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A Response to the Race and Health Observatory (RHO) rapid evidence review into ethnic inequalities in healthcare

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Introduction

The fact of group-level unequal outcomes in health has become subject to increased political attention. Shortly, we will see the Government's Health Disparity White Paper which will focus on factors including geography and race. But to what extent does the state actually have a grasp on this?

One way to answer this question is to take the NHS Race and Health Observatory (RHO) as a case study. This is an organisation within the health service that exists to 'identify and tackle ethnic inequalities' in health. Its recent report, *Ethnic Inequalities in Healthcare: A Rapid Evidence Review,* led to headlines decrying the health service for 'racial health inequality', and a 'devastating picture of a healthcare system failing minority ethnic patients in England'. Yet all this was said without acknowledgement of the fact that on many indicators, health is worse for people from the white ethnic majority.[1]

Central to the report itself was the role of racism, with 'inequalities' being 'rooted in experiences of structural, institutional and interpersonal racism'. Those who are not white are treated worse, given the wrong treatment, and avoid getting help for 'fear of racist treatment from NHS healthcare professionals'.

This would be a matter of shame were it true, but what is the credibility of the RHO report itself, and does it withstand scrutiny? Certainly, it was given a massive fanfare in certain sections of the media, for example in *The Observer,* with a measure of scepticism allocated that was inversely proportionate.

Methodology

The report itself is based on a literature review conducted by academics from the universities of Manchester, Sheffield and Sussex, led by Dharmi Kapadia. Around 13,000 studies were screened, with 178 ultimately considered. The review looked at 'access, experiences of, and outcome' in the following areas:

- Mental healthcare;
- Maternal and neonatal healthcare;
- Digital access to healthcare;
- Genetic testing and genomic medicine; and
- The NHS workforce.

[1] https://www.telegraph.co.uk/news/2021/11/12/race-report-author-vindicated-bmj-article-admits-white-people/

Missing is any appraisal of outcomes with regard to things like cancer treatment. Also overlooked is the curious fact that there are scant differences in satisfaction with hospital care between ethnic groups.[2]

Evidence on mental health

Examination of the evidence presented in the section on mental health shows the picture to be much more nuanced than the story presented to the public. The chapter itself does not entirely get off to a good start.

It claims:

> 'The recent independent review of the Mental Health Act and the subsequent White Paper, Reforming the Mental Health Act, did not sufficiently acknowledge nor provide targeted solutions to the mental health service inequalities created by institutional racism.'

It then adds in the same breath:

> 'One potentially important current initiative drafted as part of the national Advancing Mental Health Equalities Strategy, is the Patient and Carers Race Equality Framework (PCREF), which seeks to develop and implement a competency-based framework to ensure services are equitable for ethnic minority groups. This is currently taking place in four pilot sites in the UK, in consultation with ethnic minority people with lived experience.'

The PCREF programme *was* endorsed in both the Wessely Review as well as the ensuing White Paper. That is where the impetus for it comes from.

Despite the RHO review's claim that 'Ethnic inequalities in health outcomes are evident at every stage throughout the life course, from birth to death', there are many studies referenced that found either no differences between groups or differences for some but not all groups, that are inconsistent with the idea of racism as the chief explanation. I quote some examples referenced in the RHO review section on mental health (bold font added for emphasis):

> 'Kapadia and colleagues' quantitative analysis of survey data (n=2,260) of ethnic inequality in women's usage of mental health services in England… showed that Pakistani (Odds Ratio (OR)=0.23 (Confidence Interval (CI)=0.08–0.65) and Bangladeshi (OR= 0.25 (CI=0.07–0.86)) women were less likely to use mental health services compared with White women. **There was no evidence of differences** in usage between White women and White Irish, Black Caribbean or Indian women.'
>
> 'Brown and colleagues' quantitative survey of Black African and White British women living in London showed that there were **no differences** in the proportion of women

[2] https://www.ethnicity-facts-figures.service.gov.uk/health/patient-experience/inpatient-satisfaction-with-hospital-care/latest

citing GP consultation difficulties as a reason for not seeking help for mental health problems.'

