High Quality Healthcare Commissioning: Why race equality must be at its heart

Sarah Salway, Daniel Turner, Ghazala Mir, Lynne Carter, John Skinner, Bushara Bostan, Kate Gerrish and George Ellison

A Race Equality Foundation Briefing Paper

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This paper draws on findings from the Evidence and Ethnicity in Commissioning project, evidence from practice experience and other research, to demonstrate the importance of putting race (ethnic) equality at the heart of healthcare commissioning.

Key messages

1. Healthcare commissioning - the process through which health services are strategically purchased to meet the needs of local populations - has the potential to tackle inequalities in access, experiences and outcomes between ethnic groups.

2. To-date, healthcare commissioning organisations have often failed to meet the needs of their populations effectively because they have not mainstreamed attention to ethnic diversity and inequality. As such, commissioning organisations may be failing in their legal duties. Progress is hampered by national and local policy contexts that fail: to provide clear guidance on what standards of service provision are expected or what commissioning responses are appropriate; to ensure adequate skills and resource; and to performance monitor or incentivise progress.

3. Rather than being dealt with as a marginal agenda, commissioning organisations must understand and address ethnic inequalities as part of their core responsibilities, and exploit synergies with other key policy agendas, including Quality, Efficiency and Health Inequalities.

4. Strong leadership, a diverse workforce, effective partnership working, meaningful engagement of local black and minority ethnic communities, and a reflective, learning culture, could help to create more enabling strategic environments.

5. Effective generation and use of evidence and knowledge is needed to raise awareness of the scale and nature of ethnic inequalities and to challenge and support key actors to find viable solutions.

Introduction

This paper draws on findings from the Evidence and Ethnicity in Commissioning project, evidence from practice experience and other research, to demonstrate the importance of putting race (ethnic) equality at the heart of healthcare commissioning.
Ethnic identity influences the health of individuals and groups through a variety of mechanisms including:

- direct and indirect discrimination;
- differential access to health-promoting resources;
- cultural practices;
- migration;
- some genetic or biological factors.

(Nazroo, 1997; Salway and Ellison, 2010)

Rather than mitigating the social and economic disadvantage that undermines the health of many minority ethnic people, the healthcare system can make matters worse. Inaccessible services, unmet need, poor patient-provider communication, inappropriate diagnoses and treatment, and negative service experiences remain common and are not confined to new migrants or people who lack English language skills (as documented in many of the other Better Health Briefings, see for example: Chau, 2008; Moriarty, 2008; Bharj and Salway, 2008; Latif et al., 2010).

To-date, the contribution of commissioning to tackling these widespread inadequacies has been disappointing. Findings from the EEiC project, as well as evidence from elsewhere, suggest three broad obstacles to progress. First, there is ambivalence at national and local level regarding the importance of addressing ethnic inequality. This is reflected in its marginalisation from other key policy priorities, the limited resources allocated, and the lack of performance monitoring. Second, individuals charged with undertaking commissioning work lack the skills and/or confidence to engage with issues relating to ethnic diversity and inequality. These individuals also commonly fail to draw on available expertise, opting instead to ignore the issues. Third, the increasing emphasis on evidence-based policy and practice has inadvertently undermined the ethnic inequalities agenda because data and evidence are lacking, and those who might champion the cause are often ill-equipped to mobilise the available evidence effectively. Coupled with a predominant focus on achieving short-term gains measured primarily in terms of cost savings, these factors hamper action towards understanding and addressing deeply ingrained ethnic inequalities.

This briefing paper addresses the first of these obstacles, which relates to the need to establish a strategic, enabling environment. We highlight the overall role that commissioning should play in addressing ethnic inequalities in access, experiences and outcomes of healthcare services, and illustrate why this focus complements other key commissioning concerns. A second Better Health briefing paper addresses the second and third (predominantly operational) obstacles by highlighting actions that commissioners, and other stakeholders, can take to enhance the contribution of commissioning to reducing ethnic inequalities (Salway et al., 2012).
What is healthcare commissioning? Why is commissioning key to reducing ethnic inequalities in healthcare access, experiences and outcomes?

