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The report – purpose and key findings

In this section…

- The main aims and potential uses of this report are described, along with the context for the series of *Health in London* reports
- Last year's key findings are updated, and new findings are provided on the health and well-being of London's Black and minority ethnic communities
- Perspective is given on the kind of insights provided by the high-level indicators discussed in these reports
- Key messages from the indicators are summarised, and implications for action are explored.

Aims of the report

This is the third *Health in London* report. It supplements the earlier publications in the series and provides significant new information where that is available.

The aims of the report series are:

- to provide London-wide information on health and the determinants of health in a form that will support discussion and action by agencies at local, regional and national level
- to identify important inequalities in health and the determinants of health in London, and to track trends in inequalities
- to highlight how diverse communities in London experience the determinants of health, indicating key areas where action is needed to reduce inequality
- where appropriate, to draw out implications for action from the report's findings.

The 2003 report, which included a specific focus on disabled Londoners, is available at: www.londonshealth.gov.uk/hinl.htm. Also available at this website are relevant background reports, along with the first report in the *Health in London* series.

Like the earlier reports, this publication focuses on inequalities in health. A particular focus for 2004 is the health-related experience of London's Black and minority ethnic communities.

Context for the report

The Greater London Authority and the London Health Observatory collaborated in preparing this report. This collaboration was facilitated by the London Health Commission which has also published the report. (For further information on these bodies, please see the back cover.)

The report arises from work on the London Health Strategy, which was developed in 1999-2000 by a partnership of regional and local agencies and identified priorities for London-wide action to improve health. Shortly after the Greater London Authority was established in May 2000, the Mayor set up the London Health Commission to progress this work to improve the health of Londoners and reduce health inequalities across the capital. The work programme of the London Health Commission incorporates the priorities of the London Health Strategy as well as additional priority areas subsequently identified with partners. (For more information on the origins and nature of the London Health Strategy, please see Section 2 of the 2002 *Health in London* report.)

The London Health Strategy identifies high level indicators – listed on page 3 – which can be used to measure changes over time and to monitor progress towards reducing health inequalities. The indicators are discussed in Appendix 2. Section 3 reviews key developments for each indicator in London during 2003-2004.

London Health Strategy – high level indicators

1. Unemployment
2. Ethnicity and unemployment
3. Educational attainment
4. Proportion of homes judged unfit to live in
5. Domestic burglary rate
6. Air quality
7. Road traffic accidents
8. Life expectancy at birth
9. Infant mortality rate
10. Proportion of people with self-assessed good health

Who is the report for, and how might it be used?

The report is designed for use by individuals, organisations, agencies and partnerships – all those, in fact, who have an interest in improving health and well-being and reducing inequalities. The findings are directly relevant to the core business and work of a wide range of organisations, and demand urgent attention now that the government has set national targets for reducing health inequalities.

At the local level, the report is likely to be particularly helpful in the following ways:

- local strategic partnerships and their partner organisations, such as primary care trusts, can identify patterns of health and well-being in the geographical areas of most concern to them, and explore how their findings compare with the picture elsewhere in London

- multi-sector partnerships can use the findings to help inform their needs assessments of different populations and areas

- community and voluntary organisations can draw on the findings to identify outstanding needs and build a case for improved services

- public bodies of different kinds can draw on the report to help them work towards government targets in health inequality and to clarify the scope of the challenge involved in meeting their responsibilities associated with the Race Relations (Amendment) Act 2000.

At regional and national level, agencies will be able to draw on the report in order to:

- identify pan-London trends

- track emerging issues that cross borough boundaries or affect particular populations

- identify trends over time.

The previous two *Health in London* reports contained a series of recommendations and implications for action for policy makers and practitioners. These recommendations are being acted on in various ways and at different levels. For example, the London Health

Commission has been guided by the recommendations in developing its work programme. The Greater London Authority is also incorporating recommendations in planning work in relevant policy areas. For its part, the London Health Observatory will continue to promote further work to monitor and understand causes of health inequalities.

The London Health Commission is also committed to carrying out and publishing a wide-ranging review of progress on the recommendations.

