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Race on the Agenda

Response to 'Healthy lives, healthy people: Our strategy for public health in England'

Race on the Agenda, March 2011

1. Executive summary of recommendations

1. In order to achieve its vision of a fair society, Government must base all policies and subsequent action on the concept of substantive equality.

2. Government must ensure that the aims of the Public Health White Paper are consistent with all other areas of policy-making.

3. The Public Health Outcomes Framework must be based on the principle of substantive equality.

4. The Health Premium must be ring-fenced to ensure it is targeted at those facing the most acute health inequalities.

5. The Health Premium must recognise the work done by health authorities based in challenging areas where health inequalities are significant.

6. Additional support must be provided to health authorities struggling to address health inequalities.

7. The BAME voluntary sector must be engaged in the design and delivery of public health initiatives.

8. Support must be available to enable GP consortia to commission effectively and in a way that meets the diverse health needs of local populations.

9. Work aimed at ensuring commissioning processes that are inclusive must be built upon and rolled out.

10. It must be mandatory for commissioners of public health services to commission a portion of their services from BAME voluntary organisations.

11. Small grants programmes must be maintained in local areas to support the important work of small BAME and other voluntary organisations that may not have the capacity or desire to engage in commissioning.

12. There is a need for greater clarity about how Directors of Public Health will be expected to fulfil their responsibilities in relation to equality and health inequalities.

13. Gaps in evidence about the health inequalities faced by BAME and other groups protected under Equality Act 2010 must be addressed as a matter of priority.

14. There is a need to make effective use of the wealth of knowledge and evidence about health inequalities held by the BAME and other equality voluntary sectors.

2. Methodology for this response

ROTA is a research and social policy organisation focused on issues impacting on Black, Asian and minority ethnic (BAME) communities. We host four networks with a combined membership of over 3,500 organisations and individuals. Health has been one of our policy priorities for over twenty years as it has consistently been one of the main concerns identified through our networks and research over this period.

This response is based on evidence gathered through our bi-annual consultation with London's BAME voluntary and community sector, which ensures we remain abreast of ongoing and emerging inequalities faced by BAME communities in relation to health, education and criminal justice. During our bi-annual consultation we contact BAME organisations via email, telephone, outreach interviews and focus groups over a four month period.

Additionally, this response is based on evidence from:

- MiNet's ongoing work on the impact of the recession on London's BAME communities and voluntary sector. MiNet is due to launch its latest report on the recession in Summer 2011[i].
- ROTA's work on the Mayor of London's Health Inequalities Strategy[ii].
- A consultation event held by ROTA and BEAM-EM in 2009 about mental health and BAME communities[iii].
- Our Female Voice in Violence project, which is exploring the impact of serious youth and gang violence on women and girls[iv].

3. ROTA's comments the White Paper

ROTA welcomes the White Paper's emphasis on health inequalities, preventatives services, and on the wider socio-economic determinants of health.

We see weaknesses in the lack of detail. We believe government will have more success in meeting the aims of this Paper if it is based more firmly on the principle of substantive equality. In this response, we will describe this principle and make recommendations as to how the Paper can be developed further in order to ensure it adequately meets its ambitious aims of addressing health inequalities.

We provide commentary on the following aspects of the Paper:

- Health inequalities
- The Public Health Outcomes Framework

- Health premium
- Community empowerment and the voluntary and community sector
- Intervening effectively
- GP consortia
- Directors of Public Health
- Public Health Evidence

In addition to this response, ROTA has also co-produced a response to 'Healthy Lives, Healthy Places' with the Afiya Trust[v].

3.1 Health inequalities

We are pleased that the Paper recognises the links between health inequalities and socio-economic disadvantage. We are also pleased with its basis on Marmot's principle of the 'social gradient', which, if considered adequately in implementation plans, would ensure those facing the greatest disadvantages receive the most attention. We are concerned, however, with the lack of clarity in the Paper about the links between race inequality and health, which has been acknowledged by Marmot.