'Twomey and colleagues' systematic review of UK studies that predicted health service use for people with mental disorders stated that two studies in their review showed that people from non-White ethnic backgrounds were more likely to seek help from primary care services and **one study showed that there was no difference** in help-seeking for mental health problems between White groups and ethnic minority groups.'

'**The evidence was also inconclusive** for specialist mental health care services with two studies showing ethnic minority people were more likely to seek help from specialist mental health services and one study showing no difference between White and ethnic minority groups.'

'The second study published in 2018 found that anticipated discrimination was associated with increased service use for mental disorder. There was **no evidence from this study to suggest that discrimination experiences were acting as a barrier to health service use**.'

'Bhavsar and colleagues' study of almost 1,500 survey participants whose data were linked to IAPT records found **no evidence of ethnic differences** in rates of psychological treatment use.'

'Mansour and colleagues' study of older people in London (aged>=65) diagnosed with depression found that relative to White British people, Black African older people were less likely to receive CBT (OR=0.53, 95%CI=0.28–0.96), but there were **no differences found for other ethnic groups**.'

'Johns and colleagues' study evaluating CBT for psychosis found that there were **no ethnic differences** in therapy engagement…'

'Weich and colleagues' study of use of community treatment orders (CTOs) of almost 70,000 patients in England found that compared with White patients, Black patients (OR=1.43, CI=1.33 to 1.53) and Mixed ethnicity patients (OR=1.27, CI=1.13 to 1.43) were more likely to be subject to CTOs. There was **no difference** in the rates between Asian and White people (OR=1.06, CI=0.98 to 1.15).'

'In South London and Maudsley NHS Trust there were **no differences found** for Black groups but patients from Other, Mixed or unknown ethnic background were less likely to be admitted to acute services...'

'There were **no ethnic inequalities identified** in access to home treatment mental health services in Bookle and Webber's study of inpatient admission in London. Weich and colleagues' qualitative study of service users' experiences of home treatment found that this service was rated highly, irrespective of ethnic background.'

'One study (Oduola and colleagues') reported on ethnic differences in the duration of untreated psychosis (DUP); they found **no evidence for ethnic differences** in DUP in a sample of over 500 adults (aged 18 -64) in London.'

'Two studies reported on the use of seclusion or physical restraint in inpatient settings. Cullen and colleagues' study of almost 4,000 inpatient episodes in London found that there were **no ethnic inequalities** in rates of referral from acute wards to psychiatric intensive care wards (PICU, non-forensic), nor were there ethnic differences in the use of seclusion (patient isolated in a locked room).'

'In terms of discharge, a quantitative study by Ahmed and colleagues of patients discharged from the Psychosis Intervention and Early Recovery service (PIER) in Leicestershire NHS between January 2005 and December 2013, found that there was **no difference between ethnic groups** as to whether they were discharged to primary or secondary care.'

'Fernandez de la Cruz and colleagues survey of 293 parents in London which aimed to explore help-seeking attitudes for OCD amongst parents showed that there were **small differences** between the proportion of parents in the ethnic groups sampled in terms of seeking help from a GP for a child's OCD (White British: 98.6%, Black African: 98.3%, Black Caribbean: 93.5%, Indian: 91.3% (Chi squared statistic=7.289, $p<0.01$).'

'Vostanis and colleagues' study of 13 to 15 year old Indian and White British children in schools **found no evidence of a difference** in the use of CAMHS between these two groups.'

None of this is to say that there are not other studies that show ethnic differences in outcomes in mental healthcare. But these dissenting accounts, while acknowledged in the report, are brushed away without explanation in order to reach the broad conclusions of the review.

The most convincing body of evidence presented by the RHO authors is in the greater likelihood of black people to be treated or detained for severe mental illness. But all this is mentioned without reference to the fact that they are more likely to suffer from it.[3] Underlying the entire exercise are the assumptions of equality of need, and that what is expected for white people is a reasonable expectation for groups that have completely different histories and circumstances.

