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race for health



DRIVING FORWARD RACE  
EQUALITY IN THE NHS

**NHS**

# Valuing Equality

PAPER FOR NATIONAL RACE FOR HEALTH CONFERENCE  
22–23 NOVEMBER 2006

**Ruth Thorlby**  
**Natasha Curry**

**King's Fund**

11–13 CAVENDISH  
SQUARE  
LONDON W1G 0AN  
Telephone 020 7307 2400  
[www.kingsfund.org.uk](http://www.kingsfund.org.uk)

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11–13 Cavendish Square  
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# Contents

About the authors	iv
<b>Summary</b>	<b>1</b>
<b>1 Introduction</b>	<b>5</b>
<b>2 The policy context</b>	<b>7</b>
<b>3 Action required to achieve race equality in the NHS and progress made to date</b>	<b>9</b>
Staff	9
Patient care	10
Institutional response to legal obligations	14
Community engagement	15
Summary of action to achieve race equality	16
<b>4 Establishing a business case</b>	<b>17</b>
The evidence base	17
Direct financial benefits	18
Indirect benefits	23
<b>5 Discussion</b>	<b>25</b>
How is a business case relevant to the NHS?	25
Direct financial benefits	25
Indirect benefits	27
Some limitations of the business case	27
Barriers to change	27
<b>6 Conclusion</b>	<b>29</b>
References	31

# About the authors

**Ruth Thorlby** is a Fellow in Health Policy at the King's Fund. Her current interests include inequities in access to health care, particularly those experienced by some minority ethnic groups. She recently completed a study of the way that patients choose HIV units in London, and she contributed to the King's Fund Independent Audit of the NHS, published during the 2005 general election campaign.

Ruth co-ordinates King's Fund briefings on a range of NHS reform topics, including patient choice and Payment by Results. She completed an MSc in Social Policy at the London School of Economics in 2003. Before that, she was a journalist, working in BBC radio and television, in the United Kingdom and abroad.

**Natasha Curry** is a researcher in Health Policy at the King's Fund. She joined the Fund in 2005 and is working principally in the field of long-term conditions. Her current projects include the development of a risk prediction system for the NHS and research into the use of accident and emergency departments.

Natasha previously worked as a consultant at a public sector research and consultancy company, prior to which she was the evaluation officer at the Chinese National Healthy Living Centre. She has an interest in black and minority ethnic groups and their access to health services. Natasha read geography at Cambridge University and subsequently spent time working in China.

# Summary

The NHS is committed to race equality as an employer, and as a provider has promised ‘to do more to meet the particular needs of black and minority ethnic groups’ in England. This includes a commitment to addressing underlying inequalities in health, inequities in access to services and variations in patient experience. There is also an overarching commitment to respond to the linguistic, cultural and religious diversity of all patients.

Achieving race equality within the NHS represents a considerable challenge. No automatic assumptions can be made by providers of health care about the needs of multi-ethnic communities because of the enormous differences within the United Kingdom’s black and minority ethnic (BME) population, in terms of health status, language ability and the wider determinants of health, such as experience of deprivation. However, where poverty and ethnicity overlap, health needs are likely to be high, and the diversity of BME communities suggests that a variety of interventions are required to ensure equitable access to services.

The main drivers for action to date have been legal and moral. Recent evidence suggests that progress towards race equality has been uncertain, with many trusts apparently failing to meet their legal obligations in full and the existence of wide variations in activity to improve services for people from BME groups across the NHS. Previous research has found that resource constraints are the most commonly cited reasons for inaction, suggesting that addressing the needs of BME groups is seen as a net cost to organisations.

This paper looks at whether, in addition to the legal and moral drivers, a ‘business case’ can be made to promote race equality. A business case would hinge on the argument that net benefits would accrue to organisations over the short to medium term as a result of investing in interventions aimed at BME staff or patients. These benefits could be direct, in the form of financial gains or savings, or indirect, such as reputational gains.

The paper presents a brief review of the evidence on the business case for race equality. Formal, peer-reviewed evidence is sparse. Much of the evidence comes from the United States and is not always immediately applicable to the NHS. Very little of the research contains quantifiable data about cost. The research was split into two categories: evidence about interventions aimed at increasing race equality in the workforce and interventions aimed at increasing race equality for patients.

## Workforce

Many organisations, including those in the private sector, have attempted to argue that investment in hiring a diverse workforce and promoting equal opportunities yields direct benefits in terms of productivity. Robust, detailed and quantified evidence to support this appears to be lacking. However, the research implies that NHS organisations could construct a business case to support investment in equal opportunities, particularly in

the hiring, training and promotion of a diverse workforce. The benefits of this would include reducing staff turnover, reliance on temporary staff and reliance on workers from overseas.

## **Patient services**

The strongest argument to support a business case for race equality focuses on the costs that can be avoided by investing in timely and effective upstream care to prevent admissions to hospital later. Again, the evidence base is currently weak. However, it is becoming clear that some people from BME groups are being missed by preventive initiatives aimed at the majority population (for instance, those promoting the self-management of diabetes) and would benefit from specialised interventions. Poor data prevents quantification of the current cost of poor-quality care, but failure to adapt or target services will certainly result in higher costs – to individuals and their families in the first instance, but also to the NHS in the future.

It may also be possible to construct a business case based on the avoidable costs that can result from poor communication (such as the costs of re-admission following poor compliance with medication or the costs of litigation as a result of medical errors) or poor employment practices. The evidence base in the United Kingdom is currently limited in this area.

There may be some potential to use the more competitive environment being created by NHS system reforms as a lever to improve those aspects of patient experiences that relate to ethnicity. Evidence from the United States suggests that providers of health care are keen to establish a good reputation for ‘culturally competent’ care, partly as a way to increase market share and gain strategic or reputational benefits. In the case of the NHS, the decisions of both patients and commissioners could be used to drive quality improvements, provided the right sort of information was available to identify relevant quality indicators, such as scope of language provision or sensitivity to religious needs.

The potential to use the ‘consumer power’ of patients collapses when numbers are small, or if those patients are uninformed, unable to express their preferences or find it hard to switch because of the costs of travel. The ‘avoidable cost’ argument is also weak where the numbers of BME patients are small.

The business case is a poor driver for achieving change where the benefits accrue only over the longer term. The current financial horizon for the NHS is short – particularly for commissioners – which makes investment in long-term interventions problematic. This applies to interventions aimed at preventing ill health or improving data collection about the ethnicity of patients (which is still inadequate for most parts of the NHS).

## **Summing up**

In conclusion, there is some mileage in developing a business case to motivate commissioners and providers to deliver better services or improve their employment practices, but much more work is needed to develop an evidence base. An advantage of framing action to improve race equality as a business case is that it locates the issue within the mainstream of trusts’ activity, rather than leaving it to languish as a lower-order ‘add-on’ or as something that is at odds with core business.

However, the limits of the business case are clear. It will only be applicable in some cases and should not be used as a substitute for effective regulation, which has a powerful role to play in eliminating the enduring discrimination that is still experienced by some BME staff and patients within the NHS.



# 1

## Introduction

The NHS is under a legal obligation to ensure that patients and staff are treated equally. However, recent evidence from the Healthcare Commission suggests that many NHS organisations are struggling to discharge their legal obligations fully (Healthcare Commission 2006a). Previously published reviews of the legal requirements have also found that progress on race equality is uneven, even though no formal legal action has been taken against trusts (The 1990 Trust 2005; Department of Health 2006b; *see also* Bhatt 2002).