The term 'commissioning' is peculiar to the UK health system, while terms like 'strategic purchasing' or 'planning and funding' are used elsewhere. A useful definition of commissioning is provided by Woodin (2006); "the set of linked activities required to assess the healthcare needs of a population, specify the services required to meet those needs within a strategic framework, secure those services, monitor and evaluate the outcomes." Government policy emphasises the pro-active and strategic nature of commissioning, which should involve both transformational (reshaping the configuration of services) as well as transactional (custodianship of the budget, contract monitoring) elements (NHS Commissioning Board, 2012). Since 2002, Primary Care Trusts have had responsibility for commissioning most local health services, including primary care and public health interventions (DH 2001), with some specialist services and national programmes being commissioned at regional or national level. The current NHS restructuring sees Clinical Commissioning Groups (CCGs, lead by General Practitioners with support from other clinicians and commissioning managers) taking up the reins for most local healthcare commissioning. At the same time, PCT Public Health teams will be relocated to Local Authorities from where they will commission a range of services and interventions (such as sexual health services and healthy lifestyle interventions). Primary Care will be commissioned by a national NHS Commissioning Board via Local Area Teams, who will also have responsibility for commissioning some public health interventions (DH, n.d.).

This restructuring presents an important opportunity to re-emphasise both the strategic role that commissioning should play; and the responsibility that commissioning organisations have to ensure that this process delivers benefits for all, regardless of ethnicity. Commissioning organisations are required to consider the entire population whose health they are tasked with improving and to look across the whole range of services and interventions on offer (DH, 2011). Commissioning organisations must focus on improving health, not merely paying for health services, and they should give particular attention to improving the health of the most disadvantaged and to ensuring that their policies will not unduly affect the groups protected under the Equality Act. This requirement has been clearly set out in recent government policies and echoed by many of the key professional bodies involved. For instance, the Royal College of General Practitioners’ (RCGP) Centre for Commissioning identifies, under its commissioning principles, "meeting the healthcare needs of the whole population, including the disadvantaged and the vulnerable, to improve health outcomes" (RCGP, n.d.). In terms of meeting the needs of minority ethnic populations, there are four broad areas of activity in which healthcare commissioning organisations should therefore be engaged:

1. Ensuring that existing services and interventions provide equitable access, experiences and outcomes for all service users and carers regardless of ethnicity.
2. Ensuring that any transformational work such as the development of new services, the redesign of existing care pathways, or the decommissioning of provision, pays detailed attention to the potential negative impact on particular ethnic groups.

3. Examining the fit between existing services and minority ethnic health needs and responding to significant gaps through design and procurement of specialist services (where there is a clear case for specialist provision on the basis of higher quality and/or greater efficiency) or enhancement of existing provision.

4. Shifting spend towards prevention and early intervention (Imison, et al., 2011) (particularly where this accompanies action on 1-3 above, so that the most disadvantaged groups benefit in proportion to their greater need).

A failure to commission for multi-ethnic populations

Despite the rhetoric of strategic and transformational commissioning, and significant investment in commissioning skills over the past few years (particularly under the banner of World Class Commissioning, DH, 2007), it is widely recognised that structural factors (particularly the power imbalance between PCTs and large provider Foundation Trusts and the momentum of historical contracts) severely constrain commissioners’ room for manoeuvre (Smith et al., 2010; Checkland et al., 2012). This means that the bulk of expenditure by Primary Care Trusts continues to be straightforward or passive ‘purchasing’ - that is, simply buying what is on offer (Woodin, 2006; Smith et al., 2006). In the words of one of the EEiC respondents, transformational work is usually confined to 'tinkering at the margins'. That said, the EEiC project, and other research, has documented instances of active, 'brave' commissioning work (Smith et al., 2006; 2010). This has included: growth in extended primary care services; pathway redesigns; the use of Commissioning for Quality Innovation schemes (CQUINS)³ to prompt service improvement; and some decommissioning of services.

