Black History Month

Health inequalities faced by the Black population

October 2021

CordisBright

1 Overview

The longstanding health inequalities present in the UK were recently brought to the fore by the disproportionate impact of the Covid-19 pandemic on ethnic minority communities, with Black ethnic groups more likely to be diagnosed, become critically ill, and ultimately die from the virus than the white population (PHE, 2020).

However, these disparities are a replication of well-established and wide-ranging ethnic health inequalities. For example, research has found significant ethnic disparities in infant and maternal mortality (Kmietowicz et al., 2019), with Black women four times more likely to die in pregnancy or childbirth than white women (BMA, 2021). Black mothers also have higher proportions of premature and low birthweight babies than white mothers (Raleigh & Holmes, 2021).

Rates of obesity are higher in Black ethnic groups, and these groups have higher than average incidence of and mortality from hypertension, stroke, and type 2 diabetes, and suffer from the latter two at a younger age (Raleigh and Holmes, 2021). Black men are also significantly more likely than white men to be diagnosed with and die from prostate cancer (ibid.). Further, for people suffering from long term health conditions, belonging to a Black ethnic group is associated with receiving insufficient support from local services (Watkinson et al., 2021).

In mental health, Black men are more likely to have a psychotic disorder than white men, and Black people are four times more likely to be detained under the Mental Health Act than white people (Mental Health Foundation, 2021). People from Black ethnic groups have also been found to report low levels of life satisfaction (PHE, 2018), and older Black women experience worse health related quality of life than the white population (Watkinson et al., 2021).

2 Where do these inequalities stem from?

Research into the causes of these inequalities is long overdue. Historically, research has disproportionately focused on genetic causes of ethnic health disparities (Krieger, 2014). Such explanations can be dangerous, as classification according to biology has been used historically to justify segregation, and the oppression and subordination of those regarded ethnically different (Matthews, 2015). Furthermore, genetic and biological variations between different ethnic groups are no greater than differences within them (ibid.). This suggests that other factors, for example discrimination on the basis of ethnicity, may be at play.

3 What examples of discrimination have been found in the NHS?

Research has identified evidence of both interpersonal (at an individual level) and institutional (at a wider, structural level) racial discrimination within the NHS. Senior NHS staff have been found to blame ethnic minorities for their poor experiences and question the legitimacy of the ethnic equality agenda (Salway et al., 2016). It is in this context that ethnic minority doctors report bullying and harassment at twice the rate of white doctors, and are twice as likely to be referred for fitness to practice processes (BMA, 2021). Since the start of the Covid-19 pandemic, these doctors have also been more likely to feel pressured to work without adequate Personal Protective Equipment (PPE), and more afraid to speak out about safety concerns for fear of recrimination (ibid.).

Stress associated with interpersonal racial discrimination such as this has direct effects on people's mental and physical health. However, health inequalities are found at a population level, and are therefore unlikely to be the result of individual behaviours alone (Castaneda et al., 2015). Individual discriminatory behaviours typically operate in, and are upheld by, wider societal mechanisms.

There is evidence of discrimination within the health system as an institution, which encourages, perpetuates, and compounds interpersonal discrimination. Examples have been found of ethnic equity being side-lined in national healthcare policy and downgraded to an exercise of compliance, rather than considered integral to the supply of quality healthcare (Salway et al., 2016). Culturally embedded structures constrain processes that could work to increase equality, such as the identification and mobilisation of evidence on ethnicity and health. This results in a general lack of data on patterns of ethnic healthcare inequities and on effective interventional strategies (Salway et al., 2016: 107).

These factors may help to explain the injustices found in the remuneration and progression of Black NHS staff, who are significantly over-represented at lower NHS pay bands and under-represented in higher ones. Black doctors earn on average £10,000 less and Black nurses £2,700 less than white colleagues annually (Otu et al., 2020), and in 2018 there was a 3.5% pay gap between white and Black consultants (BMA, 2021). There are also unequal opportunities for progression into senior roles, as white doctors are more likely to be shortlisted and offered a first consultant post (BMA, 2021).

4 How do these interact with other inequalities experienced by Black people?

Alongside institutional discrimination within the NHS, structural discrimination throughout society is important to consider when exploring explanations for ethnic health disparities. This kind of discrimination leads Black ethnic groups to face multi-dimensional inequalities in areas that have serious implications for their health, including housing, employment and education (Krieger, 2014; Matthews, 2015). Exposure to these adverse conditions can manifest biologically, giving rise to health inequities (Krieger, 2014). With regards to Covid-19 inequalities, for example, higher rates of employment in public-facing (and typically lower paid) jobs, and greater likelihood of living in overcrowded housing and in

deprived areas, all contributed to the increased risk faced by Black ethnic groups (Raleigh & Holmes, 2021).

Recent political developments have also been found to have an impact on the healthcare experiences of Black patients. Following the introduction of the NHS charging regulations for overseas visitors in 2015, there have been numerous reports of assumptions being made by NHS staff about patients' immigration status and corresponding entitlement to care on the basis of how they speak, look and their names (Patients not Passports, 2020).

Although the regulations are ostensibly aimed at preventing illegal immigrants from taking advantage of free UK healthcare, ethnic minority British citizens are being asked to prove their entitlement to healthcare, and in some cases are denied care altogether (ibid.). As well as being highly detrimental to the health of illegal immigrants, these regulations are therefore having adverse effects on the health of ethnic minority British citizens and legal migrants. In addition, they prevent the NHS from delivering on its core principles of being free at the point of use, providing care based on clinical need, and meeting the needs of everyone (Rafighi et al., 2016). Their discriminatory application on the basis of ethnicity also constitutes a breach of the Equality Act 2010 (EHRC, 2020).

