

Better  
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Briefing

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**Race equality  
and health  
inequalities:  
towards more  
integrated  
policy and  
practice**

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## Key messages

- 1 There are many potential synergies between the Equality & Diversity and Health Inequalities agendas. Both are fundamentally concerned with reducing inequity in access to health promoting resources.
- 2 However, the origins of these two areas of work differ and, within English health policy and practice, they have tended to develop independently rather than in a coordinated fashion at both a national and a local level.
- 3 The resulting divergence in agendas and practices is reflected in the framing of much Health Inequalities work, in which socioeconomic inequality is the core focus and other dimensions of disadvantage, including ethnicity, are neglected.
- 4 The separation of these two important areas of work is not inevitable given that examples of more integrated approaches are found in some UK initiatives and internationally.
- 5 Integration of these agendas requires not only administrative, but also political and methodological alignment, but much could be gained from more joined up strategy and action.
- 6 Understanding and meeting the needs of those with the worst health outcomes – for whom there is often an interplay of multiple processes of exclusion – demands that we take a more integrated and holistic approach.

## Introduction

This paper argues that within the English health system the 'Equality and Diversity' (E&D) and 'Health Inequalities' (HI) agendas remain poorly integrated at both national and local level. In particular, the HI agenda has largely failed to pay explicit attention to axes of inequality other than the socioeconomic gradient. This paper suggests that the disconnect between E&D and HI work hampers progress towards better understanding of the processes that perpetuate poor health outcomes. It also limits coordinated intervention to address need across the health system, including action on the wider determinants of health. The paper is particularly concerned with the slow progress towards tackling ethnic inequalities in health and healthcare, but similar concerns have been voiced in relation to other key axes of difference and disadvantage, not least disability and age (CPA, 2009; Emerson and Baines, 2009).

## 1 Equality and diversity: origins, developments and critiques

In the UK context, the term 'Equality and Diversity' (E&D) refers to the set of values, rights and responsibilities relating to the promotion of equal opportunities and good relations within society. Since the first Race Relations Act in 1965 (amended in 1976) made it unlawful to discriminate on grounds of colour, race, nationality or ethnic or national origin, successive legislation has been introduced to strengthen these aims. This culminated in the 2010 Equality Act which places an Equality Duty upon all public sector organisations, including the NHS, to eliminate discrimination, advance equality and foster good relations between racial/ethnic groups as well as across a further eight 'protected characteristics' (Equality Act, 2010). The intention of this Public Sector Equality Duty is to identify and reduce institutional or systemic inequalities including those linked to ethnicity. Furthermore, an independent body - the Equality and Human Rights Commission (EHRC) - was established in 2007 to promote equality and human rights and enforce associated legislation.

During the five decades since the first Race Relations Act in 1965, a variety of E&D policy responses have emerged within the health sector: senior appointments have been made (such as the Ethnic Health Advisor in 1989, the Equality & Human Rights Director in 2004, and the National Lead for Equality at NHS England in 2013) and special initiatives have been launched including: *Personal, Fair and Diverse*; *Delivering Race Equality*; *Race for Health*; *the Equality Delivery System* and *Inside Outside*, to name but a few (Randhawa, 2007). However, despite the apparent strength of the legislative framework and significant policy-related activity, there remains disappointing progress on the ground towards reduced ethnic inequalities in healthcare access, experiences and outcomes, as evidenced by a growing body of research (see earlier Better Health briefing papers for summaries) and public enquiries, such as that into the death of David 'Rocky' Bennett (Norfolk, Suffolk and Cambridgeshire SHA, 2003).

In part this slow progress is attributed to the fact that within NHS organisations, E&D work has often been internally-focused and concerned with achieving a narrow, mechanistic version of legal compliance. NHS Trusts have been found preoccupied with the production of documents such as Equality Impact Assessments or Race Equality Schemes rather than linking these to action to address inequalities experienced within the populations served. In July 2011, the EHRC reviewed NHS performance in meeting the Public Sector Equality Duties and concluded that "The majority of organisations in the sample focused their performance on the equality duties through equality schemes and seemed to adopt a tick box approach to the duties. The research revealed very little equality consideration, planning, and outcomes-reporting in mainstream strategy and policy (for example, commissioning) plans" (Widger *et al.*, 2011, p.49). Other research has highlighted the limited attention to workforce diversification and up-skilling, so that healthcare professionals often remain ill-equipped to serve the needs of their ethnically diverse patient populations (Mir and Sheikh, 2010; Kai *et al.*, 2007).