This paper explores whether a business case can be made for promoting race equality within primary care trusts (PCTs) and the wider NHS, and whether such a case would enable change to happen faster. The paper has been produced for the Race for Health programme, sponsored by the Department of Health. Race for Health supports a growing network of PCTs around the country that aim to make the health service in their areas significantly fairer for BME communities. The programme works in partnership with local BME communities to improve health, modernise services, increase choice and create greater diversity within the NHS workforce.

This paper sets out the policy context, looks at actions to achieve equality, and examines the evidence for a business case for race equality within the health service. Executed within a limited time-frame, the paper does not claim to deliver a comprehensive review of all the literature. Rather it considers evidence from a selection of sources, including peer-reviewed academic journals, other published material and official documents of NHS institutions.

The authors recognise that considerable debate surrounds the meaning and usefulness of headline terms such as 'race' or 'black and minority ethnic' (BME) (Karlsen and Nazroo 2006). This is not least because the terms involve aggregating highly diverse and complex groups into simple categories. For example, there is a growing recognition that a full understanding of multi-ethnic Britain should extend beyond the visible 'non-white' minority groups to include 'white' people who originally migrated from Ireland or who have migrated more recently from the new EU accession countries (Karlsen and Nazroo 2006). Furthermore, within commonly used categories such as 'Asian' there can be huge variations (for example, in economic position, Chinese and Indian people have similar socio-economic profiles to white English individuals, but Pakistani and Bangladeshi families are much less likely to be in professional or managerial jobs) (Karlsen and Nazroo 2006). This picture is complicated further by differences in outcome between genders (high employment rates for black Caribbean women, in sharp contrast to black Caribbean men) (Karlsen and Nazroo 2006). Under the banner of 'culture and ethnicity' there is much heterogeneity, such as language ability within households and between generations.

For the sake of brevity, however, we have employed the language and categories used in official documents. These are generally based on the 2001 Census categories, and include the use of the term 'BME groups'.

# 2

## The policy context

In its Race Equality Scheme (RES), the Department of Health (2005–8) stresses the need to focus on race equality when designing and delivering health and social care services and explains what this means for the NHS. Where staff are concerned, it means promoting equality of opportunity in recruitment and career progression. Where patients are concerned, it means taking action to reduce underlying health inequalities and inequities in access to services, as well as addressing ‘ethnic variations in patient experience’.

The main catalyst for change has been the Race Relations Amendment Act 2000, which requires NHS institutions, as public bodies, to eliminate unlawful discrimination, promote equality of opportunity, and promote good relationships between people of different racial groups. This applies to both service delivery and employment.

Action to improve access and overall health, and to reduce health inequalities has also been driven by the high-level Public Service Agreement targets set up between the Department of Health and the Treasury. Some of these targets include action to improve the health outcomes of the poorest areas or poorer groups, but are not specific to BME groups.

There has been a recent shift of emphasis in some of the Department of Health’s documents about race equality in the NHS. In addition to the legal and moral obligations to embrace race equality, there is now a ‘business case’ for doing so. This has been articulated as bringing rewards for local NHS organisations by either placing them in a better position to meet their high-level targets or (more commonly) enabling them to become more efficient by tapping into a sustainable, local workforce:

*Undertaking this work is not only right morally and legally but makes good business sense. The NHS is the largest employer of black and minority ethnic staff in England, with 170,000 (13 per cent of its workforce). Over the next ten years, half the growth in the population of working age people will come from black and minority ethnic communities, as will 14 per cent of all graduates. The NHS and social care services need to attract this talent, retain, develop and nurture it.*

(Department of Health 2005–8)

Action to improve race equality within the NHS is patchy, despite some excellent examples of good practice (see section 3, pp 9–16). A key barrier to change has been the perception, common to other public services, that action on race equality is a ‘problem’ to be solved, involving net costs (Audit Commission 2004). The question is whether arguments for a business case, such as those outlined in the example above, which hinge on potential benefits for organisations, can be developed further, and whether there is evidence for building a broader business case.

This question is posed in a context where profound changes are taking place across the NHS in England. Many of these changes have been set in motion by government reforms that aim to deliver greater responsiveness to patients and greater efficiency through a system of financial incentives that operate at GP practice, PCT and trust levels. The reforms coincide with a period of financial turbulence that has been driven by the need to reduce overspend and prepare for a slow down in funding growth beyond 2008. Both the reforms and the financial climate have exerted considerable pressure on NHS trusts, forcing them to think about the ‘business’ of their mainstream activities. How effectively can race equality be embedded into this wider reform agenda?

# 3

## Action required to achieve race equality in the NHS and progress made to date

The objectives of the NHS that relate to race equality can be summarised under four broad headings: staff, patient care, institutional compliance with legislation and community engagement.

### Staff

The action required to promote race equality has been much more clearly formulated for staff than for patients. Progress in this area is also easier to monitor for staff because the collection of data is better for staff than it is for patients. The Department of Health's (2005–8) RES states that the NHS should continue to 'target recruitment and development opportunities' at people from different ethnic groups.

Success in the recruitment of BME staff is measured by the extent to which the ethnic profile of employees matches that of the overall population. The percentage of both non-medical and medical/dental staff who come from a BME group exceeds the percentage of BME people in the general population of England by a considerable margin (see Table 1, below).

**TABLE 1: PERCENTAGE OF BME STAFF IN THE NHS IN ENGLAND COMPARED WITH THE GENERAL POPULATION, 2004**

Group	Percentage of people from a BME group (%)
Non-medical staff	12.0
Medical/dental staff	40.0
General population	7.9*

Source: London Health Observatory 2005

\* Figure from the 2001 Census.

These headline figures represent a gradual change over time. For example, at least 40 per cent of the medical and dental workforce classified themselves as 'non-white' in 2004 compared with around 35 per cent in 2000. This picture looks rather different when the seniority and grade of staff are taken into consideration. In 2004, for example, 88 per cent of UK-qualified hospital consultants were from the white group, 5 per cent were Asian and 0.9 per cent were black or black British, according to the 2001 Census classifications (Department of Health 1995–2005). These figures are much more representative of the

population as a whole, but it does mean that BME medical staff are much more likely to be employed at lower grades (London Health Observatory 2005).

Just over 7 per cent of executive directors (including PCT professional executive committee board representatives) were drawn from BME groups in 2004, slightly below the 2001 Census figures. This nevertheless represents a year-on-year increase since the figures were first collected in 2000 (when there were no black or Asian executive directors) (Department of Health 2004). However, no figures have been published since 2004 and the number of strategic health authorities (SHAs) and PCTs has now been reduced by half, so it is not clear whether progress has been maintained and there are concerns that the proportion of BME staff at this level, particularly chief executive grade, may have dropped sharply.

## **Patient care**

According to the Department of Health (2005–8), NHS institutions need to ‘do more to deliver services which meet the particular needs of black and minority ethnic groups’. Meeting their needs includes responding to the linguistic, cultural and religious diversity of BME groups (that is, how the patient experiences care), as well as responding to clinical need and preventive care.

