Public Health England

Protecting and improving the nation's health

Local action on health inequalities

Understanding and reducing ethnic inequalities in health

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

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Executive summary

Ethnicity is a multidimensional concept with numerous links to health. While the major determinants of ill-health are largely the same across all ethnic groups, ethnicity is a salient social identifier in modern Britain, shaping people's networks of association and their social and economic opportunities. Further, minority ethnic identities continue, in many circumstances, to be stigmatised and subject to exclusion. According to the recently published Race Disparity Audit (RDA), there are disparities between ethnic groups in all areas of life affected by public organisations. Some are more pronounced than others or have a greater impact on people's life chances and quality of life. In some areas, disparities are reducing, while in others, they are static or increasing.

Action to reduce inequalities lies at the heart of PHE's mission.[1] The UK has long been recognised as a multi-ethnic society and the diversity of the population continues to increase. Therefore, without explicit consideration of ethnicity within health inequalities work, there is a risk of partial understanding of the factors leading to poor health outcomes. In collaboration with partners in Institute of Health Equity (IHE) and University of Sheffield, PHE's Health Equity Team led on a first national resource which aims to provide evidence on the patterns and causes of ethnic health inequalities in England, one of the 'protected characteristics' identified in the 2010 Equality Act. It will also assist in promoting an integrated approach to reducing health inequalities, and informing local and national action by PHE and other bodies.

This resource aims to inform local and national action by PHE and other bodies. Effective action on ethnic health inequalities will help meet the legal duty on the Secretary of State for Health, NHS England, Clinical Commissioning Groups to have regard to the need to reduce health inequalities and to comply with the Equality Act 2010[2,3]. This resource aims to:

- promote an integrated approach to reducing health inequalities by drawing out relationships between different forms of inequality and by highlighting the root causes
- clarify basic concepts and terms
- provide material on ethnicity and health for use in local joint strategic needs assessments and local health and wellbeing strategies
- inform local discussion and action on ethnic health inequalities
- identify key gaps in data by ethnic group and areas in need of better evidence for action

The resource comprises the following components:

- **Summarising the data:** Chapters 1 to 6 of the resource provide a summary of the information available on the patterns and determinants of health by ethnic group in England. Compiled from a range of sources and identifying some general approaches that can help to embed attention to ethnicity within health inequalities work.

- **Approaches to address ethnic inequalities in health:** Chapter 7 provides a helpful overview of approaches to embed attention to ethnicity within action of health inequalities

- **Practice examples:** A selection of examples and case studies of promising local action aimed at addressing ethnic inequalities in health and healthcare

A number of important messages have been identified to support better focus on ethnicity within action on health inequalities:

Mainstreaming ethnicity: Without explicit consideration of ethnicity within health inequalities work there is a risk of partial understanding of the processes producing poor health outcomes and ineffective intervention.

Influencing decision-makers and role of senior leadership: Progress on ethnic health inequalities has been slow and the need for senior leadership on this agenda has been repeatedly highlighted.

Data collection, analysis and reporting: Gaps in data collection must be filled and there must be more consistent analysis and reporting of data on ethnicity, health and healthcare so that there is adequate understanding of local needs and the extent to which they are being met by policies and services.

Action on the wider social and economic determinants of health may exacerbate ethnic health inequalities unless it adequately takes into account the ethnic patterning in residential, income, educational and occupational profiles.

Tackling racism and ethnic discrimination: The central role of racism must be acknowledged, understood and addressed. There is an urgent need to build the evidence base around effective action.

Commissioning of culturally sensitive health promotion interventions: Interventions need to work with cultural and religious understandings and values while recognising intra-group diversity and avoiding stereotyping.

Improving access, experiences and outcomes of health services: Actions at organisational level include: regular equity audits; use of Health Impact Assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff; sustained workforce development and employment practices; trust-building dialogue with service users

Engagement with minority ethnic groups: Across all areas of activity, the meaningful engagement and involvement of minority ethnic communities, patients, clinical staff and people is central to understanding needs and producing appropriate and effective responses or shaping services. A concerted effort is required by public and private sector employers and service providers.

Making use of evidence: The evidence base to inform policy and practice remains limited but more can be done to mobilise the available evidence and to document and evaluate promising local practice both locally and nationally.

Introduction

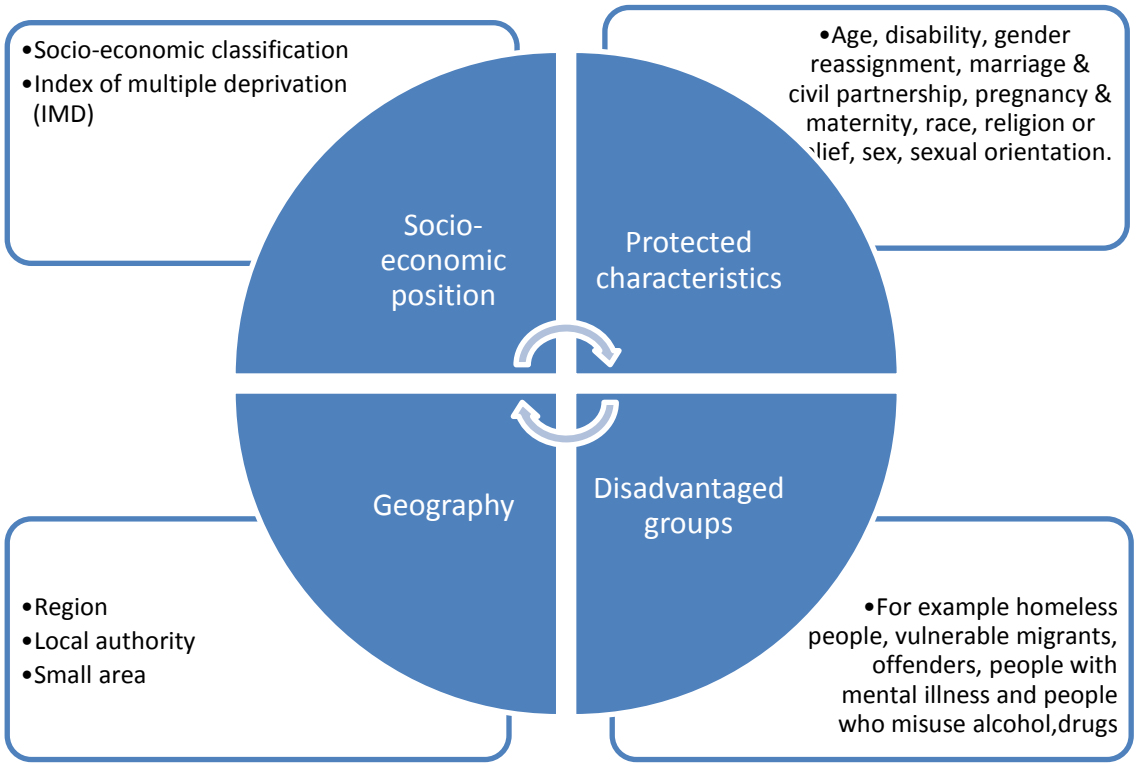
2.1 Introduction

Action to reduce inequalities lies at the heart of PHE's mission.[1] In England, the term 'health inequalities' is generally understood to mean differences in health status between different population groups that are unfair and avoidable. These health inequalities are rooted in current and past disparities in wealth, power and resources for health and differential exposure to health damaging environments and risks. Health inequalities have been documented between population groups across at least four dimensions, as illustrated in Figure 1. This resource provides evidence on the patterns and causes of ethnic health inequalities in England, one of the 'protected characteristics' identified in the 2010 Equality Act. It aims to inform local and national action by PHE and other bodies in this important area.

Public health action that specifically addresses ethnic health inequalities is timely because England's population has continued to grow and become more ethnically diverse[4] (the proportion of people in England and Wales who identified their ethnic group as White in the decennial census fell from 94.1% in 1991 to 86.0% in 2011) and because while there have been several earlier initiatives on ethnicity and health, the topic has been less visible in some recent work.[5]

Effective action in this area will help meet the legal duty on the Secretary of State for Health, NHS England, Clinical Commissioning Groups to have regard to the need to reduce health inequalities and to comply with the Equality Act 2010.[2,3] The need for action in this area has also recently been highlighted by the Prime Minister's Race Disparity Audit (RDA) which confirmed that a concerted effort by Government, partners and communities working together is required to address disparities and ethnic inequalities.

Figure 1: Four dimensions for assessing inequalities



Incorporating an explicit focus on ethnicity is important within health inequalities work because ethnic identities have implications for health independent of other socioeconomic factors. However, dimensions of disadvantage intersect and there is significant diversity within, as well as between, groups of people with particular ethnic identities. Research indicates that public health and healthcare commissioners in England often feel uncertain about engaging with ethnic inequality, an issue that can been seen as a contentious and difficult. People can be fearful of making a mistake, or worry that considering ethnicity will add complexity to their work. Meanwhile, individuals who would like to see progress on this agenda are not always able to clearly articulate the importance of addressing ethnic inequalities.[7]

This resource therefore aims to:

- promote an integrated approach to reducing health inequalities by drawing out relationships between different forms of inequality and by highlighting the root causes
- clarify basic concepts and terms
- provide material on ethnicity and health for use in local joint strategic needs assessments and local health and wellbeing strategies
- inform local discussion and action on ethnic health inequalities

- identify key gaps in data by ethnic group and areas in need of better evidence for action

2.2 Definition. What is ethnicity? How is ethnicity relevant to health?

Ethnicity has been described as “a form of collective identity that draws on notions of shared ancestry, cultural commonality, geographical origins and shared biological features.”[8] The importance of context is highlighted in this definition -“Ethnic identities are a product of the societies in which we live. In each social context particular bio-social characteristics become important markers of individual and group identity.”[9]

Ethnic identity influences health outcomes via multiple routes. For example, experiences of discrimination and exclusion, as well as the fear of such negative incidents, have been shown to have a significant impact on mental and physical health. Health-related practices, including healthcare-seeking behaviours, also vary importantly between ethnic groups (as illustrated in the following sections).

While in the past the focus has often been on ‘ethnic minority’ health, this can hide very great differences in health status between different ethnic groups and within those groups on which data are collected. As illustrated below, some minority ethnic groups appear to have much better health status than the White British population and some much worse. These differences are revealed to a greater or lesser extent depending on whether broad or more refined ethnic categories are used.

2.3 Measuring health and ethnicity

In England, self-reported ethnic group is recorded in the census, a number of national surveys and local studies, and within some routine datasets (eg when registering for some services), providing opportunities for the analysis of health-related indicators by ethnic group. There are, however, some significant challenges relating to completeness and consistency of data.

For example, ethnicity was recorded in the UK census for the first time in 1991, and census categories have developed over time, with the ‘Gypsy and Irish Traveller’ and ‘Arab’ categories only being added in 2011. Not all datasets have employed the same ethnic categories, and some commonly used categories – such as the ‘Black African’ group – have been argued to be too heterogeneous for public health purposes.[10] Small sample sizes mean that analysts have sometimes collapsed data into very broad groupings – such as ‘Asian’ – making findings difficult to interpret. Analysts have also

taken varied approaches to deriving and labelling aggregate ‘minority’ and ‘majority’ groupings, with White groups other than the White British (eg White Irish) sometimes being included within a broader ‘White’ category and at other times being included within an aggregated grouping along with non-White groups. The evidence presented in this resource is derived from a variety of sources and therefore inevitably perpetuates some of these inconsistencies.

Terminology relating to ethnicity also varies. In this paper we have used the terms ‘ethnic group’ and the simple term ‘minority ethnic’. Other common terms used in English health publications include ‘Black, Asian and minority ethnic groups’ (BAME), Black and minority ethnic groups’ (BME) and ‘ethnic minority groups’.

An investigation in 2011 found that over 90% of GP practices and 100% of hospitals had systems in place for recording ethnicity but data completeness and quality remained poor with useable ethnicity data available for 86% of new inpatients, 50% of new outpatients, 53% of new A&E patients and just over 3 quarters of new primary care registrations in 2011.[11] Ethnic group is not recorded on death certificates in England, so most analysis of mortality rates uses country of birth, an increasingly inadequate proxy for ethnic group. Findings from these prior analyses are not reported again here.[12,13,14] The last Health Survey for England that included an ethnic minority boosted sample took place in 2004. Understanding Society, a national longitudinal survey, has collected useful data on ethnicity and related characteristics as well as health indicators for a boosted sample. A range of other surveys allow some analysis by ethnicity, but small sample sizes often preclude detailed investigation and mean that results are presented for aggregated groups.

At a local level, populations vary widely and small numbers in some local populations can make it hard to analyse data effectively. Further, in some local areas groups other than those enumerated in the national statutory data collection systems may be important to consider because of their large numbers and/or particular health needs (eg Turkish, Somali). Recognising this variability, NHS England highlights the need to record ethnicity data using census categories as a standard minimum but suggests that finer, disaggregated categories also be used according to local circumstances.[15] Currently, information on health needs by ethnic group is often inadequate at local level, as reflected in very limited analyses in many JSNAs.[16]

Methodological issues clearly need to be borne in mind when considering evidence on ethnicity and health. There is also an urgent need to improve the recording and analysis of ethnicity data at local and national level.

Notwithstanding these limitations, as shown in the sections that follow, available data do allow useful description of ethnic inequalities across many key health indicators and their determinants.

2.4 Methods

Data on health indicators by ethnic group are largely taken from PHE's *Public Health Outcomes Framework: Health Equity Report. Focus on Ethnicity*,[17] with further information on mortality, morbidity and wider determinants of health being sourced from prior analyses of the Census 2011, the Health Survey for England 2004 and other national statistics and survey data. A pragmatic, rapid evidence review was also undertaken to identify a wider range of reports and published studies that could help build a more detailed picture of ethnic inequalities in health and their determinants (see Appendix 1).