Studies have shown that suicide rates for mental health patients are higher for black patients than white, but lower for Asian.[4] Such a picture is not consistent with racism as the explanation, if Asian groups are having better outcomes, and these studies do confirm inequality of need within mental healthcare provision. There is also the unanswered

[3] https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/adults-experiencing-a-psychotic-disorder/latest

[4] https://pubmed.ncbi.nlm.nih.gov/18378841/ ;
https://pubmed.ncbi.nlm.nih.gov/34762843/

question in the RHO report as to whether or not stigma of mental illness is more pronounced among minority groups, resulting in differences in access to treatment. The British Social Attitudes Survey has shown that non-white minority groups, as a whole, tend to agree more that mental illness *should* impact on promotion decisions at work, pointing to greater stigma.[5]

There is a wider problem in that correlation is not necessarily the same thing as causation, as identified by the philosopher David Hume. Yet, this appears to be the assumption underlying the RHO report. Just because a difference is evidenced, a correlation between ethnicity and any given outcome, does not mean it is necessarily to do with race or racism. Groups differ in all manner of ways, some observed by statisticians and others not. There is thus good reason to expect inequality of outcomes both with and without the existence of racial discrimination.

The case is furthered by a series of qualitative studies which document the complaints of some ethnic minority individuals who have used or worked in the NHS. The problem is that these are often based on very small sample sizes (for example, n=8, n=23) and that the complaints raised are often rather vague, such as African nurses complaining of being 'othered'. What may count as being 'othered' can mean a great range of things; moreover, it can be expected that individuals from any given ethnic or national group will not afford individuals from a different group precisely the same level of familiarity. Studies based on *very* small sample sizes are in no way sufficient grounds on which to make judgements on the whole of any given institution, in this case the NHS. There is a lack of *external validity* and the academics responsible know this very well.

Passed over are key data from the Government's *Ethnicity Facts and Figures* website. The table below shows the results of treatment for anxiety or depression with scant differences registered. [6] While the white British have the best outcomes, we are talking no more than a couple of percentage points. (Note how an odds ratio of 1.18 can be reached by comparing the black share reliably deteriorating – seven per cent – with the white share at six per cent. The absolute difference is just one percentage point, yet a claim of black people being 20 per cent more likely to get worse from treatment for anxiety or depression would be both true and politically alarming, but highly misleading.)

Table 1. Outcomes for treatment for anxiety or depression by ethnicity

	Reliably improved	No Reliable Change	Reliably deteriorated
Asian	64%	28%	8%
Bangladeshi	61%	28%	9%
Indian	66%	26%	7%
Pakistani	63%	28%	8%

[5] https://www.bsa.natcen.ac.uk/media/39109/phe-bsa-2015-attitudes-to-mental-health.pdf
[6] https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/outcomes-for-treatment-for-anxiety-and-depression/latest

Asian other	62%	29%	8%
Black	66%	26%	7%
Black African	66%	25%	7%
Black Caribbean	66%	26%	7%
Black other	66%	26%	7%
Mixed	65%	28%	7%
Mixed White/Asian	63%	29%	6%
Mixed White/Black African	66%	27%	7%
Mixed White/Black Caribbean	65%	27%	7%
Mixed other	65%	27%	7%
White	68%	25%	6%
White British	68%	25%	6%
White Irish	66%	27%	6%
White other	67%	26%	6%
Other inc. Chinese	64%	28%	7%
Chinese	67%	27%	6%
Any other	63%	28%	8%

Source: Ethnicity Facts and Figures.

Workforce and Covid-19

The section on the NHS workforce is also of interest, certainly in light of troubling claims that ethnic minority staff were more likely to contract and die from the virus. The evidence is assembled and fairly reported, only we are told this represents an 'inequality' but not why. We know that the first wave hit inner city areas hardest and where population density was highest. Such areas tend to have a higher minority concentration. We also know that the NHS has been recruiting from overseas for decades to fill hard-to-fill jobs. Little is made of the relatively large numbers of Filipino workers who died,[7] nor is the possibility of genetic causes explored.[8]

The RHO report further cites research to say ethnic minority healthcare workers were 'twice as likely… to work in areas with Covid-19 cases'. The same research shows ethnic minority healthcare workers were no more likely to be redeployed overall, but minority nurses were three times as likely to be redeployed. While some will conclude this is evidence of bias, of minorities being given the most dangerous jobs in fighting the pandemic, the same research found ethnic minority healthcare workers were 'more likely to be involved in service level implementation and planning', which is hard to sustain alongside the idea of racism as causal.