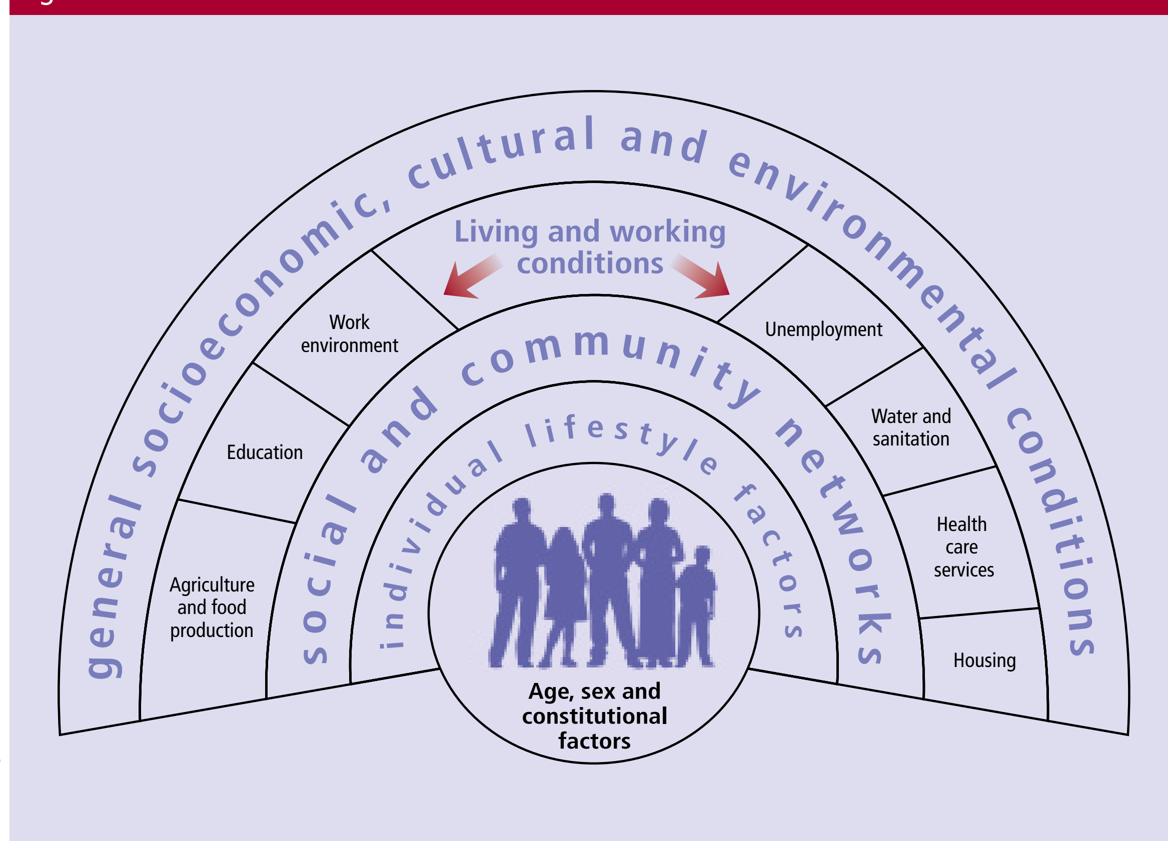
What kind of insights do the indicators provide?

Shedding light on the determinants of health

Many different factors influence people's health and well-being. The factors which have been found to have the most significant influence – for better or worse – are known as 'the determinants of health'. While health and social services make a contribution to health, most of the key determinants of health lie outside the direct influence of health and social care. Figure 1 provides a useful summary of the determinants of health described as layers of influence, starting with the individual and moving to wider society.

Included in these layers are the first seven of the ten indicators of the London Health Strategy. They have been designed to highlight significant aspects of the key factors affecting health. The final three indicators – life expectancy at birth, infant mortality rate, and the proportion of people with self-assessed fair, poor or bad health – are rather different in nature and purpose, and fall outside the scope of this particular diagram. They offer a means of judging health outcomes themselves – that is, the results for individuals and communities of the interplay of the different influences shown in the diagram.

Figure 1 The main determinants of health



Source: Dahlgren and Whitehead 1991

The ‘layers of influence’ approach to the determinants of health provides a simplified pictorial representation of the complex mix of influences that contribute to health inequalities. Section 2 looks in more detail at key influences in relation to the health inequalities experienced by London’s Black and minority ethnic communities.

Highlighting areas of health inequality

Broadly speaking, there are three types of inequality in health:

- inequalities in the determinants of health (for example, in education, employment or housing)
- inequality in access to health care (for example, refugees and several Black and minority ethnic communities in London report significant difficulty in obtaining primary health care)
- inequalities in health/health outcomes (for example, there are six years difference in average life expectancy at birth between the boroughs in London).

The high level indicators that are the subject of this report focus strongly on health outcomes and health determinants. The reason for this is that, as discussed earlier, most health is gained or lost outside the sphere of influence of the health service. That said, however, as one of London’s biggest employment sectors, the health and social services have a huge potential contribution to make to many of the key determinants of health.

More information on the determinants or indicators selected and how they are related to health is discussed in Section 3 and Appendix 2. Further background information can be found on the London Health Observatory web site at www.lho.org.uk

Health inequalities – tackling the health gap

In the summer of 2003, the government published a comprehensive cross-departmental action plan to tackle widespread inequalities in health across England *Tackling Health Inequalities: a programme for action* (DH, 2003a) – this is described and discussed below. First, though, are some reflections on the meaning of some of the key concepts used – for example, what are the key dimensions of inequality?

Dimensions of inequality

As *Tackling Health Inequalities* (DH, 2003a) demonstrates, different groups of people have very different experiences of key determinants of health, including employment, income, housing, community safety and education. These different experiences can have an effect on health. Some of the groups involved are well known – in particular, those defined by gender, class, ethnic group, age and geographical area. Others might be less obvious – such as disability, lone parenthood, quality of schooling, age of housing stock, type of road user.

‘Social exclusion’ is a shorthand term for what can happen when people suffer from a combination of inequalities in the determinants of health and in other areas of life. Similarly, ‘deprivation’ describes people’s experience where several factors combine to provide limited facilities, opportunities, and quality of life.