Key indicators of health status by ethnic group

3.1 Introduction and key messages

Key messages:

- inconsistent categories and small sample sizes compromise our understanding of ethnic differences in health. Very little information is available at local and regional levels
- there is a complex picture of ethnic differences in health across different health indicators
- some groups, notably individuals identifying as Gypsy or Irish Traveller, and to a lesser extent those identifying as Bangladeshi, Pakistani or Irish, stand out as having poor health across a range of indicators
- evidence on ethnic differences in common mental disorders is patchy and inconsistent, though those identifying as Gypsy or Irish Traveller appear to have much higher rates of anxiety and depression than other groups
- black men have higher reported rates of psychotic disorder than men in other ethnic groups
- available data suggest lower levels of reported 'wellbeing' among most minority ethnic groups than the White population
- cancer burden by site of the cancer varies between ethnic groups (e.g. prostate cancer makes up over 40% of Black men's cancer compared with around 15% among Chinese men and 25% among all men)
- there are large differences in infant mortality by ethnicity. Rates are highest among Pakistani, Black Caribbean and Black African groups
- the National Child Measurement Programme indicates that among children most minority ethnic groups have higher levels of overweight or obesity at age 10-11 than the White majority. Those in Black groups have the highest levels

In this section we draw on data from a variety of sources to describe patterns of health by ethnic group across a range of key health indicators. As noted above, inconsistent terminology, small sample sizes, old data and a lack of local and regional-level data limit the information available. In addition, the

validity of some health measures across ethnic groups is contested. Nevertheless, some important patterns are evident.

3.2 Self-reported health

Self-reported long term illness that limits everyday activities is a widely used measure of overall health status among adults. According to Bécares et al.'s analysis of the 2011 census data[18] revealed that -ethnic inequalities are most pronounced at older ages, but those identifying as White Gypsy or Irish Traveller stand out at all ages, and across both sexes, as more commonly reporting a limiting long-term illness. Among those aged 65 and over, the Bangladeshi and Pakistani groups were also more likely to report limiting long-term illness than other groups, among both men and women. Further analysis by this team, concluded that ethnic inequalities in this measure were worse in London than in other regions, but that the relative health of some ethnic minority groups had improved since 2001.[19]

Another analysis of trends in self-reported limiting long-term illness using data from the Health Survey for England concluded a generally improving relative position for Indian and Black groups but a more mixed picture, with a recent worsening in health, for a combined Bangladeshi and Pakistani group.[20] Census analysis of another indicator - self-assessed general health status ('very good', 'good', 'fair', 'bad', 'very bad') - also suggests higher levels of poor health among people identifying as Gypsy and Irish Travellers than other groups, particularly once age-profiles are accounted for.[21] Detailed analysis of ethnic inequalities among older persons aged 60 years and over using the Understanding Society survey data 2009-11 confirm that even after controlling for social and economic disadvantage, among those aged over 60, black and minority ethnic people are more likely than White British to report limiting health and poor self-rated health.[22]

3.3 Mental ill-health

Assessing ethnic differences in the prevalence of mental illness is controversial and complex since rates of recognition, reporting and diagnosis are likely to vary between ethnic groups.[23] Common mental disorders (CMDs) comprise different types of depression and anxiety. These conditions can interfere with daily living, cause significant emotional distress and have a high cost to society. In 2000, the population-based survey, EMPIRIC, included over 4,000 adults aged 16-74 years in England and used the Clinical Interview Schedule-Revised (CIS-R) to assess CMD symptoms. It found modest differences in the prevalence of CMDs between the main

ethnic groups. Prevalence was statistically significantly higher among Irish and Pakistani men aged 35-54 years, and among Indian and Pakistani women aged 55-74, compared to the corresponding White populations. CMDs were significantly lower among Bangladeshi women.[24]

More recent data are available for adults aged 16 and over from the Adult Psychiatric Morbidity Survey (APMS) conducted in 2014, which also used the Clinical Interview Schedule-Revised (CIS-R) to assess CMD symptoms, but only for broad ethnic categories. The age-standardised proportions of men reporting any CMD by ethnic group were: White British: 13.5%; White Other: 13.1%; Black/Black British: 13.5%; Asian/Asian British 12.9%; and 'Mixed, multiple of other ethnic group': 10.5%; with none of these differences being statistically significant. For women, the figures were: White British: 20.9%; White Other: 15.6%; Black/Black British: 29.3%; Asian/Asian British 23.6%; and 'Mixed, multiple of other ethnic group': 28.7%. For women, the differences between White Other and White British, and between Black/Black British and White British, were statistically significant.[25]

The APMS also collected data on self-harm, suicidal thoughts and suicide attempts; behaviours that are strongly associated with mental illness. Rates did not differ significantly by ethnic group after age-standardizing the data, though small sample sizes made the estimates imprecise.[26]

Information on mental ill health among Gypsies and Irish Travellers is limited, but provides a consistent picture of high levels of CMDs. A widely-cited study by Parry et al. used quota sampling from five localities across England to achieve a sample of 293 English speaking people identifying as Gypsies or Travellers.[27] Using the EQ-5D[28] they reported that 20% of the Gypsy and Traveller sample were moderately anxious/depressed and 8% were extremely anxious/depressed, compared to 14% and 2% respectively among an age-sex matched comparator group.[27] EQ-5D is a standardised measure of health status developed by the EuroQol Group in order to provide a simple, generic measure of health for clinical and economic appraisal [29] .

It is designed for self-completion by respondents and is ideally suited for use in postal surveys, in clinics, and in face-to-face interviews. A survey of 60 individuals in Sheffield who identified as Gypsy or Traveller reported that 26.7% were depressed (HADS score of 11+[30]), 36.7% had anxiety, and 31.7% were classified as anxious and/or depressed using the EQ-5D tool, rates that are higher than for the general population.[31]

Ethnic inequalities in the prevalence of severe mental illness have received a great deal of attention over past years. The APMS (using combined 2007

and 2014 data) reported that the prevalence of psychotic disorder in the past year was higher among Black men (3.2%) than men from other ethnic groups (0.3% of White men, 1.3% in the Asian group, and no cases in the 'mixed/other' ethnic group), a pattern reported in earlier work. There was no significant variation in psychotic disorder by ethnic group among women.[32] In this survey, bipolar disorder was assessed using the Mood Disorder Questionnaire for lifetime experience and no variation was found by ethnic group.

3.4 Wellbeing

Subjective wellbeing, people's thoughts and feelings about their own quality of life is an important aspect of national wellbeing. The Office for National Statistics (ONS) Annual Population Survey includes a series of questions directed to adults aged 16 and over designed to capture 'wellbeing', including: *'Overall, how satisfied are you with your life nowadays?'; 'To what extent do you feel the things that you do in your life are worthwhile?;* and *'Overall, how happy did you feel yesterday?',* where respondents were asked to rank their answers on a scale from nought meaning *'not at all'* to 10 meaning *'completely'*. There are wide inequalities in self-reported low life satisfaction. Findings suggest that most minority ethnic groups report lower levels of wellbeing than the White population with people in the Black ethnic group more than twice as likely to report low life satisfaction than those in the Asian ethnic group[17]. Moreover, people aged between 45 and 59, those in the Black ethnic group, the unemployed and economically inactive, and those whose health status was fair, bad, or very bad all reported higher levels of low life satisfaction than England as a whole.

3.5 Cancer incidence and stage at diagnosis

Estimates of cancer incidence by ethnic group have been produced using Hospital Episode Statistics data linked to cancer registrations. These data suggest that people from the Black ethnic group have higher rates of myeloma and stomach cancer, and males from the Black ethnic group have higher rates of prostate cancer than the White group. Liver cancer is higher amongst people from the Asian ethnic group compared with the White ethnic group, as are mouth cancer in women and cervical cancer in women over 65.[33] Data for 2006-2010 indicate that the cancer burden by site of the cancer varies between ethnic groups, with the most noticeable difference being that prostate cancer makes up over 40% of Black men's cancer, compared with around 15% of Chinese men, and 25% of all men.[32]

The stage at which cancer is diagnosed can have an impact on the success of treatment and on mortality rates. Data available on diagnosis stage for breast, lung, colorectal and prostate cancer by broad ethnic group from the former National Cancer Intelligence Network show variation in late stage diagnosis (stage 3 or 4). For breast cancer, Black women were more likely to be diagnosed at late stage compared with White women.[34] Those in the Black ethnic group were also more likely to be diagnosed with colorectal and lung cancer at late stage compared with other ethnic groups. However, for prostate cancer the pattern was different, with those identifying with the White, Asian or Chinese ethnic group having the highest proportions of late stage diagnosis. Cancer death rates are not currently reported by ethnic group, though NCIN is looking to produce such estimates in the future.

3.6 Overweight and obesity

There is little nationally representative data on the prevalence of obesity among adults by ethnic group. Estimates of adult obesity prevalence by ethnic group derived from the 2004 Health Survey for England vary depending on the measurement used. Among women, those identifying as Black African had the highest obesity prevalence when waist circumference was the measure (at 53%), and those identifying as Bangladeshi when the waist-to-hip ratio was used (at 50%). Regardless of the measure used, women and men identifying as Chinese had the lowest obesity prevalence.

A recent review of the evidence on ethnic inequalities in obesity in the UK identified significant methodological limitations and concluded that findings are inconsistent. When compared to “Caucasians” (the paper used this out-dated term), there was no consensus in studies about obesity prevalence among South Asians adults, but Black adults generally had higher risk, and Chinese adults lower risk, for obesity.[35] Furthermore, there is considerable debate regarding the validity of current measures and definitions of obesity as an indicator of health risk in non-White ethnic groups due to variations in body shapes and physiological responses to fat storage.[36]

A NICE evidence review in 2013 concluded that people from Black, Asian and other minority ethnic groups are at an equivalent risk of type 2 diabetes, other health conditions or mortality, at a lower BMI than the white European population. The resulting guideline recommended using lower thresholds (a BMI of 23 to indicate increased risk and 27.5 to indicate high risk) for BMI to trigger action to prevent type 2 diabetes among South Asian, Black African, Black Caribbean and Chinese populations, and providing those at high risk with an evidence-based, intensive programme to prevent or delay the onset of type 2 diabetes. They also recommended action to raise awareness of the

need for diet and physical activity interventions at a lower BMI threshold for these groups to prevent type 2 diabetes.[37]

3.7 Disability-free life expectancy

Since ethnicity is not recorded at death registration, a recent analysis used indirect methods to generate estimates of disability-free life expectancy (DFLE) by 2001 census ethnic group (details of the methods used can be found in the published article).[38] The highest DFLE was among those identifying as Chinese (67.0 years for women and 64.7 years for men) and the lowest DFLE for women was among the Pakistani group (55.1 years) and for men was among the Bangladeshi group (54.3 years).

3.8 Tuberculosis (TB)

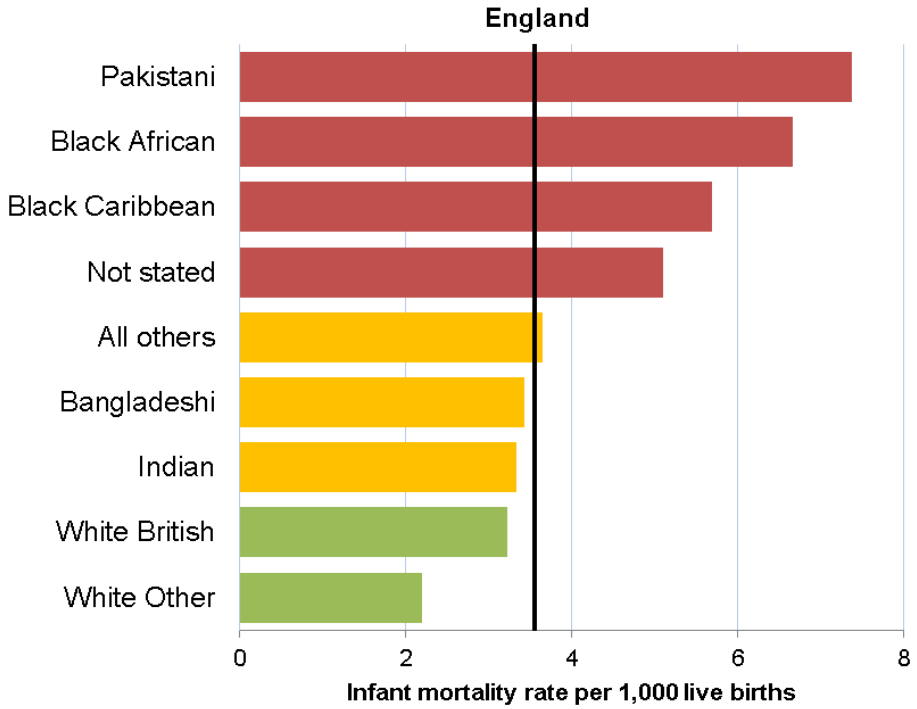
Tackling TB is currently one of the key priorities of Public Health England. Despite signs of a decreasing trend in new cases, the UK still has high rates compared to most other Western European countries.[39] The highest rates of disease are found among people of Indian, Pakistani and Bangladeshi ethnicity who were born outside the UK, with those of Black African and Black Other ethnicity who were born overseas also showing high rates.[40] While reactivation of latent infections acquired outside the UK accounts for much of the disease burden, there is evidence that transmission within established communities in the UK may be an increasing issue, particularly among South Asian communities.[38]

3.9 Infant and child health indicators

3.9.1 Infant mortality

Infant mortality rates (deaths under age 1 per 1,000 live births) vary considerably by ethnic group (with ethnicity of the child being recorded at birth notification as stated by the mother). In 2014, the Pakistani, Black African and Black Caribbean ethnic groups, and those whose ethnic group was not stated, had significantly higher rates of infant mortality than England as a whole (Figure 3), while White Other and White British had lower rates. Data for England and Wales combined show that there has been little change in inequality by ethnic group between 2009 and 2013 but narrowing in 2014.[41]

Figure 3: Infant mortality rate by ethnic group, England 2014



Source: Public Health England. Public Health Outcomes Framework: Health Equity Report. Focus on Ethnicity.