We are pleased the Paper acknowledges that different approaches are required for different groups of people in point 2.24:

"...the Government will consider different approaches for different groups of the population, taking account of the significant barriers that some people face... We should also recognise that some individuals may need more support because they face particular barriers. We need to use different approaches for different people..."

In relation to BAME communities, the White Paper, at various points, mentions 'particular barriers'. For example, it mentions the high infant mortality rates faced by Irish Travellers. But there is not enough in the Paper to support the type of targeted action required to adequately respond to such inequalities. Our point here relates to direct health inequalities such as infant mortality, but also their wider socio-economic determinants including education, employment, criminal justice, housing, where BAME communities face a range of acute and particular inequalities.

In order to ensure that "fairness" is achieved, it is essential that the concept and language of substantive equality, rather than formal equality, is incorporated into this Paper and underpins any subsequent action. Formal equality, which treats everyone equally, even in unequal situations, risks exacerbating inequality. Substantive equality, on the other hand, recognises that entitlements, opportunities and access are not equally distributed throughout societies. Substantive equality acknowledges that where policy is tailored to the majority group, other people with different needs and circumstances may not be considered. It recognises that different groups may need to be treated differently and encourages positive action to correct situational imbalances and ensure equality of outcomes.

We are concerned by the apparent conflation of race inequality and socio-economic disadvantage. It is true that certain BAME groups are significantly over-represented among those who are socio-economically disadvantaged, and this has a bearing on health and wellbeing. However, race still

has a very strong influence over opportunities, experience and outcomes, including in relation to health. There is much evidence[vi] that, even when socio-economic factors are taken into consideration – such as employment status and family structure – there are still unexplained differences in health and related outcomes across ethnic groups. Policy focused on socio-economic status alone, therefore, is unlikely to adequately ensure "fairness" for BAME communities.

We welcome the Paper's acknowledgement of the wider socio-economic determinants of health. Much of the Paper considers how Government's initiatives in its other areas of responsibility – such as employment, education and poverty – will help meet the Paper's aims. However, there is an insufficient response by Government in these other areas to inequality. In many areas reforms at best ignore inequality, and at worst risk exacerbating inequality. Our recent response to the White Paper, The Importance of Teaching, highlights a range of concerns around risks its proposed reforms will exacerbate inequality in education – a critical determinant of health and well-being[vii]. Our response to Government's draft child poverty strategy[viii] similarly highlighted how it would fail to adequately tackle child poverty within BAME communities[ix].

Recommendations

1. In order to achieve its vision of a fair society, Government must base all policies and subsequent action on the concept of substantive equality.

We are pleased funding for public health will be ring-fenced. It is unclear as to whether the total spending will be adequate and whether the workforce will be adequate, however.

We are deeply concerned that the recession and the public spending cuts, which are disproportionately impacting on BAME communities[x] and those facing socio-economic disadvantage, will prevent government from meeting this Paper's aim of addressing health inequality. The interim findings from our ongoing work with MiNet[xi] on the impact of the recession and public spending cut on BAME communities has highlighted its detrimental impact on health. This is already being exacerbated by public spending cuts.

We are pleased by the recognition given the Paper to the importance of Early Years. Early Years support is crucial in addressing health and related inequalities. However, this acknowledgment goes alongside the dismantling of Early Years support in many local areas as a result of the cuts in spending, contrary to the recommendations made by both Frank Field MP and Graham Allen MP in their recent reviews[xii].

Recommendations

2. To ensure that the aims of the Public Health White Paper are consistent with all other areas of government policy-making.

3.2 The Public Health Outcomes Framework

It is critical to the success of the Paper's aim of addressing health inequalities that equality considerations are central to each of the five 'domains' that comprise the Public Health Outcomes Framework. It is well documented by the Department of Health and others that BAME people face

inequalities in relation to each of these 'domains'. Public health initiatives should be focused on, and success should be monitored in terms of, addressing inequalities by socio-economic group, but also, for reasons argued above, by characteristics protected under the Equality Act 2010. Building the Public Health Outcomes Framework in this way would ensure work stemming from the Paper responds to Marmot's 'social gradient' principle.

