenced can occur in direct, interpersonal communication. The following passage illustrates how a religious symbol – in this case, the headscarf – functions as a marker for a culturalised image of a lack of education in women. The voice of the study participant is not heard, meaning that she is unable to express her needs as an equal – subsequently, decisions can be made without her involvement:

> *‘And so you very often find yourself in a situation, as I experienced at the doctor’s, where they ask you whether you can read these documents yourself. They talk to me in German, but had already assumed that I’m illiterate [...] because I wear a headscarf. Or that they absolutely want to make all decisions concerning my body.’ (Taslima)*

Even when study participants do not literally remain silent, the knowledge they articulate is devalued or actively ignored. Their requests are disregarded or not heard, which can sometimes lead to serious health implications. Another study participant reports:

> *‘He [the doctor] said: “I want to do a vaginal sonography.” [...], “I don’t want vaginal.” Then he said to me: “How long have you been in Germany? Well well, still not integrated.” [...] “No, I don’t want you as a man examining me vaginally. I trained in sonography myself and know that there is another way.” He said, “If you don’t like a vaginal examination, I can’t do anything for you. Bye.” [...] I knew that bleeding is not a good sign, and I also had pain. After a week, the baby was gone.’ (Mahnusch)*

The statements show how repeated experiences of othering and devaluation can lead to healthcare contexts representing an unsafe environment for the communication of concerns. Some study participants develop corresponding approaches to process experiences or protect themselves.

These include repression, ignoring, and making a conscious decision to remain silent:

> *'I work in the medical field, I can't remember my private experiences in this context because I've repressed a lot of things. For me, that's racism.' (Pari)*

The strategy of ignoring these experiences is described as painful and indicates the emotional work carried out by the participants:

> *'It is pain, it's not easy but if you have taken too much racism at the doctor's place, at the authority (Behörde), from the police… you ignore, you are quiet – you understand?' (Aziz) [English original]*

Female participants report attempting not to stand out by adapting the way they act. Some abandon wearing a headscarf in order to reduce markers of difference and thereby prevent potential racist discrimination as female Muslims:

> *'I'm waiting until one day my daughter doesn't want to wear a headscarf either, because she's had so many bad experiences. And she also has friends who don't wear headscarves.' (Mahnusch)*

Silencing can be understood primarily via its specific framework, as argued by Dotson (2011) and Bradby et al. (2019). In healthcare, asymmetrical power structures become particularly apparent in the silencing processes described here: the healthcare system is mostly accessed when people are in urgent need of help (see Bartig et al. 2021: 17). Medical personnel also have access to medical resources and professional knowledge, which places them in a position of power with regard to those searching for help. The resulting dependencies and vulnerabilities make it particularly difficult for those affected to fight back against racist discrimination. A study participant describes the inhibition against naming racism – out of concern of jeopardising the doctor-patient relationship, and subsequently the quality of medical treatment:

> *'Sometimes you want to complain but you don't want to put the word racism […] you still have the burden of being discriminated but still trying to put it in a nice way because you are still a patient. You still want to receive the service […] especially if you are in the middle of a treatment that started long ago.' (Ahmad) [English original]*

It is particularly difficult for study participants with legal conditions, such as asylum procedures. A study participant describes the cross-situational structural dependencies that shape interactions in healthcare contexts: As an asylum seeker, she – or her healthcare – is dependent on the Asylum Seekers' Benefits Act and the social welfare office, which is the authority that makes decisions regarding awarding treatment vouchers. This has effects on the behaviour of patients who are confronted with weighing up whether to address their experiences of racism or avoid naming these experiences because they anticipate consequences:

> *'If you are in a dependent situation like this, such as at the doctor's practice or a public office, you will think eight times before you actually say something against it, because you might not be able to choose another doctor because of the asylum procedure.' (Taslima)*

Other study participants report how negative experiences and the resulting silencing can contribute to the reproduction of structural discrimination. They lose trust in the medical system and stay away from the available treatment despite their needs:

> *'Why should I go to the doctor? Why should I have any trust at all? [...] if I've already had several negative experiences with a* white *doctor or a* white *institution, why should I trust that they suddenly want something good for me?' (Lilliane)*

There is a double exclusion mechanism at work here: discrimination regarding utilisation of services (when in contact with medical staff), but also via avoidance of the utilisation of care structures due to previous experiences of discrimination (see also Chapter II.3; see Aikins et al. 2021; Hamed et al. 2020).

4.3 Conclusion

This study aimed to record the processes and mechanisms of racism and discrimination in healthcare (medical practices and hospitals). The two dynamics presented – othering and silencing – make it possible to understand the experiences of and how to handle racism and discrimination in these contexts and open new perspectives for future further development of health indicators for the measurement of racism in healthcare.

People affected experience inequalities via othering on a formal and informal level: Analysis of the data shows that othering is experienced on various levels, which can also be interlinked. Othering can take place both formally through laws and informally through racist knowledge bases and practices, and exhibits itself in inequalities in healthcare. These inequalities include legal restrictions, differing access to the healthcare system, and differences in treatment and therapy. Statements from participants thus show how racist knowledge bases and behaviour patterns in healthcare can lead to a lack of assigned appointments (see Chapter II.2), long waiting times, denial or misjudgements of complaints (see also Chapter II.3), delays to and even refusal of treatment. A loss of trust in the healthcare system, avoidance of utilisation of medical care, and a deterioration in (mental and physical) health of those affected were described as possible consequences by study participants.

Othering has different effects on those perceived as Muslim and Black people: The study was able to prove specific othering practices for healthcare contexts – for example, when racist knowledge bases are used to insinuate a supposed oversensitivity or undersensitivity to pain or hypersexuality. At the same time, the study contributes to the empirical research on the specifics of different types of racism (racism against Black people, racism against Muslims). It is thus shown how othering is expressed differently with regard to those perceived as Muslim and with regard to Black people in healthcare and that this can lead to different forms of discrimination.

Silencing stops the thematisation of racism: The study results show that repeated experiences of othering, devaluation and ignorance can lead to individuals affected being implicitly silenced or remaining silent themselves out of fear of the consequences. Here, a powerful dynamic is at work, which leads to the invisibility (‘normalisation’) of racism in healthcare contexts and which can reinforce existing power inequalities. The outlined dynamics of othering and silencing, as well as their consequences, were experienced by all study participants, independently of whether they were born and grew up here or whether they came to Germany as asylum seekers or migrants.

The human right to health is legally restricted for asylum seekers: Structural differences occur for those participants who are asylum seekers, and othering is associated with the deprivation of rights. Their statements show how the restrictions to healthcare services that are anchored in the Asylum Seekers’ Benefits Act delay the treatment of certain illnesses or make treatment impossible, with serious impacts on the health of those affected in some cases. The restriction on healthcare services due to the national origin of those searching for protection violates their human right to health (see CERD 1965[53]).

Community-based participatory research provides in-depth knowledge regarding racism in healthcare: To make equal access to the healthcare system possible for all people living in Germany, targeted anti-racism strategies are required. Here, there is a need for further research that draws on the experiences and perspectives of those affected. Actively including individuals with experiences of racism in all phases of the research process reinforces the establishment of relationships and trust, as well as of democratic production of knowledge. Via the situated knowledge (see Haraway 1988) of peer researchers and participants, it was possible to collect data in a context-sensitive and diversity-sensitive manner in this study, and to interpret it from various perspectives. The qualitative analysis made it possible to demonstrate in-depth insights into processes and (latent) dynamics such as othering, as well as into their

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[53] In 1969, Germany ratified the Anti-Racism Convention, which has been binding under international law and directly applicable law in Germany ever since. The convention also contains the following obligation: ‘[...] States Parties [...] shall guarantee the right of everyone, without distinction [...] of national origin [...] to equality before the law, in particular the right to public health care, medical care, social security and social services’, Committee on the Elimination of Racial Discrimination (CERD).

intersectional manifestations. CBPR also makes it possible to confront non-intentional othering in research via optimisation of research ethics processes.

The study's research design is intentionally qualitative and can and should not make any statements beyond participants' experiences. Instead, it illustrates the operating principles of racism in healthcare and indicates the areas where there is a need for action. In contrast to classical research, CBPR studies have a goal of action, which was implemented here collaboratively with study participants in additional meetings in the form of the development of recommendations for action. These recommendations for action therefore form part of the study results and are presented here as part of the chapter, but are additionally summarised in the recommendations for action of the report as a whole (see chapter Recommendations for action).

4.4 Recommendations for action

In order to combat racism in healthcare, it is necessary to act on a micro-, meso- and macro-level, taking various parties into account. The results of the study show that it is necessary to orient healthcare and the relevant measures in a way that is critical of racism and power.

Practice

- Advanced and further training to break up racist knowledge bases for employees in hospitals and medical practices, which is certified by the Medical Chamber and offers appropriate further education points.
- A higher staffing ratio and more time available for doctor-patient interactions to improve working conditions in healthcare institutions.
- Funding for language mediation and language skills of employees, as well as multilingual and multimedial design of services to break down language barriers.
- Establishment of independent complaints bodies in order to counteract the existing mistrust of the healthcare system.
- Monitoring and evaluating cases of discrimination in the healthcare sector in order to actively counteract racism and human rights violations.

Communities

- Collaborative support for Black and African people, people belonging to the African diaspora and people perceived as Muslim via structural support of self-organisations and self-help.
- Appropriate information regarding the legal framework and legal rights in the German healthcare system.

Research

- Targeted funding of community-based participatory racism research, taking power-critical and racism-critical research ethics principles into account.
- Establishing community ethics committees at universities, colleges and other research institutions that critically accompany research processes and offer consulting support.
- Increased consideration of multiple discrimination within racially labelled communities with regard to research projects (e.g. racially labelled people with disabilities).
- Funding for racism research that focuses on the individual and collective strategies with which those who experience racism navigate through racist structures (agency).