At the same time, however, where there has been more considered attention to ethnic inequalities in health and healthcare, it has been argued that policy and practice approaches have lacked consistency (see for example, Bhui *et al.*, 2004 on mental health) and frequently served to stereotype and stigmatise minority ethnic communities, focusing on 'cultural differences' to the neglect of social and economic marginalisation and racism (see for example, Ahmad and Bradby, 2007). Some have further argued that a failure to take a sufficiently evidence-informed approach to E&D work has perpetuated unhelpful conceptualisations and inadequate understanding of the patterns and causes of inequality and thereby undermined effective action (Ali *et al.*, 2013).

Notwithstanding this generally poor picture, it is important to note that there are pockets of good practice within the NHS, as well as passionate individuals and committed organisations working within the third sector to tackle health disadvantage among minority ethnic communities. Often these initiatives are characterised by core values of E&D work: challenging discrimination; empowering marginalised groups; and advocating for the right to health (see examples of good practice in earlier Better Health briefing papers, including Mir, 2007). It could be suggested that progress towards action on ethnic health inequalities would be more widespread if E&D work elsewhere within the health sector had a stronger alignment with the HI agenda.

## 2 Health inequalities agenda: origins, developments and critiques

In the UK context, 'health inequalities' are commonly defined as differences in health status or in the distribution of health determinants between different population groups that are considered to be unjust and avoidable. The importance of tackling inequalities in health has received sustained policy attention in the UK for the past 15 years. In 1998, the then Labour Government indicated its intention to take health inequalities seriously by commissioning the independent Acheson Enquiry, followed by a governmental review in 2002 (Acheson, 1998; DH, 2002). In 2001, explicit targets were set for reducing health inequalities including reducing the gap in life expectancy between socioeconomic groups, a Programme for Action followed in 2003 (DH, 2003). In 2008, the Labour government continued its focus on health inequalities by commissioning the now much publicised independent 'Marmot Review'; a detailed review of evidence on patterns of health and socioeconomic inequality and the effectiveness of interventional strategies (Institute of Health Equity, 2010). The current Conservative-led Coalition Government has retained a focus on health inequalities, confirming its intention to act on the findings of this influential review despite it being commissioned by the previous administration. Thus, commitment to addressing health inequalities currently appears to be an accepted part of the UK political mainstream (Turner *et al.*, 2013), largely mirroring the global policy drive initiated by the WHO's Commission on the Social Determinants of Health (CSDH) established in 2005 (CSDH, 2008). Importantly, however, despite the CSDH's broad understanding of health inequalities being rooted in differential power and influence, associated with income inequality and social status, as well as differential exposure to stress, adverse

conditions, discrimination and unequal access to services, the English HI policy agenda has been predominantly framed in terms of socioeconomic disparities, with much less attention being given to other axes of diversity and disadvantage, including ethnicity.

The practice and progress achieved in the HI arena have been heavily criticised in recent years. Independent analyses show that inequalities in life expectancy between rich and poor areas steadily increased in the 1980s, 1990s and early 2000s (Shaw *et al.*, 2005; Thomas *et al.*, 2010). Similarly, the gap between socioeconomic groups in rates of infant mortality has not declined. Such trends led a recent King's Fund review to identify the lack of progress in tackling health inequalities as a significant health policy failure of the last decade (Thorlby and Maybin, 2010).

Commentators have argued that progress is hampered by a lack of serious attention being paid to addressing the structural inequalities that perpetuate poverty and poor living conditions – the so-called 'causes of the causes' that result in ill-health. Instead, interventional activity has largely targeted individual risk behaviours and health-damaging 'lifestyle choices' (Davison *et al.*, 1992; Popay *et al.*, 2010). Where interventions have sought to strengthen community resources, resilience and social capital, these have often been inadequately informed by an understanding of community characteristics and relations and, arguably as a result, have had mixed results at best (Burton *et al.*, 2006).