Nevertheless, examples of commissioning action that has actively shaped services to better meet the needs of minority ethnic patients remain few and far between. Indeed, findings from the EEiC project overwhelmingly suggest that commissioning organisations do not prioritise this agenda and that most healthcare commissioners do not view identifying, understanding and tackling ethnic inequalities in healthcare access, experience and outcomes as part-and-parcel of their job. It found that organisational cultures did not penalise or reward (in)attention to ethnic inequality and that structures and processes were ineffective at prompting commissioning staff to consistently address these issues. There was uncertainty among commissioning managers regarding whether it was appropriate to focus on the needs of minority ethnic groups, with some expressing concern that to do so would mean 'privileging' these groups, rather
than viewing such attention as addressing unfair disadvantage. There was also a lack of awareness regarding what effective strategies might look like, and a tendency to view responsibility for identifying viable service responses as lying with provider organisations. At the same time, PCT staff with an equalities and diversity remit, who might offer clarity and guidance on these issues, were few in number and tended to be isolated from 'core' commissioning work.

'So I always say that people don’t get discriminated any more, the equality and inclusion agenda gets the discrimination... it’s the area itself that gets the discrimination, that gets less resources, that gets the less importance... Which of [the] agendas do you think is going to be keeping people awake at night time? It will not be the inclusion agenda. It will be QIPP* and commissioning and providing. So there is a hierarchy in the importance of areas within the NHS.' EEiC National Key Informant, NHS.

'I think locally it still remains a very Cinderella issue I think for many groups, for many areas. ..... I think overall it’s probably still not that high on people’s radar, is it.' EEiC National Key Informant, Third Sector

'There’s a mind-set that says if we do anything for BME communities that’s on top of what we already do, rather than what we already do should incorporate the needs of BME communities’ EEiC Local Respondent, Local Authority.

Where service developments aimed at addressing ethnic inequalities have occurred, these have mainly been project based and often short lived. Providers, rather than commissioners, have tended to be the ones who highlight need and seek innovative solutions, with little evidence of resultant knock on effects for commissioning organisational policies or practice. Even large-scale national investments like Delivering Race Equality and Pacesetters do not appear to have led to systematic attention to ethnic diversity and inequality within the strategies and work programmes of commissioning organisations, despite important successes on the ground (EHRC, 2011).

There is clearly a pressing need to make a convincing case for why attention to ethnic diversity and inequality must be at the heart of commissioning work, and to provide greater challenge and support to commissioners to take concerted action on this agenda.

Aligning race equality with other drivers

While the 2010 Equality Act provides important renewed impetus for healthcare commissioning organisations to respond to the public sector equality duty, past experience suggests that a focus on legal requirements can encourage a compliance mentality, and has been insufficient to embed race equality into
the mainstream business of NHS organisations (EHRC, 2011). Therefore, while the new focus on outcomes rather than process, particularly via the requirement to publish equality data and develop equality objectives, is to be welcomed, there is a need to ensure that this work is adequately resourced, sustained over the long term, and is positioned centrally within the commissioning process. Findings from the EEiC project suggest that action on ethnic inequalities remains persistently side-lined from other commissioning agendas that have greater legitimacy, and that synergies are neither recognised nor exploited.

Given the target-driven, benchmarking culture that has come to dominate NHS governance and management (DH, 1999; Gridley et al., 2012), there is an urgent need to challenge the marginalisation of ethnic equality work and establish much more clearly what commissioners can and should be doing to address this agenda and how progress can and should be measured. There is a need to make the case for attention to ethnic diversity and equality as integral to all commissioning activity, and to highlight how this agenda can complement, rather than complicate or undermine, work on other priorities. Three such important areas where greater synergy is needed are highlighted below.