The Department of Health recommends that local NHS institutions assess need among their BME populations; where appropriate, they should design or commission services to meet those needs, ideally in consultation with patients and members of the community. There has been no comprehensive audit of the type of intervention in which NHS trusts have invested to achieve these aims. Interventions do, however, include hiring link workers, interpreters and bilingual advocates; using video and other technologies to communicate health messages; peer education schemes; and using alternative community-based health projects (London Health Observatory 2004).

## **Patient experience**

Official NHS patient surveys identify an ‘excess’ of dissatisfaction among BME groups, even when social class and other factors have been taken into account. For example, it has been found that patients from BME backgrounds (particularly Bangladeshi and Pakistani groups) are less likely to be satisfied with their inpatient care than white patients in some areas, particularly access, involvement and choice (Commission for Health Improvement 2004).

It is difficult for NHS institutions to understand why these ‘ethnic differences’ exist. The surveys do not probe patients’ experiences as BME patients, for example, by asking specifically whether language needs have been met. Research has also identified a number of different categories of ‘communication’ difficulties that go beyond language ability, for example, where patients have an understanding of human biology at odds with western scientific traditions (Kai 2003).

It is not known to what extent poor patient experience is a response to prejudice or stereotyping on the part of staff, instances of which have also been documented. For example, a recent qualitative study of a predominantly white cohort of nurses revealed attitudes towards BME patients that contrast with those in official NHS documents and which could help in understanding patients’ experiences (Vydelingum 2006):

*We don't understand them. I can't stand the lack of eye contact, especially from the male Asian patients.*

(Staff nurse)

*I work with an Indian person, my nursing auxiliary, and we don't have a problem. I'm fearful of West Indians really, they are different with their postures and their rhythms and the way they walk.*

(Sister)

*It's not just the language. Even for those who can speak English, I find that they are very restrained in expressing their problems. They don't always want to communicate with staff.*

(Sister)

These examples come from a body of qualitative research evidence suggesting that some BME patients might be treated differently by the NHS as a result of cultural assumptions made by the majority ethnic staff. It is difficult to generalise from qualitative studies; therefore, it is impossible for NHS institutions to know how prevalent such views are locally, what effects they might have on patient care or, indeed, what action to take.

More research is clearly needed to unpack the reasons underlying ethnic differences in patient experience, to disentangle the effects of social class, language ability and other factors. Without this research, it will be difficult for trusts to tackle the problem.

### ***Access to clinical and preventive services***

It is not possible to summarise all the research in this area in this paper (excellent summaries can be found elsewhere, *see Gill et al 2004; London Health Observatory 2004*). The main findings from survey-based studies suggest that, on average, many (but not all) BME groups are likely to report worse health than the white majority. There are important differences in self-reported health within BME groups, which vary by gender, age and socio-economic status (for example, the more advantaged people within each group report better health than their poorer counterparts). Many researchers argue that the 'ethnic differences' in health are to a large extent driven by socio-economic disadvantage (which disproportionately affects some groups more than others), rather than being the product of some cultural or genetic factors that are unique to BME groups. In addition, experience (and fear) of racism is also widespread and is likely to have a negative effect on health, independent of other factors (*Karlsen and Nazroo 2004*).

Epidemiological research has also shown that there are a number of illnesses for which BME groups appear to be at greater risk compared with the white majority, although the reasons are not well understood. For example, coronary heart disease (CHD) and diabetes appear to be more prevalent among people from a range of south Asian groups, there is an increased risk of prostate cancer for African and African–Caribbean men, and there is a higher incidence of stroke among African–Caribbean people. There is evidence of a higher prevalence of some mental health diagnoses among BME groups but controversy surrounds the scale of the difference between BME people and the majority population (*London Health Observatory 2004*). For a large proportion of illnesses, including those with high mortality rates for all individuals, such as cancer, BME groups have a similar or lower risk (*Gill et al 2004*).

There is no national picture of differentials among BME groups in terms of access to services, because there is often poor ethnicity coding of the routine national datasets. Studies based on smaller datasets have suggested differences in the utilisation of services, such as those provided by GPs, based on the frequency of visits (higher use among people of south Asian origin and lower among those of Chinese origin compared with the white majority). Frequency of visits may, however, be a reflection of poor-quality care, and there is some evidence of lower referral rates to secondary care (London Health Observatory 2004).

The challenge for the NHS has been translating the implications of the research into action – a task that, as mentioned above, has been hampered by poor ethnicity coding of datasets or the complete absence of data. Death certificates, for example, record country of birth but not ethnicity, thus failing to capture data about those born in the United Kingdom. There is no routine national data on the ethnicity of those registered at GP surgeries and consequently no data on the use of primary care services. Hospital Episode Statistics are still incompletely coded, although they are improving for inpatients, and there has been a start on their analysis. Other datasets, such as hospital waiting lists, are not coded for ethnicity.

The result overall has been a fragmented response by the NHS as a whole to tackling underlying inequalities and inequities in access. An example is given in the box opposite, drawing on evidence obtained from the study of CHD, which is now recognised as a serious health problem for people from a south Asian background.

## NHS RESPONSE TO TACKLING HEART DISEASE IN SOUTH ASIAN PEOPLE

Mortality rates as a result of heart disease are estimated to be 30–50 per cent higher for people from Pakistani, Bangladeshi, Indian and other south Asian backgrounds than they are within the general population (Patel and Bhopal 2006). Risk factors include age, a family history of heart disease, economic deprivation (which particularly affects those in the Pakistani and Bangladeshi communities), smoking and lack of exercise (Patel and Bhopal 2006). Not all these risk factors can be directly influenced by health care services (although they can be screened for). Despite the increased risk of heart disease in south Asian people, evidence suggests that progress in tackling the problem to date has been slow and there are still underlying inequalities in access to care and spending.

- **NHS smoking cessation programmes** Several specialist programmes have been set up around the country to target smokers from south Asian communities (British Heart Foundation and Department of Health 2004). There has been slow progress in targeting effective smoking cessation services. For example, 44 per cent of Bangladeshi men are estimated to be smokers. In 2004/5, 1,190 Bangladeshi men enrolled in NHS smoking cessation programmes (in England), compared with only 22 in 2002/3. However, it is proving harder to convert this group into ‘quitters’: in 2004/5, only 29 per cent of the Bangladeshi men who enrolled in programmes were reported to have quit after four weeks, compared with nearly 47 per cent of white men (Healthcare Commission 2006b).
- **Inequity in access to secondary care** The London Health Observatory (2006) has calculated that Bangladeshi patients in London have been receiving only about two-thirds of the revascularisations (a procedure to restore blood flow to the arteries supplying the heart) that would be expected according to an estimate of need based on emergency admissions for heart disease. More research is needed to identify where the inequity might be occurring. Are GPs failing to refer? Are patients not recognising or reporting symptoms?
- **Variations in PCT spending on circulatory disease** According to data based on the Department of Health’s Programme Budgeting Data (King’s Fund 2006a), the top 11 PCT spenders on circulatory disease in England all have tiny minorities of Asian populations (see Table 2, overleaf). This may not be significant in itself but it is in sharp contrast to the PCTs at the bottom end of the spending table (see Table 2, overleaf), some of whom have very large south Asian populations (and in some cases high mortality rates for cardiac disease). Could there be potential under-investment in services according to need? Could the underlying allocation to PCTs be wrong? (Two years’ worth of PCT programme-budgeting data is now available for analysis. The data captures PCT spending on disease areas (not including primary care). Previous work by the King’s Fund has shown that there are unexplained variations in what PCTs spend, even when factors such as deprivation and age are taken into account.)