The focus of the UK's HI agenda on socioeconomic disparities, to the neglect of other axes of disadvantage, is also seen as problematic, with ethnicity being highlighted as a significant omission. Lamont and Bhopal (2010) note that while the Acheson Enquiry had a dedicated section on ethnicity, several subsequent landmark documents, including the Marmot Review, have largely ignored this important axis of disadvantage. Ingleby (2012) has also drawn attention to this 'one dimensional' approach within policy, noting that the terms 'social determinants' and 'socioeconomic determinants' are frequently used interchangeably as if they were equivalent. Meanwhile, the Local Government Improvement and Development's review of Joint Strategic Needs Assessments (JSNAs) (2010), a key strategic document that should inform local action on health inequalities, found that "Race equality was far less prominent an issue in JSNAs as compared to socio-economic inequalities."

In some cases, the omission of attention to ethnicity within particular policies, healthcare designs, and service delivery practices appears to be motivated by a desire to avoid a focus on cultural differences that can lead to the racialisation of minority groups and 'victim blaming' (a charge that has been levelled at the providers and commissioners of mental health services in particular in past decades). Often, however, there is the assumption that ethnic inequalities are adequately taken care of by consideration of socioeconomic status, despite repeated reminders that ethnicity cannot simply be 'emptied into class' (Smaje, 1996; Bartley, 2004; Ingleby, 2012). Indeed, a failure to consider ethnicity explicitly and separately results in only a partial understanding of the social processes that produce poor health outcomes for minority ethnic people and the complex health patterns that exist within and between ethnic groups.

There are two principal reasons for the inadequacy of this approach. First, ethnicity is a complex bio-social construct; a form of collective identity that draws on notions of shared ancestry, cultural

commonality, geographical origins and shared biological features, but which also reflects processes of social stratification and the unequal distribution of status, power, wealth and risks. As such, ethnic identity impacts upon health through a variety of mechanisms. Thus, while poor socioeconomic status explains some of the health disadvantage experienced by many minority ethnic groups, it is far from the whole story (Ahmad and Bradby, 2007). For instance, using *The Fourth National Survey of Ethnic Minorities*, Chandola (2001) showed that self-rated health of Pakistani and Bangladeshi respondents remained significantly poorer compared to White respondents when social class had been accounted for. A growing body of work documents the impact of racism and fear of racism on the health of minority ethnic people (Harris *et al.*, 2006; Karlsen and Nazroo, 2002; Karlsen and Nazroo, 2004). Research also shows how low levels of cultural competence within healthcare interventions contribute to low uptake, negative experiences and poor outcomes among minority ethnic groups (Szczepura, 2005; see also earlier Better Health briefing papers). Migration patterns, cultural and genetic factors can also contribute to differences in health status between the majority White British population and particular minority ethnic groups, factors that often remain poorly understood and inadequately responded to by mainstream health services and public health action (as evidenced in earlier Better Health papers, including Atkin and Anionwu, 2010 and Latif, 2014).

Second, the structures and processes that perpetuate poor socioeconomic status among many minority ethnic people are themselves inherently racially patterned. Action to address these 'wider determinants' of health requires an explicit understanding of the interplay between multiple processes of exclusion and discrimination operating across the labour market, education, housing, and citizenship. As Nazroo and others have argued, interventions aimed at countering socioeconomic disadvantage in general – such as the early years investments advocated by the Marmot Review – may do little to improve the circumstances of minority ethnic people while structures of racist discrimination persist into later life (Nazroo, 2014).

The failure to explicitly recognise the complex dimensions of ethnic identity and the embedded nature of ethnic discrimination within much HI work hampers effective intervention. This inadequacy has been illustrated by minority ethnic peoples' poorer access to and experiences of interventions in many areas, for example, their low uptake of Sure Start services (Craig, 2007; Anning *et al.*, 2007) and under-representation in New Deal for Community partnerships (Lawless, 2004). In this way, action that is undertaken in the name of reducing inequalities in health may actually exacerbate the disadvantage experienced by some minority ethnic groups and serve to widen inequalities. Closer alignment with E&D work could help to overcome these weaknesses in the current HI agenda.

