

## Access to health care and minority ethnic groups

The NHS is under a legal and moral obligation to provide services to all people who need them, regardless of their gender, age or ethnic background. The Labour government has begun to implement a far-reaching set of reforms designed to put patients at the heart of the NHS and make providers of services far more responsive to their individual needs, using a system of powerful financial incentives. As a public body, the NHS is also bound by the terms of the Race Relations Amendment Act 2000, which obliges all NHS institutions to promote race equality across all their activities, including service provision.

So, how effective is the NHS in providing accessible health care for all Britons, regardless of their ethnic or religious background? The King's Fund is embarking on a new programme of work that aims to investigate how much progress NHS institutions have made on improving access to health care, which interventions appear to have worked, and what the barriers to progress appear to be.

This is the first in a series of briefings, designed to set out some of the background to the issues outlined above.

### Why does a person's ethnicity matter for health services?

The government's rationale for action on ethnicity and health is laid out in the Department of Health's Race Equality Scheme 2005-2008, a document it is legally required to produce under the terms of the Race Relations Amendment Act 2000. According to the Department of Health, a person's ethnic identity matters for two broad reasons.

The first is the principle of 'responsiveness'. Current reforms to the NHS have repeatedly emphasised the importance of creating a service that is more responsive to all patients' individual needs. The Department of Health's Race Equality Scheme states that 'the NHS increasingly needs to take into account not only cultural and linguistic diversity but also needs to be able to cater for varying lifestyles and faiths'.<sup>1</sup>

The second reason for concern, according to the Department of Health, is that some ethnic minority groups experience poorer health than others (health inequalities) and also experience poorer access to services and poorer quality of services (inequities in access).

The Department of Health and the NHS are therefore committed to reducing a ‘satisfaction gap’ at the same time as reducing health inequalities and inequities in access.

## Who are Britain’s minority ethnic groups?

Minority ethnic groups are most commonly classified according to the methods used by the census, which asks people to define which ethnic group they feel they belong to. In the last census, 92 per cent of the UK population defined themselves as White, with 7.9 per cent (or 4.6 million people) classifying themselves in a non-White category.<sup>2</sup> Of these, 50 per cent said they were Asian or Asian British; a quarter said they were Black or Black British; and a further 15 per cent said they were Mixed (see Table 1).

**TABLE 1: UK POPULATION BY ETHNIC GROUP, APRIL 2001**

	(Numbers)	Total population (Percentages)	Non-White population (Percentages)
White	54,153,898	92.1	.
Mixed	677,117	1.2	14.6
Indian	1,053,411	1.8	22.7
Pakistani	747,285	1.3	16.1
Bangladeshi	283,063	0.5	6.1
Other Asian	247,664	0.4	5.3
All Asian or Asian British	2,331,423	4.0	50.3
Black Caribbean	565,876	1.0	12.2
Black African	485,277	0.8	10.5
Black Other	97,585	0.2	2.1
All Black or Black British	1,148,738	2.0	24.8
Chinese	247,403	0.4	5.3
Other ethnic groups	230,615	0.4	5.0
All minority ethnic population	4,635,296	7.9	100.0
All population	58,789,194	100	

Source: Office for National Statistics, Focus on Ethnicity and Identity March 2005

Although these broad non-White categories are frequently reproduced and quoted in a range of official documents, they conceal a huge amount of detail about the diversity within minority ethnic groupings. Categories such as Black African push together people who are likely to have very different cultural or ethnic backgrounds. Other categories comprise cultural differences which are often quite profound, such as religious belief. For example, the Indian group comprises Hindus (45 per cent); Sikhs (29 per cent); Muslims (13 per cent) and Christians (5 per cent).

Limiting the analysis to looking at White groups versus non-White groups also conceals other ethnic minority groups. For example, in 2001, within the broad category of White, there were 691,000 people in Great Britain who identified themselves as White Irish, equivalent to 1 per cent of the population.

Recent work on the 2001 census data has revealed that ethnic minority groups are growing quickly, (due to differences in fertility rates and some inward migration) and account for 73 per cent of Britain's overall population growth.<sup>3</sup> Latest figures for England from the Office for National Statistics estimate that the White British and White Irish categories have declined slightly since 2001 (due to declining birth rates and net outward migration) while categories such as the Chinese group have experienced an annual average growth rate of over 11 per cent. There has also been fast growth amongst Black Africans and Other White groups.<sup>4</sup>

Recent research has also revealed that there are important changes taking place in where people live. There has been a continuation of the trend for minority ethnic groups to concentrate in urban areas, particularly London – over 40 per cent of Londoners are now estimated to belong to a non-White British group (a grouping which includes White Irish, Other White and Other Ethnic categories) and there are big numerical increases in other areas. But the fastest growth, in terms of percentage change, has been taking place in nearly all local authority areas which had only small ethnic minority populations.