3.9.2 Low birth weight

Low birth weight increases the risk of childhood mortality and of developmental problems for the child, and is associated with poorer health in later life. The percentage of babies born at term with low birth weight varies by ethnic group. In 2015, significantly higher proportions of babies in the Indian, Bangladeshi, Pakistani, Black Caribbean, or Other groups were born with low birth weight than the average for England as a whole. However, there has been a reduction in the percentage of births with low birthweight in the Bangladeshi, Indian and Pakistani ethnic groups between 2006 and 2015.[17]

3.9.3 Tooth decay

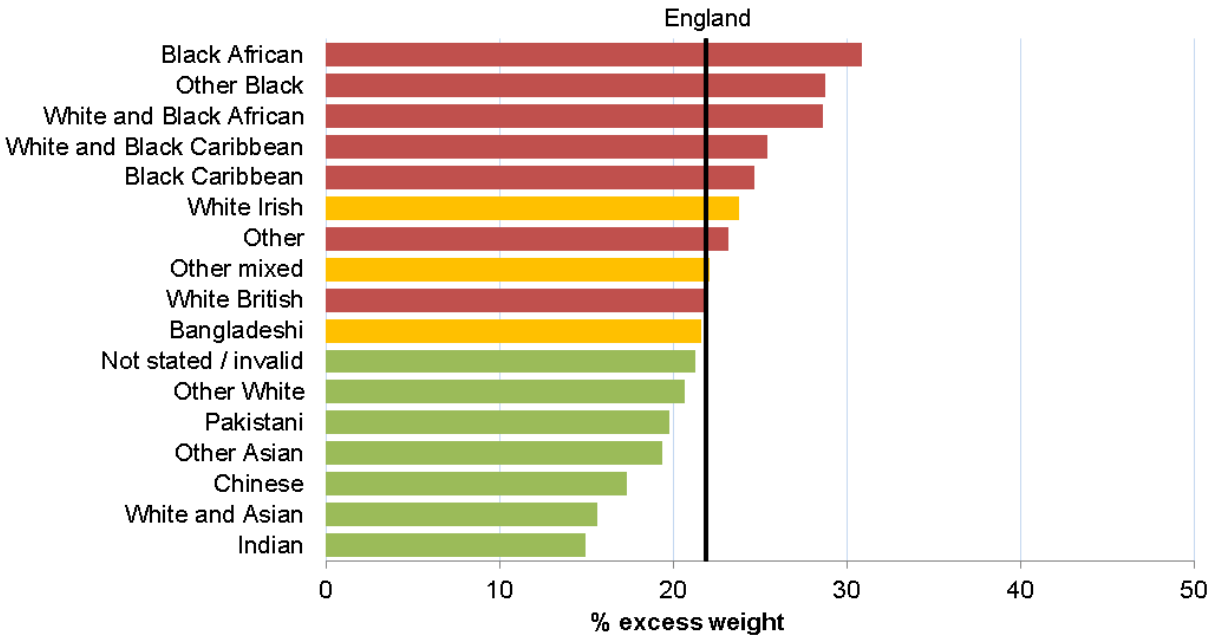
Tooth decay in children, a predominantly preventable disease, results in pain, sleep loss, time off school, and in some cases treatment under general anaesthetic. Data from the national Dental Epidemiology Programme for England indicates that a quarter of 5 year olds in England who were examined in 2014/15 had obvious dental decay, with considerable variation between broad ethnic groups. Tooth decay was significantly lower than England as a whole in the Black and White ethnic groups (just over a fifth of children) but more than double the England average in the Chinese group.[42]

3.9.4 Excess weight in 4-5 and 10-11 year olds

The health consequences of childhood obesity include type 2 diabetes, hypertension, and exacerbation of conditions such as asthma. It is also associated with poor mental health, low self-esteem, stigma and bullying.[43] Excess weight is identified in children through the National Child Measurement Programme in schools by using Body Mass Index (with overweight being defined as ≥85th centile and obesity as ≥95th centile of the UK90 growth reference for age and sex).

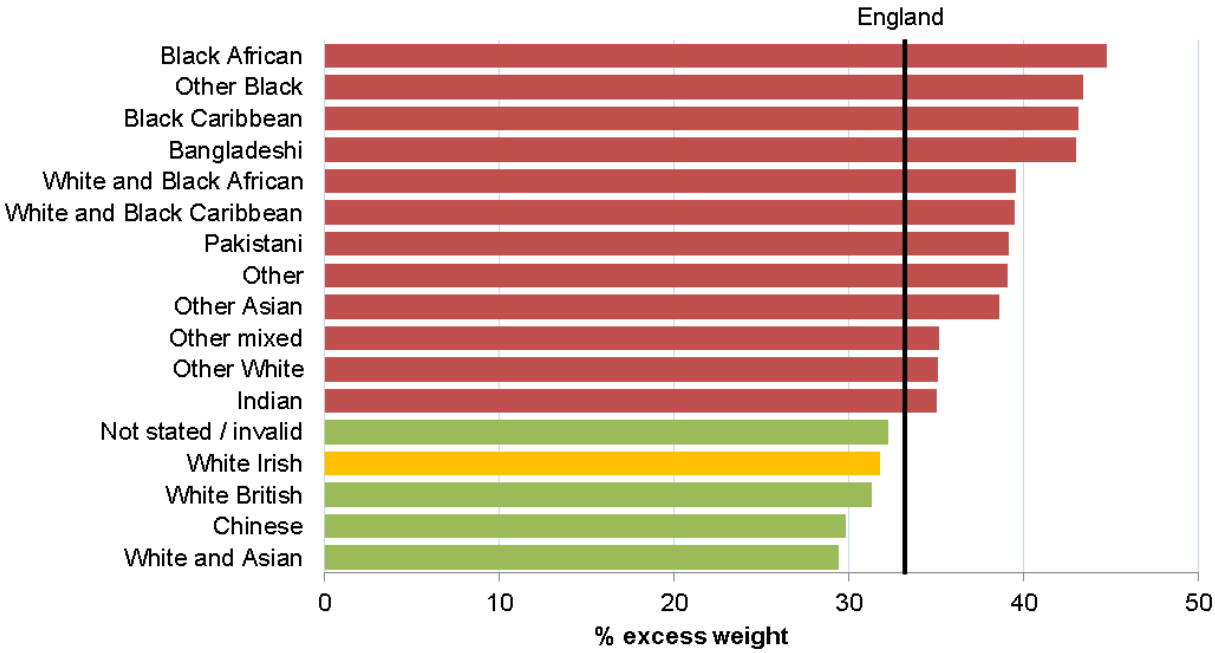
Amongst 4-5 year olds, those in the Black ethnic groups, and the mixed White and Black groups were most likely to be overweight or obese in 2014/15. Indian, Mixed White and Asian, and Chinese children were least likely to be overweight or obese (Figure 4). The proportion of children with excess weight was higher at ages 10-11 in all ethnic groups compared with ages 4-5. At ages 10-11, children in almost all minority ethnic groups had significantly higher proportions of children with excess weight compared with England as a whole (Figure 5). There has been little change in these ethnic differences since 2013/14.

Figure 4: Percentage of 4-5 year olds (both sexes combined) overweight or obese, England 2014/15



Source: Public Health England. Public Health Outcomes Framework: Health Equity Report. Focus on Ethnicity.

Figure 5: Percentage of 10-11 year olds (both sexes combined) overweight or obese, England 2014/15



Source: Public Health England. Public Health Outcomes Framework: Health Equity Report. Focus on Ethnicity.

Ethnic inequalities in the social determinants of health

4.1 Introduction and key messages

Key messages:

- educational attainment at GCSE and degree levels is highest for the Chinese and Indian ethnic groups. Gypsy and Irish Travellers have the lowest level of qualifications at both levels
- white and Indian groups are more likely to be in employment, with unemployment highest among Black and Bangladeshi/Pakistani populations
- Bangladeshi, Pakistani, Chinese and Black groups are about twice as likely to be living on a low income, and experiencing child poverty, as the White population
- ethnic minority groups are more likely to live in private rented accommodation and overcrowded households than the White British population
- Bangladeshi, Pakistani and Black groups are the most likely to be living in deprived neighbourhoods
- the poor housing and neighbourhood conditions for Gypsy and Traveller groups are a serious concern
- fascism, harassment and discrimination are widely experienced by minority ethnic people and have direct negative impacts on both mental and physical health. There are about 150,000 incidents of race hate crime each year
- migration journeys are diverse, but experiences before, during and after settlement can negatively affect both physical and mental health.
- there have been increases in ethnic inequalities in employment and housing nationwide over the 2000s
- important differences in the extent and trends in ethnic inequalities across localities indicate the need for both localised initiatives and learning from those areas that have made progress

The fundamental role of wider social and economic factors in creating and sustaining inequalities in health and wellbeing is without question. It is therefore crucial that we have a clear picture of ethnic patterning in these social determinants of health. Detailed explorations of ethnic inequalities in social and economic conditions are regularly produced by the Equality and

Human Rights Commission (see for example How Fair is Britain?).[44] The Centre on the Dynamics of Ethnicity at the University of Manchester is also a source of detailed analyses in this area, with, for example, a recent study of 2001 and 2011 Census data showing that while ethnic inequalities in social conditions were widespread, there was a mixed and changing picture across local areas.[45] Here we provide some headline indicators for the major dimensions of social and economic circumstances.

4.2 Education

> Education is a key social determinant of health acting via multiple mechanisms. The 2011 Census revealed important ethnic inequalities in educational qualifications among adults. The proportion of people aged 16 and over with a degree was highest among people identifying as Chinese (43%), Indian (42%) and Black African (40%)

Only 4 out of 18 ethnic groups had a lower proportion of people with degrees than the White British group (26%); Pakistani (25%), Bangladeshi (20%), mixed White and Black Caribbean (18%) and White Gypsy or Irish Traveller (9%).[46] Considering those people without any educational qualifications at all, the White Gypsy or Irish Traveller group stood out as particularly disadvantaged (60%), compared to White Irish (29%), Bangladeshi (28%), Pakistani (26%), White British (24%) and all other ethnic groups (20% or less). Looking at census data between 1991 and 2011, there was an overall improvement in educational attainment and those ethnic minority groups that were enumerated across these censuses experienced greater improvements compared to the White British group. People born outside of the UK were more likely to have degree level qualifications (over a third), compared to UK born people (a quarter).

Educational achievement at school – measured by the proportion of pupils gaining 5 or more GSCEs at grades A* to C for 2013/4 - was highest among pupils identifying as Chinese (86%) and Indian (81%), and lowest among pupils who identified as Gypsy/Roma (12%) and Traveller of Irish heritage (18%).[47] Data from Understanding Society (2009-12) show that all ethnic minority groups have higher proportions of students staying on in formal education, especially university, at 16 and 18, than the White population.[48]

According to RDA findings, of all regions in England, the most educational progress and best attainment in state primary and secondary schools was

found in London, where more than half of pupils were from ethnic minority groups. Disadvantaged pupils in receipt of free school meals in London made more progress and had higher attainment than their counterparts elsewhere in England.

4.3 Employment

Employment has both direct and indirect effects on health through other factors including income, environment and housing. Ethnic minority disadvantage in the UK labour market is a persistent pattern. The Labour Force Survey shows important differences in the patterns of labour force participation and (un)employment by ethnic group and by gender

The unemployment rate is normally calculated as the percentage of people who are in the labour force but are not currently in work. The average across Britain in 2014 was 6.2% but the rate was nearly 3 times higher in the Black population than in the White group[49]: White: 5.5%; Black: 15.4%; Mixed: 13.2%; Indian: 6.1%; Pakistani/Bangladeshi: 14.7%; Chinese: 7.2%; Other Asian: 6.6%; Other: 11.1%. Findings from the Understanding Society national survey show similar patterns - with the exception of Indians and Chinese, other ethnic minority men, and Pakistani/Bangladeshi women were shown to have employment rates 6 to 10 percentage points lower than those of Whites.[49]

Socio-economic classification is based on type of employment and is strongly linked to health inequalities. People in the ‘higher’ socio-economic groups fare better on many health indicators compared to people in routine and manual occupations. The 2011 census showed that the proportion of people in socio-economic groups 1 and 2 (professional and managerial) varied greatly across ethnic groups: White: 35%; Indian: 43%; Pakistani: 28%; Bangladeshi: 25%; Black African: 39%; and Black Caribbean: 33%.[50]

More detailed analysis commissioned by the Joseph Rowntree Foundation found that people in some minority ethnic groups are over-represented in certain occupation types, whereas the White British group tends to be evenly distributed across the labour market. This work also found ‘hugely variable’ patterns of unemployment by ethnicity with much more positive experiences for minority ethnic people in some geographic areas than others.[51]

Not all work is protective of health, and poor work conditions can expose workers to stress and other hazards.[45,52] The Bristol Stress and Health at Work Study found that 30% of the non-White groups reported very high, or extremely high, levels of stress at work compared to 18% of white workers.[53] A follow up analysis that combined data from the Bristol study with that from the Cardiff Health and Safety at Work study confirmed this differential, but reported that the elevated level of stress among non-Whites was primarily among those identifying as Black Caribbean.[54]

A further study in East London adopted a household interview design and recruited Black Caribbean (n-204), Bangladeshi (n=206), and White (n=216) groups. After controlling for demographic, occupational and other factors, and work characteristics, a significant association was found between work stress and ethnicity. Racial discrimination had a strong influence on work stress, and Black Caribbean women who had experienced racial discrimination were most likely to report high work stress. Work characteristics associated with work stress were similar across the three ethnic groups: higher effort reward imbalance, greater job demand, and lower control over work.[53]

4.4 Income and poverty

> The latest figures from the Department for Work and Pensions show that 15% of the UK population lives on a low income (defined as below 60% of the median national income).[55]

This statistic varies widely between ethnic groups with 35% of people living in households headed by someone of Pakistani or Bangladeshi ethnic origin living on a low income compared to 14% of the White population. The proportion on a low income is even higher after housing costs are taken into account, rising to about half of the Pakistani, Bangladeshi and Chinese populations affected. Similar inequalities are found in the proportion of children living in low income households (Table 1).