**TABLE 2: PRIMARY CARE TRUST (PCT)\* SPENDING ON CIRCULATORY DISEASE**

PCT	Spending per head on circulatory diseases adjusted (£)	Percentage of population from 'Asian or Asian British' 2001 Census categories (%)	Standard mortality rate** for CHD 2002-4
<b>Highest spending PCTs</b>			
Wyre	173	0.30	102
South and East Dorset	173	0.20	74
South Peterborough	168	1.25	101
New Forest	168	0.25	81
Horsham and Chancetonbury	167	0.61	91
North Somerset	165	0.35	89
Broadland	163	0.30	84
North Norfolk	159	0.13	81
Bexhill and Rother	159	0.30	92
North Devon	157	0.17	100
South Hams and West Devon	157	0.13	90
<b>Lowest spending PCTs</b>			
City and Hackney	68	7.98	98
Cheltenham and Tewkesbury	74	1.08	90
Bradford City	76	50.19	117
Bury	81	4.04	114
Southwark	81	4.07	98
Heart of Birmingham	81	51.67	120
Bracknell Forest	83	1.91	86
Haringey	84	6.72	96
Brighton and Hove	87	1.83	100
Islington	89	5.40	116
Tower Hamlets	89	36.62	124

Sources: King's Fund 2006a (based on original figures from the Department of Health 2006d); Office for National Statistics 2006; National Centre for Health Outcomes Development 2006

\* Prior to reconfiguration.

\*\* The standard mortality rate (SMR) makes it possible to compare the mortality rates of local areas with the national average. It is the ratio between the expected and observed deaths, in this case from heart disease. 100 = England average. Figures over 100 indicate that there is a higher incidence or risk of dying; figures below 100 indicate that there is a lower incidence or risk of dying. The SMRs are based on data from the National Centre for Health Outcomes Development (2006).

## Institutional response to legal obligations

Compliance with some of the duties contained in the Race Relations (Amendment) Act 2000 was most recently audited by the Healthcare Commission (2006). The Commission found that only seven trusts (out of 570) had published a full RES, full employment figures and the results of Race Equality Impact Assessments on the web. This figure contrasts with the high numbers of trusts (96 per cent) that declare themselves to be compliant with standard C18 of the Healthcare Commission's core standards, which states that: 'Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably' (Healthcare Commission 2005-6).

A forthcoming audit of PCTs by the King's Fund looks in more detail at the kind of action taken to address race equality, particularly in improving access to services for BME patients. It suggests that there are wide variations in the amount of energy devoted to race equality across the country. The box below exemplifies this point with examples of actions taken by two anonymous PCTs that have almost identical proportions of BME populations.

#### **ACTION TAKEN TO ADDRESS RACE EQUALITY**

##### **PCT A: rural, > 99 per cent of population white**

- no current RES available on website
- no employment statistics published
- no evidence of ethnicity monitoring
- no evidence of action to improve services.

##### **PCT B: rural, > 99 per cent of population white**

- RES, action plan, employment statistics all on web
- minority populations identified, additional to census categories: travellers and migrant workers
- bespoke GP clinic services set up for both migrant and traveller communities
- survey of primary care staff undertaken to gather evidence of problems
- RES states: 'Small numbers should not mean that people are invisible to health services. It does mean that we need to be prepared to make changes on the basis of small numbers of people, and to understand success in terms of quality of service for individuals'.

## **Community engagement**

Under section 11 of the 2001 Social Care Act, all NHS trusts are legally required to consult and co-operate with local authority overview and scrutiny committees. Regulation of how well this duty is carried out is the responsibility of the Healthcare Commission, which places consultation at the heart of C17, one of its core standards, stating: 'The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.' Ninety-seven per cent of trusts have declared themselves compliant with this standard and none of these self-assessments have been subsequently revised by the Healthcare Commission (2005/6). However, it is difficult to assess the quality or scope of the efforts made by NHS bodies to consult local communities.

Community engagement can encompass a wide variety of activities, ranging from one-off consultations to more substantial involvement in the design and delivery of services. Such engagement is important in achieving race equality for two main reasons: first, it is likely to be difficult to assess BME needs (both patient experience and clinical) unless some form of consultation is undertaken because of the limitations of the data discussed above; second, community engagement is essential to the successful delivery of programmes because of the heterogeneous nature of BME communities.

The forthcoming audit of PCTs by the King Fund has identified a small number of progressive trusts that have engaged with communities in a variety of ways. Some

have conducted baseline surveys via community groups (because the incompleteness or absence of official data makes it impossible to be sure about the nature of inequities without asking communities directly). Others have made extensive use of community engagement in order to deliver targeted services (see box, below).

### **THE WIRRAL ETHNIC HEALTH ADVISORY GROUP**

The Wirral Ethnic Health Advisory Group was formed in response to a survey that revealed the need for trained interpreters among Asian, Chinese and Vietnamese communities in 1995. The group has put together an information and resource file to help staff understand the population that they serve and to enable better engagement with the community (see [www.bkwpct.nhs.uk/Equality\\_Diversity/Equality\\_race.asp](http://www.bkwpct.nhs.uk/Equality_Diversity/Equality_race.asp)). Working with Birkenhead and Wallasey PCT, the group has also produced an Equality and Diversity Communications Toolkit, which includes multi-lingual appointment cards, NHS Direct factsheets, and posters and signs in other languages. Referral forms also indicate whether patients will need translation and interpretation. The PCT's RES indicates that it is carrying out an assessment of specific health needs of BME groups, involving users, through established community groups and networks.

Source: Birkenhead and Wallasey Primary Care Trust 2005

At the other end of the spectrum, there are many PCTs with minimal or no evidence of community engagement (including one that stated in its RES action plan: 'The diabetes group, which is run by the trust, is attended by an Asian person').

## **Summary of action to achieve race equality**

The research evidence suggests that, although there is no automatic connection between ethnicity and ill health, some people from BME backgrounds have a higher than average risk of ill health and might experience problems either accessing appropriate care or with the care itself. Even if much of the burden of ill health can be explained by socio-economic status, the heterogeneity of the United Kingdom's ethnic minorities makes it more complicated to target interventions aimed at health promotion or to improve access than it is to devise interventions to reduce inequalities among the majority population. A key barrier to action has been poor data, which has led to an absence of robust quantifiable indicators of progress, either at a national level or at a local level. The result, judged from the recent audits of trusts, has been a highly variable level of activity, which includes some excellent projects and initiatives (London Health Observatory 2004). However, there has also been either a tendency to commission short-term interventions on the margins of mainstream NHS activity or a failure to act at all.

The legal obligation has clearly pushed NHS trusts some distance along the road to race equality. However, improvement in race equality for patients requires further investment in a range of tailored services delivered by a range of providers. Race equality for staff implies investment in training and recruitment, as well as training for staff at all levels (and evaluation to assess the effectiveness of training) (Department of Health 2005–8). What remains unclear is what the appropriate level of investment should be, at which groups it should be directed and what type of interventions should be used.

# 4

## Establishing a business case

In the context of a more general improvement in quality of health care, the definition of a business case has been developed to the greatest extent in the United States, where sections of the health care system operate in a competitive environment. Drawing on the work of Leatherman *et al* (2003) and Bailit and Dyer (2004), we suggest the following definition. A business case for an improvement exists if the organisation investing in the intervention or improvement can see within a reasonable time-frame a return on their investment in terms of:

- **direct financial benefits** – return on investment (bankable dollars) or reducing losses/avoiding costs
- **indirect benefits** – perceived strategic gain or reputational improvements for the organisation.