### Are there differences in health status between different ethnic groups?

Although ethnic minority groups broadly experience the same range of illnesses and diseases as others in the UK, what has caused concern is the tendency of some within ethnic minority groups to report worse health than the general population and evidence of increased prevalence of some specific life-threatening illnesses.

According to the Department of Health, some groups consistently report higher levels of illness in surveys. The latest evidence from the 2004 Health Survey from England reveals that 15 per cent of Bangladeshi men reported their health to be 'bad or very bad' compared to 6 per cent of men in the general population.<sup>5</sup> But not all ethnic groups report worse health: the same survey reveals that men from Black African and Chinese groups report better health than average.

In addition to this self-reported evidence, the Department of Health reports that: 'some conditions and diseases are also particularly prevalent among certain ethnic groups, for example coronary heart disease among South Asians, and diabetes among South Asians (prevalence five times higher than the general population) and people from African and Caribbean backgrounds (three times higher).'<sup>6</sup>

The Department of Health has published other data, such as mortality data are for heart disease (in *Heart Disease and South Asians*<sup>7</sup>) and evidence ranging from differences in infant mortality rates between groups and visits to dentists, which has been summarised for NHS trust boards.<sup>8</sup> The Department of Health tends to use very broad ethnic categories, despite the evidence that there are big variations in experience within ethnic groups.<sup>9</sup>

### What are the causes of these variations in health?

The most recent comprehensive review of the evidence about ethnicity and health has been compiled by the London Health Observatory<sup>10</sup>. The report points out that for each apparent 'difference' between a minority ethnic group and the majority, closer scrutiny of the evidence reveals big differences *within* minority groups, suggesting that simple 'genetic' or 'cultural' explanations for ill health are unlikely to be correct in explaining why some groups seem to experience more illness than others. Another review, conducted in 2001, came to similar conclusions.<sup>11</sup>

A body of evidence has existed for some time that connects the deprivation experienced by a person with the increased chances of illness and shorter life.<sup>12</sup> Many people from ethnic minority backgrounds also experience high levels of poverty, and analysis of self-reported ill health data has shown that deprivation explains a large amount of the ill health experienced by minority ethnic groups.<sup>13</sup>

More recent research has shown that within ethnic groups there are considerable variations in health status and much of that can also be explained by differences in socio-economic status. For example not all people from Bangladeshi groups are disadvantaged, even though on average Bangladeshis are poorer than the majority.<sup>14</sup>

Factoring in socio-economic disadvantage, such as low income, does not fully explain the differences in health between ethnic minorities and the majority population. It seems highly likely that other factors, perhaps including the experience of racial discrimination or cultural insensitivity in the provision of health care, are also associated. Research continues into the role that biological factors and cultural differences might play in determining health.

### **Are there differences in experience of and access to health care services?**

There is some evidence that the NHS has not catered well to Britain's 'diverse' population. The Department of Health's own patient surveys reveal a consistent pattern of higher levels of dissatisfaction with NHS services amongst some minority ethnic groups, when compared with the White majority.<sup>15</sup> For example, those responding to the survey from Pakistani, Indian and Bangladeshi backgrounds reported significantly poorer experiences (as hospital inpatients) than White British or Irish respondents, particularly on questions of prompt access, as well as their experience of involvement and choice. There are also glimpses, from time to time, of some serious lapses in service. At one end of the spectrum are (probably non-lethal) examples of failure to respond to the most basic of needs.<sup>16</sup> At the other are cases which have resulted in fatalities.<sup>17</sup> It is not clear how common these cases are, and it is only in the arena of mental health services where an investigation into the death of a patient<sup>18</sup> has led to a nationwide review of services to minority ethnic groups.<sup>19</sup>

The evidence base for more systematic investigation of any inequities in access to care has been hampered by the failure of NHS institutions to collect ethnicity data on patients both at hospital and primary care level.

### **What is the NHS doing about this?**

The Labour government has, since it took office in 1997, made a clear commitment to reduce inequalities in health, and national targets were set in 2002. The NHS has been given a leading role to play in the reduction of health inequalities, including those between ethnic groups<sup>20</sup> (although no national targets have been set that relate specifically to minority ethnic groups).

In addition, the NHS has a legal obligation, under the terms of the Race Relations Amendment Act 2000, to promote race equality across all its activities, including the provision of services. A range of strategies have been deployed at NHS trust level to improve access to care, including better translation and interpreting services and working with minority ethnic voluntary and community groups to deliver specific services tailored to specific groups.<sup>21</sup>

Much of the Department of Health's activity on race equality has also been focused on improving the performance of the NHS as an employer, with specific programmes to increase diversity within the senior ranks of clinicians, managers and NHS trust boards.

More generally, it has also been claimed that the overarching NHS reforms of increased patient choice, competition and plurality of providers will make it much easier to design and deliver services for minority ethnic groups.<sup>22</sup>

Responsibility for monitoring progress on race equality rests with both the Commission for Racial Equality (CRE) and the Healthcare Commission.