Table 1: Percentage of children living in relatively low income households (below 60% of the median) by ethnic group, 2013/14, UK (3-year average)

Ethnic Group	Before housing costs	After housing costs
White	15	24
Mixed/Multiple ethnic groups	23	42
Asian/Asian British		
Indian	19	26
Pakistani	42	48
Bangladeshi	42	58
Chinese	33	47
Any other Asian background	24	44
Black/ African/ Caribbean/ Black British	26	47
Other Ethnic Group	22	45
All groups	17	28

Source: Department for Work and Pensions.
Note: This is a relatively small survey and some ethnic groups thus tend to show greater year-on-year variation. Three year averages have been used to smooth out statistical variation.

A recent suite of reports on ethnicity and poverty by from Joseph Rowntree Foundation shows inequalities caused by the concentration of minority ethnic people in low paid occupations, but also identifies inequalities between ethnic groups within some occupations. Overall figures pooled across the period 1993 to 2012 showed the following proportions earning less than the 'living wage': White: 24%; Black: 20%; Indian: 25%; Pakistani: 38%; Bangladeshi: 52%; Chinese: 28%; Other Asian: 29%; Other: 26%.[56] Most groups showed a higher proportion of women in low pay than men but the difference was particularly stark for the White population (31% of women earning below the living wage compared to 16% for men). One notable exception was the Bangladeshi group in which the pay difference was reversed with 37% of women earning less than the living wage compared to 57% of men (though clearly the rate is high in both genders).

4.5 Housing

Poor housing conditions have a significant detrimental impact on health of both adults and children. Recent evidence reviews document links between poor housing and increased risk of cardiovascular disease, respiratory disease, depression and anxiety, as well as lack of sleep, restricted physical activity and poor educational attainment in children.[57,58]

People from minority ethnic groups are over-represented in the private rented sector, the housing sector most associated with a range of poor conditions. A third of minority ethnic households lived in privately rented accommodation in 2013/14 compared with 18% of households in the white population (as defined by ethnicity of the household head).[59] A more detailed analysis using census data found that private renting was highest among Other White (51%) and Arab (49%) populations and lowest among Black Caribbean and White British populations (both 15%).[60]

Overall, there was an increase in private renting between 1991 and 2011 with proportionately larger increases among Indian, Pakistani and Black Caribbean populations over the 2 decades. The Department for Communities and Local Government states that households from a minority ethnic group are more likely to live in homes with problems related to damp and disrepair, to live in areas with problems in the local environment, and to live in overcrowded conditions than White households.[61]

The latest census found that minority ethnic households were nearly five times more likely to be overcrowded than White British households (13.5% compared to 2.8%),[62] with almost a third (30.2%) of Bangladeshi households being overcrowded. There is also a higher incidence of statutory homelessness among ethnic minority groups than among the White population.[63]

4.6 Multiple deprivation

Socio-economic factors are often linked together and can combine to reinforce disadvantage in communities and across generations. This multiple deprivation is often concentrated in specific geographical areas, particularly in inner city areas across the whole country and in many northern areas.

A study of 2011 Census data looked at the proportion of people in different ethnic minority groups who live in the 10% most deprived areas of the country (as measured by the Index of Multiple Deprivation 2010). [64] The variation is huge, from 8% of the White British population and 9% of the White Irish population to 31% of the Pakistani population and 34% of the Bangladeshi population. There had, however, been some changes since the 2001 Census, with the proportion of the Pakistani and Bangladeshi populations living in these deprived areas declining, in particular.

Access to good quality green space has been shown to be associated with lower all cause and circulatory disease mortality, and better physical and mental health[65,66,67] Research has shown that quality of green spaces is likely to be worse in areas with a higher population of black and minority ethnic residents. Only 50 per cent of residents in wards with more than 40 per cent of their population from black and minority ethnic groups are satisfied, compared with 70 per cent in wards with less than 2 per cent.[68] Local retail environments may also be more health-damaging in those areas that disproportionately house minority ethnic populations. Deprived urban areas are particularly obesogenic, with few attractive opportunities for physical activity, high concentration of fast food outlets, and limited availability of affordable fresh, healthy produce.[69]

4.7 Racism, discrimination and harassment

A growing body of evidence documents the prevalence of racist discrimination in England and the direct and indirect effects of such discrimination on the health of minority ethnic people.

The British Social Attitudes Survey 2013 found that 30% of the population say that they are either 'very' (3%) or 'a little' (27%) prejudiced against people of other races. [70] The proportion was highest (36%) in the over 55 age group. The 2010/11 Citizenship Survey found that 13% of people from minority ethnic backgrounds felt that racial or religious harassment was a 'very big' or 'fairly big' problem in their local area, with this proportion being highest among the Bangladeshi (18%) and Mixed (13%) ethnic groups and lowest in the White group (6%).[71]

The proportion feeling that racial or religious harassment was a 'very big' or 'fairly big' problem in their local area was highest among the Muslim respondents (14%) and lowest among Buddhists (4%), and was higher among young people aged 16-24 than older groups. Chinese men and women, Pakistani men, Indian-Sikh men, Indian-Muslim men and Bangladeshi women were more likely to experience ethnic and racial harassment than others. Women were more likely to report fear of ethnic harassment, but men were more likely to report actually experiencing it.[72]

Nazroo (2003) reported that qualitative research into experiences of racial harassment and discrimination in the UK demonstrates *"that for many people experiences of interpersonal racism are a part of everyday life, that the way they lead their lives is constrained by fear of racial harassment, and that*

being made to feel different is routine and expected" (p281).[73] Similarly, Parry et al. (2004) reported that for the Gypsy and Traveller respondents in their qualitative interviews: *'the experience of racism and negative stereotyping was pervasive and was automatically anticipated as a result. Most described a feeling of complete rejection by society"* (p45).[74]

Racism has direct effects on both mental and physical health.[75] A systematic review of 121 research studies on racism and health found much evidence of negative effects, particularly relating to mental health and wellbeing (for example anxiety, depression, and negative self-esteem).[76] A recent study of young people in London found that *'unlike other measures of adversity, perceived racism was consistently associated with poorer psychological wellbeing across gender, ethnicity and age.'*[77]

Despite this, minority ethnic respondents reported better overall mental health than White respondents, with family care and connectedness, religious involvement and ethnic diversity of friendships, being found to have protective effects. Additionally, data from UK Longitudinal Household Study has demonstrated that repeated exposure to racial discrimination has an incremental negative long-term effect on mental health of ethnic minorities in the UK.[78] Importantly, fear of racism, as well as direct experience of racist incidents, has been shown to be negatively associated with health.[79] Racism can manifest itself in a variety of ways; it can be overt or discrete, intentional and unintentional, inter-personal and institutional.[80]

In addition to direct effects, racist discrimination impacts indirectly to produce poorer health outcomes via exclusionary processes operating within the education system and within the employment and housing markets. These processes result in differential access to health-promoting resources and exposure to health-damaging risks (as demonstrated in the preceding sections). There is evidence of discrimination in the job market.

A study for the Department of Work and Pensions submitted 2,961 job applications across seven British cities. It matched job applicants on education, skills and work history, but conveyed different ethnic identities and analysed the responses. Black and Minority Ethnic applicants had to send 16 applications for a positive outcome (call back for interview) compared with 9 for White applicants. [81]

People from minority ethnic groups have a threefold higher chance of being a victim of hate crime (0.6% per year compared to 0.2% for the White population). The largest category of hate crime is related to race, with an estimated average of 154,000 incidents of such crime a year in 2011/12 and

2012/13. Similarly, there were an estimated 70,000 incidents of religiously motivated hate crime a year, with Muslim adults being the most affected group. Only about 40% of hate crime comes to the attention of the police.[82]

4.8 Social networks, social isolation and loneliness

> The health risks of loneliness and social isolation are increasingly documented. [83], 84 Recent research suggests that loneliness and social isolation may both affect health independently through their effects on health behaviours and that social isolation may also affect health through biological processes.[85]

Isolation and loneliness among older people has received particular attention, though it is experienced at any age. In general, minority ethnic populations are younger than the White British population (6.7% were aged 65 and over in 2011 compared to 18.8%).[86] The 2011 Census found significant ethnic differences in the proportion of people aged 16 and over in England and Wales who lived alone, and a rising proportion with increasing age.[87] This figure was 3.7%, 4.2% and 6.3% in the Bangladeshi, Pakistani, and Indian populations respectively, but as high as 22.7% in the Black Caribbean population and 23.7% in the Irish population.

People from minority ethnic backgrounds face some particular risks of social isolation and loneliness, linked to higher socioeconomic deprivation at household and neighbourhood level as well as exposure to exclusionary processes, structures and discourses that can undermine social connectedness, a sense of belonging and self-worth.[88, 89] Using qualitative and quantitative data, Salway et al. documented important ethnic differences in patterns of social networks and interactions, with Black African women emerging as a group with low levels of social connection and support.[90] High rates of loneliness have been found in minority ethnic groups over 60 years old, particularly those with family origins in China, Africa, the Caribbean, Pakistan and Bangladesh.[91] There is also evidence of high levels of isolation and loneliness among new migrants, asylum seekers and refugees.[92]

While concentration in deprived neighbourhoods may mean poorer access to some health-promoting resources (eg green spaces), minority ethnic people living in areas with higher ‘own group’ ethnic density appear to experience less racism and discrimination and increased social support and social networks, with positive implications for health.

In a survey of Irish, Black Caribbean, Indian, Pakistani, Bangladeshi and White British ethnic groups in England, living in areas with higher 'own-group' ethnic density was associated with significantly reduced risk of common mental health disorders among ethnic minority groups.93 Similarly, analysis of Understanding Society data shows that while life satisfaction is lower among ethnic minorities than the White majority, neighbourhood concentration of own ethnic group is associated with higher life satisfaction for Black Africans and UK born Indians and Pakistanis. [94]

4.9 Migration and mobility

In the 2011 Census, overall 14% of the resident population of England were born outside the UK, while 60% of those who identified as non-White British were migrants and 40% were born in the UK.[95] Current health outcomes for many minority ethnic people therefore reflect health risks and resources experienced both outside and within the UK.

However, the proportion of people who were born inside the UK varies considerably across ethnic groups, as does the timing of migration to the UK among those who were born elsewhere. For instance, while the majority of foreign-born people who identify as White Irish (63%) or Black Caribbean (61%) arrived in the UK prior to 1981, 73% of the largest non-UK born ethnic minority group - Other White - arrived in the UK between 2001 and 2011, reflecting recent European Union expansion.

Among migrants, the circumstances before, during and after migration vary greatly, with some groups facing much more significant risks to health than others. It has been suggested that *"Perhaps the only shared characteristic of migrants is that they come from another country. Migrant populations are diverse and like any other group have social, cultural and material assets".*[96] While migration can be a selective process with healthier people being more likely to migrate, evidence suggests that, depending on their circumstances, some migrants may have specific and/or additional health needs compared to the England population as a whole. Some of the factors that have been identified as determinants of health and wellbeing for migrants, particularly those newly arrived include:

- circumstances in the country of origin (eg disease prevalence; experience of discrimination)
- circumstances resulting in the migration (eg trauma; bereavement; torture)
- the nature of the journey (eg danger; separation from family)

- arrival and settling process (eg anxiety; entitlement confusion; poor social networks)
- ability to communicate (eg language)
- housing (eg multiple occupation, overcrowding, destitution)
- employment (eg worklessness, low pay, poor conditions)
- access to services (eg lack of awareness; unfamiliar systems; exclusion)

Among UK-born ethnic minorities, migration patterns may also be of relevance to understanding health inequalities due to: family members having a history of migration to the country; ongoing social and economic ties to the country of heritage; and transnational mobility to and from the UK. Migration patterns differ from area to area, underscoring the importance of local information and Strategic Migration Partnerships (cross-sector regional partnerships established by the Home Office to support the successful management of migration).

4.10 Regional variation

> Inequalities in socioeconomic outcomes manifest in different ways for particular ethnic groups and are characterised by local variation: in some types of districts there is large ethnic inequality, while in others; ethnic minority groups have equal or better outcomes than the White British population.

Finney and Lymperopoulou led a detailed study exploring local level patterns and trends in ethnic inequalities in education, employment and housing using census data for England and Wales for 2001 and 2011.[44] This work has confirmed widespread and persistent ethnic inequalities. However, it has also demonstrated that the extent of inequality between ethnic minorities and the White British population varies greatly between areas. Furthermore, this work identifies contrasting trends, with some areas becoming more, and others less, unequal over time. Importantly, high levels of ethnic inequality were found in areas with both large and small minority ethnic populations and with high and low levels of overall deprivation.

All these findings suggest that authorities throughout the country need to carefully consider ethnic diversity and inequality and that local action can make a difference. For instance, the analysis identifies Bradford as a district that has made important progress on ethnic inequalities, particularly in the

area of educational attainment, with the ethnic gap in pupil attainment being closed at the same time as progress for all groups was achieved.

Health-related practices

5.1 Introduction and key messages

Key messages:

- there are large ethnic inequalities in smoking rates but these also vary greatly between men and women within ethnic groups. Bangladeshi, Pakistani and Irish men have particularly high rates of smoking
- non-White minority ethnic groups have higher rates of abstinence and lower levels of frequent and heavy alcohol drinking than White British and White Irish groups
- levels of physical activity, and participation in sports, are lower among South Asian groups than other ethnic groups, with South Asian women having particularly high levels of inactivity
- evidence remains limited and contradictory on ethnic differences in healthy eating practices
- information on health-related practices is particularly limited for Gypsies, Irish Travellers and Roma populations. This is a major gap given their generally very poor health outcomes

Dietary patterns, levels of exercise and the consumption of alcohol and tobacco are recognised as major contributors to health, wellbeing and the risk of long-term health conditions. However, rather than being presented as 'life style choices', it is increasingly recognised that such behaviours must be viewed as social practices, deeply shaped by prevailing social, cultural and material circumstances within which people live.[97,98] Identifying whether and how these health-related practices systematically differ between ethnic groups is important in informing action on inequalities. However, data limitations currently obscure a clear picture in several areas.

