THE AFIYA TRUST

Race on the Agenda

A response from race equality perspectives to the public health white paper, *Healthy Lives, Healthy People*

The Afiya Trust and ROTA

Who we are

The Afiya Trust is a national second tier organisation with an England-wide remit to reduce inequalities in health and social care provision for racialised communities. Over the years, we have focused on mental health, cancer, stroke and other health issues, on service user and carer concerns, and on promoting the public health and wellbeing of England's diverse communities. We host several networks that bring together users of health and social care services, carers, professionals, academics and community members who are concerned about health and social care provision and want to see positive changes. Through our networks we have access to over 1000 individuals and organisations, and their opinions and insights inform our work and policy.

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ROTA is a research and social policy organisation focusing on race equality in health, education and criminal justice. We are a membership organisation. While we work nationally, for historical and demographic reasons, most of our work is London focused. Health has been one of our policy priorities for over twenty years as it continues to be a main concern of our membership and is consistently identified as an issue to be addressed through our varied research projects. We host MiNet, a regional network of 3000 organisations working with minority ethnic communities in London. Our views on the public health White Paper are based on evidence gathered through our bi-annual consultations with London's voluntary sector working with Black, Asian and Minority Ethnic (BAME) communities and through our recent research projects.

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Overview of our response

We welcome the Coalition Government's strategy for public health, *Healthy Lives, Healthy People*. We particularly welcome the attention paid to taking a life course approach to public health, the focus on social determinants of health inequalities, and the linkages made between health, wellbeing and mental health. The idea that local communities have a key role to play in determining the agenda for and ways of promoting public health is in line with the argument we have consistently made that local knowledge needs to be at the heart of policy development and practice.

Our response to the public health strategy is based on this general agreement with the Government's overall vision for public health. However, as organisations working with racialised groups, with an in-depth understanding of the problems and potentials of these groups, we feel that there needs to be far more clarity about several key concepts, assumptions and proposals within the White Paper. Our response, firstly, engages with some of these key concepts: health inequalities, individual responsibility and behaviours, local leadership and the idea of localism. Secondly, we examine the contribution of the voluntary sector organisations working with minority ethnic communities and the factors affecting their engagement with 'the big society'. We then make some recommendations on the specific proposals within the White Paper.

Our vision for public health

We welcome the Government's focus on fairness. However, we believe that, in an unequal society, public health protection and promotion has to go beyond 'fairness' and have deeper moral connections to broader questions of social justice, human rights and systematic disadvantage.

Regardless of the rhetoric of 'failed' multiculturalism, the 'public' in contemporary UK is comprised of multi-cultural, multi-faith and multi-lingual groups with multiple and intersecting identities, needs, and aspirations. Any strategy for public health needs to recognise this multiplicity and intersectionality and seek to set up structures and initiatives that pay attention to the diversity/difference between and within communities and to their shared common experiences.

Public health and inequalities

It is encouraging to see that the White Paper makes a clear commitment to taking into account the social determinants of health inequalities as reported in the Marmot Review. However, it is disappointing that the White Paper only makes a passing acknowledgement of the effect of inequalities based on protected equality characteristics.

Despite the fact that health inequalities have featured in policy discussions of public health since 1997, we continue to see unacceptable disparities for people from different minority

ethnic communities: in health outcomes, in access to and experiences of health and social care services, and in opportunities for influencing health policies. The publication *Achieving Equalities in Health and Social Care* has examined these disparities in detail and proposed recommendations for reducing inequalities (Afiya Trust 2010). Others have argued that ethnic inequalities are either seen as exceptional or exotic or as a reflection of class inequalities that can be addressed through a focus on socioeconomic inequalities (for example, Nazroo 2009).

To take one example, the White Paper discusses disparities in life expectancy in the context of socioeconomic deprivation as reported by the Marmot Review. Other studies have examined disparities in life expectancy in the context of ethnicity, with Bangladeshi, Pakistani, Other Black, Mixed White and Black Caribbean Groups, and Indian women having the lowest life expectancy, and Black African, White, Mixed White and Asian, White Irish, Black Caribbean, and Other Mixed Groups having lower than the overall life expectancy figures (Rees and Wohland 2008).

The Office of National Statistics figures show that many minority ethnic groups live in poorer, deprived areas and experience disparities in employment, education and access to health care. There are also levels of variance within groups (for example, 'South Asian') according to age, ability, gender, generation and migration patterns. Existing evidence clearly indicates that both physical and mental health are affected by people's experience of racist harassment and discrimination and the fear and expectation of racism (Williams 2008; Bhui et al 2005; Karlsen and Nazroo 2002). What this shows is that there is a need to understand life expectancy and other markers of public health in a much broader and interconnected way and to consider a combination of factors that are detrimental to people's health and wellbeing.