**Quality**

The Darzi Next Stage review in 2008 signalled the policy intention to make quality 'the organising principle of the NHS' (DH, 2008). At the heart of the Darzi review's recommendations was the need for services to be shaped around the characteristics and needs of the patients they serve, providing care that is 'personal, effective and safe'. A large infrastructure currently supports this national agenda including: a National Quality Board; benchmarking against a basket of Indicators for Quality Improvement (IQIs), across the three domains of safety, effectiveness and experience; annual production of Quality Accounts by NHS provider organisations; and a rolling programme of production of NICE Quality Standards. At local level, this focus is reflected in: performance monitoring via indicator dashboards; regular quality review meetings between commissioners and providers; and associated strategy documents, procedural guidelines and quality reports being produced by large dedicated teams within PCTs.

Given the wealth of qualitative and quantitative evidence that patients of minority ethnic identity frequently have poorer service experiences than majority white British patients (DH and HCC, 2008; Lakhani, 2008), and the growing body of findings that document how communication difficulties and lack of cultural competence can compromise effectiveness and safety of care (Rhodes and Nocon, 2003; Lewis, 2007; Kai, 2007; Delamothe, 2008), one would expect ethnic diversity and inequality considerations to be part-and-parcel of the overall quality agenda. In practice, however, these apparently obvious synergies remain untapped by commissioners. The EEiC project found that quality and equality were worlds apart in the PCTs studied. Quality indicators were not regularly broken down by ethnic group and CQUINS were rarely defined in terms of gains for minority ethnic patients. The quality assurance documents that were reviewed made no reference to equalities issues. Further, while guidance on the Department of Health's newly adopted Equality Delivery System (EDS) alerts managers to the alignment between the equality objectives and quality and safety standards (DH, 2012), this appears to be an afterthought. The EEiC project found that
in practice the EDS was undertaken by equality and diversity staff without reference to the quality agenda and with no involvement of staff from these teams. This isolated approach means that it is not obvious how priorities identified by the EDS process are then to be translated into action by other commissioning staff. Other commentators have also highlighted this extraordinary state of affairs (Murray and Bachus, 2005; Chin and Chien, 2006). Clearly, there is a need to raise awareness among commissioning managers of the quality and safety issues that disproportionately affect minority ethnic patients and to strongly indicate that overlooking these inequalities is unacceptable. Resources devoted to monitoring and addressing quality issues within provider and commissioner organisations should be harnessed, with appropriate indicators being reported by ethnic group and procedures being developed that are inclusive of these equality concerns. Furthermore, breaches of ethnic equality standards should prompt investigation and remedial action by commissioning managers in the same way that general quality concerns currently do.

**Efficiency**

Given the current austerity measures, the need for the NHS to curb costs and use resources efficiently is a major priority, and commissioning activity is largely driven by this agenda. Linked closely to the quality agenda, under the umbrella of QIPP - Quality, Innovation, Productivity and Prevention - there is a large infrastructure at national and local level, with regular benchmarking of spend and many other tools assisting PCT commissioners to identify areas of service provision that might warrant closer scrutiny. While inefficiency often arises due to a failure to effectively join up elements of service provision, a 'lack of fit' between services and patient needs is also often a major cause. There is evidence to suggest that a number of such inefficiency concerns show important variation along ethnic lines (though investigation to-date has been inadequate). These include: use of unscheduled care (Gilthorpe et al., 1998; Parry, Van Cleemput et al., 2004); poor uptake and adherence to treatments (Chauhan et al., 2010); late presentation and consequent more costly delayed intervention and poorer outcomes (Breast Cancer Care, 2011; Johnson et al., 2011; Addo et al., 2012); and low access to self-management support (Diabetes UK, 2007). However, the EEiC project found that commissioners exploring efficiency issues overlooked the relevance of ethnic diversity and inequality and tended to assume that giving attention to ethnicity would add cost and complexity, rather than that such consideration might improve their understanding of the issues and increase the potential for finding effective, efficient solutions. Clearly, highlighting the potential for more efficient use of resources if services better meet the needs of minority ethnic groups should be a key strategy. Equipping ‘champions’ – whether these are commissioning staff or external stakeholders - with the skills and information to develop convincing business cases for addressing ethnic inequalities was identified by EEiC respondents as a key priority.