5.2 Smoking and tobacco use

Smoking is a risk factor for many diseases including chronic obstructive pulmonary disease (COPD), heart disease and numerous cancers and a major cause of preventable morbidity and premature mortality.

Data for 2015 by broad ethnic group confirms wide variation in smoking prevalence among those aged 18 and over, with the highest prevalence in the Mixed and White ethnic groups (22.4% and 17.6% respectively).[17] However, it should be noted that there is large variation in smoking prevalence by gender within ethnic groups. More detailed data from the 2004 Health Survey for England showed that while 24% of the overall population reported being a current smoker, the highest rates were for Bangladeshi (40%), Irish (30%) and Pakistani (29%) men. The picture was very different for women, with the highest rates being among Irish (26%) and Black Caribbean women (24%), and very much lower levels among Indian (5%), Pakistani (5%), Chinese (8%) and Bangladeshi women (2%).[99]

Other forms of tobacco use are more common among some ethnic groups than others, though data is limited. Shisha (waterpipe) use was estimated in 2012/3 to be frequently practiced by about 1% of the British population with higher rates among Asian (7%), mixed (5%) and Black (4%) groups than among White adults (0.5%).[100] Shisha use is traditionally high in Middle Eastern countries, with high prevalence also among Arab populations living elsewhere.[101] The 2004 Health Survey for England reported that chewing tobacco was most common among people identifying as Bangladeshi (9% of men and 16% among women aged 18 and over), with much lower rates among men and women in the Indian and Pakistani groups.[96]

5.2.1 Smoking and tobacco use among children and young people

Data on smoking and other tobacco use are available for broad ethnic groups from the What about YOUth (WAY) 2014 survey of 15 year olds.

Overall, young people reporting a Mixed ethnic background (29%) and a White ethnic background (26%) were the most likely to have ever smoked, compared to 11% among the Asian group, 17% among the Black group and 18% of the 'Other ethnic background' group. Similarly, regular smokers made up 5% of the Mixed group and 6% of the White group, compared to 1% among the Asian, group, 1% among the Black group and 2% of the 'Other ethnic background' group. These ethnic-specific data were not, however, disaggregated by gender. Somewhat different patterns of use of other tobacco products were evident in this survey. While young people of Mixed ethnic background were again the most likely to report ever having used shisha/waterpipe at 22%, those with a White ethnic background were least

likely at 14%, with rates being 16% among the Asian group, 18% among the Black group and 22% among the Other ethnic background group.[102]

5.3 Alcohol

Available data on patterns of alcohol use by ethnicity and gender provide a complex picture. This is in part a result of the varying ethnic categories that have been employed and also because measuring alcohol consumption via self-report is difficult and the measures used vary across data sources depending on the focus of interest.

The 2004 Health Survey for England reported very large variations in the usual drinking frequency between ethnic groups. Men and women who identified as Irish were more likely than the overall population to say they usually drank on 3 or more days a week: 51% of Irish men did so, compared with 41% of men in the overall population; while for women the equivalent figures were 30% and 26%.[96] All other minority ethnic groups were less likely than the overall population to report drinking on three or more days a week; the figures for women being Black Caribbean: 11%, Chinese: 9%, Black African: 5%, Indian: 5%, Pakistani: <0.5%, and Bangladeshi: <0.5%, and for men Black Caribbean: 28%, Chinese: 18%, Black African: 17%, Indian: 18%, Pakistani: 2%, and Bangladeshi: 1%. Irish men and women were also the group most likely to have exceeded government recommendations for 'safe' drinking levels on their heaviest drinking day in the past week (71% and 53% respectively).

The PHE Equity Report reports on alcohol-related hospital admissions as a measure of alcohol misuse with significant personal and societal costs. For men, the White British, White Irish, Other White, Indian, and Other ethnic groups make up a higher proportion of alcohol admissions compared to admissions from all causes. For example, White British men make up 79.1% of alcohol specific admissions, but only 75.4% of admissions for all causes.

For women, the White British and White Irish groups are overrepresented amongst alcohol specific admissions compared to admissions from all causes, with 84.5% of alcohol specific admissions being amongst the White British group, but only 74.6% of all admissions. Among the larger ethnic groups those with lower proportions of alcohol-specific admissions than all causes include: Bangladeshi (men and women); Pakistani (men and women); Black African (men and women); Black Caribbean (men and women); Chinese (women); Indian (women).[17]

The Adult Psychiatric Morbidity Survey collected data on harmful and dependent alcohol use and showed important ethnic inequalities. In 2014, among men the proportions classed as demonstrating 'hazardous, harmful or dependent drinking' (scoring 8 or more on the AUDIT tool[103]) were: White British: 29.8%; White Other: 19.5%; Black/Black British: 8.2%; Asian/Asian British: 6.4%; Mixed/multiple/other: 15.0%. Among women these figures were generally lower, but again showed important ethnic differences: White British: 14.4%; White Other: 13.2%; Black/Black British: 8.9%; Asian/Asian British: 4.2%; Mixed/multiple/other: 10.9%.[104]

5.3.1 Alcohol use among children and young people

The WAY 2014 survey revealed large ethnic differences among 15 year olds in the proportion reporting that they had ever had an alcoholic drink. This proportion was 72% among those identifying with a White ethnic background, compared to 61% among the Mixed group, 11% among the Asian group, 32% among the Black group and 19% among the Other ethnic background group. A similar pattern was seen in those reporting that they were a regular drinker (having an alcoholic drink at least once a week): White: 7%; Mixed: 4%, Asian: 0%; Black: 1% and Other: 1%.[105]

5.4 Physical activity

> The 2004 Health Survey for England showed that 37% of men and 25% of women overall had high activity levels (defined as achieving the recommendations of participating in activity of moderate to vigorous intensity for at least 30 minutes on 5 or more days a week on average).

Among men, those identifying as Irish (39%) and Black Caribbean (37%) had the highest rates of adherence to the recommendation, while among women, Black Caribbean, Black African and Irish women had the highest rates (31%, 29% and 29% respectively). At the other end of the spectrum, 32% of men and 39% of women overall had low activity levels (defined as participation in less than one 30-minute moderate or vigorous activity session a week, on average). Low activity was particularly common among Bangladeshi and Pakistani men (both 51%) and Bangladeshi (68%) and Pakistani (52%) women.[96]

The Active People Survey (APS), conducted by Sport England, has collected data on physical activity in 2012, 2013 and 2014. In 2014, this survey found

that the percentage of all adults (aged 16+) who were 'inactive' (less than 30 minutes of Moderate or Vigorous intensity Physical Activity, calculated as minutes per week of moderate intensity activity or double the minutes of vigorous intensity activity) was 24% among men and 32% among women, suggesting some reduction in 'inactivity' over time when compared to the 2004 HSE findings. Ethnic group differences were again apparent. The figures by ethnic group for men were: White British: 24%; White Other: 19%; Asian 28%; Black: 25%; Mixed: 17%; Chinese (sample too small) and Other: 21%. Among women, these figures were higher: White British: 31%; White Other: 27%; Asian 39%; Black: 32%; Mixed: 22%; Chinese 31% and Other: 32%.[106]

Fischbacher et al. reviewed 12 studies between 1987 and 1999 that reported on physical activity among adults from UK South Asian ethnic groups. They concluded that, despite measurement issues, levels of physical activity were substantially lower in all South Asian groups than the general population (or comparator White groups). In the 4 studies that compared between South Asian groups, all found levels of activity to be lowest among people identifying as Bangladeshi. Rates of physical activity were particularly low among South Asian women in most studies.[107]

Information on physical activity levels among Gypsies and Irish Travellers is very limited, but small-scale local studies consistently report high levels of sedentary behaviour.[108] Opportunities for physical activity are likely to be severely constrained by the environmental conditions, insecurity and remote locations of residential sites and experiences of racist exclusion. Evidence on participation in sports also shows large ethnic differences, particularly among women[109] and suggests a range of barriers for minority ethnic people including: limited material resources, pervasive racism (both inter-personal and institutional), lack of public transport (and low car ownership) and cultural constraints.[110]

5.4.1 Children and young people

Parents of children enrolled in the National Child Measurement Programme aged 4-5 and 10-11 years and reported low physical activity (not achieving one hour or more physical activity per day).

WAY 2014 found that the mean number of days in the past week on which the moderate-vigorous physical activity (MVPA) guidelines were met among

15 year olds were: White: 3.8; Mixed: 3.8; Asian: 3.3; Black: 3.5 and Other: 3.4. There was an important gender difference overall, with the mean number of days being 4.1 among boys and 3.3 among girls. In terms of sedentary behaviour, on weekdays the percentage reporting 7 or more hours per day were: White: 70%; Mixed: 71%; Asian: 63%; Black: 78% and Other: 64%; and on weekends these percentages were White: 88%; Mixed: 89%; Asian: 87%; Black: 94% and Other: 88%.[102]

A study across 5 primary care trusts in 2010-11 by Falconer et al. interviewed parents of children enrolled in the National Child Measurement Programme aged 4-5 and 10-11 years and reported low physical activity (not achieving one hour or more physical activity per day) among 83% of children categorised as Asian, 80% of those categorised as Black, and 56% of those categorised as White.[111]

5.5 Healthy eating

> The measures of healthy eating that have been employed in surveys that allow exploration of ethnic differences are very limited. Furthermore, assessing divergence in dietary habits across ethnic groups using standardized instruments is not straightforward.[112]

A recent narrative review also highlights the limited, and contradictory, evidence on food choices and eating practices among minority ethnic populations in the UK and notes significant variation within ethnic groups, particularly by religion, across generations and by social class.[113]

The 2004 Health Survey for England found that 23% of men and 27% of women overall met the recommended guidelines of consuming 5 or more portions of fruit and vegetables a day. It also found that the proportion of men meeting the guidelines was higher among all minority ethnic groups than in the general population. Over a third of Indian and Chinese men met the five-a-day recommendation (37% and 36% respectively). Among women, the proportion reporting eating 5 or more portions was also highest in the Chinese and Indian groups (42% and 36% respectively). Again, the level of healthy eating was higher among all minority ethnic groups than in the overall population.[96]

The APS in 2014 reported overall much higher proportions of people reporting eating 5 or more portions of fruit and vegetables a day, perhaps suggesting a positive trend over time. This survey used the broader ‘Asian’

ethnic category and reported lower proportions among the minority ethnic groups than the White British. Methodology issues with the APS data have likely impacted on results for ethnic groups.

Among men, 49% of the White British group reported eating 5 or more portions of fruit and vegetables a day, compared to 50% among White Other; 35% among Asian; 33% among Black; 49% among Mixed; 39% among Chinese and 42% among the 'Other ethnicity' group. Among women, the figures were 59% among the White British group, 59% among White Other; 42% among Asian; 41% among Black; 55% among Mixed; 59% among Chinese and 53% among the 'Other ethnicity' group.[103]

A local study in Manchester of 255 people of African-Caribbean origin employed more extensive and culturally-specific tools to assess dietary patterns and highlights the current very limited understanding of ethnic variations in: total daily energy intake; the contribution of different food groups to total energy (eg saturated fats versus carbohydrates); portion sizes; and aspects of diet quality such as fibre and vitamin intake.[114]

Early analyses of data from Understanding Society (2011-12) explored the extent to which minority ethnic people in the UK follow or diverge from a diet associated with their 'country of origin'. This analysis showed that as a whole minority ethnic people who were born in the UK reported consuming food of ethnic origin significantly less frequently than non-UK born minorities. However, respondents identifying as Indian, Pakistani or Bangladeshi (whether UK- or non-UK born) were more likely to report eating food of ethnic origin frequently than those in the Chinese, Caribbean, Black African or mixed ethnic groups. The analysis also found an association between following a 'traditional' diet and higher intake of fruits and vegetables.[115]

There is very limited evidence regarding eating practices among Gypsies, Irish Travellers and Roma communities in England. Local studies, reviewed by Greenfields, have tended to report diets low in fruits and vegetables and high consumption of convenience foods (linked to financial constraints and practical problems of storing fresh food).[105]

5.5.1 Children and young people

Evidence on dietary behaviour among children by ethnicity is also limited and contradictory.

WAY 2014 collected data on daily fruit and vegetable consumption among 15 year olds and found that pupils identifying with a White ethnic background had the lowest mean number of daily portions at 5.01, compared to 5.53 among the Mixed group, 6.04 among the Asian group, 5.50 among the Black group and 6.70 among the Other ethnic background group.[102]

Falconer et al.'s study cited above reported on several indicators of dietary behaviour among children aged 4-5 and 10-11 years combined. Using a combined measure based on consumption of fruit and vegetables, sugary drinks, and sweet and savoury snacks, they reported that 48.8% of White children, 66.5% of Asian children and 62.6% of Black children had 'unhealthy dietary behaviours'. In this study, the percentages of children who were reported by their parents to consume less than the recommended intake of five portions of fruit and vegetables per day were: White: 66.7%; Asian: 82.3% and Black: 86.0%.[108]

Access to services and interventions

6.1 Introduction and key messages

Key messages:

- low levels of health literacy are a concern among some minority ethnic groups, particularly those with limited educational attainment and poor English language skills
- ethnic differences in the uptake of preventive interventions have been found to vary across studies and settings so that minority ethnic groups do not always experience disadvantage. This suggests the importance of local level responsiveness to need
- access to some primary care services, notably dental services and talking therapies for common mental disorders, is lower among minority ethnic groups than the White majority
- the significant barriers facing Gypsies and Travellers and asylum seekers in accessing primary care services warrant urgent action
- ethnic differences in satisfaction with healthcare have been repeatedly reported across primary and secondary care and, where these have been investigated, reflect differences in care that demand attention

While primary and secondary healthcare play a relatively small role in overall health status, a much broader range of services and support are relevant to health, including preventive measures such as immunisation and screening, health literacy, health promotion initiatives, health behaviour interventions, leisure and community-based facilities, and social care services. Differential access, experiences and outcomes of such services have been documented between ethnic groups across a range of settings. Further, equitable access extends beyond simple service uptake. It includes access to appropriate information, services that are timely, appropriate and sensitive to needs. It means being able to use services with ease and having confidence that providers will welcome you and treat you with respect.[116,117]

Insensitivity and inappropriateness in service provision is likely to contribute to health inequalities both by leading to poor care (for instance due to poor communication, missed diagnoses and poor adherence to treatment) and by undermining the mental wellbeing of patients through being stressful. Inequitable access can result from over-receipt as well as under-receipt and sub-optimal care. Assessing whether levels of service access and receipt of

interventions are equitable across ethnic groups is often difficult with the data available.[118,119]

6.2 Health literacy

> The term 'health literacy' refers to people having the appropriate skills, knowledge, understanding and confidence to access, understand, evaluate, use and navigate health and social care information and services in order to take action on the factors influencing their health.