### 3 Towards more integrated approaches

The different origins and development paths of HI and E&D work have often resulted in distinct programmes of work and separate staff groupings, with limited exchange of skills and expertise. Furthermore, recent

work suggests that the disconnect between the two areas is not merely an unfortunate by-product of their different organisational histories, but is a reflection of more general marginalisation of race equality within English health policy. Research in a number of areas has highlighted the way in which specific policies have overlooked ethnic diversity and inequality and/or addressed it in inadequate ways (see for example, Ahmad and Bradby, 2007; Bhui *et al.*, 2004; Nazroo, 2014). Recent work has highlighted the significant exclusion of race equality from policy drivers that carry legitimacy and command resource, including Quality and Efficiency as well as HI, and the lack of performance monitoring against this agenda as further evidence of its marginal status (Salway *et al.*, 2013).

While this situation suggests that there may be significant obstacles to a more joined-up approach, the organisational separation between these areas of work should not be seen as inevitable. Indeed, there are a number of promising examples of integrated practice in this regard.

For example, at the national level, Pacesetters was a collaborative initiative involving the Department of Health, the NHS and local communities that aimed to address patient and workforce inequalities that arise from discrimination and disadvantage. Led by the then Equality and Human Rights Group within DH, the programme funded over 200 local initiatives in which co-design with patients and the public was a core principle. Many of the projects focused specifically on addressing health inequalities faced by black and minority ethnic groups. One Bradford based Pacesetters project aimed to improve the uptake of cervical cancer screening by lesbian and bisexual women and involved NHS managers working in both HI (Public Health screening managers) and in E&D (PCT Equality Manager). This joint working and mutual learning led to a project which sought to explore and address the low uptake of cervical screening amongst South Asian women. Though recent restructuring of the health sector has hampered sustainability, Pacesetters was a welcome move towards a more integrated approach and efforts should be made to extract the learning gained from this initiative.

The roll out of the Equality Delivery System (now refreshed and rebranded as EDS2) is also a promising development. The EDS2 encourages NHS E&D work to be informed by evidence including the insights of local service users and community representatives. The EDS2 framework makes it clear that E&D work should have a broad sphere of influence - including commissioning and service development initiatives, patient experience, workforce diversification and leadership development - so that it contributes to the reduction in health inequalities experienced by groups with Equality Act “protected characteristics” including black and minority ethnic communities.

At a local level, there are some examples of good practice where E&D and HI teams are working closely together to understand and address the processes which perpetuate poor health outcomes for minority ethnic groups. For example in Bradford, increased confidence in knowledge mobilisation has enabled an E&D manager employed within a commissioning organisation to work with public health colleagues at the Local Authority to ensure that information describing the health inequalities and poorer patient experience of local minority ethnic communities is included in the Joint Strategic Needs Assessment. In Wakefield, the public health team is encouraging and supporting an explicit focus on the needs of minority ethnic populations (as well as other marginalised groups) through its ‘vulnerability toolkit’. The toolkit aims to

ensure that commissioned interventions intended to address health inequalities pay considered attention to these dimensions of disadvantage. The EEiC project has also documented other examples of promising work where E&D and HI expertise have been brought closer together ([www.eeic.org.uk/mcs](http://www.eeic.org.uk/mcs)).

These examples of integrated initiatives confirm that the HI and E&D agendas have the potential to be more closely aligned, both being fundamentally concerned with improving disadvantaged people's fair share of health-promoting resources.

There is much to gain by integrating these agendas more closely. E&D work could benefit from being better informed by data analysis and research evidence; a relative strength of the public health workforce that drives HI work. Meanwhile, HI work could benefit from regaining a focus on the socio-political structural determinants of health, and from an explicit recognition that discrimination (explicit, implicit, institutionalised and internalised) is an important determinant of poor health, both of which align closely with equality and human rights perspectives. More generally, the integration of skills, knowledge and networks across both areas of work could help to produce a deeper understanding of the multiple, interlocking social processes that perpetuate inequity across the whole of society and within the health system.