Specific measures for asylum seekers and people without health insurance

- Germany-wide introduction of the electronic health insurance card for asylum seekers, as is already the case in several federal states, in order to break down barriers to accessing medical treatment.
- Review of the restricted access to medical treatment (§§ 4 und 6, AsylbLG) for asylum seekers in the first 18 months or adjustment of the entitlement to medical benefits to reflect the GKV catalogue of services, in order to create discrimination-free access to healthcare for all people living in Germany.
- Curtailing § 87 of the Residence Act (the ‘reporting obligation’) for the healthcare sector, as was included in the Federal Government’s coalition agreement,[54] so that in the future ill people without a regular residency status are not prevented from receiving medical treatment.
- Germany-wide establishment and long-term secure financing of clearing offices for people without health insurance or with unclear insurance status, which not only provide advice but also make it possible to arrange medical treatment and finance treatment costs.

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[54] Section 87 of the Residence Act (AufG) (Obligation to report) obliges the social welfare office to report individuals without regular residence status to the Immigration Office or police immediately if they apply for the costs of medical services to be covered. This can lead to ill people being deported. For this reason, many undocumented migrants also avoid anonymous healthcare services for fear of deportation. The current coalition agreement stipulates that Section 87 of the Residence Act is to be reviewed or suspended for the healthcare sector. (SPD, ALLIANCE 90/THE GREENS, FDP 2021: 111, available online at: https://www.spd.de/fileadmin/Dokumente/Koalitionsvertrag/Koalitionsvertrag_2021-2025.pdf, last accessed on 3 July 2023)

5.

Racism in medical training: A participative and explorative analysis

Doctors play a central role in the provision of healthcare. Their social action competencies and areas of responsibility are far-reaching. Their training can therefore be viewed as a crucial structural element in society’s handling of health. In the USA, it is already a central component of the discussion of racist inequalities in healthcare (see Liaison Committee on Medical Education [LCME] 2023; Gonzalez, Kim & Marantz 2014). The National Skills-Based Learning Targets Catalogue for Medicine 2.0 (NKLM 2.0)[55] also addresses racist discrimination in medical training. However, this thematisation is described by the federal representation of medical students in Germany as insufficient and in general is discussed critically by the NKLM with regard to racism (see Finke, Gerhards & Honerkamp 2022).

In research, the study of medicine is examined in the context of racism in Germany by three studies above all: the Afrozensus names both difficult professional admission for Black doctors, as well as a lack of analysis of othering processes, stereotyping and the consequences of racism for health (Aikins et al. 2021: 139–145). A second study which focuses on the topic of medical training in Germany particularly refers to the perspectives of students with and without experiences of racism: racism in medicine and in the healthcare system is perceived as an omnipresent phenomenon by all students. Subsequently, students consider it important to take action on various levels against racism in medicine and the healthcare system, starting with medical training. However, as there is no consistent understanding of racism, it is difficult for many students to recognise racist behaviour patterns and structures (see Gerhards, Schweda & Weßel 2023). The work of Houda Hallal (2015) regarding diversity in human medicine training can be linked to results from international research and represents important starting points for this study (see Amutah et al. 2021; Chapman, Kaatz & Carnes 2013; Gonzalez, Kim & Marantz 2014; Hernandez 2018). Hallal therefore describes the unreflecting internalisation of ‘normative and monocultural structural characteristics of [medical] institutions’ (2015: 28) in Germany and the potentially resulting application of ‘prejudices, stereotypes and “reductionistic interpretations”’ (ibid.) in medical practice.

This analysis approaches the question of racism in medical training. It focuses on samples from teaching materials from the study of medicine in Germany and reflects on these via interviews and focus group discussions with racially labelled students and doctors. During this process, the experiences of the interview and focus group participants are the focus. The results provide initial indications of which aspects and restrictions should be given particular attention in further, more in-depth studies and practical treatments of teaching materials and teaching practices in the study of medicine. They also contribute to the development of new indicators for research

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[55] The National Competence-Based Catalogue of Learning Objectives in Medicine (see the German Association of Medical Faculties (MFT) 2021) defines ‘Competences that are based on the professional profile of the doctor [...] and that should be available after completing the respective degree programme. In addition to knowledge and skills, these also include overarching learning objectives such as attitudes, scientific competences and so-called soft skills’ (from the website of the MFT). The NKLM 2.0 is to lead to a new licence to practise medicine in Germany in 2025.

on racist discrimination in medical training. The following questions provided the guidelines for this study:

(1) Is there racist knowledge in medical teaching materials and practices? How is it conveyed and, if applicable, reflected upon?

(2) Which aspects of this knowledge are given particular weight through the reports of racially labelled medical students and doctors – both with regard to their own professional positions and regarding the influences of standards of behaviour and prejudice (bias[56]) on the part of doctors on patient care?

(3) What role do the links between various institutional dimensions (parties, documents, contexts) play in legitimising and perpetuating racist knowledge bases and practices?

5.1 Research design: Concepts and method

Central concepts in this study draw on approaches from the sociology of knowledge and studies of curriculum research and are explained below.

Medical habitus and *hidden curriculum*

This study is based on the assumption that acquiring and applying medical knowledge goes beyond purely medical and scientific knowledge and skills. Norms and behaviour patterns that are conveyed during medical training rather subliminally or informally via a *hidden curriculum* as a medical habitus are essential for training (see for example Goldie et al. 2007; Witman 2014).[57] When interacting with colleagues and patients, much depends on an internalised professional self-image in which social stratification and the corresponding differentiation are included as an important dimension (see Bourdieu 1988: 90–91). The associated standards and behaviour patterns are combined with medical expertise, scientific requirements and professional practices. All this shapes doctors' self-image and human image, and therefore their contact with patients

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[56] Bias is a term from prejudice research, taken from the field of social psychology, as it relates to the area of cognition, i.e. the perception of the individual person. The term 'implicit bias' is also frequently used. This refers to automatic (difficult-to-control) associations that can be both conscious and unconscious, and can influence people's thoughts and actions. They often result from existing stereotypes and the logic of social power relations and can therefore reproduce discrimination. This can lead to discrimination in areas such as school education and medical care, resulting in unequal or inferior treatment.

[57] Our concept of the medical habitus utilises Bourdieu's concept of habitus. Bourdieu defines habitus as a set of internalised practices, habits and modes of expression that influence the perception, thinking and actions of individual social actors in relation to the position of other actors. In this context, the medical self-image can also be seen 'as an incorporation of the class position', which is constituted through 'imposed[...] adaptation processes' (Bourdieu 1982/1989: 175). In the English-speaking world, the professional socialisation of doctors is now primarily addressed and discussed under the concept of professional identity formation (see Findyartini et al. 2022). Recently, this concept is also increasingly being used in Germany (see GMA 2023).

(see Hafferty & Franks 1994). The transfer and legitimisation of subliminal knowledge bases regarding teaching materials, seminars and practices cannot be exclusively ascribed to the actions of individual parties, such as academic staff. They are the expression and consequence of societal circumstances that precipitate in institutions and professional socialisation.

Knowledge in institutions

The study is based on a sociological concept of knowledge, which can include various socially available assumptions: scientifically established knowledge plays a role, as do individual or collective considerations, unconscious everyday routines, interpretive patterns and behaviour patterns, or recognition of organisational structures in institutions (see Keller 2011). In the case of the field considered here, the main consideration is the overlap between curricular professional knowledge – both firmly medical knowledge and that regarding doctoral ‘soft skills’ – and obliquely conveyed (racist) knowledge regarding habits, practices and norms *(hidden curriculum)* in medical training. The quality of the knowledge considered here therefore results precisely from the fact that it is directly involved in institutional processes: individual attitudes merge seamlessly into systematically conveyed professional knowledge or institutional organisational structures and are mutually dependent on them. The forms of knowledge are subject to hierarchical systems and are dependent on the institutional role of the individuals in question. This hierarchical system flows back into the institutions, both regarding content and formally.

One example of this is the apparently trivial phenomenon that the personal assessment of a member of teaching staff as a representative of the institution is, in general, listened to more than a student’s interjection. The perspective of someone studying rather tends to be labelled with the ‘flaw’ of ignorance or subjective bias – although both cases are personal assessments. One form of knowledge is recognised on a formal level as valid and neutral, while the other tends to be devalued due to the hierarchical structure as being restricted and subjective. This example illustrates that the term ‘institution’ is understood here in a direct relationship to individuals and higher-level structures.

Research perspectives: Explorative-participative approach

For an explorative approach to the research questions, four empirical key points were used as starting points (Figure 28), which were evaluated using a qualitative triangulation[58]: in the first step, (1) there were preliminary talks with eight scientific experts who work or have worked qualitatively in Germany regarding racism in the medical curriculum, as well as with twelve people from the field of racism-critical involvement in a medical context (students and doctors who it was possible to contact through professional associations). Subsequently, (2) teaching materials from the study of medicine in Germany (four relevant textbooks, two learning apps or online platforms) as well as the NKLM 2.0 were viewed and collated on a random basis[59]. From this, (3) examples were summarised in a text document corresponding to the leading definition of racism (see chapter Preliminary historical and theoretical considerations). They then were discussed in semi-structured individual interviews with five doctors, twelve medical students and one medical psychologist who had identified themselves as being affected by racism.[60] The joint, participative consideration of the examples was accompanied by a survey of participants' personal experiences in their day-to-day studies or clinical work. This opened up a perspective on the connection between different levels of institutions and racism (e.g. with regard to formal and informal teaching content). The results from the interviews, which were encoded using the analysis software MAXQDA 2022 (VERBI Software 2021), were then (4) thematically summarised in another text document and jointly reflected upon in two focus group (n = 5 and n = 7) conversations. Finally, all the material was subjected to thematic and content-based analysis via triangulation.

