Health and Wellbeing

Stevenson and Rao point out that "*self-reported wellbeing*", i.e., feeling good and functioning well, varies between different ethnic groups in the UK. Even controlling for the social and economic factors known to influence wellbeing, there appears to be a "*residual, non-random difference*", with people from "*Black and Minority Ethnic (BME)*" communities reporting "*lower levels*" of wellbeing than their White counterparts.[i]

In a study which considered the "*broad question of life satisfaction*", asking participants "*overall, how satisfied are you with your life*". The findings of the survey indicate that "*life satisfaction is lower*" for people from BME groups, with a "*larger effect*" for people of "*second generation status*". This difference in life satisfaction is the same when controlled for individual characteristics and neighbourhood factors.[ii] The Annual Population Survey published a summary of differences in wellbeing by ethnicity, which reports disparities for BME groups. With respect to life satisfaction, the White ethnic group reported an average of 7.4 out of 10, compared to 6.7 in the Black ethnic group, though some other ethnic groups reported similar or slightly higher averages. On the question of "*how worthwhile the things they do are"* also, the White ethnic group reported a higher average than all other ethnic groups.[iii]

It has been pointed out that there is a positive association between "*higher levels of subjective wellbeing*" and both health and longevity. High levels of wellbeing can add 4 to 10 years to life.[iv] The review indicated links between "*wellbeing and child development, living well and ageing well*", and reported that "*higher levels of subjective wellbeing*" increases longevity, is associated with good health outcomes, improves recovery from illness and supports ageing well.[v]

Stevenson and Rao point out that lower wellbeing is associated with poorer health and longevity and that if there is a difference in wellbeing for ethnic minority populations, this has serious implications.[vi] They assert that the "*apparent differences*" hold when controlling for known factors influencing wellbeing such as employment, housing and household income, suggests there

is a “*particular association*” between “*BME status and lower subjective wellbeing”*. The possible implications include poorer physical and mental health outcomes, with impact on life expectancy amongst other negative outcomes.[vii]

The impact of race on ethnicity was first recognized as a “*serious Issue*” in the 1970's.[viii] In this regard, it has been indicated that, on average, individuals from black and minority ethnic backgrounds “*display greater levels of poor health*” than the general population.[ix] There is an absence of any evidence to suggest any biological and genetic reasons for this disparity,[x] with the genes of “*global populations*”, although impacting hair, eye and skin colour, being of “*little importance in predicting susceptibility to disease*”.[xi] Rather, it has been indicated that the social and economic inequalities are the main causes for this anomaly.[xii]

As asserted by Matthews, focusing on race “*directs attention at individuals rather than unequal social relationships*” that cause ill health.[xiii] In this regard, imperial expansion between the 17th and 19th centuries led to the “*classification*” of different global populations based on the idea of “*inherent biological variations*”. This was premised on “*physical characteristics*”, such as “*skin colour, head shape, body size and hair texture*”, being used to support the erroneous racist assumption that some indigenous populations were “*naturally inferior*” to others,[xiv] used to justify the “*subjugation, exploitation and subordination*” of a large proportion of the global population considered “*racially different*”.[xv] Such racist inspired ideas have long been debunked and discredited.[xvi] Nevertheless, in the past few decades the notion of White genetic racial superiority has been resurrected in Western scholarship, including the works of Geneticist James Watson, a co-discoverer of DNA’s double helix structure, and Willaim Shockley, who was awarded the Nobel Prize for Physics.[xvii] Many of the proponents of this discredited racist ideology view their work as scientific, disputing the term “*racism”* and advocating terms such as "*race realism*" or "racialism".[xviii] British science journalist and author, Angela Saini, has expressed strong concern about the return of these ideas into the mainstream, pointing out that:

“Mainstream scientists, geneticists and medical researchers still invoke race and use these categories in their work, even though we have been told for 70 years that they have no biological meaning, that they have only social meaning”.[xix]

Saini emphasizes that since race is a social construct, it doesn’t belong in genetics research. She indicates that scientists in other fields have the freedom to study race but “*with that freedom comes responsibility*” and that they can’t

afford to leave room for "*misinterpretation*". Researchers using racial categories "*should fully understand*" what they mean, be able to "*define them*", and "*know their history*".[xx]

