



# RACE EQUALITY SCHEME

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<b>Ratified by PCT Board</b>	
<b>Review Date</b>	
<b>Important Note</b> : This is an interim Scheme developed for the PCT to meet the legal requirements of the Race Relations (Amendment) Act 2000. It is still subject to further consultation within the PCT. The PCT has agreed to develop a Single Equality Scheme to also meet the requirements of the Disability Discrimination Act 2005 and Equality Act 2006 . This interim Scheme will be superseded by that Scheme when agreed.	

# **RACE EQUALITY SCHEME**

## **FOREWORD BY THE CHIEF EXECUTIVE AND CHAIR**

It is the belief of South Staffordshire Primary Care Trust that racial inequality is unacceptable. This is stated clearly in the PCT's Equality and Diversity Policy.

At the heart of the PCT is the need to improve services delivered to our local population and to reduce health inequalities.

This relates to ALL regardless of race, gender, disability, sexual orientation, social background etc.

The PCT will strive to promote racial equality for everyone who comes into contact with the services provided by the PCT and also promote racial equality for both potential and existing staff.

This should not be considered as another Human Resources initiative; the requirements of the Race Relation (Amendment) Act 2000 have implications for the delivery of Human Resources and Organisational Development practices across the PCT, but they equally have far reaching implications for service delivery and with the requirement to demonstrate action in improvements in service delivery the challenges may be greater.

It is also important that these issues are not seen in isolation or seen as targeting one group within society to the disadvantage of another. Therefore, wherever possible, the PCT will aim to deliver a Racial Equality Scheme that is integrated within existing processes and procedures. For example, the monitoring and target setting for representation within the workforce will be delivered through performance management arrangements.

Evaluation and reporting mechanisms relating to race will be established through mechanisms such as the Annual Report, Clinical Governance and Staff Opinion Survey to ensure that they are seen as an essential part of mainstream PCT business.

User and carer groups will also be asked to look at service access issues through established arrangements.

## INTRODUCTION

The tragic death of Stephen Lawrence and the subsequent findings of the public inquiry left a clear legacy in ensuring how public institutions behave towards black and minority ethnic citizens they serve. The amendment to the 1976 Race Relations Act places a new statutory duty on all public bodies to positively promote race equality in service delivery and employment. Organisations were no longer being asked to *'make appropriate arrangements'* as in previous legislation but to pay *'due regard'* to promoting race equality. This is the challenge facing all public bodies and an opportunity to learn, develop and implement policies and strategies that provide equal access to all in an inclusive, non-discriminatory and culturally appropriate way.

The Stephen Lawrence inquiry defined institutional racism as

*"A collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes, and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantages minority ethnic people"*  
(para 6.34 Stephen Lawrence Inquiry Report).

This definition needs to be carefully considered by all that work in the public sector within the context of daily work practices.

South Staffordshire PCT is committed to promoting equality of opportunity for all the different groups within the population of South Staffordshire. It takes seriously its obligations under the Race Relations Amendment Act 2000 and wider equality legislation enshrined within the Disability Discrimination Act (DDA), Equal Opportunities Act, Human Rights Act and regulations under article 13 of the European Communities Act covering sexuality, age, religion and belief.

## THE RACE RELATIONS AMENDMENT ACT 2000

Under the Act, the Primary Care Trust is a public authority defined as a *"body named, defined or described in schedule 1A to the Race Relations Act or, depending on the context, a body named, defined or described in one of the schedules to the Race Relations Act 1976 (Statutory Duties) Order 2001."* (CRE Code of Practice). It also meets the requirements in performing a public function defined as "functions that affect, or are likely to affect, the public or a section of the public" (CRE Code of Practice) The Race Relations (Amendment) Act 2000 came into force in April 2001 outlining a general duty and specific duties for public authorities to comply with.