Studies are reported on that show minority nurses reporting racism as well as discrimination. However, the measures are based on perception and we do not know what behaviours they actually refer to. There is also a lack of consistency that is further difficult to

[7] https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article
[8] https://www.ox.ac.uk/news/2021-11-05-researchers-uncover-gene-doubles-risk-death-covid-19

reconcile, with racism as the chief explanation. One study cited found ‘ethnic minority nurses and midwives were significantly less likely to have received professional training in the previous year’ and had to apply more often for promotion. But the same study further found ‘no ethnic inequalities in the perceived level of managerial support for progression in the previous year as white nurses and midwives’. It also found ‘no significant ethnic difference’ in promotion success rates. This suggests selection effects into these professions, as well as the possibility that decisions and support offered are fair.

Yet none of these details do anything to even caveat the broad conclusion of racism, racism, racism. The RHO report calls for further research of ‘what interventions work’ that uses ‘a conceptual model which centres institutional racism’. This is assuming your conclusion before you have begun to look. Certainly, the RHO authors have been unable to substantiate its existence. The conclusion is asserted, not inferred from evidence.

Reference is made in the RHO report to something called the Workforce Race Equality Standard (WRES). This is an NHS programme designed to measure ‘inequalities’ among workers in NHS trusts using a series of statistical indicators. The report mentions ‘limitations of WRES’ but these seem to amount to complaints that there is not enough WRES, which its authors are happy to oblige with calls for its extension. But overlooked and fundamental inadequacies of the programme include the fact that the indicators themselves do not inter-correlate, implying a lack of validity, and have largely not budged since the programme began. Nor is the fact that the programme’s initial architects have criticised it, with one having described its chances of changing things as ‘not a hope in hell’.[9]

Looking at who is involved in the RHO and the WRES, you see substantial overlap. RHO director Habib Naqvi is a former director of WRES. One of the authors of the RHO report, Aneez Esmail, campaigned for its establishment. Yvonne Coghill, the founder of WRES, is listed as a ‘stakeholder’ as well as on the board of the RHO. Jabeer Butt of the Race Equality Foundation, which contributed to the report, has sat on the WRES Strategic Advisory Board.

The RHO website further reveals its Chair, Marie Gabriel, is a former chair of the same WRES board. Lord Victor Adebowale sits on the RHO board as well as having being on WRES. The same applies to Professor Stephanie Hatch. The American academic David Williams, who has advocated for WRES, is also present, and co-authored a paper on ‘what works’ in bringing about racial equality in the workforce, which largely cited measures shown subsequently not to work.[10]

Following publication, Butt published a letter in *The Guardian* in which he wrote:

> ‘But what has been missed is that even in the last decade alone, there have been a myriad of NHS-led plans, strategies and initiatives to tackle inequality.’

In other words, they have tried many things before, to little apparent avail. He continues:

[9] https://civitas.org.uk/content/files/WRES-critique-FINAL-1-2.pdf
[10] https://civitas.org.uk/content/files/WRES-critique-FINAL-1-2.pdf

> ‘Almost every equality plan or initiative has had some form of oversight group. Almost always, these are led and dominated by the NHS, with race equality organisations such as ours often in a minority of one…
>
> ‘Unless we have accountability that is not led by the usual suspects and have regulators that are willing to act, the actions that follow this damning report will go the same way as in the past.’[11]

All that is missing, in order to bring about race equality, that is always tantalisingly out of reach, is more of the same old argument.

Inference and language

The beginning of the RHO report is explicit that there is a problem of racism. In his foreword, Habib Naqvi writes:

> ‘But perhaps more importantly… was the need for the Observatory to engage with the forces that create and reinforce these inequalities in the first place, including structural, institutional and interpersonal racism.’
>
> ‘This report is the first of its kind to analyse the overwhelming evidence of ethnic health inequality through the lens of racism.’