The *Health in London* reports attempt to deepen understanding of many of these dimensions in London – though by no means all. The 2003 report highlighted the experience of disabled Londoners and

contributed to a sharper focus in both the Greater London Authority and the London Health Commission on working with disabled people to gain a better understanding of, and to reduce, the inequalities that they experience. This report updates key information on a range of equality dimensions. Section 2 provides an additional focus on the broader issues related to the experience of Black and minority ethnic communities in London.

There is much debate about terminology relating to race and ethnicity and about whether any terms or categories, including those used in official statistics (e.g. 'non-White'), can claim to be accurate, appropriate, sensitive or value free. We can only touch on this debate here. No single term is entirely adequate and none will serve all purposes, as most commentators observe. Clearly, however, some choice of terms has to be made – for example, in citing official statistics. Accordingly, as discussed further in Section 2, a range of 'umbrella' terms is used in this publication.

The national context

This report fits well with work being carried out nationally to identify and combat inequalities in health and the factors influencing health.

In 1998 the *Independent Inquiry into Inequalities in Health* (Acheson, 1998) reviewed health inequalities in England, including analysis by geography, age, class, gender and ethnicity and made 39 recommendations for action. In July 1999 the White Paper *Saving Lives: Our Healthier Nation* (DH 1999) was published. It aims to 'improve the health of everyone and the worst off in particular'. Following this, the Government gave a commitment to reducing health inequalities in *The NHS Plan* (DH, 2000).

New national targets for reducing the gaps in life expectancy and infant mortality were announced in February 2001 (DH, 2001a). In a streamlined form, these targets appear in the Department of Health public service agreement, which took effect from 2003. Life expectancy and infant mortality are included as two of the indicators in this report, which contributes to the ongoing monitoring of these outcomes for Londoners.

The importance of addressing health inequalities is being actively acknowledged well beyond the Department of Health. A Treasury-led cross-government review of health inequalities (DH, 2002a) considered how best to match existing resources to health need and develop a long-term strategy to narrow the health gap. Following this, in July 2003, *Tackling Health Inequalities: a programme for action* (DH, 2003a) was launched. This sets out a cross-government programme to deliver the national health inequalities targets and to make wider, more long-term progress on reducing health inequalities.

The programme proposes twelve national headline indicators to monitor progress in tackling health inequalities. These indicators are: access to primary care; accidents; child poverty; diet; education; homelessness; housing quality; influenza vaccination; PE and school sport; smoking prevalence; teenage conceptions; mortality for the major killer diseases. These indicators will be supported through the adoption of local baskets of indicators to monitor progress within different areas and communities. More information on the indicators most relevant to London can be found on the London Health Observatory website: http://www.lho.org.uk/HIL/Inequalities_In_Health/Basket_Of_Indicators/Basket.htm

The programme acknowledges that health inequalities are stubborn, persistent and difficult to change. Accordingly, there is emphasis on creating movement in the following key areas:

- reversing the 'inverse care law' – whereby people with the greatest need tend to have poorer access to quality services
- getting a better balance between treatment and prevention
- creating an environment where families and communities have the chance to lead longer and healthier lives.

So, what does it look like in practice? The programme is organised around four themes, all of them requiring action at both national and local level:

- **supporting families, mothers and children** – to ensure the best possible start in life and break the inter-generational cycle of ill health
- **engaging communities and individuals** – to ensure the relevance, responsiveness and sustainability of initiatives
- **preventing illness and providing effective treatment and care** – to ensure that the NHS provides leadership and makes the contribution to reducing inequalities that is expected of it
- **addressing the underlying determinants of health** – to deal with the long-term underlying causes of ill health.

These themes are underpinned by five discrete principles that will guide how health inequalities are tackled in practice:

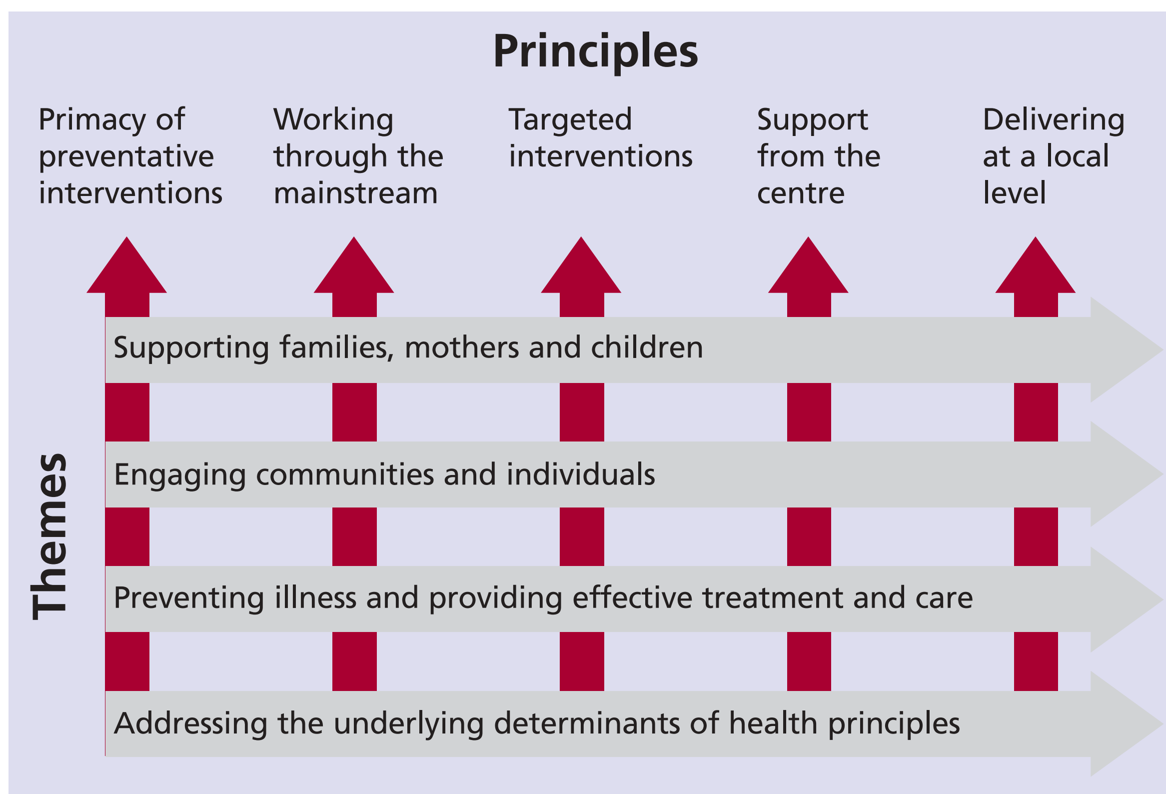
- preventing health inequalities getting worse by reducing exposure to risks and addressing the underlying causes of ill health
- working through mainstream services, making them more responsive to the needs of disadvantaged populations
- targeting specific interventions through new ways of meeting need, particularly in areas resistant to change
- supporting action at national level by clear policies effectively managed
- delivering at a local level and meeting national standards through diversity of provision.

