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The NHS is not an island—tackling racial disparities in healthcare

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In February 2022, the NHS Race and Health Observatory published its much anticipated rapid review of ethnic health disparities. The need for greater NHS action to address racial inequalities in health has long been undeniable, but their pervasiveness across a whole range of service areas reflects the insidiousness of structural, institutional, and interpersonal racism in society. The NHS is not an island. To drive desperately needed progress we must be clear about where that change can come from within, and where we rely on much broader action.

The evidence base from mental health is the perfect example of how discrimination within the NHS interplays with the root causes of racial inequality and discrimination outside it. Societal marginalisation and exclusion happen early and drives lifelong health inequality. For example, one of the Race and Health Observatory's key findings is that Black children are 10 times more likely to be referred to CAMHS via social services than via a GP. Clearly there are barriers to accessing primary care that are not noticed, that are neglected, and thus remain unaddressed. This inaction in the face of need is the very essence of systemic discrimination. This can lead to later mental health problems that are more difficult to treat.

The report also speaks to a significant level of mistrust of formal healthcare services, which can impact care seeking. We know that delays in seeking care are associated with more severe presentations; presenting in crisis; more police contact; greater rates of detention under the Mental Health Act; and once in hospital, greater likelihood of restraint and seclusion. This is particularly so for people from ethnic minority groups, especially those who are Black. Looking at the Race and Health Observatory's findings across other sectors of the health system, we see the same dynamics repeated, again and again.

The NHS clearly needs to get its own house in order, but these findings also highlight how by the time patients get to us, they've often been failed many times over by institutions across education, health, social services, housing, and the justice system. The NHS is a microcosm of wider society, and what's happening across the threshold of health services is happening in the day-to-day lives of ethnic minority people. Michael Marmot's work has repeatedly highlighted the structural factors that have a hugely detrimental impact on the social factors that determine a person's health outcomes. As he says: "inequalities in health arise because of inequalities in the conditions of daily life and the fundamental drivers that give rise to them: inequities in power, money and resources."[1] His more recent work has demonstrated a "deepening" of this inequality across the UK, and we know that these disadvantages will be compounded even further for people from ethnic minority backgrounds. Fundamentally, these problems will remain unless the government starts to tackle the "causes of the causes."[2]

That broader context can never be an excuse for inaction within the health service itself. Despite the efforts of many across the NHS, the Race and Health Observatory's report shows that direct and indirect racism continues to cause harm to both patients and staff. This must be tackled head on. We can also take account of that broader context and put systems in place to ensure the NHS does not perpetuate the structural, institutional, and interpersonal racism that got us here in the first place. As part of this, the Race and Health Observatory is calling for local NHS organisations to work with voluntary and third sector organisations to produce local solutions. The Royal College of Psychiatrists "Advancing Mental Health Equality" Resource and Collaborative are there to support mental health commissioners and providers in that process, as are our NHS teams driving this agenda across the regions. The significant progress made in recent years has further highlighted the importance of concrete action, even when the broader context is far from ideal.

As we take this work forward, however, we need to be clear about what the NHS can achieve on its own and where more societal level interventions are needed. The rhetoric on levelling up will come to little if there is not enough focus and sufficient resources to ensure the most marginalised and disadvantaged no longer fall through the gaping holes in our social fabric.

As the Race and Health Observatory states, greater systematic data collection would prove invaluable to health system leaders wanting to take well informed action on this agenda, and health leaders can and should put in place systems to collect this data now—not only for their own services, but also to inform action on the social determinants of health. Meanwhile, grand plans for covid-19 recovery will rely on a workforce sufficient in number and skills to go beyond business as usual to innovate and meet the needs of those who faced the greatest harm from the pandemic. While the government's acceptance of several amendments tackling inequalities to the Health and Care Bill making its way through Parliament is welcome, we encourage them to shift their position on widespread calls for more robust workforce planning and monitoring.

The NHS can no longer ignore the racial disparities in health and certainly in mental healthcare steps are being taken to address this issue. However, active attention must be given to the structural inequality that drives the racial inequality by all institutions, led by the government. The RHO review is not simply there to highlight the same evidence that we have known about for years, it is a call to act and act now.

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2 Marmot M. (2021) The Sewell report cited my work – just not the parts highlighting structural racism. The Guardian. 7 April 2021.https://www.theguardian.com/commentisfree/2021/apr/07/sewell-report-structural-racism-research

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