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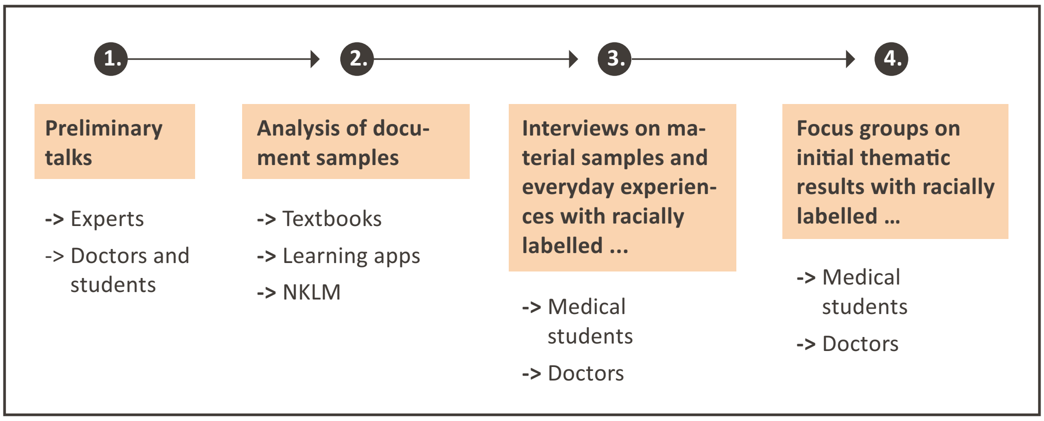
[58] Triangulation here means 'the adoption of different perspectives on an object under investigation or, more generally, in answering research questions. These perspectives can be concretised in different methods that are applied and/or different chosen theoretical approaches, where both are related to each other in turn or should be linked' (Flick 2011: 12).

[59] The sample was primarily collected using the criterion of usage distribution, which was determined via the Germany-wide online preliminary interviews with medical students. It consisted of text and image material (e.g. approx. 100 case studies and approx. 800 photographs) from relevant textbooks on dermatology, anaesthesia and clinical examination as well as general medicine and family medicine, widely used online learning platforms (including 'Blickdiagnose') on various specialist disciplines and exam questions from 2005-2021 on various specialist disciplines) and the contents of the NKLM 2.0 (see Medizinischer Fakultätentag 2021).

[60] The people were recruited via an open letter addressed to doctors and medical students 'who themselves are affected by racism'. The letter was distributed via various channels such as social media, journals of state medical associations or online newsletters of student and doctor organisations (e.g. student councils or the Association of Democratic Doctors).

Figure 28 . **Step-by-step empirical approach**



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5.2 Results

Medical differentiation relies on racist knowledge

In our society, medical knowledge and medical practices play a fundamental role in the context of healthcare and, in certain situations, can be a matter of life or death. In this context, doctors are reliant, among other aspects, on practically implementing population-related scientific knowledge and applying categories or classifications to individual cases in order to make decisions for or with patients to the best of their abilities. Often, these decisions have to be made under a high workload and time pressure, with a high level of responsibility and in contact with a large number of different people. This means that rapid, difficult and serious decisions are often required, for example with regard to a patient's medical history, diagnosis or the treatment of illnesses. Although or precisely because doctors make their decisions based on professional and experienced knowledge, in the context of the differentiations required, they run the risk of making assumptions which do not (or cannot) do justice to a particular situation or person (for more on this, see also Fleck 1927/1983).

The results of this study make two conclusions clear: on the one hand, it is shown that the necessary differentiation of clinical pictures or patient groups leads to the systematic and socio-historically rooted omission of entire groups of patients within certain normative models. On the other hand, medical differentiation also results in patterns of active racialisation, different treatment, and marginalisation of certain demographic groups. In the following sequence from an interview, the resulting challenges and negotiation processes on the part of the person practising become apparent:

> *'So you notice when diagnosing too that it just works that way: okay, symptoms fit there, treat this way. That there's always this tree that*

> *you somehow follow. And I think that’s how it is with this allocation of illnesses to certain cultures or ethnicities, that you’re just trying to create a system, which is simply arbitrary in some parts, but which just helps to find your way. Like I say, I don’t know if it’s right. I don’t have a better suggestion. But that’s just how it is. And it definitely has the potential to be a problem, though.’ (Stud003, pos. 87)*

As will be shown throughout this chapter, the line between a useful, appropriate and advisable classification of a situation and an unjustified, devaluing and potentially dangerous ascription or stereotyping of a person or group is often a narrow one.

Underrepresentation of racially labelled groups in medical teaching practice

The systematic application of categories and classifications in medicine means that in practice, doctors refer to models, which represent socio-historically rooted standardised concepts of health and of humans (see section Racism and medicine – historical continuities). Alongside old people, women, or people with disabilities[61], certain racially labelled groups also do not fit into the pattern of ‘normality’. This does not manifest explicitly in the material sample examined[62], but in some places implicitly, for example in characteristics such as light skin[63] or belonging to their ‘own cultural group […]’ (Herrmann, Schwantes & Topserver 2017). The underrepresentation of certain groups is shown particularly clearly in photographic material from textbooks and learning apps, which almost exclusively depict bodies with light skin. This not only applies to the field of dermatology, but affects a variety of fields, as could be seen on various learning platforms regarding the topic of ‘visual diagnosis’. This structural omission is reflected by practical study and professional experiences of the interview partners regarding (their own) treatment of patients, as suggested for example by the description of a racially labelled, non-Black doctor:

> *‘Or I have to honestly admit, with Black patients when I’ve taken a blood sample or insert an IV […], I was surprised at myself, that I thought: “Wow, you can’t see the vein so well”. Really typical. I mean we had […]courses on drawing blood or about inserting Braunüles using those dummies. […] Of course they all had beige skin. Light-beige skin. […]*

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[61] The important aspect of intersectionality should be mentioned in this context: individuals and groups can be affected simultaneously by different and mutually influencing forms of marginalisation and discrimination.

[62] Text and image material (e.g. case studies and approx. 800 photographs) from relevant textbooks and widely used online learning platforms (including ‘Blickdiagnose’ on various disciplines and exam questions from the years 2005-2021 on various disciplines).

[63] In the following examples, we refer to the medical categorisation of skin types according to Fitzpatrick (see Moll 2016: 491). Light skin in this context means types I, II, III and IV; dark skin means types V and VI.

> *I can understand that too, if you had simulated Black skin it wouldn't have been as easy for a beginner or someone practising. But then I really thought: "Oh crap. Wow." I haven't done it often, either. And I can still remember it really well, that I thought, it just didn't come up that much.' (Aerz003, pos. 184)*

In the interviews and focus groups, the complexity of the area of tension covering the question of whether to take various characteristics into account in medicine or not also became apparent:

> *'On the one hand […] you have to be sure that it's not just deleted, because it's already caused so much, […] racist thinking. That's why you can't just approach the whole thing and be colour-blind, you just have to process it and deconstruct it. […] And on the other hand, you still have to make sure that no one is simply […] somehow judged just on the basis of how they're perceived, but that you realise that people are really individual, that there are probably still phenomena that haven't even been addressed as much, the measuring methods haven't been invented yet that would be able to uncover other things, and so on. That it's simply a dynamic process, that just has to be considered in both directions.' (Stud010, pos. 77)*

The question of considering certain characteristics was largely viewed by study participants as a difficult process of negotiation. At the same time, it seemed obvious to most interview partners that in many respects, medicine is shaped by normative[64] exclusivity:

> *'Of course, the pictures you use in lectures, the anatomy atlases, […] there are just* white *people in them, and these illustrations too. I mean, they're not always original photos. So the illustrations are also "central European standard", so to speak. And that needs to be changed.' (Aerz003, pos. 192)*

The examples cited thus far already indicate that systematic non-consideration or omission of certain groups and contexts in medical teaching practice can directly generate inequalities in medical care. The following interview sequence describes this emphatically:

> *'Just the fact that the reality of non-*white *people is not discussed in medical studies is, if we're honest, a subtle fact of racism. Or, for example, we've got this course called History, Ethics and Law in Medicine […], and they just started with the Holocaust, because for*

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[64] Normativity refers to the creation, maintenance and legitimisation of social norms. See also FN 7 regarding norms.

> *German history that's painful enough, but they just didn't mention colonialism or the role of medicine in colonialism. [...] For me, it's a subtle way of producing racism, by not naming this type of history, not telling it.' (Stud011, pos. 43)*

The omission of racially labelled groups is therefore also reflected in the fact that certain historical contexts of medicine, as well as racism as a factor in health and illness are barely mentioned in teaching.

Overrepresentation and stereotyping of racially labelled groups

The omissions described not only point to potentially serious (data) gaps in research, teaching and practices, as well as general structural practices of marginalisation. They also imply different treatment of racially labelled groups as soon as they are taken into account. This is shown by the teaching material samples in mostly subtle but sometimes literal us-them differentiations and stereotyping to exoticising[65] patterns of ascription (see also Chapter II.4). They refer to characteristics such as skin colour, origin, religion, nationality or language skills in comparison to supposed properties of society as a whole or the majority of society. This complementary us-them relationship is based on racialisation processes (see also chapter Preliminary historical and theoretical considerations). In the interviews, it was repeatedly reported that:

> *'[…] symptoms simply weren't discussed with reference to dark skin, or, if they were discussed with reference to dark skin, it was just tropical diseases, so then that also has something exotic.' (Stud001, pos. 72)*

In the rare cases in which dark skin types were found in the teaching materials (books and online learning platforms), the patients in question were often labelled in the corresponding text material as exotic, foreign (e.g. from another country) or anomalous (e.g. due to irresponsible behaviour). The group with the characteristic of 'dark skin' was therefore situated outside of the common standardised conception or outside of the 'own group'. Additionally, beyond the illustrations – for example, in text-based case examples for exam preparation – markings were used whose relevance in the medical context was often unclear and which seamlessly merged

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[65] Exoticisation describes a variant of racism in which supposedly positive characteristics such as temperament, emotionality and closeness to nature are attributed to racially labelled groups. These attributions also attest to the supposed 'uncivilised' nature of these groups, which is attributed with an assumed divergence from a *white* or Western norm. the idea of a special 'civilisedness' of *white* people is created reflecting this. Exoticising processes often go hand in hand with a romanticisation of the other person.

