Health Inequalities and BAME: The Key Challenges and Solutions

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Friends,

Addressing and tackling health inequalities amongst our Black and Minority Ethnic (BAME) communities are one of the biggest healthcare challenges that we currently face as a society.

There is no doubt these health inequalities exist, and policymakers in Public Health and healthcare have identified some practical solutions towards addressing those differences in health outcomes. For example, there has been much discussion of removing what can only be considered as insurmountable barriers to accessing healthcare and other public services for marginalised ethnic groups in society, and that interventions need to relentlessly focus on improving access to healthcare and other public services.

But what I want to say today – and the key point of this lecture - is that a community development approach is one of the most fundamental ways in which we can address health inequalities among BAME communities and which has perhaps has been overlooked.

And I would like to suggest a few recommendations of my own to support this community development approach.

So what does community development mean in practice? Well, I believe community development could mean firstly, encouraging and supporting communities to use their own assets to improve their own health and wellbeing.

And secondly, helping communities and public agencies such as the NHS to cooperate and work together in partnership to improve services including the manner in which decisions are made about healthcare.

I think a community development approach is appealing because it is based on the deep and inclusive values of social justice, equality and respect for diversity and

culture. These include principles such as self-determination, empowerment, collective action and collaboration, with a view towards making community development work and function effectively for the benefit of society.

Given these principles and putting them into practice, community development can be highly effective in facilitating and improving access to primary health care and other public services. This approach will lead to improved health experiences and better health outcomes for our BAME communities and reduce the current burden on secondary care.

So, rather than concentrating all significant resources and efforts in improving access at GP practices, I recommend that health policy makers, commissioners and providers of services (including the Community and Voluntary Sector) consider how this community development can be incorporated, applied and developed into their area of responsibility.

In order to reduce the impact of health inequalities successfully, policy and strategy need to adopt a community development-based approach and which should include the following principal elements to provide a focus on:

- improving access as an outcome in itself;
- user and community empowerment as outcomes;
- engaging in a partnership and working across disciplinary and departmental boundaries to achieve the desired community development objectives.

So in this part of the lecture, I would now like to put forward some of my own recommendations based on my experience about this community -development approach.

Recommendations for NHS Commissioners

They could become more effective by -

1. Developing health strategies based on community development principles which I have just described.
2. Applying the principles to existing initiatives, especially to transform community services into local implementation.

3. Cooperating and coordinating effectively to offer more specialised services in a community setting. Services that would suit this approach are: therapeutic counselling, routine physical exams including smear tests and mammograms, vaccinations and pre-natal and post-natal care.
4. Adopting community development objectives as an essential part of programmes and initiatives to reduce health inequalities and work in partnership with local authorities to support the capacity of the community sector in their areas.
5. Incorporating in all commissioning and contract monitoring, a recognition of the timescales involved in addressing barriers to effective access to healthcare and other public services, and move away from an emphasis on measurable health outcomes as a short-term objective and success indicator. Objectives relating to improved access and community empowerment should be a required outcome.
6. Writing tenders in a way that does not exclude the voluntary sector from bidding.
7. Building flexibility into funding so that service providers can be more responsive to emerging needs and to provide the required funding in such circumstances.

Improving access to healthcare:

Recommendations for Service Providers

Community health centres can be learning points for community-based service providers. Service providers could become more effective by:

1. Implementing a multidisciplinary approach.
2. Working in partnership with the voluntary and community sector. As commissioners are frequently expecting healthcare providers to engage with their local communities, this model of being community-led could be the basis to engage and understand the health needs of the BAME community and those facing health inequalities.
3. Being community-led in the development of new services by healthcare providers will help to demonstrate flexibility and innovation within tenders.
4. Adopting policies that commit organisations to anti-discrimination to make them be seen as equal opportunity providers and reflecting the communities where they work. Such policies would assist healthcare providers to meet their statutory duties to eliminate discrimination and to meet the Care Quality Commission's core standards (C7e, C13a).

Recommendations for the local voluntary & community sector (VCS)

1. I would suggest that there should be a creation of a stronger evidence base through community-based research for the effectiveness of the VCS in addressing health inequality, improving health outcomes and reaching those in the community that the statutory sector finds hard to engage- namely, our BAME community.
2. Build capacity so as to be able to tender for projects such as the management of primary care facilities and mainstream health and social care services; making sure governance structures are robust and operationally functional.
3. Provide primary care services by employing salaried GPs, nurse practitioners, dieticians, counsellors and other health professionals including pharmacists.
4. Make it easier for those outside of the VCS to engage with the sector. For example, provide a single point of contact and coordination for health professionals and the public to liaise with, and find information with relative ease about health activities offered by VCOs .