The 'framework for action' at the heart of the programme, made up of these themes and principles, is summarised in Figure 2.

The programme will play an important role in informing local debates about how to tackle health inequalities. In particular, the framework for action, described above, is likely to offer a useful basis for local planning and investment. There is an on-going debate at local level on the need for 'targeted' versus 'universal' approaches to the design of services and interventions. While universal approaches can improve overall performance on some indicators, the inequalities underlying these headlines may remain static or even increase. The need for targeted interventions to address the distribution of effects has been largely unmet, since it is often difficult to attract mainstream funds for initiatives of this kind at local level.

Further evidence to support the programme for action has emerged from the Wanless report on NHS spending,

Figure 2 Health inequalities programme of action



Securing Our Future Health: Taking a Long-Term View (HM Treasury, 2002). This independent review was the first ever evidence-based assessment of the long-term resource requirements for the NHS. Following this, a further review, *Securing Good Health for the Whole Population* (HM Treasury, 2004), was carried out. It examines how public health spending decisions are taken, and how to ensure that they are cost effective and consistent in order to improve health outcomes. The government has announced that it intends to publish a White Paper on public health in 2004, and has launched a large public consultation to inform its development.

The London context

London's population was estimated to be more than 7.3 million in 2003 and this is projected to grow by another 810,000 by the year 2016 – equivalent to adding a whole new city to London's existing population. The profile of the population will continue to change, as it has throughout the city's history. In particular, changes in age and ethnicity are predicted so that, for example, by 2016 London's working age population will have grown by 516,000 and of these 80 per cent are likely to be from Black and minority ethnic communities (GLA, 2004a, Feb).

London is already a culturally diverse city, with one in three Londoners being from an ethnic minority community, and over 300 languages being spoken. This diversity is one of the features that makes London such a vibrant world city – yet we know that London's communities do not benefit in equal measure from the opportunities and wealth the capital has to offer.

London is characterised by marked contrasts between affluence and poverty. In 2003, London's GDP was estimated to be £180 billion, with 375 of the top 500 global companies having offices here,

cultural and creative industries generating an annual turnover of £25-29 billion, and visitors spending approximately £15 billion in total. However, Greater London also has 20 of the 88 poorest local authorities in the UK, and there continues to be a spatial distribution of disadvantage, with a greater concentration of deprived wards being in inner London. One in three older people and 43% of children in Greater London are estimated to be living below the UK poverty line, and most minority groups continue to experience high levels of unemployment and of child poverty (GLA, 2002, Nov).

The challenge in London is two-fold:

- more effectively understanding and tackling existing inequalities
- working together to ensure that growth over coming years does not result in an even greater divide between those best and worst off.

The London Health Commission, the Greater London Authority, the Regional Public Health Group and the London Health Observatory all have important London-wide roles to play in meeting these challenges.

Working at local level to tackle health inequalities in London

London boroughs have clear responsibility for addressing the well-being of the local community. The Local Government Act 2000 introduced a general power to take action to promote the economic, social and environmental well-being of their areas. The Health and Social Care Act 2001 provided additional health scrutiny powers (for information on these, see Democratic Health Network, 2002). The boroughs work through their programmes, including education, housing, community safety, social services and environment, often in partnership with statutory and voluntary sector agencies.

NHS services come together at local level through primary care trusts (PCTs), which work within the same boundaries as local authorities in London. PCTs are responsible for improving and protecting the health of their populations, and for reducing health inequalities within those populations. Specific responsibilities include:

- ensuring delivery of primary care services (for example, those health services provided by GPs, community nurses and midwives, pharmacists or therapists)
- commissioning hospital and mental health services
- developing and implementing local delivery plans, in accordance with the national NHS planning and priorities framework.