The report itself adds:

> ‘Ethnic inequalities in access to, experiences of, and outcomes of healthcare are longstanding problems in the NHS, and are rooted in experiences of structural, institutional and interpersonal racism.’

The problem is this is based on nothing more than assertion. There is nothing to say why differences between groups must be evidence of three types of racism, or in what combination. Definitions are provided:

> ‘Racism can be structural, institutional or interpersonal in nature: structural racism refers to the processes that lead to disadvantage in accessing economic, physical and social resources; institutional racism is legitimated by discriminatory policies and norms embedded in large institutions (such as the NHS), and captures a broad range of practices that perpetuate differential access to services, and opportunities within institutions; interpersonal racism refers to discriminatory treatment during personal interactions, such as verbal or physical abuse but also refers to acts of ignoring or avoiding people due their ethnic background.’

Missing is a sense of precisely *how* such ‘processes’ lead to disadvantage, or what they even are. Nor are we supplied with an explication of how racism can be evidenced from a literature review based largely on observational studies and correlation, getting round the

[11] https://www.theguardian.com/society/2022/feb/15/grim-diagnosis-of-racial-inequality-in-healthcare

causation/correlation problem. Indeed, the academics shy away from this in the main body of the text, preferring instead merely to describe what the literature found.

Moreover, if the authors wish to maintain that differences between groups are evidence of racism, then how are they to avoid the tautology that follows from their assertion they are also caused by racism?

These problems are largely disguised through the use of terminology that has certain moral connotations. Differences between groups are termed 'inequalities' and 'iniquities', and so it becomes easier to present them as evidence of moral wrongdoing that necessitate intervention from third parties, rather than prove their case.

Politics is awash with claims of the existence of things called 'inequalities'. Inequality is though, an abstract noun, that cannot exist in the plural. It denotes the idea of difference between individuals or things. Yet we have these things, named 'inequalities', that are basically statistical differences that someone has adjudged to be morally wrong, only how many there are in sum is never told. Who the adjudicators are, and how they know what is just or not, is largely a matter of self-appointment and proclamation from on high. The moral vehemence that accompanies their judgments tends to act as a smokescreen that hides questions pertaining to their competence in manufacturing improvements in other people's lives and behaviour, who they have never met, nor ever will. This usually proves to be highly lucrative for those at the top, while for others, the pay is little and the career is at the expense of one that might be meaningful.

Recommendations

The press release put out by the RHO to promote their research went heavy on the need for *radical action*. Naqvi is quoted saying:

> 'By drawing together the evidence, and plugging the gaps where we find them, we have made a clear and overwhelming case for radical action on race inequity in our healthcare system.'

He speaks of the report as a 'tool' for identifying both the evidence and recommendations for change. The problem is that this report is not a summary of the evidence of what works to bring about equality of outcomes. It is a summary of the evidence for inequality of outcomes in certain areas. Again, we go back to Hume in that as he pointed out, you cannot infer an 'ought' from an 'is'. The recommendations made are not evidenced as having worked elsewhere before, but are based on the belief that they will bring about a desired outcome. Evidence as to what works is non-existent since nowhere before has an equality of outcomes been successfully manufactured. Evidence of what does not work is ample, given public authorities have been trying to end 'racism' in healthcare for decades, globally.

Calls for 'radical action' will nearly always entail trying something new as well as drastic, and thus their efficacy cannot be evidenced from past endeavours but only through their application. Should such measures fail, then the costs will fall not on those who advocate them, but in this case, on the sick and needy.

In any case, the recommendations made by the report are arguably not radical but simply an extension of already existing drives within healthcare. The recommendations are summarised in the report as five broad areas. They are:

1. More data on ethnicity.
2. Better statistics.
3. More interpreters.
4. More 'voluntary, community and social enterprise organisations' (VCSE).
5. More research.

It should also be pointed out that these recommendations suit the interests of the people who wrote the review. Academics and researchers want more research and better data, only these will not produce the desired goal of equality of outcomes. This is because they only present evidence of differences between groups, not the knowledge necessary for third parties to bring about improvements in other people's behaviour. Also, if you conclude you need better data, how is it we are to have any confidence in your substantive findings, based on the very same data they have judged to be not good enough? It cannot be had both ways.