Based on evidence of associations between the perceptions and experience of racism and health conditions like hypertension, anxiety, depression and stress-related issues, it has been argued that "considering racism as causative is an important step in developing the research agenda and response from health services" (McKenzie 2003). If a good public health policy is one that is based on nurturing environments of good health and wellbeing, countering racism, harassment and discrimination becomes a key task for public health, as is the removal of 'ethnic penalties' that affect the health outcomes of specific groups of people. The relative poverty of many racialised groups and the broader inequalities faced by marginalised groups are very well evidenced and so often repeated that they should be at the heart of any public health programme that strives to base itself on 'fairness'.

Localism, local leadership and involvement

As organisations working with other small, community based organisations and groups, we have always argued that the knowledge of 'what works' and the skills to make it happen are within communities and people at the local level. In that sense, it is encouraging to see that the Government has made a clear commitment to local leadership and decision making, and backed this up with a funding strategy that, in theory, will drive resources to where it is most needed.

While we understand community as a largely organising force which may share cultures, values, languages, histories and geography, our work has made us acutely aware that it is in no way a uniform or homogenised group. Localism is to be encouraged, but there are two important aspects that we need to be vigilant about:

a) The tendency to romanticise the 'local' or 'community' as a cohesive whole, which masks the hierarchies, attitudes, inequalities and power structures within communities and local areas
b) The tendency to see the 'local' as somehow removed and unaffected by national or transnational contexts and in isolation from a global/national political economy (Khan 2007; Mohan and Stokke 2000)

Despite its constant presence in recent public policy discussions, what constitutes the 'local' remains unclear. In terms of responsibility for taking the government's public health policies, would the local constitute borough, multi-borough, local authority area, neighbourhood or regions?

While there is a general acceptance that people and communities should be at the heart of policy development, the opportunities for participation or leadership in influencing policy and in local democratic structures and processes for people from racialised communities have remained minimal (ROTA 2007, Voice4Change 2007, Kalathil 2009). This situation needs changing if people from racialised communities are to play a realistic role in local leadership.

To counter these dangers, there needs to be robust democratic accountability and transparency systems in place to ensure that those less powerful or marginalised within communities have an equal input into making decisions and reaping the benefits of public health programmes. Given the persistence of acute inequalities, race equality is an exceptional area where central government should continue to play a strong leadership role, including central regulation and direction to set up local accountability mechanisms.

Individual responsibility and 'behaviour'

We agree with the Government that individuals have personal responsibilities in enhancing their health and wellbeing. However, individual responsibility needs to be defined within the contexts in which individuals live, the real choices and extent of control they have over their life circumstances.

We are not convinced that the White Paper has achieved a balance between the amount of state input and support and individual responsibility. 'Nudging' vulnerable people into a healthy life style will have limited effect when they are surrounded by debilitating social, environmental and economic factors, including racism and discrimination, limited access to information and real choices, decreasing financial capability due to jobs and benefit cuts, cuts to many existing services, and market forces like aggressive advertising.

Focusing on behaviours has an inherent danger of essentialising individual behaviours and, by extension, behaviours of the communities to which these individuals belong, creating

stereotypes. Behaviours need to be addressed within the context of choice, rights and capability of individuals and communities.

Public health outcomes framework

It is well documented that people from racialised groups face inequalities in each of the five domains outlined in the public health outcomes framework. The indicators in each of these domains are all relevant in measuring the progress of public health and wellbeing. However, our concern is that there is not enough direction from the centre to ensure that local data collection and analysis is transparent and suitable to the needs of local communities, including collection of robust data for all communities. Unless, as argued above, all communities have an influential role to play in local policy development, it will be difficult to ensure that public health outcomes that matter to them are measured systematically.

A general approach to measuring outcomes will fail to show that public health initiatives are reaching everyone, especially those who are most disadvantaged. A case in point is black men with disabilities and in employment. Evidence shows that African men's employment rates remain lower than average and that the proportion of black Caribbean and those described as 'Other Black' in work are actually falling (Sainsbury Centre for Mental Health 2008). Black or Black British people aged 16 to 24 years old have the highest rates of unemployment at over 48%, an increase of nearly 12.8% since the start of the recession (IPPR 2010). At the same time, these are also communities who are overrepresented within mental health services, under compulsory treatment (Care Quality Commission 2010). It would be entirely possible to show that initiatives in a given local area have been successful in increasing the number of people with mental health problems or disabilities in employment, without these initiatives having any impact on young black men diagnosed with schizophrenia.

We propose that there should be regular equality audits of public health initiatives on all characteristics protected by the Equality Act 2010 and that the specific barriers and issues faced by different communities should be taken into account while thinking about public health outcomes.