It is important to note that, when defined in this way, the business case hinges on the ability of an institution or organisation to benefit over the short to medium term. Although arguments that relate to benefits accruing mostly to individuals or to wider society over a longer time-frame may be compelling (and may constitute an economic case), they do not constitute a business case unless the organisation itself also benefits. The other important feature of the business case, noted by the researchers in the United States, is that the first element – direct financial benefits – is by far the more powerful aspect of the business case, and it is rare to see indirect benefits put forward in isolation to justify an intervention or improvement.

The attraction of using the business case as a lever for change is that, if it works, it will drive improvement faster and be more self-sustaining than any legal or moral arguments for change.

### The evidence base

A review of the literature was undertaken in order to establish whether data could be found on the costs and benefits of race equality, in addition to other quantifiable outcomes. A preliminary search revealed little relevant evidence in the United Kingdom, particularly on costs. More evidence was found in the United States, but this was still not extensive. To establish the full potential of a business case, the search was extended to include evidence from non-health areas, on the assumption that generic evidence about workforce productivity might be of some relevance to the health care sector.

As a result, the evidence presented below derives from both the United Kingdom and the United States and includes data from health and non-health areas, organised under categories relating specifically to health. In accordance with the definition of a business case set out above, the evidence has been organised under two main headings: direct financial benefits and indirect benefits.

## Direct financial benefits

### *Return on investment*

#### **IMPROVING PRODUCTIVITY**

In the United Kingdom, the financial case for investing in race equality has been set out by the Commission for Racial Equality. The case centres on the productivity of the workforce: if the employment practices of a business are rooted in equality of opportunity, then productivity will increase and as a result the business will witness a positive financial result (Commission for Racial Equality 2004). Evidence to support this proposition comes from the Cabinet Office (2006), which found that more than 80 per cent of businesses said that there was a link between good diversity practice and overall business performance. In addition, the Race For Opportunity group (Business in the Community 2006) has found that many businesses see race equality as key to improving their bottom line. This association is not necessarily limited to employment practices; it can be considered more widely. One example, cited by the Institute for Public Policy Research (ippr), is British Telecom, which witnessed an increase in revenue after implementing multi-lingual customer service support (ippr 2004).

According to the Commission for Racial Equality (2004), not only does diversity in the workforce facilitate creativity, but also good race equality practices can lead to enhanced productivity through reduced absentee rates – absenteeism costs businesses over £11.5 billion every year. Research reported by ippr (2004) found that a multi-ethnic workforce creates flexibility (for example, workers will want to take holidays at different times of the year) and therefore promotes productivity. The report also highlighted the importance of promoting understanding among staff of each others' beliefs because misunderstandings can lead to losses in productivity. Evidence for this work was collected from a number of small and medium-sized businesses.

It is worth noting that most of the evidence cited above comes from non-academic 'grey literature' or from surveys. In addition, there is a body of peer-reviewed literature, which explores the connection between diversity and productivity from a management and organisational psychology perspective, with evidence drawn from mainstream businesses rather than health. This literature suggests that there is some evidence to support the productivity connection, but that equally there is some evidence against (diversity can bring increased conflict and lower group performance), with some researchers arguing that the quality of management may be key (see Brodbeck, forthcoming).

#### **IMPROVING STAFF RETENTION**

The US health care organisation Aetna (2005) states that the main driver of race equality initiatives is staff recruitment and retention. There is clearly a strong business case for retaining staff: not only are training and recruitment costs lower (Business Link 2006), but also a stable workforce is generally more productive. A Canadian paper (Gandz 2001) suggests that attracting and retaining good quality staff ultimately results in a better bottom line. The Commission for Racial Equality (2006) has estimated that the average cost to businesses of labour turnover is over £4,600 per year. The turnover rate for the United Kingdom is 18.3 per cent (Chartered Institute for Personnel Development 2006) so although turnover rates in the public sector (13.3 per cent) are lower than in the private sector (22.9 per cent), this represents a significant cost to all organisations.

Evidence from the NHS is scant, but London's SHAs have estimated that 'it costs organisations around £10,000 to replace each staff member. This accounts for recruitment costs (which will fall with the increased use of e-recruitment) and loss of productivity (which varies with the reason for replacement)' (Select Committee on Health 2006). Although this evidence is not linked specifically to race equality, it could be argued that an organisation with good working practices (including a commitment to equal opportunities and race equality) is likely to have a low staff turnover.

Good employment practices can have a direct effect on finances. Good race equality practice will also ensure that the business or organisation does not become involved in costly discrimination cases. There is no maximum fine that a business can receive, and research by ippr shows that employers are paying higher awards in race discrimination cases, citing a record case in 2002 for which £761,867 was awarded. Such data around the cost of discrimination cases within the NHS is not collated centrally, so it is difficult to assess the size of financial impact on trusts as a whole. As each case is assessed individually, there is no standard cost and, where cases are settled out of court, the sum is frequently not disclosed. Examples from the health sector that have been reported include three race discrimination cases in one trust where no monetary figures were given (Dyer 2001), a nurse awarded £20,000 in 2004 (The Guardian 2004) and a doctor awarded a record £635,000 because his attempts to become a consultant were thwarted on the grounds of his race (The Guardian 2003). These examples illustrate the variation in payouts and underline the potential impact on the NHS, but they also show that, without centralised data of this sort, the actual impact remains unknown.

As the evidence above makes clear, the data available in this area is at best patchy and underdeveloped in the health field. Although piecemeal information about discrimination payouts and general staff recruitment costs in the NHS is available, data is not centrally or consistently collected, making it difficult to construct a full business case. As a contact at Aetna stated: 'the science of establishing a financial business case for embedding race and ethnicity data into health care quality programmes is in its infancy' (personal communication 2006). However, there is evidence from other sectors to suggest that, as a large employer, the NHS has a lot to gain by promoting race equality.

### ***Reducing losses or avoiding costs***

The bulk of the evidence for a business case for race equality appears to centre around reducing losses or avoiding costs. The literature suggests that race equality initiatives can reduce expenditure and avoidable costs in a number of ways: improving safety and reducing the associated litigation costs; improving use of resources; reducing use of services; and increasing patient adherence to medication.

### **IMPROVING SAFETY**

Safety is one of the most frequently cited reasons for investment in race equality initiatives; problems resulting from communication failures have been found to be the root cause of both medical error and dangerous mixing of medications. These failures of communication extend beyond simple language problems, but most of the published evidence refers to specific difficulties with interpretation and translation.

Poor communication can lead to patients not understanding their treatment plans, not being able to ask questions about their care, not being able to explain their symptoms to doctors or not telling doctors about other drugs that they are taking. Brach and Fraser (2002) found that 25 per cent of Americans experience problems communicating with their physicians. Research in the United States has shown that when untrained interpreters are used to mediate between patients and doctors, error rates are double those with trained interpreters. One US study showed that Spanish-speaking children whose families face a language barrier when communicating with doctors have a significantly increased risk of serious medical events during hospitalisation compared with children whose families do not face a language barrier (Cohen *et al* 2005).

