postnote

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ETHNICITY AND HEALTH

Black and minority ethnic (BME) groups generally have worse health than the overall population, although some BME groups fare much worse than others, and patterns vary from one health condition to the next. Evidence suggests that the poorer socio-economic position of BME groups is the main factor driving ethnic health inequalities. Several policies have aimed to tackle health inequalities in recent years, although to date, ethnicity has not been a consistent focus. This POSTnote reviews the evidence on ethnic health inequalities, the causes and policy options.

Ethnicity

Ethnicity results from many aspects of difference which are socially and politically important in the UK. These include race, culture, religion and nationality, which impact on a person's identity and how they are seen by others. People identify with ethnic groups at many different levels. They may see themselves as British, Asian, Indian, Punjabi and Glaswegian at different times and in different circumstances. However, to allow data to be collected and analysed on a large scale, ethnicity is often treated as a fixed characteristic. BME groups are usually classified by the methods used in the UK census, which asks people to indicate to which of 16 ethnic groups they feel they belong (Box 1).

Box 1: BME groups in the UK
According to the 2001 census, 92% of the UK population is White, which includes significant non-British White minorities such as Irish people. A further 4% of the population is Asian or Asian British, 2% are Black or Black British and 1.5% are Mixed. BME populations are concentrated in urban areas, particularly in deprived areas, where they make up a much bigger share of the population. However, the distribution of BME groups in the UK is currently changing, and they are becoming less geographically segregated. The UK is likely to become more multi-ethnic in the future. BME groups now account for 73% of the UK's total population growth, due to differences in fertility rates and some inward migration.

Health inequalities

Health inequalities are differences in health status that are driven by inequalities in society. Health is shaped by many different factors, such as lifestyle, material wealth, educational attainment, job security, housing conditions, psycho-social stress, discrimination and the health services. Health inequalities represent the cumulative effect of these factors over the life-course; they can be passed on from one generation to the next through maternal influences on baby and child development.

Ethnic health inequalities

Large-scale surveys like the Health Survey for England show that BME groups as a whole are more likely to report ill-health, and that ill-health among BME people starts at a younger age than in the White British. There is more variation in the rates of some diseases by ethnicity than by other socio-economic factors[1]. However, patterns of ethnic variation in health are extremely diverse, and inter-link with many overlapping factors:

- Some BME groups experience worse health than others. For example, surveys commonly show that Pakistani, Bangladeshi and Black-Caribbean people report the poorest health, with Indian, East African Asian and Black African people reporting the same health as White British, and Chinese people reporting better health.
- Patterns of ethnic inequalities in health vary from one health condition to the next. For example, BME groups tend to have higher rates of cardio-vascular disease than White British people, but lower rates of many cancers (see Box 2).
- Ethnic differences in health vary across age groups, so that the greatest variation by ethnicity is seen among the elderly.
- Ethnic differences in health vary between men and women, as well as between geographic areas.
- Ethnic differences in health may vary between generations. For example, in some BME groups, rates of ill-health are worse among those born in the UK than in first generation migrants.

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Box 2: Examples of ethnic health inequalities

Cardio-vascular disease (CVD)
Men born in South Asia are 50% more likely to have a heart attack or angina than men in the general population. Bangladeshis have the highest rates, followed by Pakistanis, then Indians and other South Asians. By contrast, men born in the Caribbean are 50% more likely to die of stroke than the general population, but they have much lower mortality to coronary heart disease. Classical risk factors like smoking, blood pressure, obesity and cholesterol fail to account for all these ethnic variations, and there is debate about how much they can be explained by socio-economic factors. Many researchers think that there are biological differences between ethnic groups, and a lot of research has been carried out on the potential mechanisms.

Cancer
Overall, cancer rates tend to be lower in BME groups. For lung cancer, mortality rates are lower in people from South Asia, the Caribbean and Africa, which relates to lower levels of smoking. The highest mortality is found in people from Ireland and Scotland. Mortality from breast cancer is lower for migrant women than for women born in England and Wales. Researchers think this reflects the fact that it takes time to acquire the detrimental lifestyle and other risk factors associated with living in this country.