Recommendations

3. To base the Public Health Outcomes Framework on the principle of substantive equality.

3.3 Health premium

We welcome the proposed Health Premium to reward local authorities for progress made against elements of the Public Health Outcomes Framework. We expect the Health Premium to be ring-fenced, even within the public health budget, to ensure it disproportionately benefits those facing the most acute health inequalities in keeping with Marmot's concept of the 'social gradient'.

Local authorities working in areas with complex and significant health inequalities will be disadvantaged if the Public Health Outcomes Framework does not have equality considerations at the heart of each of the five domains. Without an approach that adequately acknowledges local authorities working in challenging circumstances, there is a risk that the Health Premium will in essence financially punish authorities, thereby paradoxically exacerbating health inequalities.

In areas with high levels of health inequalities where local authorities are poorly performing, rather than financially punishing them, extra support should be made available from Public Health England to enable improvement. Financially penalising authorities that are failing to address health inequalities risks exacerbating these inequalities.

Recommendations

4. To ring-fence the Health Premium and ensure it is targeted at those facing the most acute health inequalities.

5. To ensure the Health Premium appropriately recognises the work done by health authorities working in challenging circumstances with prevalent health inequalities.

6. To provide additional support to health authorities struggling to address health inequalities.

3.4 Community empowerment and the voluntary and community sector

We welcome the rhetoric around communities taking control of their health and wellbeing. However, there is a need for greater detail on how this will be achieved.

We have concerns about the lack of clarity around responsibility and the implications that this may have for people who are vulnerable and face inequalities and, as a result, have less control over their circumstances and their responses to it. Attaching conditions to support for people in difficult circumstances over which they have limited control must be avoided.

The considerable investment over recent years aimed at giving local communities more influence has not adequately benefited BAME communities who remain excluded as evidenced by much of ROTA's work, for example:

- ROTA's Building Bridges and Female Voices in Violence Projects on serious group offending have reported the under-engagement of BAME organisations in the development of relevant policy and practice.
- ROTA's 2007 report[xiii] on the previous Mayor's Health Inequalities Strategy, and 2009 consultation on mental health[xiv] both found that BAME communities were not fully engaged in the development of health policies and services locally and regionally.

Others[xv] have evidenced the under-representation of BAME communities in local democratic structures and processes. Additionally, our work indicates patchy engagement of BAME organisations in Local Involvement Networks (LINks) across London boroughs. The barriers faced by BAME communities in engaging in decision-making should be acknowledged and specific actions taken under the Paper to address them.

We are very pleased by the recognition of the key role the voluntary sector play in working to address health inequalities. This is true not only of larger voluntary organisations that are delivering public services, but also small community-based organisations. As well documented by ROTA[xvi] and others[xvii], BAME organisations have a unique and vital role to play in addressing the health inequalities by:

- Bridging the gap between BAME communities and generic services
- Providing services to meet needs that mainstream providers are either unaware of or do not have the expertise to address
- Empowering BAME communities and supporting their engagement in decision-making
- Representing BAME communities and informing policy development
- Tackling the wider socio-economic determinants of health
- Advocating on behalf of people suffering discrimination
- Engaging otherwise isolated communities and acting as bridges to other communities, and therefore in strengthening cohesion.

The findings from our Female Voice in Violence project, for example, highlighted the critical role of BAME organisations in addressing a particular health inequality. Female Voice in Violence has found that the majority of girls and young women that have been victimised as a result of their gang association are unlikely to take up generic health services and are sceptical of the independence of Haven and Rape Crisis Centres from the state, questioning their ability to maintain confidentiality and are of the opinion that, as their experiences are gang-related, they will be reported to the police. There is a vital role for specialist BAME women's organisations to play here in both bringing such young women to generic services, and in supporting the services to develop the expertise needed to appropriately respond to the complex needs of these young women.