Health literacy depends not only on cognitive abilities, but also on the empowerment of individuals, the accessibility, relevance and trustworthiness of information on offer, and the responsiveness of the health system.[120,121] An earlier IHE/PHE publication has set out the case for improving health literacy to reduce health inequalities, and described the relationships between limited health literacy and low use of preventive health services, health-damaging behaviours and increased risk of morbidity and premature death.[122] That report identifies some migrants and minority ethnic groups as having poorer health literacy than the general population. It notes greater difficulties in obtaining, understanding and acting on health information, particularly for those with limited educational attainment and poor English language skills (given the limited provision of interpretation services within healthcare settings).[123]

More recent research confirms this picture but also highlights the importance of culturally compatible information and collaboration with patients and community members.[124,125] Other research highlights the way in which low levels of trust in statutory services and past poor interactions with health professionals can undermine health literacy among minority ethnic people. While this has been a prominent theme within mental health research, mistrust is not confined to this area of health.[126]

A further factor that has been noted in a large number of studies, again particularly those focused on mental health, is stigma. For example, Memon et al. in a recent paper identify 'inability to recognise and accept mental health problems' and 'negative perception of and social stigma against mental health' as factors that undermine mental health service access among the Black and minority ethnic respondents in their qualitative study.[127]

6.3 Health promotion and preventive interventions

Though evidence is patchy, a number of studies have indicated ethnic differences in engagement with health promotion initiatives and uptake of preventive interventions. However, while some evidence suggests minority ethnic disadvantage, findings are mixed with some local studies suggesting a more equitable picture, and others indicating that the White majority group may require attention.

Screening services are an important part of efforts to reduce cancer mortality. Several studies have documented lower levels of breast and cervical cancer screening among women from minority ethnic groups, particularly South Asians. A recent study found that in London, White British women were more likely than other ethnic groups to attend breast screening appointments as part of the national breast screening programme. This difference was not explained by socioeconomic deprivation or place of residence. Great variation in uptake was found across ethnic groups with the lowest rates being for Bangladeshi, Black African and mixed White and Black African women.[128]

There is evidence that uptake of some immunisations is lower among individuals from some Black and minority ethnic groups than the White majority population, and that uptake may be particularly low among Irish Traveller, Gypsy and Roma communities.[129,130,131]

Some studies suggest that use of NHS Stop Smoking Services is lower among some minority ethnic groups than the White majority, given the prevalence of smoking, but NICE indicates this evidence is inconclusive.[132] A qualitative study of Bangladeshi and Pakistani adults in Newcastle found that despite high levels of motivation to stop smoking few participants had sought advice from health professionals or received cessation aids or support. Participants perceived services unfavourably and identified cultural and language barriers to access.[133]

Among those attending NHS stop smoking services in 2014/5, there were differences in success rates between ethnic groups. For men, the range was from 38% for ‘other ethnic group’ and 45% for people of mixed ethnicity, up to 56% for Pakistani men. Similarly, for women the range was from 30% for ‘other ethnic group’ and 44% for people of mixed ethnicity, up to 58% for Pakistani women.[134]

A study of the NHS health checks programme in Newham, City and Hackney and Tower Hamlets in 2011/12[135] found that Black African, Black Caribbean and South Asian ethnic groups were more likely to attend than White groups in each of the three boroughs.

There is evidence to suggest poorer engagement by people from minority ethnic groups with some broader-based, neighbourhood initiatives aimed at tackling health and wellbeing inequalities. For instance, low uptake of Sure Start services[136] and under-representation in New Deal for Community partnerships[137] were documented.

6.4 Primary care and community health services

In terms of general use of primary care, a study using data from the Health Survey for England 1999 and 2004 indicated that Caribbean, Indian, Pakistani and Bangladeshi people were significantly more likely to have used GP services in the previous two weeks than the White population.

This took account of age and gender differences and the pattern persisted (though to a lesser extent) after adjusting for self-reported health status. In contrast to visits to the GP, this study indicated that people in all ethnic minority groups were significantly less likely to report visiting a dentist for check-ups than the White group.[138]

Problematic access to primary mental healthcare and mental health promotion has been reported for people from minority ethnic backgrounds over many years.[139,140] Data from the Increasing Access to Psychological Therapies (IAPT) programme suggest that these services for CMDs may be less accessible to people from minority ethnic communities.[141] There have also been claims that black people are more likely to be turned away from mental health services when they seek help.[142] There are concerns that children and young people from black and minority ethnic groups are under-represented in child and adolescent mental health services.[143]

Research amongst Gypsies and Travellers found that some 16% were not registered with a general practitioner, rising to 37% amongst those who travel all year round. Gypsies and Travellers were much less likely than the general population to use primary care services (including general practice, dentists and pharmacists) during the course of the year but were more likely to be seen by health visiting, social care and accident and emergency services.[72]

For Roma, Gypsy and Irish Traveller communities real, perceived and anticipated discrimination and a lack of cultural awareness from health professionals and GP receptionists are frequently reported and create barriers to accessing health care.[72] Similar obstacles to GP services face asylum seekers as reported by Aspinall and Watters: *"There is now an extensive evidence base on the difficulties experienced by asylum seekers in accessing GP treatment"* (p20).[144]

In terms of satisfaction with primary care services, GP Patient Surveys suggest that levels of access in relation to expectations and demand are lower among minority ethnic groups when compared to the White British majority. For example, 45% of Pakistani and 37% of Bangladeshi respondents answered 'no' when asked whether they were able to book an advance appointment at their doctor's surgery, compared to 24% of White British respondents.Other indicators of satisfaction were also worse and there were differences in satisfaction by ethnicity within the same practices.[145] More recent in-depth studies have examined the possible explanatory factors behind low levels of reported satisfaction, focusing particularly on South Asian patients, with findings suggesting that lower scores represent genuinely worse experiences of communication and care compared to the White British majority.[146,147] Chinese patients have also been repeatedly found to express low satisfaction with NHS primary care services.[148]

In terms of quality of care, available evidence is limited and the picture is mixed. For example, poorer intermediate outcomes for minority ethnic patients with diabetes have been documented in a number of local-level studies.[149,150,151,152] However, in contrast, Nazroo et al.'s (2009) analyses of the national HSE data found little evidence of important ethnic differences in outcomes of care for 3 chronic conditions: hypertension, cholesterol and diabetes.[134]

6.5 Secondary care

Access to secondary care services and follow-on treatments vary among different ethnic groups.

Nazroo et al. (2009) found significantly lower levels of hospital utilisation (out- or day-patient visit in the last year) among Indian, Pakistani, Bangladeshi and Chinese respondents when compared to Whites, though explanations were not available from the survey data analysed.[134]

Looking at services that relate to cardiovascular disease – a condition that has received some attention in relation to ethnicity - there is some evidence of differential access to hospital and follow-on treatments. Sekhri et al. concluded that at an early stage after presentation with suspected angina, coronary angiography is underused in South Asians (as well as in older people, women and people from deprived areas).[153] Uptake of cardiac rehabilitation has also been found to be lower among minority ethnic groups (as well as women and those from lower socioeconomic backgrounds).[154] A more recent study using small-area estimation techniques has also documented ethnic differentials in utilisation of cardiovascular care.[155]

A literature review on palliative care services found that low uptake of palliative and end of life care services was commonly reported among minority ethnic groups. Potential explanatory factors included: lack of referrals; lack of knowledge about services; religious traditions and family values in conflict with the idea of palliative/hospice care. Other factors included structural barriers such as geographical location of inpatient hospices, social segregation and previous bad experiences of care.[156]

Mirroring the pattern found in primary care, ethnic differences in satisfaction have been found repeatedly among cancer patients. The most recent cancer patient experience survey157 collected information from 70,000 patients across 153 NHS Trusts in England. It found that there were statistically significant differences between ethnic groups on a third of the questions answered.158 For example, the proportion who rated their care as being either ‘very good’ or ‘excellent’ ranged from 70% among patients from ‘Other’ ethnic group and 75% among Asian patients up to 90% among White patients.

Ethnic differentials in access to, and experience of, secondary mental healthcare have received considerable attention over several decades in the UK. Black African, Black Caribbean and Black/White Mixed groups are 44% more likely to be sectioned under the Mental Health Act. Adverse experiences of hospital mental health services among minority ethnic patients, including excessive restraint and medication, are also a persistent cause for concern. Rates of recovery are also found to be lower among minority, particularly Black, groups. These issues have led to a mistrust of services and fear of inappropriate and poor treatment and delays in seeking care. There is also wide variation in the pathways and patterns of use of mental health services. Black people with serious mental illness are more likely than other groups to come into contact with secondary care services through non-health agencies, in particular, the police.[136,159]

Embedding attention to ethnicity within action on health inequalities

7.1 Introduction and key messages

Key messages:

- **mainstreaming ethnicity**: Without explicit consideration of ethnicity within health inequalities work there is a risk of partial understanding of the processes producing poor health outcomes and ineffective intervention
- **influencing decision-makers and role of senior leadership**: Progress on ethnic health inequalities has been slow and the need for senior leadership on this agenda has been repeatedly highlighted
- **data collection, analysis and reporting**: Gaps in data collection must be filled and there must be more consistent analysis and reporting of data on ethnicity, health and healthcare so that there is adequate understanding of local needs and the extent to which they are being met by policies and services
- **action on the wider social and economic determinants of health** may exacerbate ethnic health inequalities unless it adequately takes into account the ethnic patterning in residential, income, educational and occupational profiles
- **tackling racism** and ethnic discrimination: the central role of racism must be acknowledged, understood and addressed. There is an urgent need to build the evidence base around effective action
- **commissioning of culturally sensitive health promotion interventions:** Interventions need to work with cultural and religious understandings and values while recognising intra-group diversity and avoiding stereotyping
- **improving access, experiences and outcomes of health services**: Actions at organisational level include: regular equity audits; integration of equality into quality systems; good representation of black and minority ethnic communities among staff; sustained workforce development; trust-building dialogue with service users
- **engagement with minority ethnic groups**: Across all areas of activity, the meaningful engagement and involvement of minority ethnic communities, patients, clinical staff and people is central to understanding needs and producing appropriate and effective

responses or shaping services. A concerted effort is required by public and private sector employers and service providers
- **making use of evidence**: The evidence base to inform policy and practice remains limited but more can be done to mobilise the available evidence and to document and evaluate promising local practice both locally and nationally

The major determinants of ill-health are largely the same across all ethnic groups. However, ethnicity is a salient social identifier in modern Britain, shaping people's networks of association and their social and economic opportunities. Further, minority ethnic identities continue, in many circumstances, to be stigmatised and subject to exclusionary forces. Therefore, without explicit consideration of ethnicity within health inequalities work, there is a risk of partial understanding of the social processes producing poor health outcomes and ineffective, or even harmful, intervention.8 Though data are limited, observed local variations in ethnic inequalities across the determinants of health point to the importance of local-level action and the possibility of progress towards greater equality. In this final section, we identify some general approaches that can support the embedding of attention to ethnic diversity and inequality within action on health inequalities.

7.2 Strategic leadership

The need for action on ethnic inequality to be championed by senior leaders at local and national level and to be firmly integrated into health inequalities policies has been repeatedly highlighted in the English context.[7,160] Unlike several other countries, notably the US, ethnic inequality remains a marginalised issue within much public health, as well as wider social, policy in England. The Equality and Human Rights Commission has undertaken a number of pieces of work that highlight good practice in relation to equalities in general and ethnic/racial equality specifically.

For example, a review of Local Strategic Partnerships (LSP) and Local Area Agreements (LAA) highlights the key leadership and championing role of local authorities in this area and identifies the different ways that this can be demonstrated, including: political championing through a cabinet portfolio holder; explicit and visible senior management support; designated equalities champions within partnerships; and dedicated officer posts.[161] The importance of senior backing that supports and presents this work as mainstream business, rather than as an add-on, was also emphasised along with the development of greater numbers of black and minority ethnic

individuals as leaders. The Equality Framework for Local Government also identifies 'leadership, partnership and organisational commitment' as one of its five performance areas.[162] According to the recent report Delivering through Diversity Report, CEO and senior leadership commitment is critical in galvanizing the organisation, encouraging role modelling, holding their staff to account, and ensuring efforts are sufficiently resourced and supported centrally.