5 What progress has been made?

In 2015, the NHS Workforce Race Equality Standard (WRES) was established to support the monitoring of staff experience. Its leadership strategy includes a target for the NHS to reach equality in BAME representation across the workforce by 2028 (Sotubo, 2021). However, the latest WRES report indicates that only 10% of trust board seats are held by people from ethnic minority backgrounds, which is less than half of the proportion of overall NHS staff (BMA, 2021).

This year, the NHS established a Race and Health Observatory (NHSRHO), 'to examine ethnic inequalities in health across England and beyond, and to support national bodies in implementing meaningful change for Black and minority ethnic communities, patients and members of the health and care workforce' (NHSRHO, 2021). While this suggests a step in the right direction, it is too early to say whether the NHSRHO will have any tangible impact on ethnic health inequalities.

6 How can these health inequalities be tackled?

Long-term commitment and enthusiasm for the ethnic equity agenda is required at national and local level, in particular from white leaders, and staff must become strong allies for the Black community. Work to address ethnic health inequalities must be elevated from a 'nice to have' to a 'must do', and become business as usual for the NHS.

6.1 Improvement of data

A key barrier to tackling ethnic health inequalities is the lack of accurate data relating to patients' ethnicities. In 2019-2020, ethnicity was not recorded for a significant proportion of inpatients (13%) and outpatients (17%), and this represents a rise over the past eight years (Scobie et al., 2021). Patients from ethnic minorities are also more likely to be assigned different ethnicity codes if they have multiple contacts with the NHS, and it is

likely that Black African and Black Caribbean patients are too often assigned 'Other Black' codes (ibid.). This could mean that deaths and hospitalisations are being miscounted, differences in disease risks and patterns are being misunderstood, and poor decisions are being made as a result (ibid.).

Guidance for ethnicity data collection in the NHS has not been updated in 20 years, and the definitions used for ethnic groups are different to those defined in the 2011 and 2021 censuses (Scobie et al. 2021). In addition, ethnic minority groups are commonly aggregated in reporting, meaning it is often only possible to ascertain a picture of health issues encountered by ethnic minorities as a whole. This potentially obscures and erases the nuances in experiences and outcomes of specific ethnic groups, and minimises the ability to identify and cater to their health problems and needs.

Stratification of ethnicity data is therefore essential to truly understanding and addressing ethnic health inequalities. The Nuffield Trust argue that new guidance and new categories akin to those used in the 2021 census should be issued as a matter of urgency (Scobie et al., 2021). They also suggest that the quality of patient ethnicity coding should be taken into account in CQC inspections (ibid.). This should help to more accurately identify the needs of different ethnic groups, monitor their healthcare access and outcomes, and support action to address inequalities (Robertson et al., 2021). A more systematic approach should also be taken to building and mobilising the evidence base on interventions and good practice in tackling health inequalities (ibid.).

6.2 Culturally tailored engagement activity and services

Healthcare services should have an awareness of the healthcare needs, risk factors, and treatment requirements in different communities and ensure services are culturally tailored (Raleigh & Holmes, 2021). In order to better understand the needs of Black communities, Clinical Commissioning Groups and Primary Care Networks should organise patient groups in neutral or familiar settings for these communities, and develop health programmes with their needs in mind to ensure they are appropriately tailored (Sotubo, 2021).

Investment in strategic and ongoing programmes of community engagement should help the development and delivery of culturally competent services, and build sustained and trusting relationships with Black communities (Robertson et al., 2021). Culturally tailored programmes, such as those to address type 2 diabetes and participation in cancer screening, have been found effective in improving outcomes (Raleigh & Holmes, 2021). Investments should therefore be made in culturally competent measures such as these, that can identify and target groups at risk of poor health.

6.3 Black representation in NHS leadership

Senior positions in the NHS at both a national and local level should be representative of the population the organisation serves, so that it can understand and appropriately respond to its needs (Robertson et al., 2021).

6.4 Staff and leadership awareness and development

All NHS staff should be supported to fully understand local ethnic health inequalities, their root causes, and the ways the NHS may help to address them (Robertson et al., 2021). Leadership programmes should be developed to improve staff's awareness of diversity, inclusion and ethnic health inequalities, and improve their capabilities to address these (ibid.).

6.5 Holding the NHS to account

Local systems and leaders should be held to account for action taken to reduce ethnic health inequalities in the access, experiences and outcomes of ethnic minority patients. This action should form part of accountability, performance and improvement systems, including ongoing performance management and appraisals, and be given weight equal to other key priorities such as wait times (Robertson et al., 2021).

Providers and commissioners of services should take action in response to information gained from WRES reports and staff surveys. This should form part of organisational performance monitoring, and, where progress is lacking, support interventions and sanctions that are used to respond to other critical system issues should be triggered (Robertson et al., 2021).

Bullying and harassment should be systematically tackled within the NHS and disciplinary processes established. Effective reporting channels, which guarantee confidentiality, should be created to encourage people who feel bullied within the NHS to come forward and report it (Otu et al., 2020).

6.6 Building equality into Integrated Care Systems

All of the above factors should be considered in the development of Integrated Care Systems (ICSs). The prioritisation of addressing ethnic health inequalities should be embedded in the design and development of ICSs. The link between ethnicity and health should be considered in the development of the financial allocation formula for ICSs, and budgets should clearly address how allocation to place matches identified health and health inequality need among local populations (Robertson et al., 2021). The need for diversification and representativeness of senior leadership should be reflected in processes for appointing senior leaders to new ICS roles (ibid.). Finally, the CQC should ensure progress in addressing health inequalities is given appropriate weighting in any new processes developed for inspecting ICSs (ibid.).

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