A national study[xviii] found that a significant proportion of BAME organisations are already doing work on health (14% of BAME organisations provide health services, including mental health. Other main services provided include: advocacy and advice on, for example, immigration, legal

issues, equal opportunities and anti-racism (17%); welfare and income support services (11%); housing and accommodation services (11%); and school-related education (11%)). There is huge potential for government to achieve its aims to address health inequality by working more supportively with the BAME voluntary sector.

Additionally, there is growing evidence of the economic benefits of community-based services that work with disadvantaged or vulnerable communities. For example:

- A 2007 evaluation[xix] of the Evolve Project, which is based at a women's organisation and supports female offenders, compared its cost of support for 250 women a year at £222,000 to the cost of keeping one women in custody at £77,000 per year.
- A 2006 study[xx] published by the Women's Resource Centre proved women's organisations represent a return on funding of 385%.
- A 2008 study[xxi] by the Joseph Rowntree Foundation recommended that local authorities increasingly move towards low-cost but high impact community projects in addressing poverty and reducing public spending.

Despite its unique value and economic potential, the BAME voluntary sector is under-valued and under-supported. The general picture presented by existing regional and national research is that it remains relatively fragile, suffering from a substantial lack of capacity due to severe under-investment and access to adequate infrastructure support. Many organisations struggle to grow and develop and even to sustain their operations. They operate in an increasingly challenging environment. They are being disproportionately impacted on by the recession[xxii], the public spending cuts, and the move from grant making to commissioning, which is favouring large and more resilient mainstream voluntary organisations.

Government, through its work on Public Health and other means, should explicitly recognise the unique and vital role BAME organisations play in addressing inequality and strengthening cohesion. The Department of Health and its partners should develop initiatives to ensure greater support and sustainable funding for the BAME sector by, for example, raising awareness about the BAME voluntary sector among local statutory partners and encouraging them to develop inclusive commissioning and procurement practices.

Local Health and Wellbeing Boards should be expected to include representation from the local voluntary and community sector, in particular organisations that work with communities facing the greatest inequalities.

Recommendations

7. To ensure the BAME voluntary sector is engaged in the design and delivery of public health initiatives.

3.4 Intervening effectively

We see the benefit of the Paper's emphasis on freeing up local government and local communities to decide how best to improve the health and wellbeing of their citizens, deciding what actions to take locally with the NHS and other key partners, without undue interference from the centre. However, we are concerned with the lack of emphasis in the Paper on race equality and the duties

public bodies should adhere to from the Equality Act 2010. Race equality is an exceptional area where central government should continue to play a strong leadership role, including central regulation, given the acute inequalities that persist and which are well documented. There are also significant economic arguments to Government enabling disadvantaged BAME groups to fulfil their economic potential through addressing health inequalities[xxiii]. Additionally, equality considerations should be central to local accountability mechanisms.

3.5 GP consortia

It could take years for GPs to develop the skills to effectively commission preventative community-based services, particularly those from organisations that are best placed to work with communities facing the greatest health inequalities that mainstream services find 'hard-to-reach'. We are pleased with the commitment in the Paper that: "The Government will encourage partnership working and opportunities for providers from all sectors to offer relevant services". As alluded to earlier, many of the barriers BAME communities face in accessing health services could in part be addressed through commissioning BAME organisations to engage in the delivery of health services. However, ROTA and others[xxiv] have found BAME organisations face significant barriers in engaging in commissioning. While some good work has been done to address these barriers, it is patchy[xxv]. There is a need for a coordinated and concentrated effort to ensure recommendations from existing work are taken up by commissioners.

The Department of Health must make it mandatory for commissioners of public health services to commission a portion of their services from BAME voluntary organisations in order to meet this Paper's aim of addressing health inequalities.