The national NHS planning and priorities framework highlights *health equity audit* as a tool for focusing work on tackling inequalities in health. Health equity audit involves reviewing in a systematic way, within defined populations, inequities in:

- the causes of ill health
- access to effective health services and their outcomes.

Audits of this kind can generate actions for local services and plans, and therefore can usefully shape the evaluation of work by the NHS and other partners to reduce health inequalities.

In short, they can be used to:

- inform the commissioning of services
- contribute to local performance management
- support partnership working, and the distribution of resources
- encourage community involvement.

The **voluntary and community sectors** in London have been shown to add considerable value to the design, planning and delivery of public services. This is particularly true when it comes to services developed for the capital's Black and minority ethnic communities.

Increasingly, different sectors work together through regeneration and local strategic partnerships. These can be particularly valuable in creating employment and training opportunities, strengthening joint work and tackling health concerns. Community plans and partnerships can provide the focus on tackling inequalities and promoting social inclusion, providing a focus for action at neighbourhood or community level. Local authority overview and scrutiny committees can undertake scrutiny of health and health services in their area, and the Association of London Government and Greater London Authority are working together on scrutiny arrangements for London-wide health services.

Overall local councils, health and social care services, community and voluntary organisations all have an important part to play in improving the health and well-being of Londoners and improving the public health of the community. The challenge is to identify and make best use of the expertise, experience and opportunities each sector brings to this area of work, and to demonstrate the relevance of the health inequalities agenda to their core business and responsibilities.

Update on findings

The report contains an update of findings for each of the ten indicators. Collection and analysis of information on some indicators have produced new findings. With others, the emerging picture is broadly similar to last year's. Details of findings, as well as gaps in current knowledge, are described in Section 3 and key findings are summarised below, indicator by indicator.

Taken together, the findings on the indicators continue to contribute to a collective understanding of inequalities in health across London's population. The report shows that some inroads have been made, but inequalities persist, for a range of reasons discussed in Section 3. Key findings from the main body of the report and their implications for future action are summarised below.

Key findings on the indicators

The indicators are designed to provide information on, and to monitor, trends in key determinants of health – and in particular, trends in inequalities in health and in the determinants of health. These trends can help to identify areas for action. They are 'high level indicators' and are not designed to be used for monitoring the effects of a specific project or strategy. The *Health in London* reports show how many different factors affect each of the indicators and it would not be possible to attribute a change in one of them to a specific activity.

Indicator 1 Unemployment

1. Newham, Tower Hamlets and Hackney have the highest unemployment rates of all local authorities in England and Wales.

2. Eight inner London boroughs have unemployment rates above 30 per cent in the 16-19 age-group.

3. Lack of qualifications is much more closely related to unemployment in people under 25 than in older age groups.

Indicator 2 Ethnicity and unemployment

1. Bangladeshis have the highest unemployment rate in London, more than four times that of the White British. They are followed by the Black African and Other Black groups. (2001 Census)

2. In the under 25 age-group, unemployment is highest for the three Black groups. Within each group, unemployment of under 25's stands at nearly one third. (2001 Census)

3. A government review of research concludes that differences in key factors, like qualifications, social class, age and area, fail to explain most of the ethnic differences in labour market achievement.

Indicator 3 Educational attainment: percentage of pupils achieving 5 GCSE grades A*-C

1. London is closing the gap with England, and this is mainly due to the improved performance of pupils at inner London schools.

2. There are major differences in the educational attainment of the different Black groups. This is especially evident when economic factors are taken into account.

3. The majority of Indian, Pakistani, Bangladeshi, Black African and Chinese pupils are registered as EAL (English as an additional language). Native English speakers do better at each stage of school. EAL pupils in different ethnic groups catch up to some extent, though not entirely. Bilingual pupils continue to need support for writing, even when they are fluent English speakers. (Findings are for England).

Indicator 4 Proportion of homes judged unfit to live in

1. The proportion of unfit dwellings in London has fallen every year from 1997 to 2002.

2. In England in 2001, 9.2 per cent of Asian and 8 per cent of Black households were in unfit homes, compared with 3.5 per cent of White households.

3. All ethnic groups benefited from the improvements in housing conditions in England between 1996 and 2001, but the relative position of ethnic minorities has not improved.

Indicator 5 Domestic burglary rate

1. Between 2001/02 and 2002/03, the domestic burglary rate in London fell from 10.1 to 9.8 per thousand residents.

2. In Britain, there are substantially increased risks of burglary, vehicle crime and street crime for all ethnic minorities, whichever method of measurement is used. However, White people are at above-average risk of

several other types of crime, like assault and household vandalism.

3. In Britain from 1988 to 1999, Pakistanis have been the group at greatest risk of crime overall. They have also been the group most susceptible to racially motivated crime. (The few separate results for Bangladeshis suggest that they faced a similar risk).

Indicator 6 Air quality indicators: NO_2 and PM_{10}

1. In London between November 1996 and December 2002, annual mean NO_2 has decreased by only 10 per cent, not enough to meet objectives. Many background sites exceed the limit.

2. There are many sites in London which continue to exceed the daily mean objectives for PM_{10}, but they are all near the road or on the kerb.

3. In 2001, ozone levels were exceeded at most sites for which data were available. The polluted areas were mainly in outer London.