This is not to suggest that aligning these two areas of work more closely is an easy task. Indeed, closer working requires not only administrative adjustments but also a process of aligning underlying values, worldviews and methodological approaches.



## Conclusion

### Future directions

The recent restructuring of the health sector offers some significant opportunities for a more integrated approach. The move of public health teams to local authorities may encourage a stronger focus on equality and diversity within their health inequalities work, since councils have tended to have closer connections to local communities than Primary Care Trusts had, and more explicit mechanisms for feeding local voices into decision-making processes. The move may also be an opportunity for local policy makers to refocus public health resources and expertise towards tackling the wider determinants of health, including the processes of discrimination and marginalisation that hamper black and minority ethnic people's access to health promoting resources of various kinds. JSNAs could also be strengthened by greater collaborative working across the NHS and local authorities to combine evidence sources and build a better picture of healthcare access, experiences and outcomes and the broader health profiles of local populations and their diverse sub-groups. The NHS EDS2 also holds promise, and use of this framework should be encouraged by those commissioning and delivering NHS services since it can support more diverse community and patient involvement and more evidence based and outcome focussed E&D work. Though different to the Equality Framework for Local Government, the EDS2 has a welcome focus on tackling health inequalities and efforts should be made to bring these initiatives closer together across public health and healthcare and to link them into local JSNAs and Health and Wellbeing Strategies (Skinner *et al.*, 2013).

At the local level, much may depend on individual Health and Wellbeing Boards and the extent to which they manage to achieve a shared vision and collaborative working across local agencies that recognises and exploits the potential synergies across E&D and HI work. At the national level, whether the newly established NHS England Equalities and Health Inequalities team can result in more consistent, evidence-based policy to address ethnic health inequalities and engender closer collaboration between E&D and HI practice, remains to be seen. Nonetheless, this integrated team would appear to be a promising development.

Despite these potential opportunities, the obstacles to achieving greater integration across HI and E&D work should not be underestimated. As noted above, more than organisational restructuring will be required to align political and operational approaches. Experience over the past fifty years has underscored the need for persistent effort to counter the marginalisation of race equality within the UK health sector and to challenge the racialisation of minority ethnic groups. Furthermore, stubborn political narratives that locate the causes of health inequalities with 'individual lifestyle choices' rather than structurally embedded disadvantage must be countered if HI work is to reclaim its focus on reducing inequity. Indeed, in the United States where the HI agenda has been more consistently framed in terms of racial/ethnic disadvantage, resultant policy and practice has not effectively addressed the key socio-political processes that underpin poor health, as highlighted by Krieger (1993).

Nevertheless, an integrated approach is essential to understand and address the needs of those with the poorest health outcomes, for whom processes of social, economic, political and cultural marginalisation intersect and reinforce one another to exacerbate the impact of each separate aspect of disadvantage. Furthermore, given the many competing agendas and drive to curb costs, a combined approach that draws on the strengths of both the E&D and the HI arenas may help to improve credibility and leverage greater resource.

## Resources

### **Wakefield Vulnerability toolkit**

[www.wakefieldcommissioningvulnerabilitytoolkit.co.uk/Log-In.aspx](http://www.wakefieldcommissioningvulnerabilitytoolkit.co.uk/Log-In.aspx)

### **EDS2**

[www.england.nhs.uk/ourwork/gov/edc/eds](http://www.england.nhs.uk/ourwork/gov/edc/eds)

### **Race Equality Foundation toolkit**

[www.better-health.org.uk/resources/toolkits/dialogue-equals-pacesetters-programme-community-engagement-guide](http://www.better-health.org.uk/resources/toolkits/dialogue-equals-pacesetters-programme-community-engagement-guide)

### **Race Equality Foundation Better Health briefing papers**

<http://better-health.org.uk/briefings>

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We welcome feedback on this paper and on all aspects of our work. Please email [briefings@racefound.org.uk](mailto:briefings@racefound.org.uk)

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