Public health in 'the big society'

We have argued, in the context of our response to the NHS White Paper, that marginalised and minority ethnic community and voluntary sector organisations have been 'doing the big society' for a very long time, despite the fact that they have been consistently under-resourced and over-stretched, an argument supported by evidence (Nea and Cox 2008, Perry and El-Hassan 2008, Chouhan and Lusane 2004). These organisations have a unique role to play in addressing health inequalities by:

- Bridging the gap between communities and generic services
- Providing services to meet the needs that mainstream providers are either unaware of or do not have the expertise to address

- Empowering communities and supporting their engagement in decision making and leadership
- Informing policy development
- Tackling the wider socio-economic determinants of health
- Tackling discrimination and disadvantage
- Engaging isolated communities and strengthening cohesion

In the current climate of austerity and cuts in public spending, it is imperative that these community organisations are fully resourced and supported if we are to continue this work. A coalition of organisations, including the Afiya Trust, working with racialised communities, recently argued: "Achieving economic justice, race equality and social inclusion is not just critical for forging the 'new' inter-cultural, inter-racial Britain. It is an economic and moral necessity for the nation as a whole" (Equanomics et.al., 2010). We hope that the government's pledge for local leadership and fairness will mean more support for this sector.

Recommendations

The proposals in the White Paper are read against our response to the conceptual positions as outlined above. Our fundamental concern is that any public health strategy should be based on a moral and political commitment to social justice and human rights for racialised groups. The following recommendations are made to help clarify how this can be achieved within the proposals put forth by the Government.

1) **On tackling race inequalities:**

- There needs to be a firm acknowledgement of the interconnectedness of people's material and social circumstances, including everyday experiences of discrimination, racism and social exclusion
- The strategy needs a clearer articulation of how these would be addressed in the new structures and procedures proposed in the White Paper
- Specific outcome measures should be set in place to assess the impact of local initiatives on racialised communities

2) **On democratic accountability:**

- There has to be a firmer steer from the centre to ensure that all programmes and strategies around public health comply with the Equality Act 2010
- National minimum standards should be set (by Public Health England) for human rights and race equality against which local authorities should be assessed
- Equality impact assessments should be carried out and results published

3) **Public Health England:**

- There needs to be a specific task focus within Public Health England (PHE) on race equality, with representation at board and management levels

- An advisory board should be established to review the equality impact of PHE activities
- PHE is tasked with establishing national minimum standards for race equality in public health programmes

4) **Health and wellbeing boards:**

- As above, there needs to be representation from racialised groups at board levels and a dedicated advisory group on minority ethnic health and wellbeing
- Establish local health equality targets in partnership with local organisations and the voluntary sector

5) **Health premium:**

- An inclusive local partnership needs to be established to monitor local public health developments. Progress should be assessed against targets, including race equality, set by this partnership
- Where no progress has been made, the reasons for this needs to be assessed before withdrawing resources

6) **Public health evidence:**

- There needs to be investment in studying the impact of racism as a social determinant of health inequalities and in developing ways of countering this
- There needs to be systematic collation of evidence on public health outcomes for various communities through periodic health equality audits. The systems of collecting this evidence should be set up in partnership with community/academic organisations with skills in robust research
- Evidence should be based on long term outcome measures specifically suited to the needs of communities. This should include social and wellbeing outcomes that go beyond clinical evidence
- Encourage the evaluation of non-clinical interventions that reduce health inequalities and recognition of these findings as 'evidence'
- Public health evidence using insights from behavioural sciences need to be firmly placed within the multidimensional contexts of individuals' and communities' everyday lives

7) **Role of GPs in public health:**

- GPs should be supported through cross-partner training to understand and acknowledge the needs of specific groups of people and deliver public health services accordingly
- Monitoring health outcomes by ethnicity should be promoted and developed at primary care level

8) **Race equality in public health campaigns:**

- Local authorities should be directed to forego 'one size fits all' programmes and develop social marketing campaigns in partnership with voluntary sector and community organisations
- Campaigns should reflect the diverse range of needs within communities and not assume homogeneity
- All public health and social marketing campaigns need to undergo equality impact assessment
- Race equality should be part of the brief for commissioning social marketing campaigns

9) **Funding:**

- In line with the 'big society' ideal, community organisations should be resourced on a long term basis to support local work on public health
- Resource allocation for social marketing campaigns should reflect the 'equal but different' nature of our diverse communities
- Third sector organisations working with racialised communities should be resourced and commissioned to develop social marketing campaigns
- A periodic audit of how and where money is spent needs to happen to ensure that value for communities is reflected in value for money considerations

Signatories to this response

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