Mental health
Ethnic differences in mental health are controversial. Most of the data are based on treatment rates, which show that BME people are much more likely to receive a diagnosis of mental illness than the White British. Studies show up to 7 times higher rates of new diagnosis of psychosis among Black Caribbean people than among the White British. However, surveys on the prevalence of mental illness in the community show smaller ethnic differences. There is evidence of ethnic differences in risk factors that operate before a patient comes into contact with the health services, such as discrimination, social exclusion and urban living. There is also evidence of differences in treatment. For example, Black Caribbean and African people are more likely to enter psychiatric care through the criminal justice system than through contact with the health services. Some researchers suggest that psychiatrists diagnose potential symptoms of mental illness differently depending on the ethnicity of the patient.

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Use of health services by BME groups
Ethnic differences in health service delivery and the up-take of services have been reported, although this varies between different parts of the NHS. There are some positive findings. For example, most BME groups access primary care at rates as high as the general population (in relation to need). However, there is also some evidence of lower access to hospital care among BME groups. For example, South Asians have been found to have lower access to care for coronary heart disease. Looking at prevention, rates of smoking cessation have been lower in BME groups than in White groups. In addition, rates of dissatisfaction with NHS services are higher among some BME groups than their White British counterparts. For instance, South Asians report poorer experiences as hospital inpatients, according to Healthcare Commission patient surveys.

Causes of ethnic health inequalities
Many BME groups experience higher rates of poverty than the White British, in terms of income, benefits use, worklessness, lacking basic necessities and area deprivation[2]. Much of the variation in self-reported health between and within BME groups can be explained by differences in socio-economic status[3]. However, there is a complex interplay of factors affecting ethnic health, such as the long-term impact of migration, racism and discrimination, poor delivery and take-up of health care, differences in culture and lifestyles, and biological susceptibility (Box 2).

Health inequalities policies
A number of recent policy developments have aimed to tackle health inequalities. Sir Donald Acheson's *Independent Inquiry into Inequalities in Health* (1998) was a key initiative which put health inequalities onto the policy agenda. It put a strong emphasis on the effects of wider inequalities, poverty and social exclusion on health inequalities. Subsequent policies have broadly recognised the issues as multi-faceted and inter-linked. Twelve departments signed up to cross-government work on health inequalities in the Treasury's *Tackling Health Inequalities: A Programme for Action* (2003). To date, the main policy targets have focussed on socio-economic class and area deprivation, rather than ethnic inequalities (Box 3).

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Box 3: Health inequalities targets
The *NHS Plan* (2000) committed to two national Public Service Agreement (PSA) targets to reduce health inequalities, which were set in February 2001:
- To reduce by at least 10% the gap between the fifth of local authorities with the worst health and deprivation indicators (the Spearhead Areas) (Box 6) and the population as a whole, by 2010.
- To reduce by at least 10% the gap in infant mortality between routine and manual groups and the population as a whole, by 2010.

Since then, a number of local authorities have agreed health inequalities targets as part of their Local Area Agreements. In some cases, the targets attract financial incentives through the reward element initiative (formerly Local PSAs). Local authorities, their partners and communities have been encouraged to collaborate on delivery in the hope of ensuring greater accountability for meeting the targets. Nonetheless, evidence shows that health inequalities have increased nationally since 1997. For instance, for the targets above the gap in life expectancy has increased by 2% for men and 8% for women, while the gap in infant mortality has increased by 6%. However, some of the Spearhead Areas are making progress on the life expectancy target (Box 6).

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Tackling ethnic health inequalities
The Acheson Inquiry made three recommendations for reducing ethnic health inequalities. These were that:
- policies on reducing socio-economic inequalities should consider the needs of BME groups;
- services should be sensitive to the needs of BME groups and promote awareness of their health risks;
- the needs of BME groups should be specifically considered in planning and providing health care.

However, ethnicity has not been a consistent focus of health inequalities policies to date, and few policies have been specifically targeted at BME groups[4]. Two important cross-cutting factors affecting the feasibility and likelihood of action on ethnic health inequalities are the availability of data on ethnicity, and legal obligations towards racial equality.