7.3 Data collection, analysis and systematic evaluation

Despite statutory requirements, the collection, analysis and reporting of data on ethnicity and health remains patchy at local and national levels. A review of JSNAs in 2010 concluded that there was considerable scope for improvement in the presentation and analysis of data on ethnicity as well as its translation into identified action.[16] A 2016 review in South East and South West regions focused on 'Gypsy Traveller' health and reported that 44% of JSNAs had explicit chapters devoted to the needs of these groups, that the level of detail was highly variable even where a chapter was included, and that information on Roma populations was particularly limited.[163] The current state of many JSNAs clearly compromises their goal of identifying local health inequalities with a view to improving the health and wellbeing of the local population. However, the significant variability across the country in the collection and use of ethnicity and health data suggests that obstacles lie at organisational level and that good practice could be shared to bring about wider improvements.

Furthermore, as highlighted by Aspinall and Jacobsen in 2007, strategies exist for using incomplete data and data limitations should not preclude useful analyses.[164] Indeed, the active use of data to inform understanding and action should, over time, also prompt improvements in data completeness and quality. A number of prior resources provide helpful guidance on data and insight generating initiatives, all of which emphasise the importance of effective engagement with marginalised communities, and the sharing of data across partner organisations, to develop more complete understanding.[157,165] In addition, better systematic evaluation and documentation of local level initiatives aimed at tackling ethnic inequalities is needed. Many missed opportunities for sharing good practice and informing improvement through lessons learned are currently missed.[7]A more systematic approach of engaging and involving professional audiences (eg local authority staff, clinicians, decision makers) would help raise the profile of ethnic inequalities, share best practice and influence local action.

7.4 Action on the wider social determinants of health

Much local authority business is focused on the wider social and economic determinants of health, whether or not it is actually framed in these terms. So, for example, housing improvement programmes, poverty alleviation strategies and management of green space, can all have significant positive impacts on health. Furthermore, many other areas of local authority activity can be health-promoting, or indeed health-damaging, depending on how they are designed and delivered. Importantly, such policies and programmes may often play out differently across ethnic groups and result in differential benefits. It is therefore important that attention to ethnic diversity and inequality is part-and-parcel of planning and delivering such action.

As an example, initiatives aimed at promoting active transport would need to consider residential patterns, commuting distances, local physical and social terrain, and transport options, all of which may vary across ethnic groups and mean that some people benefit more than others from such programmes. For example, local authorities could use urban design more actively and creatively in shaping community development. Moreover, better engagement of various ethnicities in the process would contribute to creating more cohesive and culturally competent environments.

4 broad approaches can help: knowing your communities (particularly in terms of ethnic residential and occupational patterning); undertaking detailed Equality Impact Assessments (EIA); giving explicit attention to racism and not under-estimating exclusionary forces; and learning from places that are making progress.

7.5 Action on racism and ethnic discrimination

Given its significant direct and indirect effects on health of minority ethnic people, action on racism and ethnic discrimination deserves particular attention. A review by the Equality and Human Rights Commission explored the evidence on ways of reducing prejudice including promoting contact between people from different ethnic groups, media campaigns and diversity training. It found promising evidence relating to working with children and through schools suggesting that “prejudices towards different groups emerge at different points during childhood, but there is scope to influence prejudice early on”. There were signs that interventions based on multicultural curricula and inter-group contact in particular work well.[166] However the review found that there is very little high quality research on the effectiveness of different interventions in the UK. It noted that “although schools, organisations and government agencies have many strategies for reducing prejudice and

increasing good relations, the tendency is to assume these will be effective simply because they have been implemented". Although scientific evidence of the effectiveness of interventions is currently limited, the positioning of public health in local authorities offers a good environment for co-ordinated local responses and these should be carefully evaluated to build the evidence base going forward.

7.6 Action on health-damaging practices

It is now widely accepted that progress on the major health-damaging practices – smoking, alcohol misuse, low physical activity, and unhealthy diets - requires action at multiple levels. For example, in relation to tackling obesity and promoting healthy weight, NICE has produced a whole suite of documents that provide guidance on what action local authorities and other commissioners can take from the clinical management of obese patients, through interventions aimed at shifting individual behaviours around diet and physical activity, to wider structural changes that tackle the prevailing obesogenic and sedentary environmental conditions within which most people live and work. These documents also note the importance of ensuring that individual, family and community-level interventions aimed at reducing health-damaging health practices are accessible and acceptable to all, regardless of ethnicity.[167]

Several recent reviews have identified common approaches to tailoring or adapting health promotion interventions for minority ethnic communities. The importance of engaging local people in the co-production of interventions and drawing on community resources to publicise initiatives and increase accessibility has been emphasised. Identifying and addressing access barriers, including giving explicit attention to racism and processes of exclusion, have also been highlighted. Communication strategies give attention to reaching those with limited English language skills as well as to the sensitive use of language and to meeting the felt information needs of local people (eg via use of appropriate images, accessible terminology and resonant cultural references).

Adapted interventions also often aim to work with, rather than overlook, the cultural or religious understandings and values that people have that can either promote or hamper positive change. For example, in relation to encouraging physical activity among certain South Asian women, beliefs around modesty and dress codes and preferences for gender specific facilities and culturally appropriate exercise services will need to be considered. However, structural obstacles may be equally important such as

a lack of walkable and safe routes, racial harassment and family caring responsibilities.[111]

Importantly, however, intra-group diversity and the need to avoid stereotyping are also recognised, so that interventions must accommodate varying degrees of ethnic identification.[168,169] More generally, the important role of voluntary and community-based organisations in the design and delivery of interventions has been emphasised, since these organisations will often have trusted relationships and detailed insights into both community assets and needs. Importantly also, ensuring the sustainability of interventions has been a focus, with some initiatives involving the training of community members to run activities for themselves and strategies to make mainstream services more accessible via confidence and competence raising among both minority ethnic users and service providers.[170] It should be recognised, however, that there is very limited evidence on the effectiveness of culturally-adapted interventions among minority ethnic populations in England or elsewhere, and therefore a need for ongoing evaluation of promising local level initiatives.[171]

7.7 Action on inclusive and culturally-competent healthcare

Persistent inequalities in access, experience and outcomes of healthcare for minority ethnic patients suggest that action on inclusivity and cultural competence should be a priority. The Race Equality Foundation has published a suite of over 40 briefing papers over the past years focused on various aspects of ethnicity, health and health-related services that provide useful guidance. See, for example, Truswell on dementia care[172] and Costa on language support.[173] There are also several guides for commissioners and service managers on how to make services more accessible and appropriate to ethnically diverse populations. For example, in the areas of maternity care[174] and mental health services,[175] and for particular groups.[176]

A common message within these resources is that action is needed at organisational as well as individual and inter-personal level. There is a need to acknowledge, understand and address Institutional Racism – defined by Macpherson as '… *the collective failure of an organisation to provide an appropriate or professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, ignorance, thoughtlessness and racist stereotyping, which disadvantage minority ethnic people*.'[177] This means action at systemic level, including: regular equity audits to assess accessibility; the establishment of clear policies and procedures; integration of equality into quality systems;

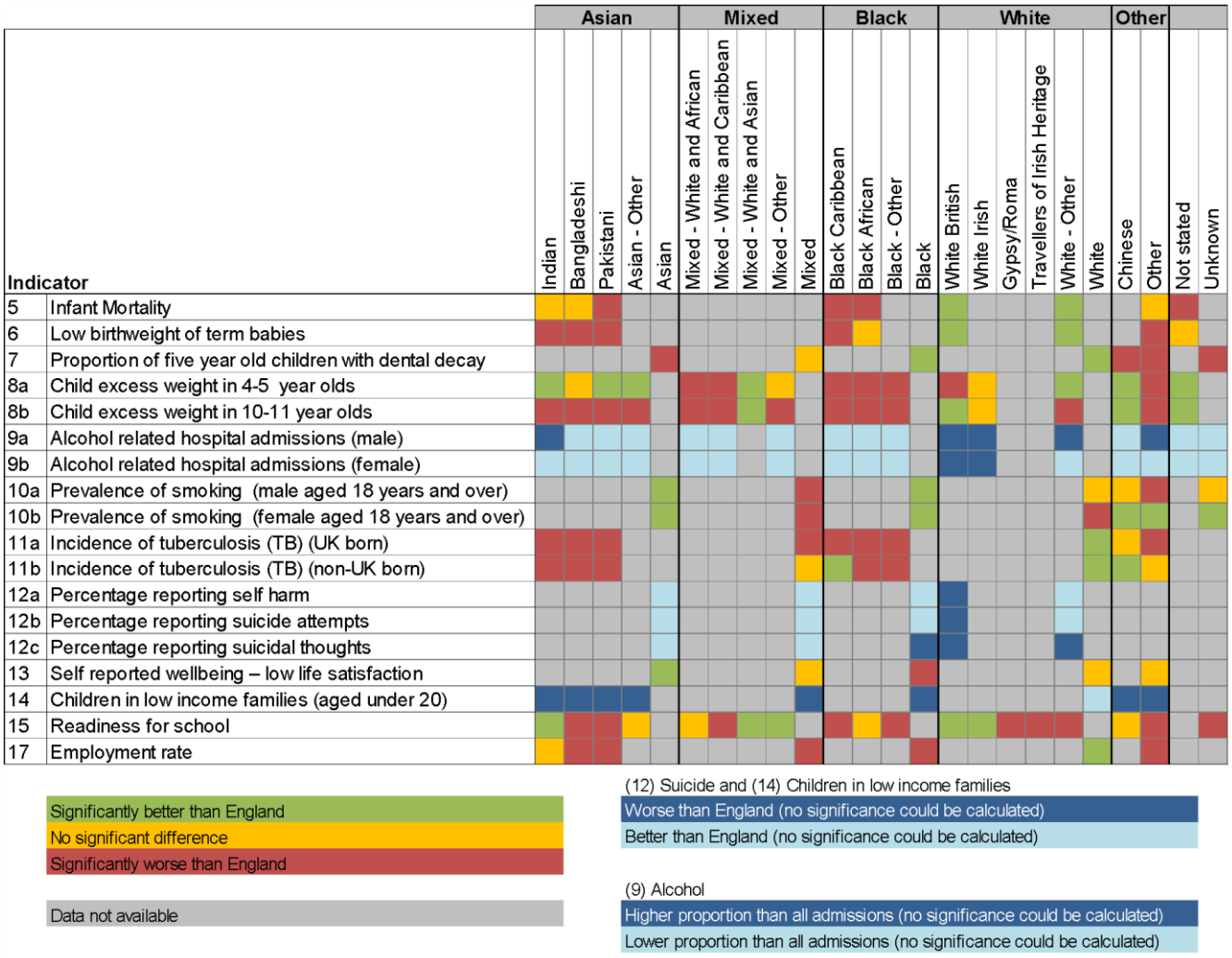
sustained workforce development; the embedding of race equality within professional training programmes; increasing representation and visibility of minority staff and investment in their capacity development; the creation of spaces where communities, service users, practitioners and managers can develop meaningful dialogue and develop trust; and the effective mobilisation of evidence to inform good practice.[176,178.179]

A key issue for consideration relates to the potential advantages and disadvantages of specialist versus mainstream service responses. There may be arguments in favour of specialist services, particularly where there is a history of extreme marginalisation or oppressive practice, or where specific health needs affect particular communities. For instance, the 'eurocentricity' of mainstream models of mental healthcare delivery has been identified as a particular obstacle to effective mainstream practice and community-level services tailored to minority ethnic communities have been found to be more accessible and appropriate.[176] Similarly, some holistic services that address the needs of asylum seekers, other vulnerable migrants and/or Gypsy and Traveller groups have been found to be effective in building trust and dealing with complex and enduring disadvantage.[180]

Summary points

Equality and action to reduce ethnic inequalities need greater prominence in strategies to achieve change. The preceding sections of this resource have shown that the observed patterns of ill-health by ethnic group in England are complex. As illustrated in Figure 6, it is not true to say that the White British population – or any other ethnic group - has the best health indicators across the board.

Figure 6: Summary of key public health indicators by ethnic group



Source: Public Health England. Public Health Outcomes Framework: Health Equity Report. Focus on Ethnicity.

Furthermore, the contribution of different factors to the observed differences between ethnic groups vary depending on the particular health outcome of interest. Nevertheless, some minority ethnic groups do fare consistently badly, particularly those identifying as Gypsy and/or (Irish) Traveller, Roma, Bangladeshi, Pakistani and, to a lesser extent, Irish. Detailed evidence

reviews of explanations for these observed ethnic health inequalities undertaken for the Marmot Review and the Equality and Human Rights Commission Triennial Review conclude that it is the social and economic inequalities associated with ethnicity that are the major drivers of the large inequalities in health status observed.[4,115] An adaptation of these findings is shown in Box 1. This analysis is consistent with WHO's Commission on the Social Determinants of Health (CSDH) established in 2005, which identified health inequalities as 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.[181]

The major determinants of ill-health are largely the same across all ethnic groups. However, ethnicity is a salient social identifier in modern Britain, shaping people's networks of association and their social and economic opportunities. Further, minority ethnic identities continue, in many circumstances, to be stigmatised and subject to exclusionary forces. Therefore, without explicit consideration of ethnicity within health inequalities work, there is a risk of partial understanding of the social processes producing poor health outcomes and ineffective, or even harmful, intervention.[8]

Currently, there remain significant gaps in data and a lack of robust evidence on effective interventions across many areas; limitations that must urgently be addressed. However, at the same time, observed local variations in ethnic inequalities in both the determinants of health, and health outcomes, point to the importance of local-level action and the possibility of learning across areas to make progress towards greater equality. Importantly, however, these variations, and the slow progress in many areas, also indicate systemic obstacles. There is a need to acknowledge, understand and address these issues for sustained progress to be made. This will require collaborative action from all parts of the system, including meaningful engagement of minority ethnic communities.