into racialising classifications (see examples below). Such markings are often accompanied by misrepresentations and stereotyping, which can stigmatise, devalue and harm those affected in (medical) practice (see also the section State of research: Racism, health and healthcare and Chapter II.4). However, they can also lead to internalised biases of doctors during professional treatment:

> *‘Really, the longer you read it, the more it just seems that way to you. I mean, now for certain groups of the population, I think, are they vaccinated against yellow fever? And then I think, why am I thinking that all at once? I never would have thought that before. And then I realise, I mean right now, while I’m studying for exams, it really stands out to me that many of the [examination] questions really work using those stereotypes.’ (Stud008, pos. 70)*

Below, textbook examples and descriptions from the interviews are used as examples to demonstrate various areas of medical studies that can initially produce or reinforce racist prejudices (‘race’-based bias; Amutah et al. 2021) in future doctors. Here, terminology and the labels used play a fundamental role. First and foremost, biological ‘race’-related terms such as ‘Caucasian’ or ‘racial[…]’ (Füeßl & Middeke 2022: 417) continue to be used in lectures, training, teaching materials, and practice:

> *‘Where it stood out to me even more starkly was sometimes in those oral training sessions, when the lecturers were explaining something and then – I mean really up to using the N-word. […] And in past years too. […] Terms like “southerners” or those typical racist descriptions. […] Not in the curriculum as such, but definitely, let’s say, working instructions, that sort of thing. I mean, how can some things be implemented when there are just appalling notions in them in some cases?’ (Aerz001, pos. 42–44)*

Furthermore, terms are used inconsistently and in a vague manner. One book chapter from a widely used textbook of general medicine, for example, already implies a potentially problematic (linguistic and content-based) separation of the group of ‘foreigners’ in its title, ‘Foreign patients’. In addition, a variety of backgrounds of this demographic group are listed, always outside of the narrative of ‘Western culture’ (for more on this, see also Hall 2001). For example, a ‘Tamil’ or ‘Turkish’ patient falls into the generalising category of ‘foreigners’, as do ‘migrants’, ‘asylum seekers’, ‘Eastern European […] men’ or ‘adults […] [from] sub-Saharan Africa, parts of the Caribbean [and] Thailand’. Various of these groups are often only vaguely specified and are associated, for example, with excess ‘consumption of alcohol and drugs’, ‘increased risk of sexually transmitted diseases’ or ‘magical concepts’ such as voodoo, superstitions etc.’ (Herrmann, Schwantes & Topserver 2017: 179–190). In the process, not only is the use of the group names which are linked to ‘ethnicity’ not consistently explained (e.g. with regard to migration backgrounds, citizenship or residence), but also the question of how or using which ‘markers’ these classifications should or could take place in question is not problematised (see ibid.).

While in Germany, the terms ‘Rasse’ or ‘race’ – with the exception of international studies in seminars or lectures – are being used increasingly rarely, vaguely defined categories or replacement terms such as ‘ethnicity’, ‘migration background’ or ‘foreigner’ are often used (see also the chapter Preliminary historical and theoretical considerations). Examples of this type of use of replacement terms and the associated problematic blending of social and biological contexts can be seen, for example, in a textbook on patient history and clinical examination. While in the 2018 edition (see Füeßl & Middeke 2018), the term ‘Rasse’ was still used, this term was avoided in the next edition (ibid. 2022). ‘Rasse’ became ‘Abstammung’ [‘origin’] (ibid.: 54), ‘ethnische Herkunft’ [‘ethnic origin’] (ibid.: 74) or ‘Hautfarbe’ [‘skin colour’] (ibid.: 404), while in the context of ‘increased bodily hair […]’, even the new edition still names ‘racial dispositions’ as a factor and differentiates this from ‘ethnic dispositions’ (ibid.: 417). As with the use of the term ‘race’ in the USA, a problematic overlap between biological and racial patterns of ascription can also be seen in the terms used in Germany, which can blend together, homogenise and devalue contexts of behaviour, groups or illness through hegemonial contextualisations in a reductionist manner.

The results indicate that in lectures and teaching materials, differences regarding the prevalence of illnesses in various groups are often conveyed without sufficient context or the required transparency (e.g. regarding socio-economic conditions). This can imply a subtle naturalisation of certain correlations. Supposed links between characteristics that are labelled in a racist way and certain behaviour patterns or prevalence of illnesses are thus often represented as given and can thus be potentially falsely interpreted by students:

> *‘“Why do you [lecturer] associate their origin with the behaviour or with an illness?” [...] Because the students here will associate the case with the origin and always think: okay, I see a person with this background, this is how I have to act. And this is how I have to treat them because they fall into this or that category because of their origin.’ (Stud011, pos. 17)*

This type of internalisation can lead to distortions of diagnosis in medical practice and to serious consequences for patients.

Medical habitus

The medical ‘we’ as a non-labelled norm in contrast to racially labelled groups

The empirical focus of this analysis was on the perspectives of racially labelled medical students and doctors, both with regard to their own position in the contexts of their studies or job and with regard to racist discrimination against certain groups of patients. Their positions as spokespeople in a double role as racially labelled people and doctors (in training) made a non-labelled normative self-image of doctors as ‘ideal’ visible. This represents an important element in the structures of institutional racism in medical training. As mentioned in the introduction to this chapter, a habitus, subtly conveyed during medical training, is a central factor of professional identity and practice.

The systematic omission, generalisation and stereotyping of certain groups of patients described above can be seen in the construction of a normative, non-labelled ‘we’ of the medical profession. The following extract from a textbook on GP care shows, for example, how a medical self-image (‘us’, ‘own culture’) is subtly conveyed to medical students. It is also constituted by the contrast to racially labelled patients as ‘foreign’. This form of othering (for more on othering, see also Chapter II.4) becomes apparent in the following section regarding ‘people of different backgrounds’ from the textbook chapter on general medicine quoted above:

> *’Reasons for [their] utilisation of healthcare services, expectations of the encounter with the doctor and the nature of the symptoms of complaints appear strange to us [...]. Discrepancies between the patient’s assessment and the doctor’s assessment are often greater than with patients from our own culture.’ (Herrmann, Schwantes & Topserver 2017: 190)*

The differentiation between a supposed ‘own’ and ‘foreign’ culture and the associated understanding of illnesses has already been observed in a qualitative study regarding the experiences of German GPs when treating Black patients and patients with migration backgrounds (see Gerlach et al. 2008). In this study, too, interpretative knowledge was seen that contrasts the medical profession or medical students as the representatives of a dominant, normative culture and those patients who were not perceived as the supposed norm or the supposed ‘own culture’. This can result in different treatment, stigmatisation and mistreatment.

Belonging, respect and professional motivation

Here, the ‘we’ conveyed to the students not only implies a potential marginalisation of racially labelled patient groups. This interpretative knowledge is also associated with

the marginalisation and lack of representation of racially labelled doctors and medical students in training. This was seen in the semantics and terminology of various teaching materials from the samples, but also in the descriptions of the interview partners.
The following quote from a German doctor who has the surname of his father, who immigrated to Germany from Turkey in the 1970s, indicates this:

> *'"Yes, [...] a colleague will see you. He's a Turkish doctor, but he's a really nice one." And I thought, Turkish doctor, that's not my self-image. And the funny thing is, I actually got the feeling that yes, I don't belong. I'm somehow… I'm not part of this team. That's what I ended up feeling. And [...] my identification with the team was really increasingly affected by that.' (Aerz001, pos. 14)*

This example also shows how normative concepts, racialisation and marginalisation practices are intertwined: the implicit devaluation of the ascription 'Turkish' is based on the construction of an unnamed norm, which is portrayed as superior, and with which the doctor is denied affiliation due to his surname – which has negative effects on the doctor's sense of belonging, the collegial relationship and possibly on the perception of the patients to be treated and therefore on the doctor-patient relationship.

On the other hand, a sense of belonging as well as recognition and identification as a doctor are essential for motivation in studies and professional life, and are closely linked to the type of representation of racially labelled groups in the medical profession. This becomes apparent in the following quote, which also labels racism on the part of the patients as well as the mental stress (see also Chapter II.1) for racially labelled students:

> *'Because it's difficult to hold on to the motivation to study [...] when people don't see me as a doctor anyway. And [...] especially in the first two years, which are very, very busy and very exhausting, and then I say to myself, okay, why am I actually doing this when I really have patients here who say: "I won't let them treat me". [...] And that's difficult. Because even if you have racist experiences during your studies [...] I thought to myself, wow, that means that [...] perhaps many of my colleagues will also reproduce racism themselves in the future, so that I'm then in this system that's racist. And that I myself, even though I don't really want to, might support it. [...] Yes, that's true, even with racist experiences. It's simply expected of you [...] that you come to terms with it and now to the next course. So it's not at all easy to find your way back into everyday life.' (Stud008, pos. 40)*

The self-image described here and the associated marginalisation of racially labelled people complement the image described in the following section regarding the neutrality of the medical profession, which plays an important role in the context of racism in healthcare.