Indicator 7 Road traffic accidents

1. London's road casualty rate in 2002 was 5.6 per 1000 residents, an improvement on the previous year's rate of 6.1. This was due to a 7 per cent fall both in the number of slight and of serious/fatal injuries.

2. After a sharp rise in London between 1995 and 2001, powered two wheeler casualties dropped in 2002; however, they are still far above the 1994-98 average.

3. The pedestrian casualty rate of Afro-Caribbean children in London is more than double that of the next highest ethnic group.

Indicator 8 Life expectancy at birth

1. Life expectancy is generally increasing in London as a whole and nationally; London as a whole has similar life expectancy as England.

2. At borough level average life expectancy is closely related to the level of deprivation, with a stronger association between life expectancy and deprivation for males than for females.

3. There are wide variations in life expectancy by ward in London. Most of the wards with significantly low male and female life expectancy are in inner London. However, there are pockets of areas in more prosperous outer London with low life expectancy.

Indicator 9 Infant mortality rate

1. The overall infant mortality rate in London continues to be very similar to infant mortality in the rest of the country.

2. The infant mortality rate in London as a whole has declined from 7.3 infants deaths per 1,000 live births in 1990-92 to 5.7 in 2000-02.

3. There were wide variations in infant mortality by borough. Brent, Lambeth, Southwark, Newham, Hackney and Waltham Forest had the highest rates and along with Croydon were significantly higher than the England rate.

Indicator 10 Proportion of people with self-assessed good health

1. The information from the 2001 census shows that slightly more Londoners

assess their health as good than England as a whole.

2. Boroughs that had the lowest percentages of residents reporting good health are Tower Hamlets, Hackney and Newham for males, and for females it was the same boroughs as well as Barking and Dagenham and Islington. There are wide variations in the percentage reporting good health by ward in London. Most of the wards with significantly low male and female good health were in inner London. However, there are pockets of areas in inner London with high percentages reporting good health.

3. There are wide variations in the percentage reporting their health as not good by ethnic group. The percentage who reported their health as not good was highest in the Asian British Bangladeshi and Pakistani groups and was also high in the Indian and Black Caribbean groups.

Inequality – key findings across the indicators

Area

In burglary and road casualty rates, London has narrowed the gap with national figures in the last year. Among the seven determinants, there has been one significant change from last year – the narrowing of the range for domestic burglary.

The gaps in both life expectancy and in infant mortality rates between boroughs are similar to those that appear in previous *Health in London* reports. The boroughs with the highest and lowest measures do change from year to year. This, however, is likely to be a result of changes in underlying population estimates for life expectancy and a random variation in the number of infant deaths each year for infant mortality. The group of boroughs with the highest and lowest infant mortality rates remains similar from year to year

This is the first time we have been able to present standardised good health ratios for London boroughs, London and England. This is the only indicator where London fared better than England as a whole, with approximately 3% more males and females who reported their health as good in London. Despite this, there are areas of London which had a lower than average proportion reporting their health as good.

Gender

Men have higher unemployment rates than women, but the difference is greatest in the 55-64 age-group.

Long-term trends in different ethnic groups show that women's unemployment rates are less volatile than men's.

The gap between London boroughs with the longest and shortest life expectancies for men has narrowed since 1999-2001, but the gap between London boroughs for women's life expectancy has increased over the same period.

Disability and/or ill health

Last year's *Health in London* report focused on disability and contains more detail. This showed that disabled people fared worse on the seven determinants of health, and suggested that people with learning difficulties and mental health needs were particularly at risk.

The most significant new findings in this report are from the *English House Condition Survey 2001* (ODPM, 2003a). This shows, for example, that disabled/ long-term ill people are at risk in private tenancies.

Focus on ethnicity

In general, non-White groups fare worse on the indicators for which data are available – unemployment, GCSE attainment, unfit housing, domestic burglary, road casualties and self-assessed health status. The evidence is most clear-cut for the first three of these and for self-assessed health status:

1. Non-White groups are more than twice as likely as White people to be **unemployed**. Bangladeshis are most at risk, while Indians are only slightly more at risk than White people. Youth unemployment is highest for the three Black groups.

2. **GCSE attainment** is below average for most non-White minorities, especially Black Caribbeans. (If non-census categories are included, Gypsy/ Roma and Travellers of Irish Heritage have the lowest attainment levels). Pakistanis, Bangladeshis and Black Africans have intermediate results, which vary in different regions. Indians and Chinese perform well above average.

3. London research found that Bangladeshis had the highest levels of housing need. Housing conditions are also below average for Black groups, especially Black Africans.

4. Non-White groups are more likely to be burgled but not necessarily at greater risk of **crime** overall.

5. Children from ethnic minority backgrounds suffer a substantially greater risk of pedestrian **road casualties** than do their peers in the majority population. Afro-Caribbean children in London tend to be casualties.

6. Information from the 2001 census looking at self-assessed health status among those over the age of 50 shows that the percentage who reported their health as not good was highest in the Bangladeshi and Pakistani groups, but also high in the Indian and Black Caribbean groups. The White British group had the lowest percentage that reported not good health.

A composite indicator would probably show that among non-White minorities, Bangladeshis score lowest on the health determinants and Indians the highest. (Details for Chinese people are missing on several of the indicators.)