Ethnicity data
Large-scale surveys are currently the most useful source of data on ethnic health. For example, under its current design, the Health Survey for England measures ethnic health inequalities every five years. However, ethnicity is not recorded at death registration, so mortality can be estimated only by country of birth. There is also a lack of regular, accurate data to monitor ethnic variation in the use of NHS services. Currently the collection of ethnicity data is only mandatory in secondary care. The Department of Health's (DH) Quality of Outcome Framework recently introduced a small financial incentive to GP practices that have complete ethnicity data on their patient profiles. However, the patchy ethnicity data in primary care undermine the planning and evaluation of policy and precludes the monitoring of changes over time. The Commission for Racial Equality (CRE) has recommended that the DH accelerates its implementation of ethnic monitoring. The electronic patient record should make this easier. In addition, the Audit Commission has highlighted the need to understand better how evidence can be used to bring about change in racial equality. The London Health Observatory has produced a tool to guide NHS bodies in using ethnic data for health impact assessment.

Legal obligations
Under the Race Relations Amendment Act (2000), all public bodies have a legal obligation to outlaw racial discrimination and promote equal opportunities by:
* producing a Racial Equality Scheme;
* carrying out a Race Equality Impact Assessment on all new and proposed policies;
* monitoring outcomes by ethnic group.

However, a King's Fund review of 300 Primary Care Trusts (PCTs) found that a third did not comply with the Act. The CRE, which is responsible for monitoring progress on race equality, wrote to the DH in summer 2006 about progress on compliance with the Act.

Health care
Health care and NHS funding have been the central focus of health inequalities policies[5]. Besides issues of poor health provision in deprived areas, policies have also explicitly focussed on equity between ethnic groups. The main approach has been to identify good practice in racial equality and then try to mainstream the strategies throughout the health services.

Delivering equity in health care for BME groups
The government's commitments to improving health service use by BME groups are laid out in the DH's *Race Equality Scheme 2005-2008*. The most action on ethnic inequalities is taking place in mental health services. The government has set specific goals under the Delivering Racial Equality (DRE) initiative (Box 4).

Box 4: Delivering racial equality (DRE) in mental health care
NHS mental health services were accused of institutional racism in the Independent Inquiry into the institutionalization and death of David Bennett, a Black Caribbean psychiatric inpatient. In 2005, the DH responded with DRE. This commits PCTs to providing race equality training in their mental health services, and appointing race equality leads and community development workers. DRE is being rolled out in specific PCTs called Focused Implementation Sites. However, some critics think the goals of DRE are inappropriate as they do not take underlying ethnic differences in prevalence and need into account. Others support the goals of DRE, but feel that it is undermined by a lack of accountability. They argue that DRE has been implemented patchily, relying too much on the commitment of specific individuals in PCTs, and that the funding for the initiatives has not been ring-fenced[6]. In October 2006, the Minister of State for Health Services wrote to the heads of Strategic Health Authorities and PCTs reminding them of their commitments to DRE.

Good practice
The DH has commissioned a number of initiatives to generate or collate good practice in race equality, such as *Pacesetters*, *Race for Health* and the *NHS Specialist Library for Ethnicity and Health,* tackling problems such as barriers to access, language and cultural competence (Box 5). However, the lack of baseline data on ethnicity makes it difficult to evaluate the impact of such projects, which in turn makes it hard to identify good practice.

Box 5: Race for Health
Race for Health is a DH funded programme which seeks to embed racial equality into the mainstream of health and social care. Initially, 13 PCTs were included in the programme. In early 2007, a further 12 PCTs will be added, so that there will be at least two in each Strategic Health Authority. Although most of the PCTs in the programme are urban and have large and concentrated BME populations, some rural PCTs are also included, like Shropshire County where only 1.2% of the population is from BME groups. Such PCTs face tough challenges in providing appropriate services to sparse BME populations, but the solutions will be increasingly important as these are the types of areas with the fastest BME population growth.