In the United Kingdom many health trusts and GPs rely on informal or ad hoc interpreters, including family members. Where family members are used for interpreting, there is a risk that patients may not be willing to disclose information (Taylor and Lurie 2004) or that the family member may not always be available for appointments (Tran 2006). A further, and potentially more serious, risk arises where there are limitations with vocabulary – a situation that arises, for example, when children act as interpreters (Carter-Pokras 2004).

Such communication problems can lead to expensive litigation. NHS clinical negligence expenditure in 2001/2 was £446 million and, in 2002/3, the NHS Litigation Authority dealt with almost 7,000 claims for clinical negligence. It is not known if any of these claims are the result of communication failures stemming from language or cultural differences, but the US research cited above suggests that this may be a possibility.

### **IMPROVING USE OF RESOURCES**

Poor communication can have implications for efficiency as well as safety. Patients who are unable to understand a letter from a doctor are more likely to miss appointments than English-speaking patients (Taylor and Lurie 2004). Misunderstandings about the time or place of an appointment, or even problems in registration when the patient arrives, can lead to missed or delayed appointments (Diversity Rx 2006). The *British Journal of Healthcare Computing* (2004) reports that more than 11 per cent of the 44 million NHS outpatient appointments are missed every year, which – at an average cost of £67 per appointment – costs the service around £320 million a year. In the case of the NHS, it is not known exactly what proportion of missed appointments could have been avoided by investing in translating or multi-lingual booking services; however, some trusts have taken action in this area on the assumption that the proportion is likely to be significant:

*Reducing 'Did Not Attends' was one of the motivations behind an ethnic monitoring project in a practice in Sheffield North PCT, which employed an ethnic minority support worker to develop a database to record ethnicity and identify language needs. Better interpretation services were developed and bilingual reception staff were hired. There was a reported reduction in DNAs and better systems for recalling patients. The cost of the scheme is not known.*

(British Heart Foundation and Department of Health 2004)

### **INCREASING ADHERENCE TO TREATMENT REGIMES**

There is considerable evidence in the literature that non-adherence to a medication or treatment can be a direct result of poor communication and a lack of culturally competent care. Improved patient–provider communications have been shown to lead to better adherence to treatment plans (Taylor and Lurie 2004). Rand *et al* (1998), among others,

have also found that adherence to a medication plan is less likely when a patient does not clearly understand the physician's instructions and explanation of side-effects. This is particularly true for patients with multiple complex conditions. Non-adherence to medication in such cases is likely to result in hospitalisation. In the United States, the cost of non-compliance has been estimated to be in the region of £1.3 billion (Evans 2006). In many cases, it is not simply a language barrier or patient illiteracy that is the problem, but the level of so-called 'health literacy'. Health literacy refers to a person's ability to read, comprehend and act appropriately in response to medical information and instruction. The concept is not restricted to the use of language, but encompasses wider cultural and social issues. A lack of health literacy is a particular problem when patients' educational levels are low or the terminology used by doctors is unfamiliar. According to one US health care provider, the cost of health illiteracy, which often results in non-adherence to treatment plans, is estimated to be US\$73 billion (Keystone Mercy Health Plan 2002).

### **REDUCING USE OF EMERGENCY AND ACUTE SERVICES**

If primary and preventive care services are not perceived to be accessible to minority populations (whether because of cost, language or other communication barriers, or lack of cultural understanding among clinicians), there is the risk that they will be under-used. Possible consequences of this are that preventable or manageable conditions or illnesses will be allowed to deteriorate to a point where they are no longer manageable in the community and expensive and invasive treatment is required (Diversity Rx 2006).

#### **CASE STUDY: USING TRANSLATORS TO PROVIDE APPROPRIATE CARE**

A telephone triage service run by nurses with translators, designed to direct patients to appropriate care services, has reduced both the number of visits to accident and emergency departments and inappropriate admissions to hospital.

Source: Baquet *et al* 2004

Recognising this, a number of organisations have invested in equality programmes to facilitate access to primary and preventive care services in the hope that the use of expensive services will be reduced (for an example of such a programme, see box above). The incentives for this are particularly strong in the United States where providers are exposed to the financial risk of expensive or high-intensity acute treatment; as a consequence, US providers are now beginning to quantify the benefits of investing in preventive care that is culturally competent, against the costs of failing to do so. The Kaiser Family Foundation (part of Kaiser Permanente) runs a number of preventive and targeted health programmes, of which some have been shown to be cost-effective. One example is its immunisation programme aimed at groups with low uptake (in this case, specifically African-American individuals). According to Kaiser, this has 'reduced the long term costs of care' and has been shown to be 'the most cost-effective medical intervention' (Kaiser Permanente and National Diversity Council 2001). The box overleaf gives an example of another programme run by Kaiser, the impact of which it has been possible to quantify.

### CASE STUDY: TARGETING CARE TO REDUCE USE OF SERVICES

Kaiser Permanente runs a sickle cell anaemia programme for its African–American population in west Los Angeles. The programme offers cultural group appointments, including family members, and health education tailored to beliefs and diet. This results not only in better understanding and trust but also in higher levels of treatment adherence, which, in turn, leads to better health outcomes. The programme has seen a 22 per cent decrease in hospital stays in just a year and has thus been shown to be cost-effective.

Source: Kaiser Permanente Community Benefit 2006

Unfortunately, examples where the impact has been quantified specifically in relation to ethnicity are sparse. In the NHS, an evidence base is being developed for the underlying principle of avoiding unnecessary admissions among patients in general. Much work has already gone into tools designed to flag up and identify all patients in the general population who are at risk of frequent hospital admissions. Tools include High-impact User Management (HUM) (Dr Foster Intelligence 2006) and Patient at Risk of Readmission (PARR) (King's Fund 2006b), which have been designed for use by PCTs. The PARR tool includes a number of scenarios to demonstrate the financial benefits of preventive interventions, based on assumptions about the cost of interventions versus the savings generated by avoided admissions. For example, given that a typical PCT has to pay for 9,000 emergency hospital admissions annually, PARR estimates that by targeting preventive treatment at patients at risk of frequent admissions, a PCT could generate potential savings of over £200,000 annually, assuming a 10 per cent reduction in admissions, average savings of £2,100 per patient per admission, and average costs of £500 per intervention (Billings *et al* 2006). To provide an example of the type of admissions that PARR is designed to prevent, the authors of the tool cite the case of an individual suffering from sickle cell anaemia, who was admitted to hospital on more than 30 separate occasions in one year, which, at current NHS tariffs, would have cost in excess of £68,000 (Billings *et al* 2006).

Tools such as PARR and Dr Foster's HUM have not flagged up ethnicity as a significant risk factor (Bottle *et al* 2006) (although this could be a reflection of poor NHS data), and they do not consider to what extent the cost of interventions would vary for different ethnic groups (if advocacy or interpreting services were needed for effective case management, for example). This is partly because the evidence base for the cost-effectiveness of interventions tailored to patients' language or other cultural needs is limited. Sometimes the evidence can be contradictory. To illustrate this point, the box opposite summarises the outcomes of three randomised controlled trials (RCTs) relating to diabetes care (which do not include cost data).