Factors affecting ethnic inequalities

Occupational background and economic disadvantage have an important bearing on the labour market and educational achievement of ethnic minorities, and on their experiences of crime, but this is not the whole story. There is strong qualitative evidence that language and recency of migration are important for education. Cultural and lifestyle factors almost certainly play a role, for example in the strong educational performance of the Chinese, and in certain types of crime risk. Discrimination and prejudice are significant factors in employment, education and crime victimisation, but may be most extensive in employment. There is little recent evidence in the housing field, although some practices can have an indirect discriminatory effect (ODPM, 2003b).

Long-term trends

There is evidence that ethnic inequalities in employment, education, housing and crime are very persistent. (Information on long-term ethnic road casualty trends is not available.) Only for unemployment can the degree of inequality be reliably measured over time; the results show that, in the last twenty years, the gap has widened, although unemployment itself is lower for everyone. In education, housing and crime, there have been persistent problems for some groups.

There are also some encouraging signs. For instance:

- There is evidence that British-born people from ethnic minorities have made progress in terms of earnings and access to professional/managerial jobs. It is in unemployment that least economic progress has been made.

- There has been a steady rise in the employment rate of women in non-White groups. Qualifications are helping Pakistani and Black African women into employment.

- Good educational data are now available for the first time, and they indicate that, given the right policies, several groups should reach or surpass the average level before long.

The most recent crime analysis suggests that ethnic minorities may no longer be at greater risk of crime overall, but this needs to be confirmed by further information.

Implications for action

This final part of the section highlights ongoing and additional implications for action on health inequalities arising from the key findings of the 2004 report.

Strategic change of the kind suggested can, in time, achieve real improvements in front-line services and in the experience of different communities. Better collection, analysis and use of information can, and should, have a powerful impact on decisions about resource allocations and service delivery. In addition, an increased focus on joint working with diverse communities should help service planners and providers to gain a better understanding of London's needs and strengths – as well as our collective potential to challenge discrimination and reduce inequalities.

Local and regional organisations and partnerships are encouraged to explore in a practical way how they can take action to:

- increase awareness and understanding of health inequalities

- develop and implement local initiatives to tackle inequalities, working closely with disadvantaged communities to identify priorities for action

- contribute to the development and delivery of regional and national programmes to reduce health inequalities and improve health and well-being.

On a practical level, the following challenges have implications for action at both regional and local level:

- What further information needs to be collected and shared? Gaps in our existing knowledge need to be filled to enable us to work together to direct our effort more effectively.

- How can more use be made of existing information in order to bring

about change? We need to review, plan and coordinate our activities and programmes so as to build on what has already been learned.

Further information to be collected and shared

- There are constant and often rapid changes in the make-up of London's population. For example, the 2001 census was the first to record information about the proportions from mixed race groups; and it showed that substantial numbers of people from mixed race heritage are living in London. **Data from the 2001 census needs to be supplemented** by the systematic gathering of information, at London-wide and local level, on emerging health needs within the different populations.

- Building on data emerging from the 2001 census, there is an ongoing need for research to increase our understand of how different factors, such as socio-economic standing, gender, ethnicity, faith and disability, interact to determine the health status of groups within wider communities. While this is progressing, **action to tackle health inequalities needs to take into account a range of determinants**, rather than attempting to deal with individual factors in isolation.

- Where it has been introduced, **service user profiling** is making a useful contribution to planning public services which meet the needs of different groups within wider communities.

- **Information about service users should be routinely recorded, shared, and used** in order to increase understanding of local people's health, along with their access to services that impact on health, and to plan for improved services.

- The statutory requirements associated with the Race Relations (Amendment) Act 2000 provide a framework for increased monitoring and use of information about ethnicity. Much needs to be done, within and beyond the health service, to **establish the routine monitoring of self-defined ethnicity** in different settings at local level.

- **Ethnic categories should be refined as much as possible by those collecting information for research and service planning**. The new educational statistics have demonstrated the inadequacy of broad categories like 'Black' and 'Asian'. Further refinement is needed at local level, to establish the needs, for example, of the Turkish Cypriot and Somali communities in London. In this way, a more focused approach can be taken to establishing health needs and challenging health inequalities, making the best use of the information available. (Recently published guidelines address some of the difficulties of recording and measuring ethnicity (Office for National Statistics, 2003a).)

- **Better links need to be established between qualitative and statistical information, at London-wide and local level**. Broad references to 'cultural factors' are too vague. We know they exist, but how do they affect, for example, the risks of being a crime victim? Good qualitative research can, in principle, be linked to official statistics. (This is more easily done on an area basis. It is sometimes also possible to establish individualised links, provided that there is no breach of confidentiality).

- Further work is needed to identify with London's diverse communities their own experience and expertise in dealing with health issues. Better use should be made of **community intelligence** to increase understanding of community-led responses to health issues, and to learn from them about culturally-determined approaches to improving health and responding to illness. Medical research resources should be allocated in such a way as to make this possible – supporting research based on a wider range of perspectives about health, as well as concentrating on health service delivery and on western medical models of health and disease.