Structural reforms to the NHS
In recent years there have been major reforms to the structure of the NHS. The role of PCTs has been expanded, and changes have been made in practice-based commissioning, patient involvement, patient choice, competition, and the plurality of providers. Advocates argue that these reforms will make it easier to tailor services for specific local populations, thus helping to meet the needs of BME groups. The DH has sponsored the *Mosaic* programme, which aims to develop good practice in procurement based on CRE guidelines. However, critics have expressed concerns that BME and other deprived groups may not benefit from the choice initiative and have called for called for the reforms to be examined for their overall impact on equalities.

Redirecting funds

In 2002, the DH reformed the resource allocation formula for PCTs, to redirect funds towards areas with sizeable BME populations and other deprived groups with high levels of unmet need. It has helped to fund activities in the Spearhead Areas, and specific BME services like translation and interpreting (Box 6).

Reducing poverty and social exclusion

Initiatives aiming to reduce poverty and social exclusion have the potential to tackle what many believe to be the root causes of health inequalities. However, a Social Exclusion Unit review of initiatives questions whether BME groups have benefited from the drive to reduce social exclusion. Rather than explicitly targeting BME groups, policies tend to assume that BME groups will benefit by virtue of their relative poverty and concentration in deprived areas.

Financial poverty

Several policies have aimed at reducing income poverty in recent years, through benefits levels, tax credits, and welfare to work programmes. There has been little ethnic targeting of welfare policies to date, despite persistently high levels of poverty in some BME groups. However, there are indications that BME groups may not have benefited from policies aimed at reducing income inequalities as much as other groups. For instance, the gap between the employment rates of BME groups and the overall population improved by just 4% between 1997-2005, compared with improvements of 6-13% in the employment rates of older workers, lone parents and disabled people[7].

Life-course interventions

The targets on child poverty and initiatives like Sure Start aim to improve child development, to prevent the passing-on of social deprivation and vulnerability to ill-health between generations. However, despite high levels of child poverty in certain BME groups, there has been no ethnic targeting in the policies to redress child poverty. For instance, the Joseph Rowntree Foundation has recommended changes to benefits and tax credits, which still favour small families above the larger families which are mostly represented by BME groups.

Area-based initiatives

Health Action Zones, Neighbourhood Renewal, the New Deal for Communities, Sure Start, and most recently, the Spearhead Area initiatives (Box 6) are aimed at reducing health inequalities and social exclusion by targeting deprived areas. They involve partnerships between PCTs, local authorities, voluntary sector organisations and industry. Studies conclude that they can have benefits for health, although evaluating the impact of area-based initiatives is very complex[8]. The initiatives focus on areas which often have high BME populations. However, the lack of ethnic monitoring means it is not usually possible to examine BME involvement in the activities, or look at outcomes by ethnic group.

Box 6: The Spearhead Areas
The Spearhead Areas are the fifth of local authorities in England with the worst health and deprivation indicators. They are the focus of specific DH activities to improve health care. Using evidence on the efficacy of known interventions, DH has calculated that it is possible to narrow the gap in life expectancy by the 10% called for by the PSA target by 2010 (see Box 3) via:

- smoking cessation clinics;
- secondary prevention of cardiovascular disease;
- primary prevention of cardiovascular disease for people with high blood pressure, using medications;
- other locally determined projects including early cancer detection, action on respiratory diseases, alcohol-related disease and infant mortality;
- health trainers, to motivate individuals to change their lifestyles and help them to navigate care pathways.

Despite the increasing gaps in life expectancy nationally (see Box 3), the DH has claimed a relative success for the Spearhead programme. The 2003-05 data show that 60% of the Spearhead Areas are on track to meet the target either for males, females or for both sexes, by 2010. Nearly 45% of the BME population of England lives in Spearhead Areas compared with 28% of the general population, so BME groups should benefit from the programme. The DH recommends that local authorities set their own targets. Ethnic inequalities are a focus of activities in some areas, according to local demography.

Overview

- Black and minority ethnic (BME) groups generally have worse health than the overall population, although the patterns of ethnic health inequalities are very diverse.
- Ethnic health inequalities result from many inter-linking factors, of which the relative poverty of BME groups is probably the most important.
- Policy responses are wide-ranging and incorporate initiatives to improve the use of health services by BME groups, as well as tackling broader socio-economic inequalities between ethnic groups.

Endnotes
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