The Department of Health should allow for a programme of learning about the diverse voluntary sector for health commissioners. Such work could build on the 2007/08 work by the Housing Associations' Charitable Trust (HACT) which worked with commissioners and refugee and migrant community organisations and produced a guide.[xxvi]

The Department of Health must encourage local and regional statutory partners to maintain grants programmes to support the key role identified within this Paper for smaller voluntary organisations, which provide valuable services that are not necessarily of a scale suitable for commissioning.

Guidance should be available to GP consortia on how to identify and work effectively with BAME organisations and other organisations working with groups that face health inequalities.

Recommendations

8. To ensure that support is available to enable GP consortia to commission effectively and in a way that meets the diverse health needs of local populations.

9. To build on and roll out work aimed at ensuring commissioning processes that are inclusive.

10. To make it mandatory for commissioners of public health services to commission a portion of their services from BAME voluntary organisations.

11. To ensure small grants programmes are maintained in local areas to support the

important work of small BAME and other voluntary organisations that may not have the capacity or desire to engage in commissioning.

3.6 Directors of Public Health

We are pleased that one of the five key areas of responsibility for Directors of Public Health relate to: "developing an approach to improving health and wellbeing locally, including promoting equalities and tackling health inequalities". There is a need for greater clarity about how Directors of Public Health will be expected to fulfil this responsibility and what support will be available to them from Public Health England in relation to this.

Recommendations

12. To ensure greater clarity about how Directors of Public Health will be expected to fulfil their responsibilities in relation to equality and health inequalities.

3.7 Public Health Evidence

There are considerable gaps in evidence about the health inequalities faced by BAME communities, which were highlighted recently in EHRC's triennial review[xxvii]. The gaps identified in this Review should be addressed as a matter of priority by the Department of Health.

The BAME sector holds a wealth of knowledge and evidence about emerging health inequalities and those that are under-researched. The value and potential of this evidence and knowledge should be recognised and systems put in place to harness and use it effectively.

Recommendations

13. To ensure gaps in evidence about the health inequalities faced by BAME and other groups protected under Equality Act 2010 are addressed as a matter of priority.

14. To make effective use of the wealth of knowledge and evidence about health inequalities held by the BAME and other equality voluntary sectors.