Claims to neutrality and objectivity as an obstacle to the thematisation of racism

The results indicate that claims to and assumptions of humanistic neutrality as well as scientific objectivity play an important role with regard to racist standards of behaviour:

> *'So the medical profession is political. I think this neutral image is deceptive. [...] Everything that happens in society is directly reflected in everyday clinical practice. We're seeing that now in the pandemic.' (Aerz-003, pos. 194)*

Assumptions regarding doctors' supposed neutrality are both expressed by society towards the medical profession and reproduced by the medical profession itself (for more regarding this, see also Lewicki 2022). They overlap with problematic aspects such as an inadequate error culture and the associated de-thematising of racism 'in our own ranks'. In the study of medicine as well as in practical day-to-day professional life, there are indications of ways in which racism or silencing processes become taboos (see also Chapter II.4), which were also mentioned in the interviews and focus groups in the context of the claim to neutrality:

> *'But at university, for example [...]. Then it's more than just a problem, in my view. It really is a taboo, so to speak. So [...] something like the Third Reich, for example, can be discussed. But [...] beyond such individual aspects, it feels like this accusation must not be properly expressed or dealt with.' (Focus group 1, pos. 60)*

Naming racism within institutions which have to meet societal demands of neutrality and objectivity can outweigh racist situations themselves:

> *'[W]hen you somehow say that this example is racist, then first of all it is a much bigger problem that you perceive it that way [...] than the fact that it is actually racist and does not belong in the classroom.' (Stud010, pos. 123)*

These types of defensive attitudes may also arise when there is a lack of clarity regarding what racism actually is, for example when racism is equated to right-wing extremism. The self-image of neutrality therefore contributes to not being able to clarify these questions, since the thematisation of racism is complicated to begin with. The following quotes show how closely the claim to neutrality is linked to an internalised defensive attitude among doctors and medical students:

> *‘Then there is this self-image that we are not discriminatory, we treat everyone equally. That definitely stands in the way of recognising that we don’t treat everyone equally, of course. Again, I believe these are these fundamental processes [...] that I actually think you have to question yourself more as a doctor, also in what you do and -. [...] Error culture has also been a big debate in medicine in recent years. Yes, perhaps at some point you can think about it a way that this is one of the mistakes we have made and still make, that we’re socialised in a racist way and allow ourselves to be influenced by this. And can we all admit that to ourselves and try to work on it?’ (Aerz001, pos. 92)*

> *‘Sometimes I have the feeling that people think: Yep, I’m a doctor, so I love everyone and am open towards everyone. But […] that they don’t want to or can’t properly realise at all that, although they like people and want to treat them equally, it’s just not like that. That there are just internalised thoughts and other feelings, which none of us have any influence over, just because they’re so omnipresent, yeah, that that’s sometimes not comprehensible for some people:’ (Stud003, pos. 175)*

Both quotes show that the doctors and students surveyed are aware of the existing racist realities in the medical context. At the same time, the claims to neutrality and objectivity of the medical habitus complicate critical analysis of racism, both in medical practice and in medical training.

De-thematisation and reproduction of racism within institutional hierarchies and work contexts

Institutional structures and working contexts in studies and medical practice can contribute to promoting and maintaining racism. The example of dealing with language barriers shows how economic constraints and time pressure can lead to or favour exclusionary patterns of action:

> *‘Time is also a big problem. I used to work in a GP practice and every patient has a slot of ten minutes. And if a patient doesn’t speak German, well, they only get ten minutes and no extra effort is made to understand them. It’s simply that people often act on the basis of assumptions.’ (Stud016, pos. 11)*

The challenging work contexts are linked to hierarchical structures that often represent, promote and maintain racist relationships. The following quote illustrates how professional dependency relationships can reinforce the de-thematisation of racism:

> ”
> *‘Yes, I think that’s very pronounced in medicine too, because we have a very hierarchical system, yes. There is a clear pecking order, so to speak, and then, especially as a student, you’re at the bottom of the medical food chain, so to speak, and of course there are simply people you have to impress, yes. And then I honestly say: I do what I have to do, yes. [...] You just have to get through it [...].’ (Aerz002, pos. 34)*

The pronounced hierarchies and the high time and performance pressure in the degree programme are also linked to a lack of (opportunity for) reflection on study content and contexts by the students, especially with regard to exchange with teachers.
The following quote clearly shows frustration on the part of a student in the face of lecturers’ hostility towards dealing with racism (self-)critically:

> ”
> *‘I sometimes find it very problematic that [...] a lot of old* white *men at my university realise their problematic behaviour but ignore it. [...] I can understand that to a certain extent, if you don’t manage to take that step to understand how problematic it really is for [...] the person in front of you. But it makes me angry when people realise the problematic behaviour but then only provoke even more with their behaviour by deliberately saying it anyway.’ (Focus group 1, pos. 62)*

One Black doctor reported that she had learnt to understand that addressing racism towards patients was an integral part of her medical practice and to intervene if necessary. However, she explains that she tends to problematise the racism she has experienced less often in order to conserve physical and emotional resources, although not addressing the issue can also be stressful:

> ”
> *‘When I talk to superiors or even colleagues about it, well, it usually leads to nothing. And then this ultimately has no benefit for me [...] You just have to organise your resources. [...] [T]he question is always, do I really invest the 20 minutes in my working day, which is relatively stressful anyway, to explain this to my colleague if they aren’t open to accept it anyway?’ (Aerz002, pos. 22-24)*

Here, it becomes clear that raising the issue of racism draws on the resources of the individual, which are already limited by the economic and time constraints of the medical profession. This leads to the consideration in terms of personal coping or a change in circumstances of to which extent it is expedient to address the issue of racism or not.

5.3 Conclusion

In accordance with the theoretical approach to an institution as a multidimensional action area, institutional racism was operationalised from multiple perspectives in the investigation presented here. This means that overlaps and connections between teaching material, everyday experiences and group experiences were sought. Various analysis methods (such as analysis of documents, topics or content) were therefore combined in order to estimate the mutual effects of structural, institutional and collective knowledge bases, but also of individual knowledge bases. The triangulations selected did present analytical challenges and were limited to document samples and experience reports. However, they also offer the opportunity to explore the intertwining of various levels and contexts of the institutional space in an explorative manner, which represents an important research desideratum and can be used productively for further research.

This explorative analysis provides strong indications that racist knowledge bases are circulating and fused together in various forms and in a range of areas within medical training in Germany.

Underrepresentation of racially labelled patient groups: In medical teaching materials and knowledge transfer practices, racially labelled groups are largely and systematically not considered. This omission is seen on various levels. For example, people with dark skin types are only very rarely seen in dermatological and other teaching materials, racist societal conditions are barely addressed as the reason and trigger for illnesses, and colonial medical backgrounds are often blocked out.

Misrepresentation and overrepresentation of racially labelled patient groups: If racially labelled groups are considered, this often takes place within situations outside of supposed Western or supposed German norms and values. In the process, very different groups are generalised as ‘foreign’, ‘different’ or ‘particularly challenging’. At the same time, they are stereotyped through specific attributions and often linked to particular clinical pictures (e.g. HIV or tuberculosis) or behavioural patterns (e.g. consumption of alcohol or drugs). In many cases, these ascriptions are made without sufficient empirical transparency and contextualisation.

The medical self-image in contrast to racially labelled groups: In the study of medicine, a standardised self-image of the medical profession is promoted, which forms itself in contrast to a stereotyped and exoticised ‘other’ or ‘foreign’ person. Regarding scientific rationality and classification systems, a medical habitus is conveyed that can contribute to the marginalisation and lack of recognition of both racially labelled patients and racially labelled medical students and doctors.

The medical claim to neutrality leads to racism not being addressed: The self-ascription and societal expectation of doctors to be neutral towards their patients reinforce the medical self-image described above and are therefore a central component of the racist conditions themselves. Furthermore, they pose a barrier to critical analysis of racism, because it is a societally condemned phenomenon which is diametrically opposed to the claims to humanistic neutrality and is therefore a taboo.

Institutional structures as a mirror of racist conditions: Medical care is often shaped by a lack of personnel, a lack of time, a heavy workload and rigid hierarchies. The latter is seen firstly in the societally disadvantaged position of women and racially labelled groups and also impedes critical analysis of power structures. Discriminatory practices are particularly facilitated by care contexts which are characterised by the consequences and constraints of the increasing economisation of the healthcare system (including lack of personnel, time pressure, and changes to the doctor-patient relationship). Racist conditions are inscribed in these specific institutional structures of medical care systems and at the same time cause racist dynamics to be reproduced.

The results of this study indicate that racist knowledge bases in medical training can lead to different treatment and marginalisation processes. This applies both to racially labelled students and doctors, in training and in practice, and to racially labelled patient groups in everyday medical care of the population resident in Germany.

Recommendations for action

In order to consistently combat and break down discrimination and racism, targeted measures need to be taken on various levels. The recommendations for action presented here are derived from the findings of the report. Alongside breaking down barriers and protection from discrimination and racism, some measures are aimed at explicitly developing trust in institutions and relate primarily to the healthcare field. Furthermore, recommendations and demands for political, scientific and civic parties are considered, because the NaDiRa results provide the existing recommendations with evidence-based emphasis.

As demonstrated by this monitoring report, the intertwining of individual, institutional and structural levels is characteristic of discrimination and racism. It is therefore necessary to act on various levels simultaneously in order to sustainably break down discrimination and racism. The recommendations are aimed both at parties from politics and from civic society and healthcare. They are divided into three areas:

1. Addressing discrimination and racism in institutional contexts
2. Improved resources for counselling and legal protection as well as structural changes towards reduced barriers
3. Development of research and boost to networking

There are concrete recommendations for various fields of action: according to the strategy of **mainstreaming**, comprehensive general thematisation of discrimination and racism is recommended (Recommendation 1). For **institutions**, the necessity of establishing measures again racism and discrimination is apparent Recommendation 2). Furthermore, additional research on institutional racism is required, for which the required access points should be ensured (Recommendation14). With regard to the **knowledge** field of action, discriminatory knowledge bases need to be dismantled, particularly in healthcare (Recommendation 3). The **language** field of action is also considered cross-sectionally. Alongside reinforcing language and images that are sensitive to discrimination and racism in healthcare and medical training (Recommendation 4), as well as establishing discrimination-sensitive language in research (Recommendation 16), language barriers in general need to be broken down, particularly in healthcare (Recommendation 10). Further recommendations refer to the aspect of intersectionality. Based on the findings presented in this report, it is not only recommended to combine gender-sensitive medicine, which is already being promoted, with medicine that is sensitive to discrimination and racism (Recommendation 5), but also to research multiple discrimination in general in a more targeted way (Recommendation 15). The proposal to reform the General Equal Treatment Act (AGG) is aimed at **policymakers** in order to close gaps in discrimination protection, particularly in the field of healthcare and in institutional contexts (Recommendation 6). This is linked to a nationwide expansion of reporting and counselling centres in the field of **counselling** (Recommendation 7) and the strengthening of community-based structures and services, especially with regard to **individuals affected** (Recommendation 11). Closing concrete gaps in **healthcare** is urgently required. More places providing psychotherapeutic treatment (Recommendation 8) as well as discrimination-free appointment allocation in practices (Recommendation 9) need to be ensured. To improve the healthcare situation, it is also necessary to take specific measures regarding asylum seekers and people without health insurance (Recommendation 12). In order to develop appropriate measures against discrimination and racism in Germany, it is urgently necessary to ensure communication between various societal parties. Concretely, networking between research, civic society and the political sphere needs to be facilitated (Recommendation 18). This is linked to the requirement for more in-depth research. Not only must **research** in the field of racism and health be further developed (Recommendation 17), but German-language racism research in general needs to be established (Recommendation 13). The individual recommendations for action are described in detail below.