One area of the NHS where the evidence base for avoiding costs through targeted interventions is beginning to grow is mental health. Coding of patients' use of services (both as an inpatient and in the community) has been vastly improved in response to the government's commitments to improve mental health services in the aftermath of the Blofeld Inquiry. Camden and Islington Mental Health and Social Care Trust (2005–8) has begun to build a business case for targeted interventions based on data generated from a study by the Sainsbury Centre for Mental Health. The study aimed at quantifying the cost of

## DIABETES INTERVENTIONS

### Better understanding of illness?

A randomised controlled study of the effectiveness of a diabetes education programme was conducted on a multi-ethnic population in Glasgow. Baseline assessment found that Indian and Pakistani people had a lower level of knowledge about their illness. The researchers found that a ‘culturally competent’ educational programme could improve knowledge in the intervention group but that there was no net benefit when this result was compared with those of the control groups, whose knowledge also improved despite receiving no educational programmes (Baradaran *et al* 2006).

### Better control of multiple diabetes risk factors?

In an RCT in the West Midlands, patients from practices with a high proportion of south Asian patients were assigned either to an intervention group, which was given access to Asian link workers and specialist nurse sessions, or to a control group, which received standard GP practice care. The study found that ‘small reductions in blood pressure and cholesterol were achieved’ in the intervention group but no differences in glycaemic control were observed (O’Hare *et al* 2004).

### Better glycaemic control?

A controlled study in the Netherlands offered a control group of Turkish patients routine care only and a second group education from two Turkish-speaking health educators, including training about diabetes management. The study found ‘no clear effect’ of education in terms of glycaemic control or cardiovascular disease risk factors (Uitewaal *et al* 2005).

treatment for African–Caribbean and black African mental health patients (which has tended to be more coercive and intensive, because of a number of factors including poor access to primary care services). The study found that the total cost of services for an average black user was 58 per cent higher than the cost of services for an average white user. The difference was partly explained by higher use of acute inpatient and intensive outreach services (Sainsbury Centre for Mental Health 2006). As the quotes below illustrate, trusts are starting to calculate their own costs as a first step in designing ‘upstream’ services that engage black service users earlier and more effectively, before illness deteriorates to the point where acute treatment becomes more necessary:

*A preliminary but reliable analysis of distribution of spend by an independent health economist indicated that for the White population the care trust spends around £45,000 per 100,000 population. For the Black population the figure is £120,000.*

*The care trust spends significantly higher amounts of money on the Black population because the services with which we are predominantly providing them are more intensive and restrictive and therefore more costly.*

(Camden and Islington Mental Health and Social Care Trust 2005–8)

## Indirect benefits

The bulk of the evidence available points to a business case for race equality constructed principally around reducing losses and avoiding costs. However, there is also evidence to suggest that improving the quality of public sector services with specific race equality

initiatives can have indirect benefits. Although difficult to quantify in monetary terms, these benefits can constitute a business case for such initiatives, especially when coupled with the direct benefits of cost-avoidance already mentioned. Although there is little evidence about the indirect benefits of race-specific interventions in the field of health, examples from other sectors are discussed below.

### **Widening recruitment**

In addition to staff retention and productivity considerations, it is becoming increasingly important in the United Kingdom to be able to recruit from a diverse pool of workers. The Race for Opportunity group estimates that 8 per cent of the workforce will be from BME groups by 2010 (Business in the Community 2006) and 18 per cent of people from BME groups have a degree. According to the Commission for Racial Equality (2006) many businesses believe that a diverse workforce enhances creativity and facilitates innovation and, as such, sharpens their competitive edge.

### **Boosting reputation and market share**

After reducing losses and avoiding costs, boosting reputation is possibly the second strongest incentive for health organisations to invest in race equality initiatives. Having a good reputation is important for two reasons: first, it enables an organisation to attract and retain quality staff – the benefits of which are outlined above; second, it enables an organisation to attract ‘customers’ and increase its market share.

The US health care organisation Aetna maintains that organisations that have a commitment to equality and diversity, through employment of a diverse workforce, are better able to understand customer needs and are therefore more likely to have satisfied customers. Central to patient satisfaction is the ability to communicate with health professionals. Many studies in the United States have found that patients who are unable either to understand their treatment plan or to ask their physician questions are likely to receive lower-quality care and be less satisfied (Brach and Fraser 2002; Taylor and Lurie 2004; Thiel de Bocanegra and Gany 2004; Zambrana *et al* 2004). Indeed, Rand *et al* (1998) have found a negative correlation between language barriers and patient satisfaction.

A number of health care organisations in the United States have recently won awards from the National Committee for Quality Assurance for the provision of innovative programmes that deliver care to linguistically, racially and ethnically diverse populations. The resulting press coverage boosts the profiles of the organisations that win the awards and can help to increase their market share. Examples of programmes aimed at BME populations include:

- **Blue Cross of California Partnership Plan, Inc** Asthma programme with pharmacists serving diverse and low-income members who have a higher risk of uncontrolled asthma symptoms
- **Care First BlueCross BlueShield** A multi-disciplinary programme focused on diabetes in Latino individuals, cervical cancer among Vietnamese women and cardiovascular disease among African-American individuals
- **Chinese Community Health Plan** A bilingual health education website offering monolingual Chinese consumers access to up-to-date education materials
- **Kaiser Permanente** Two interpretation programmes set up to address the shortage of interpreters.

(For a full list see National Committee for Quality Assurance 2006.)

# 5

## Discussion

### How is a business case relevant to the NHS?

Most of the theory and evidence to support a race equality business case has been drawn from literature from the United States. However, the US health care system is very different to the NHS, with far more competition between providers and a different system of funding. This begs the question of how relevant is this evidence to the NHS? The definition of a business case outlined earlier (see p 17) assumes that there is a competitive market place, with the possibility of exit, new entrants and mobile consumers. Given the system reforms to the NHS in England that are now taking place, it is possible – in theory – to imagine a situation developing in which NHS organisations are able to make coherent business cases that argue for interventions to improve race equality. The reforms that are key to this shift are:

- giving some NHS organisations the ability to generate and retain savings
- developing a hospital payment system that, among other things, reflects the choices made by patients and is linked to hospital activity
- giving patients a choice of hospitals in which to receive treatment
- creating a competitive environment for providers to operate in by bringing in new entrants and the possibility of market exit.

### Direct financial benefits

#### *Return on investment*

The arguments for race equality initiatives that centre on improving productivity and staff retention clearly hold some relevance for the NHS. In particular, large NHS providers operating in ethnically diverse areas would be able to base a business case on the argument that a reduction in the cost of agency staff and turnover could be offset by better recruitment from the local community. However, such arguments might be less effective at building a business case to deliver equality at higher levels of an organisation. More evidence is needed to demonstrate this in practice.

With regard to the potential for investment in patient care to generate direct financial returns, the acute sector is the only part of the NHS currently set up, in theory, to compete for patients. One of the aims of increased patient choice and the new payment system – Payment by Results – is to encourage trusts to deliver more responsive care. In theory, trusts could benefit if they were able to attract BME patients away from rivals in areas with high concentrations of BME patients and more than one accessible hospital. For example, according to Hospital Episode Statistics, non-white British people accounted for more than 100,000 inpatient admissions carried out in the Heart of Birmingham PCT area in 2004/5 (The Information Centre 2006). Hospitals operating in this region might therefore make some gains from attracting patients from this group with specially targeted services. The

theory of competition predicts that providers may well choose to specialise in a niche market in order to thrive.