- In addition to the broader implications summarised above, the report also highlights the need for **specific research** into:

  - the health needs of more recently-arrived communities whose needs were not identified in earlier studies (such as some African communities)

  - the implications for health-related services of London's changing profile related to faith and religion

  - the links between ethnicity, socio-economic status and road casualties; in London, Afro-Caribbean children have a greatly increased risk of being involved in a road accident

  - the effects of parental background and generation on the labour market achievement of ethnic minorities; generation (1st, 2nd etc) and age should be considered together

  - the effects of economic disadvantage on the educational attainment of ethnic minorities

  - analysis of ethnicity in relation to specific crimes (assault, robbery etc), especially racist crimes, needs to be updated, along the lines of a Home Office study in 1996 (Fitzgerald & Hale, 1996)

  - identification of recruitment and employment policies and practices most likely to offer appropriate job opportunities to socially excluded Londoners, and analysis of information about approaches which overcome barriers to employment.

Making more use of existing information in order to bring about change

- Much potentially valuable **data from the 2001 census and other sources remains unused** at local level. More should be done to:

  - identify the barriers which prevent people in the voluntary and statutory sectors from accessing and using this data when planning work on health inequalities

  - encourage and support people at local level in making active use of what is known about the interaction between different influences on health, and, where possible, in supplementing the national and regional data with local information.

- Where research findings have led to **good practice in tackling health inequalities** – or where good practice has been confirmed by research – efforts should be made at all levels to disseminate this good practice widely. For example, the Health Development Agency (2003) has published a compendium of 'promising practice'

in tackling health inequalities (see Resources, page 136, for other examples). Where information about effective interventions is not available, it should be sought, evaluated and disseminated. Agencies and partnerships should actively seek to evaluate the effectiveness of their local interventions, so that our collective understanding of how best to tackle health inequalities continues to increase.

- There is a need for more detailed **profiling of health inequalities at local level** to better inform strategies and programmes for action. This should build on the experience and learning of those local partnerships already engaged in building local profiles from a range of existing data sources. It should ensure that good use is made of relevant data collected by partner agencies, including boroughs, primary care trusts, and local voluntary sector organisations.

- Good use should be made of **local mechanisms and opportunities to investigate and influence services** (including health scrutiny, health equity audits and best value reviews) to make use of equality information to influence decisions about resource allocation and service delivery. Such information should be used to identify where resources need to be targeted to improve the health of London's most deprived communities, including communities known to be experiencing multiple deprivation

- Every effort should be made to **raise awareness of the national programme, *Tackling Health Inequalities: a programme for action*** (DH, 2003a), and its implications for local planning, action and monitoring. The high level indicators used by the London Health Commission should be reviewed in the light of the national work to identify a 'basket of indicators' for measuring health inequalities.

- **Comparative data** should increasingly be collected and used to raise questions about why the experience of some groups and/or areas seems worse than others' experience in London, and to identify priorities for action. Action needs to continue at both local and regional levels to understand and reduce health inequalities both within and between boroughs.

- Information gathered during 2003, European Year of Disabled People, should be disseminated and made use of to **increase awareness of disabled Londoners' experience and views**, and to focus attention on key areas requiring action.

- The **Disability Discrimination Act should be used at all levels** to focus on health inequalities and disability, to tackle barriers to services and opportunities, and to address the needs of disabled people more effectively.

- The perspectives associated with **social models of health and disability** need to be made more widely known and used to challenge policies and practice. In addition, information about minority ethnic communities' perceptions of health and illness should be more effectively disseminated to organisations providing services and opportunities which impact on health.

Areas for focused action

In addition to the broader implications summarised above, many of which are

relevant to a range of BME communities, the report also highlights the need to take specific action to:

- prepare maps at ward level to provide a graphic demonstration of local health needs and health inequalities, including any pockets of deprivation
- provide appropriate language support, making use of the available evidence – for example, that women from Bangladeshi, Pakistani and African communities benefit from language study support to enable them to take part in economic activity.

Key actions – a checklist

Further information to be collected and shared

- Data from the 2001 census needs to be supplemented by the systematic gathering of information, at London-wide and local level, on emerging health needs within the different populations
- Action to tackle health inequalities needs to take into account a range of health determinants
- Information about service users should be routinely recorded, shared, and used
- The Race Relations (Amendment) Act 2000 provides a helpful framework for establishing the routine monitoring of self-defined ethnicity
- Ethnic categories should be refined as much as possible by those collecting information for research and service planning
- Better links need to be established between qualitative and statistical information, at London-wide and local level
- Better use should be made of community intelligence to increase understanding of community-led responses to health issues
- Certain issues demand specific research and action.

Making more use of existing information in order to bring about change

- More use should be made of data from the 2001 census and other sources
- Good practice in tackling health inequalities should be disseminated widely
- There is a need for more detailed profiling of health inequalities at local level
- Good use should be made of local mechanisms and opportunities to investigate and influence services

Key actions – a checklist (continued)

- Every effort should be made to raise awareness of the national programme, *Tackling Health Inequalities: a programme for action,* and its implications for local planning, action and monitoring
- Comparative data should increasingly be collected and used to raise questions about why the experience of some groups and/or areas seems worse than others' experience in London, and to identify priorities for action
- The Disability Discrimination Act should be used at all levels to focus on health inequalities and disability, and to address the needs of disabled people more effectively
- The perspectives associated with social models of health and disability need to be made more widely known and used to challenge policies and practice.