In this context, it has been asserted that the arbitrary nature of how an ethnic group is defined is "*challenging for health researchers*", as understanding varies "*culturally and historically*".[xxi] British statistics are driven by government data, based on "*varying interpretations*" of what constitutes an ethnic group.[xxii] Currently, classifications include White British, White and Black Caribbean, Black British "*of African or Caribbean origin*", gypsy and Irish traveller, Indian and Pakistani.[xxiii] (Office for National Statistics, 2012). Matthews indicates that these show that ethnicity is defined by "*racial understandings as well as cultural and national variations*", resulting in a "*complex picture*" of Britain's "*ethnic construction*".[xxiv] Therefore, "*researchers have no choice but to use these classifications*",[xxv] despite the fact that attempts to understand the "*impact of ethnicity as a social factor*" are hampered by the fact that there are "*few large-scale survey data sets*" reflecting the social distribution of health among ethnic groups.[xxvi] Matthews indicates that data from a "*variety of independent and academic sources*" allows us to establish a "*broad picture*".[xxvii]

From the aforementioned, a picture emerges that, overall, "*minority ethnic groups*" in Britain have "*poorer health*" than the rest of the population, as indicated in data from the Office of National Statistics.[xxviii] The *Health Survey for England* indicates that "*BME*" groups as a whole are more likely to report ill-health, and that ill-health among "*BME*" people starts at a younger age than in the White British. There is more variation in the rates of some diseases by ethnicity than by other socio-economic factors.[xxix] Some "*BME*" groups experience worse health than others. For example, surveys commonly show that Pakistani, Bangladeshi and Black-Caribbean people report the poorest health.[xxx]

Men born in South Asia are 50% more likely to have a heart attack or angina than men in the general population. Bangladeshis have the highest rates, followed by Pakistanis, then Indians and other South Asians. By contrast, men born in the Caribbean are 50% more likely to die of stroke than the general population, but they have much lower mortality to coronary heart disease.xxxi Classical risk factors like smoking, blood pressure, obesity and cholesterol fail to account for all these ethnic variations, and there is debate about how much they can be explained by socio-economic factors.[xxxii]

Further, it has been demonstrated that "*doctor-diagnosed diabetes*" was more

than five times as likely among Pakistani women, at least three times as likely in Bangladeshi and Black Caribbean women, and two-and-a-half times as likely in Indian women compared to women in the general population. This was also the case in 1999, when diabetes was more than five times as prevalent in Pakistani and Bangladeshi men and women, and more than four times as likely in Black Caribbean women (compared to men and women in the general population).[xxxiii] Also, the evidence indicates that Black Caribbean and Irish men had the highest prevalence of obesity; Pakistani and Bangladeshi men and women, and Black Caribbean and Black African women, were more likely than the general population to have raised waist to hip ratio and raised waist circumference. Indian, Pakistani and Bangladeshi men and women were less likely than the general population to meet the physical activity recommendations (of at least thirty minutes of moderate or vigorous exercise on at least five days a week).[xxxiv] Further, Black African boys were more likely to be obese than boys in the general population (31% and 16% respectively) with the prevalence of obesity among Black Caribbean and Bangladeshi boys increasing between 1999 and 2004 from 16% to 28% and 12% to 22% respectively.[xxxv]

It has been indicated that Ethnic differences in mental health are controversial. Most of the data are based on treatment rates, which show that "*BME*" people are much more likely to receive a diagnosis of mental illness than the White British. Studies show up to 7 times higher rates of new diagnosis of psychosis among Black Caribbean people than among the White British.[xxxvi] However, surveys on the prevalence of mental illness in the community show smaller ethnic differences. There is evidence of ethnic differences in risk factors that operate before a patient comes into contact with the health services, such as discrimination, social exclusion and urban living. There is also evidence of differences in treatment. For example, Black Caribbean and African people are more likely to enter psychiatric care through the criminal justice system than through contact with the health services. Some researchers suggest that psychiatrists diagnose potential symptoms of mental illness differently depending on the ethnicity of the patient.[xxxvii]

The Parliamentary Office of Science and Technology indicate that there is also some evidence of lower access to hospital care among "*BME*" groups. For example, South Asians have been found to have lower access to care for coronary heart disease. Looking at prevention, rates of smoking cessation are lower in "*BME*" groups than in White groups. In addition, rates of dissatisfaction with NHS services are higher among some "*BME*" groups than their White British counterparts. For instance, South Asians report poorer experiences as

hospital inpatients, according to Healthcare Commission patient surveys.[xxxviii]