Addressing discrimination and racism in institutional contexts

1 ___ Field of action: Mainstreaming

Comprehensive thematisation of discrimination and racism

As shown by the empirical findings from the NaDiRa.panel (see Section I), experiences of discrimination and racism are widespread. For this reason, general societal discourse must create awareness of racism and discrimination. The topic should be at the top of the agenda both in politics and in institutional contexts, for example in schools, training facilities and the world of work, as well as in civil organisations and lobby groups. Here, racist discrimination and racism should be taken into consideration in combination with other forms of discrimination and in the context of social inequality. For example, sensitising measures such as awareness training could be introduced in the various institutional contexts.

2 ___ *Field of action: Institutions*

Establishment of research-based measures against racism and discrimination in institutional contexts

The findings of the report illustrate a loss of trust in state institutions when discrimination and racism are experienced in contact with them. It is particularly important to combat unequal treatment from public authorities with political measures. With regard to the police, there are repeated debates regarding whether there are structural problems of racism or not. An initial empirical answer to this question can be found in the interim report of the police study carried out by the Deutsche Hochschule der Polizei [German Police University]. Misanthropic attitudes with regard to Muslims and homeless people were indeed more widespread among the police officers surveyed in comparison to the general population (see Deutsche Hochschule der Polizei 2023: 57). This finding matches the results of this report: alongside Black people, it is above all Muslim people who most often report experiences of discrimination in contact with the police. Thus, similar investigations should also be carried out in other state institutions and authorities. Only when the extent of the problems with discrimination and racism become visible and analysis of them takes place will it be possible to systematically take action against institutionally anchored forms of discrimination and racism.

3 ___ *Field of action: Knowledge*

Breaking down discriminatory knowledge bases in medical care through initial and continuing training

In medical care, prejudices regarding certain groups of patients and their exaggerated perception of pain are widespread to the extent that these assumptions precipitate diagnostic labels. While terms such as ‘Morbus mediterraneus’, ‘Morbus bosporus’ or ‘Mamma mia syndrome’ suggest that this particularly affects people with direct or indirect migration experiences from Mediterranean countries, the findings of this report instead reveal extensive practices of discrimination. The chapter on healthcare (see II.3) reveals that various groups are exposed to an increased risk of not being taken seriously by doctors, to the extent that they have had to change doctor. This means that the medical diagnosis of a distorted perception of pain appears not to be limited to people from a particular region of origin. Furthermore, women – regardless of whether they are racially labelled or not – are particularly affected by this. For this reason, a new term was introduced in this report: ‘Morbus aliorum’. It describes the hitherto unnamed practice on the basis of which all demographic groups that deviate from the established standardised image – namely that of *white* male patients – experience discrimination in medical care. Two points therefore appear to be essential to sustainably dismantle discrimination and racism in medical treatment.

Firstly, sensitising training programmes, potentially certified by the Medical Chamber (see Enquetekommission des Thüringer Landtags 2019: 542), for educators (e.g. senior physicians) and other healthcare personnel (e.g. doctors, medical professionals and nursing staff) should be offered and held, as well as anti-racism concepts being set up (e.g. the training programmes described above) for hospitals, medical practices and training institutions. These measures can help to develop a deeper understanding of various forms of racism in specific contexts with regard to health and healthcare. They should also reduce and proactively counter de-thematisation, defensive attitudes and trivialisation. In addition, the topic of racism should be formally anchored in medical and nursing training in line with 'racism-critical professionalisation' (Mecheril & Mehring 2022: 14–16), in order to create awareness of the specific problems in healthcare among future personnel.

Secondly, the provision of time resources in everyday working life is a further central condition in this context. Limited time and financial resources can be decisive factors that lead healthcare professionals to fall back on prejudices and stereotypes in order to bring about more rapid decisions and diagnoses. Better working conditions in healthcare are crucial to dismantling discrimination and racism. The findings from Chapter II.5 illustrate that there is barely scope for medical personnel to critically reflect upon their own assumptions or thinking and behaviour patterns, or their own social position, method of working and error culture. For example, an improved staffing ratio could yield more time for diversity-sensitive and racism-critical analysis with colleagues and patients in working contexts.

4 Field of action: Language

Reinforcing discrimination-sensitive and racism-sensitive language and images in healthcare and medical teaching

Prejudices against groups in a healthcare context arise, among other contexts, within medical training, for example through teaching materials, as shown exploratively in Chapter II.5 . For this reason, teaching material should be examined with a view to when and for what reasons certain patient characteristics or illnesses are linked to certain demographic groups within the teaching and practice of healthcare professionals. Both the systematic lack of consideration of specific groups and racially labelled stereotyping and biological viewpoints in medical teaching content need to be problematised, reflected on and changed. Transparent and consistent group-related language and classifications should be reviewed in cooperation with community organisations, textbook publishers and medical faculties. As is noted by research in the USA, cases of skin cancer in Black people, for example, are often discovered too late (see e.g. Shao & Feng 2022). Among other aspects, this is explained by the fact that skin cancer in Black people is not depicted in medical teaching materials. A direct appeal is therefore made to the authors of medical studies and textbooks as well as editors and publishers: alongside a fundamental discrimination-sensitive and racism-sensitive review of reference books and textbooks, additional materials which deal with this topic could be provided, for example in online appendices. In this way, it would be possible to rapidly ensure comprehensive and diversity-sensitive depictions of pathologies, for example.

5 —— Field of action: Intersectionality

Shaping medical research in a more interdisciplinary way – researching gender-based discrimination in a combined way

The coalition agreement of the current Federal Government explicitly announced funding for gender-sensitive or gender-specific medicine (see SPD, BÜNDNIS 90/DIE GRÜNEN, FDP 2021: 86). Twelve projects are currently being funded by the Federal Government under the funding priority of 'Gender-specific particularities in healthcare, prevention and health promotion' (see Bundesministerium für Gesundheit [Federal Ministry of Health] 2023a). While this development is most welcome, the opportunity should also be used to additionally integrate a discrimination-sensitive and racism-sensitive perspective as well as an intersectional analysis. The RKI already pointed out in its women's health report of 2020 that there are enormous data gaps, among other aspects regarding female migrants and their state of health, health behaviour and healthcare (see Robert Koch Institute 2020). This report also emphasises the relevance of an intersectional perspective that not only focuses on the role of gender in healthcare, but also considers the particular living conditions and barriers of women and men who face multiple types of discrimination.

In the context of the NaDiRa.panel's findings (see Chapter II.3), it is particularly women – both racially labelled and non-racially labelled – who tend to delay medical treatment when they have experienced discrimination in a health-related context. If barriers to access to healthcare during appointment allocations are added to this, the accumulation of these processes can lead to significantly delayed treatments and therefore to higher rates of morbidity and mortality among women in general, but in particular among racially labelled women. For this reason, we highly recommend that gender-specific particularities are not established as an isolated topic in medical research and training, but instead always considered in connection with other discrimination characteristics.

Improved resources for counselling and legal protection as well as structural changes towards reduced barriers

6 — ***Field of action: Politics***

Reforming the General Equal Treatment Act (AGG)

The General Equal Treatment Act (AGG) has been in force since 2006. It regulates protection from 'discrimination for reasons of 'race', ethnic origin, sex, religion or ideology, a disability, age or sexual identity' (§ 1 AGG, 2006/23.05.2023). It applies in the context of employment and in parts of civil law contact, and therefore includes discrimination protection in day-to-day and working life. As found by the Federal Anti-Discrimination Agency, however, to date the AGG does not offer any protection against discrimination in state contexts (see Antidiskriminierungsstelle des Bundes 2023b). The findings regarding experiences of discrimination and racism (see Section I) in state institutions also indicate that the AGG should be extended to include government activity, above all in order to guarantee appropriate legal protection in cases of institutional discrimination (see Bartsch & Aalders 2023). The ADS also calls for this type of reform to the AGG and the abolition of the limitation on discrimination protection for bulk businesses (see Antidiskriminierungsstelle des Bundes 2023a). This abolition would also create legal clarity for the applicability of the AGG to the healthcare field and medical care, in particular with regard to treatment contracts between doctors and patients (see Antidiskriminierungsstelle des Bundes 2020b; Bündnis AGG Reform – Jetzt! 2023).

7 — ***Field of action: Counselling***

Nationwide development of reporting and counselling centres

With the aid of the NaDiRa.panel data presented, there is an evident necessity to extensively document cases of racism, both regarding numbers and also with regard to subjective reports of experiences. For this reason, it is recommended to firmly anchor independent and low-threshold reporting centres for those affected. Additionally, services for sociopsychological and legal counselling could help to support those affected. To this end, the existing network of anti-discrimination counselling centres and specialised victim counselling centres should be developed nationwide (see Bartel & Kalpaka 2022). Financial resources should be provided for this in the future by the federal state governments and the Federal Government. With the funding programme 'respekt*land', the ADS laid an important foundation for safeguarding the development of nationwide structures of the civic anti-discrimination counselling network.