**Health Inequalities**

Reducing health inequalities has been an explicit policy objective in the UK for the past 15 years, with the independent review - *Fair Society, Healthy Lives* (Marmot, 2010) - providing the current policy direction at national and local level. The repeated failure of this agenda to pay explicit and considered attention to ethnic diversity and inequality has been highlighted elsewhere (Salway et al., 2010; Ingleby, 2012). The
health inequalities programme is particularly concerned with tackling the wider social determinants of health, as well as the prevention of, and early interventions for, long-term conditions through public health and primary care (DH, 2009). Key social determinants of poor health, including poor housing, poverty and low educational attainment show important ethnic differentials, with some of the enumerated minority ethnic groups standing out as particularly disadvantaged (notably people identifying as Bangladeshi/British Bangladeshi and Pakistani/British Pakistani; Platt, 2007). However, these inequalities reflect the particular disadvantages faced by minority ethnic people, as socioeconomic deprivation inter-relates closely with racist exclusion and discrimination across the life-cycle. There is evidence that health outcomes of some minority ethnic groups are worse than would be expected on the basis of their socioeconomic circumstances alone, and that the direct and indirect experience of racism in everyday life is an important contributory factor (Karlsen and Nazroo, 2002; Nazroo 2003). Interventions aimed at tackling the ‘upstream’ social determinants of health have been found to fail to engage and meet the needs of minority ethnic people (Craig, 2007). Furthermore, there is widespread evidence that uptake of key preventive interventions including screening services, vaccination, and ‘healthy lifestyle’ promotion, also show important ethnic inequalities (Crozier and McNeill, 2003; Webb, 2004; Szczepura, 2005), with services often suffering the same ‘lack of fit’ that arises within curative healthcare settings. Clearly, there are strong reasons why commissioners with responsibility for addressing health inequalities should pay explicit attention to understanding and addressing ethnic health inequalities. However, findings from the EEiC confirmed earlier work that shows attention to ethnicity within UK health inequalities policy and practice remains patchy at best (Exworthy et al., 2006). Public health commissioners were found to be focused on targets that were not defined in terms of ethnic inequalities, and often exhibited the same uncertainties around focusing on minority ethnic needs as those commissioning curative health services. There is a need to challenge this omission, through which public health practice essentially reinforces the exclusionary processes operating in wider society. There is also a need to emphasise that progress on key outcome measures (such as infant mortality) will be undermined unless ethnic inequalities are taken seriously, particularly in the areas of greatest deprivation, which often have high concentrations of minority ethnic people (Raleigh, 2008).

Putting race equality at the heart of commissioning: creating a strategic, enabling environment

Many readers of this paper will recognise reducing ethnic inequalities in healthcare access, experiences and outcomes as the most effective way to deliver healthcare to the population as a whole. It is also the morally right thing to do as well as being supported in law. Nevertheless, experience suggests that without clear direction, challenge and support, this agenda will remain side-lined, and concerted action rare, within commissioning. The discussion above has explained why this marginalisation is both unacceptable and counter-productive, and highlighted the need for action to:
align race equality with core commissioning agendas, particularly quality, efficiency and health inequalities;

spell out much more clearly: how and why ethnicity affects health and healthcare; what standards of service provision are expected; and what commissioning responses are appropriate;

ensure that sufficient resource is allocated to this agenda, and that resources directed to other priorities also work for, rather than against, action on ethnic inequalities;

performance manage and reward progress on this work;

equip commissioners with the confidence and competence to undertake work to identify, understand and address ethnic inequalities.