However, this would depend, first, on patients being able to act on the basis of quality information (relevant to ethnicity) and, second, on mechanisms whereby hospitals could understand why patients were choosing or avoiding them. In the first instance, such quality information is currently not collected or published. To resolve this problem, PCTs in areas of high diversity could specify in contracts with providers that they should publish a key set of indicators, tailored to their patients, such as the provision of indicators for the presence of advocates, interpreters, translation services, food and religious support. Alternatively, they could encourage patients to switch providers by other means, for example, by promoting websites such as [www.patientopinion.org](http://www.patientopinion.org) where patients post their experiences of different hospitals.

In the end, even if change is not produced by large volumes of patients switching, it is possible that the collection of such data would have a beneficial effect on provider behaviour. Evidence from the United States suggests that collecting and publishing quality data, such as mortality rates, has an impact on provider behaviour, independent of whether consumers actually choose to switch (Chassin 2002).

However, as the literature from the United States also emphasises, financial benefits need not always be market driven. Incentive systems (and regulation) can also be manipulated to reward quality as well as volume – an important principle that has been incorporated into the most recent guidance to PCTs on commissioning (Department of Health 2006a). PCTs have already exercised some latitude in manipulating the Quality and Outcome Framework (QOF) system to give direct incentives to GPs to collect data:

*As part of Wandsworth PCT's work programme to improve the level of smoking cessation and the ethnic monitoring in primary care, the PCT introduced the following indicator as 'platinum points' for the Quality and Outcome Framework (QOF) for 2004/05: a practice will achieve 5/10/15 points if they reach a level of 55%/65%/75% ethnic coding.*

*With the introduction of the new GMS contract Quality & Outcome Framework, Central Liverpool PCT was able to link patients' ethnicity (from their patient profiling project) and their conditions. The PCT included four conditions to start with: coronary heart disease, diabetes, smoking and obesity. By doing so, the PCT gained a clearer picture than before about who, living where, has what condition in order to plan an appropriate service for patients.*

(Department of Health 2005)

PCTs are also now being encouraged to develop and commission services from new types of providers, including social enterprises. They have in theory been given the latitude to build quality-based incentives into specifications for contracts with providers; the government is also exploring the possibility of allowing extra quality payments to be given to providers in addition to the national tariff. There has, as yet, been little exploration of which dimensions of quality might be targeted for incentives. However, it might be feasible to reward action to reduce inequalities or inequities in access.

## **Avoiding costs**

Although hospitals stand to gain from increasing admissions, the incentive is reversed for PCTs and GP practices that are fully involved in practice-based commissioning. If costly and unnecessary hospital admissions can be avoided, then so can the accompanying costs. If the evidence base around avoidable admissions could be developed further for BME populations, it could form the backbone of a business case for reducing admissions that would benefit both race equality and PCTs' commissioning obligations for the whole population. A business case based on this argument has the greatest potential to drive improvements in the care provided for BME patients.

## **Indirect benefits**

### **Boosting reputation**

It is not clear how far the reputational dimension of the business case could apply to PCTs directly, given that patients cannot choose which PCT to belong to. However, concern about reputation might carry some weight among primary care providers, as well as the acute sector, particularly if successful practices are able to increase their market share and deliver more services outside hospital. If patient mobility between practices is achieved (as promised in the recent White Paper *Our Health, Our Care, Our Say* (Department of Health 2006c)), then greater sensitivity to diverse patient needs might be achievable.

## **Some limitations of the business case**

Arguments that hinge on the purchasing power of minority groups, the potential 'market' created by patients as consumers or even the 'avoidable costs' will work only if there are sufficient numbers of BME people as a proportion of the population or if they have distinctive preferences compared with other groups. Where numbers are small there is no business case, and different arguments are needed to secure good care for minorities who number only in the hundreds or low thousands within individual PCTs. This applies to significant parts of England. In addition, the numbers of BME groups are often too small, even in more diverse PCTs, to be confident of accurately quantifying the scale of any inequities.

A key message from the US literature is the inability of the business case, on its own, to provide incentives to organisations to engage in prevention strategies that yield results too far in the future. This can only be counteracted by putting strong non-market incentives in place to reward action for improving population health; these are currently lacking both in the United Kingdom and in the United States.

## **Barriers to change**

As discussed above, the evidence base for the scale of inequalities in health and inequities in access to services is weak because of persistently poor monitoring of ethnicity within the NHS.

In addition to poor data on ethnicity, the literature from the United States has also highlighted the tendency, of both projects and evaluations of projects in peer-reviewed

journals, to neglect the inclusion of cost data, making it much harder to build an evidence base for a business case. A British review of the literature on the ‘costs of ethnicity’, which was conducted in 1999 and included a sweep of the ‘grey literature’, encountered a similar problem, ‘particularly in terms of precise costs associated with procedures and conditions or in associating precise and consistent categories of ethnic group with epidemiological and operational service provision data’ (Johnson *et al* 1998). The increasing use of health care resource groups (HRGs) and tariff-based payments systems in the NHS does hold out the promise of greater clarity in the future, but it is clear that an evidence base needs to be established.

Although the benefits of a business case might be apparent to NHS organisations in some cases, there is no doubt that the costs also need to include penalties on trusts for failures to improve race equality enforced by more efficient regulation.

# 6

## Conclusion

There is as yet no strong evidence base to show how a business case might improve performance on race equality in the NHS. Nevertheless, a business case approach to improving race equality does have the potential to improve services and the performance of the NHS as an employer. Furthermore, the current NHS reforms have, in theory, vastly improved the prospects of making business cases to improve the quality of care for all patients, including BME groups.

It is instructive that health care organisations in the United States have aspired to generate business cases for diversity, even if the evidence base is lacking. As Bhopal has argued in the case of public health interventions, building up a valid evidence base for ethnic health 'will be [a] multi-million pound endeavour and will take 10–20 years'. In the meantime, the challenge will be to modify existing practices in the light of what we already know to be 'cross-culturally effective' (Bhopal 2006).

In areas of high diversity, the business case based on generating a return on investment could potentially result in greater sensitivity to patient needs (especially those related to the 'patient experience') through the use of the mechanism of patient choice and provider competition in the acute sector. There is some potential in primary care, but only if choice is increased. A radical change in the content and quality of information, as well as consumer behaviour, would be needed.

In areas of high diversity and deprivation, the business case based on reducing losses and avoiding costs could drive improvements in primary and preventive care, if a similar step change in the quality of information were to be forthcoming. A big advantage of the avoidable cost argument is that, rather than attempting to identify all BME patients as a separate 'problem' to be addressed, it focuses the commissioners' efforts (PCTs or GPs) on identifying the experiences of all vulnerable patients (based on the data) and then devising different solutions for different groups. However, if the data quality is poor, inequities will be deepened.

If the business case were to be truly viable, substantial investment would be needed to make better information about health care available to patients and better information about patients and costs available to NHS organisation. Changes to existing incentive schemes would also be needed to motivate providers to deliver better services. These might take into account the fact that, over the short or medium term, the creation of interventions that target BME patients might involve net costs rather than benefits – for example, because of the additional costs of introducing an interpreting service.

Much more work needs to be done to connect the NHS system reform agenda (patient choice, practice-based commissioning, provider diversity, and so on) with the race equality

agenda, to realise the full potential of the reforms for driving change in this area. Failure to do so will risk leaving the race equality agenda outside of the mainstream.

Finally, whether or not a robust business case can be constructed, regulation should not be weakened or downgraded. It remains a key catalyst for change to improve race equality in the NHS.

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