Platt points out that many "*BME*" groups experience higher rates of poverty than the White British, in terms of income, benefits use, worklessness, lacking basic necessities and area deprivation.[xxxix] Similarly, it has been asserted that much of the variation in self-reported health between and within "*BME*" groups can be explained by differences in socio-economic status.[xl] However, the Parliamentary Office of Science and Technology contend that there is a "*complex interplay of factors*" affecting ethnic health, such as the long-term impact of migration, racism and discrimination, poor delivery and take-up of health care, differences in culture and lifestyles, and biological susceptibility.[xli] The Acheson Independent Inquiry into Inequalities in Health highlighted the impact of wider inequalities, poverty and social exclusion on health inequalities.[xlii] The Acheson Inquiry made three recommendations for reducing ethnic health inequalities, namely that "*policies on reducing socio-economic inequalities*" should consider the needs of "*BME*" groups; services should be "*sensitive to the needs of BME groups*" and promote "*awareness of their health risks*"; and that the needs of "*BME*" groups should be specifically considered in planning and providing health care.[xliii] It has been indicated that this Independent Inquiry was a key initiative which put health inequalities onto the policy agenda.[xliv]

Subsequent policies have broadly recognised the issues as multi-faceted and inter-linked. In response to the Acheson Inquiry Report, twelve departments signed up to cross-government work on health inequalities in the Treasury's Tackling Health Inequalities: A Programme for Action,xlv but to date, the main policy targets have focused on socio-economic class and area deprivation, rather than ethnic inequalities, and ethnicity has not been a consistent focus of health inequalities policies to date, and few policies have been specifically targeted at "*BME*" groups.xlvi This is despite the Government's *Cross Cutting Review of Health Inequalities* finding that not only do health gaps still exist in the UK but, in some cases, they are growing ever wider.[xlvii] The report indicates that:

> *"There are wide geographical variations in health status, reflecting the multiple problems of material disadvantage facing some communities. These differences begin at conception and continue throughout life. Babies born to poorer families are more likely to be born prematurely, are at greater risk of infant mortality and have a greater likelihood of poverty, impaired development and chronic disease in later life. This sets up an inter-generational cycle of health inequalities".*[xlviii]

However, it has been argued that two important cross-cutting factors affecting

the feasibility and likelihood of action on ethnic health inequalities are the availability of data on ethnicity, and legal obligations towards racial equality.[xlix]

It is important to consider the assertion that *Inquiries* and *Serious Case Reviews* (*SCRs*) have become a feature of the "landscape of health and social care services", with it "*clearly vitally important*" that all professionals and agencies seek to learn the lessons from "*serious or critical incidents*".[l] However, unfortunately, there are "*potential drawbacks*" to the development of an "*Inquiry culture*". These include the fact that such investigations become a "*scapegoating exercise*" rather than a "*genuine attempt*" to address "*organisational, cultural or professional failings*".[li]

Cummins points out that t*he* failings of "*community care*" in the late 1980s and early 1990s led to a number of Inquiries, with two of those inquiries both from the early 1990s approaching the issues of "*race, racism and psychiatry*". The two Inquiries are the *Ritchie Inquiry* (1994) into the "*Care and Treatment*" of Christopher Clunis[lii] and *Report of the Committee of Inquiry into the death of Orville Blackwood and a Review of the Deaths of Two Other African-Caribbean Patients.*[liii] The Ritchie Inquiry was established following the murder of Jonathan Zito by Christopher Clunis.liv The Prins Inquiry examined the circumstances of the death of Orville Blackwood at Broadmoor Special Hospital.[lv] Cummins contends that these two Inquiries are used as "*contrasting case studies*" as a means of examining the approaches to the questions of race and racism. However, the "*attitudes and approaches*" that the Inquiries took to the issue of race are "*startling different*". The Prins Inquiry takes a "*very clear position*" that racism was a "*feature of service provision*" whilst the Ritchie Inquiry is "*much more equivocal*".[lvi] These issues remain "*relevant for current practice*" across mental health and CJS systems where young black men are "*still over-represented*". The deaths of black men in mental health and CJS systems continue to scar these institutions and family continue to struggle for answers and justice.lvii In the *Blofeld Report of an Independent Inquiry into the institutionalisation and death of David Bennett*, NHS mental health services were accused of institutional racism in the death of a Black Caribbean psychiatric inpatient.[lviii] As Thomas contends, mental health services are not provided in a "*vacuum*". He argues that "*schizophrenia is emblematic of the oppression and mistreatment of black people by psychiatry*".[lix]

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