## Has any progress been made?

Assessing the progress of the NHS on race equality is problematic. Given the evidence presented above about the complexity of causation of ill health, it is perhaps unlikely that the NHS on its own can have much impact in reducing the overall inequalities in health status (and the latest evidence suggests that the inequalities targets are not being met).<sup>23</sup> There is, however, an increasing commitment in government to work across traditional departmental boundaries both at local and national level which will ultimately be key to any progress.

Although there has clearly been a great deal of activity aimed at improving access to health care services for BME groups, evaluating the outcome of that activity has been difficult due to the absence of reliable routine data on ethnicity. Up to a third of hospital data is still not coded, according to the London Health Observatory,<sup>24</sup> and few GP surgeries routinely collect information about their patients.

A recent review of the Department of Health's leadership interventions aimed at minority ethnic groups noted that while there was commitment at the highest levels of the Department, it has 'been difficult to get a sense of commitment from the other areas of the NHS'.<sup>25</sup>

New flagship NHS programmes, such as patient choice and the quality and outcomes framework for GPs, were apparently designed and rolled out without routine ethnicity data collection being built in (although a small incentive of £120 will be available to GPs next year if they can code 100 per cent of their new patients).

There are worries that any progress made so far is under threat from new reform policies. Primary care trusts involved in a programme set up and funded by the Department of Health have expressed concern that the next wave of reform (aimed at improving commissioning structures) 'has the potential to stall progress and divert attention to other agendas'.<sup>26</sup>

The Healthcare Commission is currently reviewing how it will assess NHS institutions in improving access to care for people from minority ethnic groups in the future.

## The future

The gaps in data collection and the lack of systematic collation and evaluation of examples of good practice have been stated clearly by recent reviews.<sup>27</sup>

The King's Fund is embarking on a new programme of work that aims to investigate how much progress NHS institutions have made on improving access to health care, which interventions appear to have worked, and what the barriers to progress appear to be.

The work will include:

- a review of the literature on access (both in the UK and abroad)
- original data analysis
- an audit of Race Equality Schemes in relation to access
- a critical review of action by NHS institutions to improve access to health care.

Over the medium term the King's Fund will be looking to work with others to identify a set of meaningful indicators that will ultimately assist NHS institutions to deliver effective health care to black and minority ethnic groups. We will also be collecting evidence about practical interventions that work as a resource to both the NHS and the voluntary and community sector.

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[http://www.statistics.gov.uk/downloads/theme\\_compedia/foe2004/Ethnicity.pdf](http://www.statistics.gov.uk/downloads/theme_compedia/foe2004/Ethnicity.pdf)
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<http://sticerd.lse.ac.uk/case/publications/census.asp>
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- <sup>5</sup> Health and Social Care Information Centre. Health Survey for England 2004, Health of ethnic minorities  
<http://www.ic.nhs.uk/pubs/hlthsvyeng2004ethnic>
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- <sup>7</sup> *Heart Disease and South Asians: Delivering the National Service Framework for Coronary Heart Disease*. Department of Health 2004. <http://www.dh.gov.uk/assetRoot/04/10/29/18/04102918.pdf>
- <sup>8</sup> *Promoting Equality and Human Rights in the NHS: A guide for non-executive directors of NHS Boards*. Department of Health 2005. <http://www.dh.gov.uk/assetRoot/04/11/63/29/04116329.pdf>
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- <sup>10</sup> Ethnic Disparities in health and health care London Health Observatory <http://www.lho.org.uk/viewResource.aspx?id=8831>
- <sup>11</sup> Gill PS, Kai J, Bhopal RS, Wild S. The *Health Care Needs Assessment* series, chapter on Black and minority ethnic groups.  
<http://hcna.radcliffe-oxford.com/bemgframe.htm>
- <sup>12</sup> See, for example, *An Independent Inquiry into Inequalities in Health*, The Stationery Office, 1998  
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- <sup>14</sup> Nazroo J. 'The Structuring of Ethnic Inequalities in Health: economic position, racial discrimination, and racism'. *American Journal of Public Health* Vol 93 No 2 February 2003
- <sup>15</sup> *Unpacking the patient's perspective: variations in NHS patient experience in England*. Commission for Health Improvement 2004. <http://www.healthcarecommission.org.uk/assetRoot/04/00/34/96/04003496.pdf>
- <sup>16</sup> See, for example, 'Victory for black limb patient who was offered a white leg', *Independent*, 26 August 2003  
<http://www.blink.org.uk/pdescription.asp?key=2412&grp=5&cat=198>
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- <sup>20</sup> See Department of Health Race Equality Scheme 2005-2008 May 2005  
<http://www.dh.gov.uk/assetRoot/04/11/21/59/04112159.pdf>
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