Particularly in healthcare, reporting and counselling services could counteract patients' loss of trust (see Section I.1.3). This needs to be in the form of low-threshold (ideally multilingual) and independent points of contact in the event of experiences of discrimination and racism in medical treatment. These counselling services could offer support to individuals affected to report their experiences of discrimination in healthcare, to find out more about their own rights and, if necessary, to make a stand against discrimination. Furthermore, they could help with uncertainties regarding health insurance or residency status. Internal complaints and counselling centres should be further developed, particularly for employees in the healthcare field (doctors, nurses, etc.) who are affected by discrimination and racism.

A positive example for the concrete implementation of this type of counselling service is the University of Cologne's racism-critical counselling centre for employees (see University of Cologne 2020).

8 — Field of action: Healthcare

Creating more psychotherapy treatment places

If the central findings on health status (Chapter II.1), the experiment regarding the allocation of appointments (Chapter II.2) and findings on healthcare (Chapter II.3) are combined, it becomes apparent that experiences of discrimination and racism are closely linked to mental health: people who are exposed to these negative experiences in their day-to-day lives also describe their mental health as being worse. At the same time, discrimination against people with names that are common in Nigeria or Turkey appears to be rather pronounced with regard to the allocation of appointments in psychotherapy practices. Finally, the results show that people vulnerable to racism in particular give up their search for psychotherapeutic treatment more quickly. Not least in the context of long waiting times for therapy appointments in general, these results are alarming. In its press releases, the Federal Chamber of Psychotherapists has repeatedly called attention to the extremely long waiting times before starting psychotherapy (see BPtK 2018, 2021, 2023). In view of these results, it can be assumed that the situation is even more drastic for patients who are vulnerable to racism. Not only is the BPtK's call for more places offering psychotherapeutic treatment therefore justified, but there is also an urgent need for action in the context of discrimination and racism. It must be ensured that all people have equal access to these places and are not discriminated against with regard to the allocation of appointments.

In addition, professional handling of experiences of discrimination and racism during treatment must be ensured. The analysis of discrimination and racism should be integrated as a component of training. For psychotherapists who are already practising, appropriate further training measures should be developed (see Recommendation 3). Psychotherapists who are themselves potentially affected by racism and racist discrimination can offer important points of contact to those affected and should be supported. Additionally, sufficient places offering therapy should be created, particularly in structurally weak areas.

9 ___ Field of action: Healthcare

Establish discrimination-free allocation of appointments

With the exception of paediatric practices, name-based discrimination was found at all medical practices examined (see Chapter II.2). The results of the experiment are also supported by the descriptions in the qualitative interviews of the community-based participatory study (see Chapter II.4). In order to guarantee discrimination-free access to healthcare, each individual practice can make an independent contribution. Firstly, appointments can be allocated via digital platforms or apps. As convincingly demonstrated by the experiment carried out, appointment allocation via email is not a suitable tool to avoid discrimination occurring. Even if an identical email is sent, people with names that suggest non-German origins are visibly discriminated against in the allocation of appointments. For this reason, it is recommended to move to digital forms of allocation, for which patients do not need to contact practices directly. These can be practice-specific online portals or app-based programmes (such as Doctolib). Secondly, staff responsible for the allocation of appointments should be trained accordingly (see Recommendation 3). As certain demographic groups are not experienced with the Internet and rely on direct contact with practices for the allocation of appointments, equal access must be made possible regardless of sociodemographic characteristics. Many practices focus on multilingual staff in order to overcome potential language barriers. However, there are also some digital solutions such as direct translation apps, which could potentially be used to bypass any language barriers in medical practice.

10 ___ Field of action: Language

Breaking down language barriers

The basis of equal participation in healthcare is secure understanding. The negative influence of language barriers on access, treatment quality and satisfaction, and on the adequate use of health resources is one of the results of this report (see Chapter II.4; see also Bauer & Alegría 2010; Gebhardt, David & Borde 2008; Wolf & Özkan 2012).

There are various recommendations to overcome language barriers. Needs-based financing of language mediation (e.g. interpreters), support for multilingualism among staff in the healthcare system as well as multilingual and multimedial designs for services help to sustainably break down barriers. These measures should be enhanced and sustainably funded (see Antidiskriminierungsstelle des Bundes 2023a:

158; Schödwell et al. 2022). Particularly vulnerable people, such as asylum seekers who are entitled to health-related services in accordance with the Asylum Seekers Benefits' Act, require protected access to language mediation. However, in the AsylbLG, language mediation is currently only listed as a possible service, which has to be applied for separately and approved. This arrangement is in no way sufficient to ensure understanding. Including language mediation services in the service catalogue of the GKV and in other laws, for example in the AsylbLG, is necessary and follows on from the demands on scientific and civic parties (see TransVer 2022).

*11 —— **Field of action: People affected***

Strengthening communities

The empirical findings from the NaDiRa.panel (see Section I) prove that racially labelled people experience discrimination and racism particularly often. One possibility of addressing these experiences is a nationwide network of discrimination- and racism-sensitive advice centres (see also Recommendation 7). In particular, community-based advice can be one route to appropriate representation of the experiences and perspectives of those affected by racism. An initial important step in developing this type of service is the Anti-Racism Commissioner's pilot scheme regarding the financing of community-based advice networks in migrant self-organisations. Structurally anchoring these advice services at state and communal level should be an aspiration. The community-based participatory study in the field of healthcare (see Chapter II.4) also leads to the recommendation to support self-representation and self-help organisations for racially labelled people more intensely and continually. These demands have already been made by civil society, for example in the *Afrozensus* (see Aikins et al. 2021). As our study results came to similar conclusions, these recommendations for action also complement the existing demands. The following measures could contribute to strengthening individuals affected in terms of self-organisation and self-representation: long-term protection of resources for self-organisations and self-help (including financing, venues) as well as support with establishing and developing of self-organisations and self-help groups, particularly in rural areas.

There are existing projects from affected communities in Germany which are particularly active in the promotion of help (among others, Maisha e. V., SOFRA – Queer Migrants e. V. and the Afrikanische Gesundheits- & HIV-Netzwerk in Deutschland). To date, these are neither sufficiently well-known nor networked with each other. For this reason, their networking must be supported for the exchange of knowledge and experience, as well as mutual support on all levels: at a communal level, a state level, and Germany-wide. In community-based contexts, too, the handling of societal, institutional, interpersonal and internalised racism must be addressed more strongly, and specific strategies for coping and action need to be sustainably facilitated (e.g. through community-based services, specific empowerment training and appropriate information regarding the legal framework and legal rights in the German healthcare system). Community organisations and self-representation organisations of racially labelled people are important parties. In order to reinforce them, additional resources are required in order to train members of the community and make appropriate payment for their work structurally possible.

12 — Field of action: Healthcare

Designing specific measures for asylum seekers and people without health insurance

The study ‘Community perspectives of racism in healthcare’ (Chapter II.4) showed that asylum seekers in particular have restricted access to healthcare services and thus experience discrimination (see also Gottlieb & Schülle 2021). A review of these regulations (§§ 4 and 6, AsylbLG) or adaptation to match the medical entitlements in the GKV service catalogue would be necessary in order to create discrimination-free access to healthcare for all people living in Germany (see Bader, Gach & Offe 2022: 13; Bundesarbeitsgemeinschaft der Freien Wohlfahrtspflege [BAGFW] 2022).

Nationwide introduction of the electronic healthcare card for asylum seekers – as already exists in several states – could break down access barriers to medical treatment. In addition, as listed in the Federal Government’s coalition agreement in 2021 (see SPD, BÜNDNIS 90/DIE GRÜNEN, FDP 2021: 111) and recommended by international human rights committees (see Bader, Gach & Offe 2022; Committee on Economic, Social and Cultural Rights [CESCR] 2018), the reporting obligation in the field of healthcare should be curtailed so that ill people without papers are not prevented from obtaining medical treatment in the future (see Ärzte der Welt e. V. 2022). For people without health insurance, some states have set up clearing offices for support, which differ in their design and courses of action. Alongside advice, the contact points also provide medical treatments. Depending on the concept, financing of treatment costs is also possible. They therefore fulfil an important role as navigators and support people without health insurance in obtaining access to standard medical care. Nationwide establishment and better resources for clearing offices is an important goal and has already been recommended by civic parties (see ibid.; BAG & BACK 2023).

Development of research and boost to networking

13 ___ *Field of action: Research*

Systematic establishment and development of German-language racism research

Racism research in German has been barely institutionalised to date, which means that it is heavily fragmented, and the status of data regarding the topic proves complicated. In order to address these problems, an interdisciplinary and transdisciplinary research infrastructure should be established. This requires racism criticism to be anchored as a key skill in university teaching and also to be introduced in other areas of education in Germany. The goal here should not only be recognising the added value offered by racism-critical perspectives but also conveying expertise for active anti-discrimination. In order to establish modern, internationally competitive German-language racism research, further development of ethical research standards is also recommended. Damage to people vulnerable to racism during or via research must be avoided.

If possible, results of racism research should flow back into the organisations and policies of those affected by racism. For this, it is necessary to increase the visibility of research results on the topic of racism in Germany and to intensify the communication between German-language and international racism research. Although the NaDiRa makes an important contribution to institutionalising this type of racism research, there is plenty of work still to be done in future on developing suitable survey tools and scales to make broad recording of racism possible. This refers to fundamental racism-critical research that goes beyond the existing research regarding attitudes.

14 ___ *Field of action: Institutions*

Research on institutional racism – and creating access to this research

The NaDiRa findings regarding experiences of discrimination and racism indicate that state institutions such as public authorities are significant locations in which discrimination is experienced. Research that considers how the established routines and practice in this type of establishment favour and reproduce racism and discrimination is therefore essential, and state establishments should thus make research access possible or easier. This applies particularly to access to and use of processing data. The release of this type of data has already been initiated, as shown for example by the establishment of the research database of the Federal Ministry of Health (see Bundesministerium für Gesundheit 2023b). This process is also desirable for other institutional contexts and could contribute to an improved data situation with regard to racism and discrimination in Germany.