The recommendation that the NHS work more closely with 'VCSE' organisations, or advocacy groups, is entirely unsurprising since the recommendations are largely based on their input. The report reads:

> 'We also conducted two stakeholder engagement groups consisting of community practitioners working with ethnic minority people with health problems, or more generally, in a community setting (e.g., peer supporters, community development workers). The aim of these stakeholder groups was to engage individuals working in the field to ascertain their views on what needs to happen on a practical level to ensure ethnic health inequalities are addressed.
>
> 'These groups were conducted by two voluntary, community and social enterprise (VCSE) organisations: The Ubele Initiative, and Race Equality Foundation (REF). In total, six focus group sessions and one structured interview were conducted during September and October 2021 with a total of 40 participants. Participants held varied job roles working directly with ethnic minority communities…
>
> 'The experiences and views of the community stakeholders **were used to draft recommendations for the report**.' [Bold font added for emphasis]

Other than the two named organisations, we are not told who these individuals and organisations are, but the latter often vary in quality, and tend to assume racism as an explanation for disparate statistical outcomes *a priori*. But we do know they are economically precarious, in that they are reliant on donations and grants for their existence, and so will always recommend more of themselves to the state. Calls for more interpretation services further undermine integration and would likely also be met by these very same types of organisation. Moreover, the RHO review seems blind to the

contradiction that encouraging alternatives to mental health care does nothing to counter a lack of trust in the mainstream NHS, but actually bolsters it.

Simply put, the RHO's call to 'Establish relationships between ethnic minority VCSE organisations and NHS provider services in order to provide the high-quality services for ethnic minority patients' is there on the say-so of those who stand to benefit from it, made in a report commissioned by an organisation which makes a claim of 'providing evidence-based health policy recommendations' on its website.

Civil servants as well as academics are obliged either by law or professional standards to be neutral, but this report seems to verge on advancing what is a substantial vested interest, but with no idea as to what actually works to bring about equality of outcomes. Indeed, one of the specific recommendations is:

> 'Conduct a process and outcome review of interventions to address ethnic inequalities in both the NHS and VCSE organisations to establish 'what works', why and for whom.'

In other words, radical action includes finding out what radical action is.

Media coverage

The RHO report was promoted on the front page of *The Observer*, under the headline 'Radical action needed to tackle racial health inequality in NHS, says damning report'.[12]

The Observer story is largely a write-up of the RHO press release. No comment from a sceptical viewpoint is made room for, nor any critical analysis attempted by the journalist responsible. As I have shown, the RHO report itself is a summary of academic research, which on the whole is nuanced and limited, with many instances of equality of outcomes. All this is gradually lost as you move up from chapter-specific conclusions, to general conclusion, to press release, to media coverage. The RHO/WRES nexus are not wonder-workers but rather recipients of considerable amounts of public money, and their claims demand the same level of scrutiny as any other branch of government.

The NHS Race and Health Observatory

The RHO exists to bring about equality of outcomes in healthcare, despite the fact that groups are different in many ways and so inequality of outcomes should be expected. It calls for radical action, but makes calls for more research to find out precisely what that entails. That this suits many of the parties that float around this enterprise does not seem to be an issue.

[12] https://www.theguardian.com/society/2022/feb/13/radical-action-needed-to-tackle-racial-health-inequality-in-nhs-says-damning-report

The NHS 'constitution for England' contains the stipulation that the NHS 'is committed to providing best value for taxpayers' money' and that 'It is committed to providing the most effective, fair and sustainable use of finite resources. Public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves.' It is possible this report will have cost in the region of £86,000 to produce, given that is what a similar official report cost.[13] Those behind the RHO and WRES need to explain precisely how their labours are compatible with these quasi-legal sentiments.

Regarding the impending White Paper, ministers need to be aware that many of those who work on this area have no magic bullets to solve the conundrum of disparity, as well as records on which they can be judged. They do not tell an encouraging story.

[13] https://order-order.com/2022/03/01/beis-spent-86000-on-net-zero-race-and-social-inclusion-report/

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