Box 1. Summary of evidence relating to explanations for health inequalities between ethnic groups

Factor	Summary of available evidence
Socio-economic deprivation (access to health-promoting resources)	Most analysts agree that these make a substantial contribution to ethnic inequalities in health. There is evidence that morbidity and mortality within all ethnic groups is strongly patterned by socio-economic position.
Racism and discrimination	There is growing evidence that racism plays a role in the poorer physical and mental health of minority ethnic populations via direct personal experience of racist victimisation or discrimination and via the fear or expectation that racism may be encountered. The pervasive experience of racism in day-to-day life may also increase the likelihood of negative experiences and low satisfaction with health and other statutory services. Racism also impacts indirectly on health via exclusionary processes operating within education, employment and housing.
Residential location (access to health-promoting resources; exposure to health risks)	There is clear evidence that ethnic minority people reside disproportionately in areas of high deprivation with poor environmental conditions, with concomitant negative impacts on health. However, the aggregation of ethnic minority people may have some beneficial effects on health.
Access to preventive and curative health services	There is growing evidence of differentially poor access to primary and secondary preventive and curative healthcare that could help to reduce inequalities in the major causes of morbidity and mortality (eg uptake of cancer screening and access to smoking cessation services) among some minority ethnic groups. Individuals identifying as Gypsies and Irish

	Travellers experience significant barriers to both primary and secondary health care. Lower satisfaction with services among minority ethnic people than the White British majority has been widely documented.
Health-related practices	Evidence in some areas remains limited. There is great diversity within ethnic groups, as well as change over time and space, in health-related practices. However, at an aggregate level culturally informed beliefs, attitudes, preferences and associated behaviours contribute to some of the observed inequalities in health between ethnic groups. Patterns are varied for different health-related practices (eg smoking, alcohol consumption) across gender, generation and class, as well as ethnicity. Protective practices may be diminishing across generations and other practices, when transposed into different environments, can increase risk.
Migration effects	Migrants into the UK tend to be healthier than those who do not migrate, but this advantage wears off over time and across generations. A history of migration and ongoing transnational mobility can mean exposure to some particular health risks.
Genetic and biological factors	There is more genetic variation within than between ethnic groups. Genetic variation along ethnic lines arises because group classification frequently draws on visible difference or geographical ancestry and because marriage/partnering within ethnic groups is often encouraged. Some genetic traits do become more common amongst individuals identifying with particular ethnic groups. However, socially constructed ethnic groups are generally poor markers for genetic traits. We still know little about the role of genetic and environmental factors in producing some observed biological differences between ethnic groups. There is widespread consensus

	amongst geneticists and epidemiologists that genetic factors contribute only marginally to ethnic inequalities in health.

Practice examples

Practical examples in this document illustrate local action to reduce ethnic inequalities and improve lives of different ethnic communities.

City Talent Management (Bradford)

The Bradford Producer City Talent Management Programme run by Bradford Council has developed a set of activities to address local skills gaps and an ageing workforce in the local textiles industry. Working with a local further education college in Keighley and a group of local textiles employers, the council has facilitated the setting up of an employer-led textiles academy, to develop sewing skills in the local population. Bradford has targeted a specific group within the local population – Asian, largely Pakistani women – and works with a community-based women's centre which was already running local sewing classes, and the local Jobcentre Plus. Importantly, local textile employers are part of the board overseeing the development and running of the textile academy at Keighley College, and have helped design the course which provides elementary sewing machinist training. Some have contributed to the set-up costs of the academy and provision of training materials.

The ageing population across the local textiles industry is largely White, but with a local population in Keighley which is approximately 25% Asian, the Bradford council project team has worked with local employers to recognise one way of closing their skills gaps would be to draw on the ethnic diversity in the existing surrounding working-age population. Employers visit the college, which ensures that business owners meet students while they are studying, improving familiarity between employer and course attendee, which has had a positive impact on the recruitment process. More information can be found in the Poverty and ethnicity in the labour market report (2017).

The Mayor's Fund for London

The Mayor's Fund for London provides employment support, training and job brokerage for disadvantaged young people across the city. The En-route to sustainable employment programme involves direct links with the transport sector, one which struggles to recruit and progress both women and young people from BME backgrounds beyond entry-level work. Working with major local employers such as Transport for London, Stagecoach and Network Rail among others, Mayor's Fund runs a transport employer group through which employers help shape the project's developing solutions.

In these meetings the project team talks to employers about the importance of increasing workforce diversity. Part of the project involves running pre-employment courses with young people which can lead to work placement opportunities. Employers give them access to their internal jobs boards which means course participants can apply for jobs and apprenticeships they might have otherwise been unaware of. It also means that the project is tied to potential vacancies, improving the engagement of young people, and gives employers and participants the opportunity to meet.

Strengthening Families, Strengthening Communities (SFSC) Parenting Programme

The SFSC universal programme has been established by the Race Equality Foundation designed to promote protective factors which are associated with good parenting and better outcomes for children. It helps parents with children aged up to 18 years to think about how their actions and experiences may influence their parenting style.

SFSC has enjoyed success with parents from a number of backgrounds, including black and minority ethnic parents, teenaged parents, parents with learning disabilities and parents from marginalised communities, including those with experience of drugs, alcohol or violence.

Studies using data gathered from pre- and post-test questionnaires completed by parents have reported statistically significant change in parents' self-esteem, confidence in their parenting, relationships with children and child's self-esteem etc.

Action on health literacy– engaging South Asian men with diabetes (Stoke on Trent)

As part of a broader strategy to promote health literacy in Stoke-on-Trent, research was commissioned to assess health literacy levels among South Asian men in the local area. STOFHLA-UK scores (Shortened Test of Functional Health Literacy Assessment) suggested that more than half of the South Asian participants could not read, understand or interpret most health texts, particularly older Asian men. In response to this, pilot interventions were designed and implemented as part of the programme which included a peer mentoring scheme for South Asian men.

The hypothesis was that engagement with this target group could be improved by involving an interpreter or someone with an insider perspective of their culture. 2 peer mentors were recruited to facilitate one-to-one

sessions with the target group. A learning session, looking at improving communication skills, making sense of health information, navigating through the healthcare systems and improving ability to manage diabetes, aimed to facilitate peer learning and discussion of health literacy-related matters with South Asian men with diabetes to enable them to manage their condition better. Mentoring sessions were facilitated using ABC flash cards, which made use of symbols related to diabetes.

Qualitative feedback from the participants concerning the peer mentorship programme was positive. The programme helped improve their ability to understand health information, communicate with healthcare professionals and use health services effectively, and to improve their knowledge of diabetes. A guide for working with black and minority ethnic communities in Scotland living with long-term conditions is available from Diabetes UK Scotland.

Project Polska (Leicester)

'Me & My Health' is a targeted, 8 week educational programme for Eastern European migrants in Leicester, focusing on building up knowledge and behaviour skills, alongside with changing migrants exposure to health related risk factors and reducing their chances of obesity, cardiovascular and poor mental health conditions. The learning programme commissioned by Leicester City Council aims to develop a sustainable mechanism within the Polish and economic migrant communities, in which by nurturing the participants skills and train them as local 'health champions', they will in turn lead and spread the healthy messages to their networks. It will also help participants to develop knowledge about physical activity, healthy eating habits, and increase their skills to engage with local public health campaigns and services.

The feedback from participants was very positive. The programme improved their understanding and skills to lead healthier lives and facilitate conversations with peers. It has also increased their confidence levels to engage with local communities on lifestyle choices.

The African Caribbean Community Initiative (ACCI). The ACCI Counselling and Therapeutic Service

African Caribbean individuals within the mental health system often do not have access to psychological therapies. A service was established to rectify to provide a range of holistic and culturally appropriate interventions aimed at assisting members to come to terms with their mental health diagnosis and,

to provide a primary care service with the aim to promote psychological well-being and enable individuals to learn essential skills and knowledge in order to manage their distress independently.

In providing a holistic service a number of programmes have been developed and are continually reviewed to ensure that the programmes are relevant and meets the needs of the service users. More information can be found on: www.acci.org.uk/services/acci-counselling-therapeutic-service

Vitamin D - free universal distribution in East Lancashire

The Healthy Start vitamin programme only attracts a small proportion of beneficiaries even though far more people are entitled to claim free vitamins using this national scheme. To increase vitamin uptake, Lancashire County Council (LCC) offers a universal service in the east of the County where there is a high BME population – 12% of the population with a variation between the five districts ranging from 20% of the population in Pendle to 2% in Ribble Valley (Lancashire = 7.7%).

NICE guidelines define BME populations as an 'at risk' group for vitamin D deficiency so LCC order vitamin drops and tablets centrally and distribute them as a universal offer via the children's centres in East Lancashire. The aim of the universal offer is to increase the uptake of vitamin D amongst vulnerable groups by reducing the effects of stigmatisation for Healthy Start beneficiaries. As part pf the project, the ambition was to increase the uptake amongst healthy start beneficiaries as the figure is low nationally (1.4% breastfeeding and pregnant mums and <1% children).

Recommendation 4 and 5 of the NICE guidelines for increasing vitamin D use were the main drivers for the project but local evidence showed that a high concentration of BME communities live in East Lancashire and there was also a corresponding high rate of hospital admissions for 0-19 year olds for vitamin D deficiency in this area. The children's centres agreed to distribute the vitamins as a universal offer and these were ordered and paid for centrally by the public health team (as per recommendation 6 of the NICE guidelines). The children's centre management information system (CCMIS) was also adapted to monitor uptake by ethnicity for evaluation purposes.

Local evaluation revealed an increased awareness of vitamin D deficiency and associated issues amongst at risk groups. Service users provided a positive feedback including an increased awareness of importance of vitamin D among families. Feedback revealed that users felt more confident accessing other services offered at the children's centres. Cost effectiveness

would be challenging without linkage data to health records whilst community satisfaction is high.

Shape Up for Arabic women (Brighton and Hove)

Shape Up is a 10 week health improvement programme run according to NICE guidelines that provides nutritional advice and exercise to aid weight loss. The Shape Up Arabic programme is a female only group specifically aimed at Arabic speaking women living or working in the Brighton and Hove area. Shape Up Arabic has been adapted to meet the different cultural and language requirements of this ethnic group with the aim of improving their health by providing information that they may not be able to access elsewhere in the community.

The programme involved a 45 minute session on nutrition led by a Community Nutritionist, covering a different topic each week. This is then followed by a 45 minute exercise class which is run by an instructor from the council's Active for Life team. Shape Up Arabic had an additional element of working with an Arabic interpreter during the nutrition sessions and the exercise instructions have been simplified to accommodate the language differences. Shape Up Arabic is a female only group as the majority of Arabic speakers using the service were women and it also provided a safe and comfortable space for women to exercise in, taking into consideration any religious needs of Muslim Arabic speakers.

When recruiting participants to Shape Up Arabic, local BME groups were contacted to encourage attendees to sign up to the programmes as well as encouraging promotion through word of mouth. A particularly helpful source of recruitment was through Sussex Interpreting Services who were able to promote the programme to its service users through their interpreters as well as using their volunteer linguists. Volunteer linguists work in the city promoting health and wellbeing services to those who would find it difficult to access them without their assistance.

Shape Up Arabic participants were asked to complete a questionnaire at the start and end of the 10 week programme to establish any improvements in health as well as obtaining feedback on their experiences while participating in the group. Due to the language differences a volunteer Arabic speaker involved with the programme undertook some evaluation telephone calls with the women involved in the group. All respondents agreed that the programme had led to an increase in their knowledge about healthy lifestyles, and physical activity. At least half reported that they had experienced improved fitness, sleeping patterns and confidence since attending the programme.

Based on the success of Shape Up Arabic, the same format may be adapted so that similar programmes can be offered to other ethnic groups in the Brighton and Hove area.

Mini case book (Sheffield Hallam University, Centre for Health and Social Research)

The book published a helpful handbook of examples which reference local services and initiatives aimed at improving health for minority ethnic groups. The brief examples in the case book aim to inform and inspire the reader to take action on this agenda, with examples linked to different stages of the commissioning cycle. The examples illustrate real stories of how using different kinds of evidence on ethnic diversity and inequality can help to commission better services for multi-ethnic populations. Resource can be accessed here: www.eeic.org.uk

Appendix: Methodology

Rapid evidence assessment

A pragmatic rapid evidence assessment approach was used, following Cabinet Office guidance.[182] Search and inclusion criteria was established and agreed upon, detailing search words and phrases to be used.

Online journals, papers, and reports, including social science, community health, epidemiological, medical and psychology journals were identified and accessed through Google, Google Scholar, and UCL Online Library (providing access to a number of databases). Relevant evidence was electronically imported into a Reference Manager file (Endnote), along with abstracts/summaries where possible. Abstracts and summaries were reviewed against agreed criteria for inclusion, including relevance to the research question, date of publication, language of publication, contextual relevance, and study design and quality. All relevant evidence was selected for in depth review and extraction of information. Desk based research also included a review of relevant grey material through internet searches.

IHE have also sought grey material including expert papers, policy analysis, journals and other data from key representatives within health, ethnicity and community fields. Principles used to assess the quality of grey literature, included: Institutional origins; Authority; Peer reviewed; and Accuracy.

The following search terms were used

Ethnic or Ethnicity + Health or Cardio Vascular disease (or Coronary Heart Disease) or diabetes or cancer or obesity or lung + drivers or causes or social determinants.

Pakistani or Bangladeshi or Gypsy or Irish or Indian or Black Caribbean or Black African + Health or Cardio vascular disease or diabetes or cancer or obesity or lung + drivers or causes or social determinants.

Other search terms were used focusing on the main social determinants, causes or drivers for specific health outcomes, including:

Pakistani or Bangladeshi or Gypsy or Irish or Indian or Black Caribbean or Black African + smoking or diet + culture

Pakistani or Bangladeshi or Gypsy or Irish or Indian or Black Caribbean or Black African + access + health care

Pakistani or Bangladeshi or Gypsy or Irish or Indian or Black Caribbean or Black African + genetics + genes + obesity or infant mortality or cancer

Where possible the literature search was limited to data published in the last 10 years, unless there was a significant lack of evidence within this timescale, or where systematic reviews of evidence published in the last 10 years utilised evidence published prior to this time frame.

For the most part, publications were selected that used UK data. A fuller systematic review, with wider search terms, could potentially add nuance to the findings presented in this report, but was out of scope for this commission.

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