While stronger leadership and greater resource at a national level would be beneficial, there is much that can be done locally within the emerging commissioning structures. Indeed, findings from the EEiC project, together with wider experience, suggest that some PCTs and other commissioning bodies, have done better than others at putting attention to ethnic diversity and inequality at the heart of their work. For instance, NHS North West's equality grading tool - EPIT (a precursor to the current Equality Delivery System; DH, 2012) - identified Liverpool PCT as 'achieving' across a number of relevant indicators. Key factors that seem to encourage a strategic enabling environment include:

Leadership and senior management - People at the top of organisations who: make it clear to their staff that race equality is a priority area for which everyone is responsible; make public statements in high profile gatherings to this effect; commit adequate resources to this agenda; ensure effective linkages and synergies across work-streams; establish structures and processes that enhance the confidence and competence of all staff, hold them to account and reward progress in this area; and actively support and value the work of 'champions' for this agenda.

A diverse workforce - An organisation that: includes people with a direct connection to the issues at all levels of seniority; values the diversity of its staff and draws on this to increase the confidence and competence of its workforce; and has effective mechanisms for connecting senior decision-makers to more junior knowledge-bearers.

Effective partnership working - An organisation that: builds effective partnerships to increase understanding of, and action on, race equality issues; recognises service providers as key stakeholders and knowledge-bearers; recognises the key role of the Voluntary Community and Faith sector and facilitates its active engagement and development as a service provider; and creates a commissioning arena in which partners are encouraged to be 'external agitators' both challenging and supporting commissioners in their role.
Meaningful engagement of local black and minority ethnic communities - An organisation that: recognises the often large social distance between commissioners and the people whose interests they serve; promotes involvement of minority ethnic patients and public via focused as well as broad mechanisms for gaining input and guidance; and accepts its responsibility for ensuring sustained and meaningful relationships.

A reflective, learning environment - An organisation that: gives time and space for reflection and critical analysis; shares learning around failures as well as successes; discourages silo working; and manages collective knowledge effectively both internally and across partnerships.

In addition to the core characteristics of an enabling environment identified above, progress towards ethnic equality requires more effective generation and mobilisation of evidence and knowledge. This is important both to raise awareness of the scale and nature of ethnic inequalities and to challenge and support key actors to find viable solutions. Commissioning organisations must: draw on a wide range of relevant evidence and knowledge to describe, understand and seek solutions to ethnic inequalities; appropriately appraise and synthesise different sources; identify inadequacies in data/intelligence on ethnic inequality and actively work to improve systems of data collection; and contribute to and learn from networks and forums to improve the evidence base around ethnic health inequalities and effective intervention.

Conclusion

The potential for commissioning to leverage improved access to, experiences and outcomes of healthcare for minority ethnic people has not yet been realised. Race equality remains a side-lined concern with insufficient resource and expertise. The current restructuring of the NHS presents an important opportunity for commissioning organisations to recognise their responsibility and establish a strategic environment which embeds attention to ethnic diversity and inequality into all commissioning work, and a strong case can be made for its inclusion. A second Better Health briefing paper from the EEiC project sets out in more detail actions that can be taken during the commissioning cycle by commissioners and other stakeholders to improve healthcare for minority ethnic people (Salway, et al., 2013).

Various commissioning toolkits have been produced to support commissioners, some of which make some reference to the needs of minority ethnic patients and carers. These documents can be helpful for those who want to understand more about commissioning processes and how they might influence them to prompt greater attention to ethnic diversity and inequality. Examples include:


Some organisations have produced commissioning guidance with a focus on the needs of migrants and/or minority ethnic people:


The EEiC project has produced a range of tools and resources to support this agenda in commissioning. www.eeic.org.uk
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Notes

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In keeping with the terminology of the Equality Act (2010) and the Race Equality Foundation, we use the term 'Race Equality' to refer to the broader agenda of promoting equality between racial/ethnic groups and removing racist discrimination. However, elsewhere in the paper we use the terms 'ethnicity', 'ethnic group' and 'minority ethnic group', as these are in more common usage in the UK and are preferred by those who are wary of the association of the term 'race' with discredited 19th century work labelled as 'scientific racism'.

The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to reward excellence by linking a proportion of providers’ income to the achievement of local quality improvement goals.

Quality, Innovation, Productivity and Prevention - a major strategic agenda for the NHS
http://www.dh.gov.uk/health/category/policy-areas/nhs/quality/qipp/