Having set out my proposed recommendations, I would like to look at how my recommendations are informed by the available evidence.

There are clear and persistent health inequalities of our BAME communities across England. The Marmot Review, Fair Society, Healthy Lives, published in 2010, described that people with lower socioeconomic status have worse health outcomes and shorter life expectancy than those higher up the socioeconomic scale. The updated data in 2015 shows clear inequalities in life expectancy and disability-free life expectancy (how long a person can expect to live without a life-limiting disability) for men and women in England and for our BAME communities. Both life expectancy and disability-free life expectancy are closely related to level of neighbourhood deprivation.

There is a clear social class issue in both life expectancy and disability-free life expectancy and for a wide range of other health outcomes. These issues have significant implications for our National Health Service and in particular local access to a range of health services: it is not just the poorest or most excluded who are at risk of poor health outcomes, but everyone below the very top, at least to some extent. It is evident that the risks are higher for a person the poorer and more isolated they are, so approaches that are proportionate to need are required in order to raise and flatten

(to use that well known term) the gradient and in turn to reduce inequalities in health for our BAME community.

Many studies have described how it is not healthcare that influences health the most, but social and economic factors that need to be prevalent. Reviews of evidence describe that most of the drivers of ill health relate to social, economic, environmental, cultural and political factors that lie outside the immediate remit of our healthcare system. This is a key challenge for us and relies on true partnerships being built, developed and strengthened.

Differences in the health of BAME groups are most evident in the following areas of health: mental health, cancer, heart disease and related illnesses such as stroke, Human Immunodeficiency Virus (HIV), Tuberculosis (TB) and diabetes. Additionally, an increase in the number of BAME older people is likely to lead to a greater need for provision of dementia services as well as the provision of culturally competent social care and palliative care. Differences in health based on an individual's ethnicity, compared to the rest of the population, are well documented nationally and locally - this has been further heightened and illustrated by the Covid-19 crisis. Such differences are also evident across several risk factors for disease and disability such as smoking, obesity and lack of physical exercise. For example, there are higher tobacco consumption rates in Bangladeshi men in comparison to the general population.

Social and economic factors lead to long-term ill health and premature death for the most deprived; so, what can local government do about it? We know that those living in the most deprived communities experience poorer mental health, higher rates of smoking and greater levels of obesity than the more affluent. They spend more years in ill-health and they die sooner. Reducing health inequalities is an economic and social challenge as well as a moral one which we all need to address and find the practical solutions which I have outlined.

Since 2013, local government has been responsible for public health and has specific responsibilities to tackle health inequalities, as well as improving the public's health overall. Local authorities and public health teams are trying to maximise their contribution to closing the unjust health inequalities gap, even when resources are tighter and scarce. However, Westminster also has to play its part in reducing poverty and breaking the link between deprivation, ill health and lower life expectancy, but there is much that local government can do by reducing harm from what we know as

the ‘social determinants of health’ – those factors in people’s social, economic and built environment which play the greatest part in determining how long and with what quality of life they will live. These include many of local authorities’ core functions, such as planning, housing, environmental services, education, community regeneration and engagement, leisure and the arts. We need to think and act critically with a community-focused ICE- breaking outlook through Innovation, Creativity and Enterprise (Social).

There are vast opportunities through this outlook to support the development of an effective local community-based health system with a focus on health improvement and reducing health inequalities for our BAME communities. However, while there are opportunities, they are not sufficiently capitalised on and there is greater potential, throughout a community-based approach, to do more to reduce health inequalities.

Let me conclude by sharing with you that moving towards sustainable and transformative community-based partnerships and a truly integrated care service is highly relevant and important in society today. A community development outlook can embed approaches to health and health inequality that allow for wide approaches, that focus on prevention and equity through tackling the wider drivers of health.

The Covid-19 crisis has taught us that local healthcare, support and services need to be aligned to have a strong strategic focus on health inequalities and all available levers – strategic, system and resource levers – should be deployed to ensure an effective response to health inequalities locally. Health is a community issue and one which cannot be ignored.

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