15 — Field of action: Intersectionality
Researching multiple discrimination in a more targeted way

In this report, analyses were explicitly carried out in a gender-specific way. In many places, it became apparent that everyday experiences of discrimination and racism are different for men and for women. Context-dependent differences between the genders were also seen. While men more frequently reported general experiences of discrimination and racism, in the field of healthcare it was above all women who were affected by discrimination. Some of our findings clearly show that sexism and discrimination or racism are intertwined: particularly for women, a change of doctor was frequently observed because they were not taken seriously. Racially labelled women in particular appear to be affected more than average by discrimination in the healthcare system. These connections and empirical patterns can only be uncovered when multiple forms of discrimination are investigated. Therefore, in the future, further discrimination characteristics need to be researched comprehensively in combination with racism. Only by recognising the links between racialising characteristics and other sociodemographic factors, such as gender or age, is it possible to understand and combat dynamics of discrimination and racism.

16 — Field of action: Language
Establishing discrimination-sensitive language in research

Throughout the entire research process – when addressing potential participants, in verbal and written communication, in study information and when publishing results – care should be taken not to reproduce stereotypes and stigmatisation. Guidelines and an overview of relevant terms and concepts for discrimination-sensitive use of language regarding migration and health have been made available by the Robert Koch Institute (Robert Koch-Institut 2022; see also Bilgic et al. 2022).

17 — Field of action: Research
Developing research on racism and health

This report provides initial indications about various fields of action regarding racism and health and therefore also makes apparent which aspects still need to be investigated in future. Discrimination and racism in the context of health must be monitored systematically and in a sustainably scientific manner. This should happen in collaboration with various establishments and organisations on various levels (e.g. community organisations, ADS, hospitals, medical chambers and other associations). With the help of further research, both broad data (e.g. through quantitative studies on the extent of the prevalence of illnesses) and in-depth data (e.g. qualitative studies on structures, processes and mechanisms) must be generated in order to better understand racist circumstances with regard to health and healthcare and in order to be able to take targeted measures to reduce and remove them (for a discussion of concrete suggested research topics, see Conclusion).

18 —— Field of action: Communication

Promoting networking

The networking of various scientific, political and practice-oriented parties and projects can contribute to establishing and improving racism research. This is therefore urgently required and should be supported and financed further in future. In addition, regular conferences with the participation of sciences, politicians and practitioners are necessary in order to discuss developments, measures and further research requirements.

Conclusion

A democracy lives on the trust with which the members of its society view the state and its institutions. However, this is damaged by repeated experiences of discrimination and racism. As shown by this report, these experiences are widespread in society and pose a structural problem in various areas of German society: both individual and societal consequences of (racist) discrimination were demonstrated. Racially labelled people in particular experience these consequences more frequently than average. Alongside a loss of trust in state institutions, effects on health and healthcare were also seen. For example, (racist) discrimination was experienced particularly strongly in the field of health. At the same time, this discrimination is linked to the general perception of health. A racism-critical perspective on the German healthcare system – as taken by this report – makes structural challenges as well as new dynamics of exclusions and mistreatment or undertreatment apparent. These are dramatic, as it is particularly the field of healthcare where people are especially vulnerable and, in many cases, reliant on help and solidarity resources. Accordingly, access to healthcare as well as medical knowledge and medical practices can be a matter of life and death. Health therefore represents an existential basis of life and is a human right. For this very reason, the report and its findings aim to trigger societal analysis of racism, in order to develop political measures which sustainably counteract it. For this to happen, it is also necessary to critically discuss how racism in Germany can be appropriately recorded and researched.

Critical methodological reflection

Multimethod approaches to the research of racism in Germany are required to record the breadth of the phenomenon – at the same time, they are challenging:

Quantitative racism research is fundamentally confronted with the conceptional question of which categorisations are suitable and preferable in order to represent racist experiences and structures. Here, the question is how to reach racially labelled population groups for surveys and which criteria to use to collate them in different categories. To date, research has mostly attempted to use the categories of 'migration background' and 'citizenship' to record inequalities in various areas of society. Particularly for the field of healthcare, however, the Robert Koch Institute points out that these categories are insufficient to depict the inequalities in the healthcare system and the heterogeneity of the living situations and experiences of racially labelled people. Additionally, the RKI calls for an intersectional perspective as a basis (see Kajikhina et al. 2023). These two gaps were addressed in this monitoring report.

In the process, categories were taken up which, independently of citizenship or legal status, gave those being surveyed the opportunity to provide self-reports on their understanding of their identities and perceived ascriptions from others (see Supik 2022). The various options for categorisation, however, are linked to limitations, which need to be further researched and put to the test in future. Through its juxtaposition of the various analysis categories and sampling with particular representation of Black, Muslim and Asian people, the NaDiRa.panel makes an important contribution to the methodical conceptual discussion regarding the further development of quantitative racism research. A particular strength of the NaDiRa.panel was that, due to the large sample of these three groups, for the first time it was possible to make representative statements regarding their perspectives and experiences. For quantitative surveys in the German context to date, it has been difficult to reach Black, Muslim and Asian people in particular and hardly possible to represent them. The processes of ascribing racist characteristics cannot be recorded through quantitative surveys. The perspectives of those affected can also only help here to a limited extent in quantitative investigations. Alongside recording attitudes and racist knowledge bases, supplementation via qualitative methods is indispensable to understanding how and in what concrete situations racist knowledge bases are used and therefore create unequal societal positions and possible actions. Here, the important aspects are research into interactions (actions and (non-) verbal communication) in institutional contexts.

Qualitative and participatory approaches (see Chapters II.4 and II.5) provide in-depth insights into often latent – yet fundamental – processes and dynamics of racism and racialisation. In this respect, for example, the participative analysis of teaching materials in the medical curriculum is helpful for the explorative investigation of institutional racism in the provision of healthcare. The triangulation approach used in the relevant study of this report permits the ‘intake of different perspectives of the object to be investigated’ (Flick 2011: 12). Only the combination of different qualitative methods (analysis of documents, thematic analysis, analysis of contents) makes it possible to approach the mutual relationships between collective and individual knowledge bases and institutional structural dimensions of racism. Although a triangulation process is associated with the challenge of appropriately evaluating different types of sources and relating them to each other, it also provides findings regarding these connections, which had rarely been examined in the past. Here, the participants’ self-identification was an important basis for limiting the reproduction of racism in the research through ascriptions and external labels. Including community perspectives could contribute to increasing the quality of data as real-life knowledge is incorporated during the design of studies and the collection and interpretation of data (see von Unger 2014). In this way, it is possible to gather data in a context- and diversity-sensitive manner and to interpret it from various perspectives. The community-based approach (CBPR) also entails research ethics advantages, as damage can be avoided or reduced through codetermination. This approach thus makes it possible to counteract non-intentional othering in research. CBPR includes knowledge targets and action targets and thus displays direct benefits and relevance beyond the research itself. However, these approaches also have limitations. The selection of co-researchers and study participants set a direction that would significantly affect the further course of the study, both in a positive sense and in a negative one, opening certain accesses and closing others. Additionally, qualitative studies do not claim to be representative but follow other scientific quality criteria (see Misoch 2019). They can and should not make statements beyond the experiences of the individuals surveyed.

Subsequent research questions and outlook

The NaDiRa findings collected in this report may highlight that racism is manifest in various places in the healthcare system, but they only represent a first step in more comprehensive analysis of racist modes of action in the healthcare field. It should be noted here that racism is not only expressed in immediate medical care contexts: racially labelled people and non-labelled people do not enter the healthcare system with the same starting conditions with regard to their health. Discrimination and devaluation of racially labelled people does not begin with their use of healthcare services. Present forms of (indirect) racist discrimination can also be based on past (direct) experiences of marginalisation, or can maintain or reinforce them. In the context of the USA, this is described by the term ‘past-in-present discrimination’ (see Feagin & Eckberg 1980: 12–13).

This report and various international and national studies lead to various and more in-depth questions. On the one hand, further research is required into specific forms of racism, for example against Black people, those perceived as Muslim or Asian, or Sinti and Roma people (see Section I). On the other hand, intersectional interrelationships must be examined. This refers, for example, to the overlap and simultaneity of types of racism. Racist, sexist, classical or age-based discrimination, fundamental power imbalances in the doctor-patient relationship and other institutional particularities of healthcare (such as time pressure or the increased vulnerability of patients) are also relevant (see Section II). Racism must therefore be investigated both with regard to patients and various professional groups in the healthcare field, such as nursing staff and trainees, as well as with regard to various specialities (see Section II). In this context, more in-depth studies investigating institutional working conditions and the precise operating principles of the *hidden curriculum* – for example, in the context of hierarchies, norms, the medical habitus and racism – would be important. The debate around professional identity formation could be a starting point for this (see Chapter II.5).

Furthermore, more research is required which focuses on the ability to act (agency) of racially labelled people and groups, i.e. the individual and collective strategies with which racially labelled people navigate through racist structures. In addition, more research projects, for example on empowerment, are necessary[66] to better understand this (see Aikins et al. 2021: 270–271). In order to design this type of research in a modern way, it is necessary to reinforce research strategies such as community-based participatory research (CBPR) or participatory action research (PAR). These work along power- and racism-critical research ethics principles, which should be facilitated. This is associated with establishing community ethics committees at universities, colleges and research institutions, which can critically accompany research processes and offer them advice and support. In addition, innovative methods such as the use of audiovisual data (e.g. via Photovoice or Storytelling) can provide important insights and contribute to better communication of knowledge between research and practice.

Racism represents a societal relationship which can produce and maintain hierarchies and social inequalities. The future reports from the NaDiRa should therefore provide specific empirical findings in the spheres of work, accommodation and education. In this sense, institutional focuses for follow-up surveys can be prioritised that directly structure people's day-to-day life and participation chances.

The NaDiRa's goal is to use medium- and long-term multi-method monitoring in order to make statements on how racist inequalities in various spheres can be determined and what can be done to counteract them.

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[66] For example, in the participatory research project EMPOW (see Ludwig Maximilian University [LMU], without date).

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