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[i] MiNet (2009) *The Economic Downturn and the Black, Asian and minority ethnic (BAME) third sector*. London: ROTA. The report from Phase 2 of MiNet's work on the recession is due to be launched in Summer 2011.
[ii] See for example' ROTA (2010) *Response to the Mayor of London's draft Health Inequalities Strategy'* which is available at http://www.rota.org.uk/pages/Reports.aspx.
[iii] Feedback from this event is summarised in ROTA (2009) Response to '*New Horizons: Towards a shared vision for mental health*. Available at http://www.rota.org.uk/Downloads/New%20Horizons%20submitted%20F.pdf.
[iv] Firmin, C. (2011) *This is it. This is my life. Female Voice in Violence Final Report on the impact of serious youth violence and criminal gangs on women and girls across the country.* ROTA.
[v] To find out more about the Afiya Trust and our partnership please visit http://www.afiya-trust.org/.
[vi] For examples of evidence see 'Platt, L., Institute for Social and Economic Research, University of Essex (2009) *Ethnicity and child poverty, Research Report No 576*. Department for Work and Pensions'.
[vii] For example see 'ROTA (2010) *Briefing on the Importance of Teaching',* available at http://www.rota.org.uk//Downloads/Briefing%20the%20importance%20of%20teaching.pdf, which considers how educational reforms risk exacerbating educational inequalities faced by certain BAME communities.
[viii] Department for Work and Pensions (December 2010) *Tackling Child Poverty and Improving Life Chances: Consulting on a New Approach.*
[ix] ROTA (2011) *ROTA's response to 'Tackling Child Poverty and Improving Life Chances: Consulting on a New Approach'.* Available at http://www.rota.org.uk/Downloads/Response%20to%20child%20poverty%20strategy.pdf.
[x] For evidence and analysis that suggests BAME communities are being disproportionately affected, see for example 'EHRC & GEO (2009) *Monitoring update on the impact of the recession on various demographic groups*'; 'MiNet (2009) *The Economic Downturn and the Black, Asian and minority ethnic (BAME) third sector*. London: ROTA.'; and 'Trust for London (2010) *London's Poverty Profile'*.
[xi] MiNet (2009) *The Economic Downturn and the Black, Asian and minority ethnic (BAME) third sector*. London: ROTA. The report from Phase 2 of MiNet's work on the recession is due to be launched in Summer 2011. MiNet is a regional network in London including 3,000 BAME organisations. MiNet is an independent network which has been hosted by ROTA since 2002. To find out more please visit MiNet's webpages on ROTA's website at www.rota.org.uk.
[xii] Field, F. (2010) *The Foundation Years: preventing poor children from becoming poor adults. The report of the Independent Review on Poverty and Life Chances.* HM Government; Allen, G., MP (2011) *Early Intervention: The Next Steps. An Independent Report to Her Majesty's Government.* HM Government.
[xiii] ROTA (2007) *Developing the Mayor's Health Inequality Strategy for London: Stakeholder Engagement on Race Equality. Event repor*t
[xiv] ROTA/BEAM-EM (October 2009) *Consultation on New Horizons: Towards a shared vision for mental health*
[xv] For example, 'Voice 4 Change England (2007) *Bridge the Gap: What is known about the BME Third Sector in England*. Final report & appendices. Abridged version', which reviews a wide range of existing literature about the BAME sector, reports the under-representation of BAME communities in the development of policy that affects them at many levels and in many areas; 'Kalathil (2009) *NHS Bradford and Airedale/UCLAN'* reports service users and carers from BME communities are not as involved as they would like to be in commissioning and service development processes and decision making; MiNet has conducted a survey which has evidenced patchy engagement of BAME communities in local democratic processes and structures across London boroughs.
[xvi] For example see 'Nea, B. & Cox, D. (2008) *Gaps & solutions: Supporting London's equalities sectors.* HEAR. (HEAR is a London regional network that was hosted by ROTA at the time this report was produced).
[xvii] For example see 'Perry, J. & El-Hassan, A. A., Hact (2008) *More responsive public services. A guide to commissioning for refugee community organisations*. JRF; Delivering Race Equality Action Plan
[xviii] Chouhan, K., Lusane, C., (2004) *Black Voluntary and Community Sector funding: its impact on civic engagement and capacity building*. JRF.
[xix] NACRO (2007) *Evaluating the evolve project, Interim Report, Prisons and Resettlement Research*.
[xx] Matrix Research and Consultancy (2006) *The economic and social impact of the women's voluntary and community sector - a pilot study.* The Women's Resource Centre.
[xxi] Arradone, G. (2008). *What role for community enterprises in tackling poverty.* Joseph Rowntree Foundation, York.
[xxii] 'MiNet (2009) *The Economic Downturn and the Black, Asian and minority ethnic (BAME) third sector*. London: ROTA; The report from Phase 2 of MiNet's work on the recession is due to be launched in Summer 2011; and 'NEP (2008) *Supporting Equality Groups: An overview of support to the diverse third sector in England*. Women's Resource Centre'.
[xxiii] The National Audit Office estimating that the overall cost to the economy from failure to fully use the talents of people from ethnic minorities could be around £8.6 billion annually.
[xxiv] For example see 'Kalathil (2009) *NHS Bradford and Airedale/UCLAN'.*

[xxv] For example 'Perry, J. & El-Hassan, A (2008) *More responsive public services? A guide to commissioning migrant and refugee community organisations*. Joseph Rowntree Foundation'.
[xxvi] Perry, J. & El-Hassan, A (2008) *More responsive public services? A guide to commissioning migrant and refugee community organisations*. Joseph Rowntree Foundation.
[xxvii] Equality and Human Rights Commission (2010) *How Fair is Britain? The First Triennial Review* available at www.equalityhumanrights.com/key-projects/triennial-review/.