## **THE GENERAL DUTY**

A general duty is placed on all public authorities to have due regard to:

- a) Eliminate unlawful racial discrimination
- b) Promote equality of opportunity
- c) Promote good relations between people of different racial groups

There are also four underlying principles that support the implementation of the general duty and need to be borne in mind in delivering on this important agenda:

- 1) Promoting race equality is obligatory for all public authorities listed in schedule 1A to the Act
- 2) Public authorities must meet the duty to promote race equality in all relevant functions
- 3) The weight given to race equality should be proportionate to its relevance.
- 4) The elements of the duty are complementary, as they are all necessary to meet the whole duty.

### **Specific duties**

Under the Act the Home Secretary has powers to place specific duties on public authorities that will assist them in meeting the general duty to promote race equality. The specific duties came into effect on 31 December 2001 with bodies given until 31 May 2002 to, as part of the specific duties, prepare and publish a race equality scheme (RES) setting out the 'functions' or 'policies' relevant in meeting the general duty.

The contents of a Race Equality Scheme are clearly defined by the Act and in particular articles 2(2) and 2(3) of the 1976 Race Relations Act (Statutory Duties Order 2001).

The scheme should state:

- Functions or policies or proposed policies relevant to meeting the general duty
- Assessing and consulting on likely impact of its proposed policies
- Monitoring policies or any adverse impact
- Publishing the results of the assessments and consultation and monitoring
- Ensuring public access to information and services
- Training staff in respect to the duties imposed in the general duty

### **Employment duties**

Under the specific duties on employment South Staffordshire PCT undertake to monitor by racial group:

- Numbers of staff in post and
- applicants for employment

- training and employment from each racial group

Public authorities that have 150 or more full time staff are required to meet additional duties under the Act. As a public authority with more than 2000 employees, South Staffordshire PCT will as a matter of good practice adhere to the additional duties in monitoring by racial group those employees who:

- receive training
- benefit or suffer detriment as a result of its performance assessment procedures
- are involved in grievance procedures
- are the subject of disciplinary procedures
- cease employment

These results are to be published annually.

South Staffordshire PCT will also review its race equality scheme every three years in accordance with the obligations under the Act. This document will be subject to continual development and improvement to ensure a more flexible and rapid response to eliminating adverse impact on race equality.

Our aim is to make race equality become the responsibility of all our stakeholders within South Staffordshire PCT, internally with our own staff and organisation, as well as with external partners.

## **THE ROLE OF THE PCT**

South Staffordshire Primary Care Trust came into being on 1st October 2006, following the merger of Burntwood, Lichfield & Tamworth, Cannock Chase, East Staffordshire and South Western Staffordshire Primary Care Trusts.

South Staffordshire Primary Care Trust serves a population of approximately 604,000 people and is located within the geographical boundaries of Staffordshire County. It employs just over 2,000 staff and its forecast turnover for 2006/07 is £675M.

Although largely rural, the Primary Care Trust contains a number of urban centres including Burton upon Trent, Cannock, Stafford and Tamworth.

The PCT strives to:

- Secure the provision of safe, high quality services delivered in the most appropriate settings, based on need, with the patient user as the focus
- Tackle the major determinants of ill health and promote good health.

The PCT is responsible for ensuring the population it covers receives appropriate care from local and specialist hospitals, community services (ie District Nurses and Health Visitors) and primary care services from doctors, dentists, opticians and pharmacists.

Where the PCT does not provide services itself, it commissions them from other healthcare providers. These commissioned services include:

- General acute services
- Specialised Services eg renal and cardiac
- Services for people with mental health needs
- Services for people with learning disabilities
- Ambulance services

The acute hospitals located within this Primary Care Trust area are: Cannock Chase Hospital, Queen's Hospital Burton and Mid Staffordshire General Hospital. South Staffordshire Healthcare NHS Trust provides care for adults and children including specialised mental health, learning disability services and community services.

Accountability to the local population is achieved by having a Board, which has a majority of local, independent people appointed by the Appointments Commission.

The Board has a primary purpose of setting the strategic direction of the PCT, taking into account guidance from the Department of Health. It then has the role of monitoring performance against this strategy.

The Board is supported by the Professional Executive Committee (PEC) where local clinicians are in the majority to provide specialist, clinical input to the Board. Board and PEC meetings are held in public.

### **South Staffordshire - Black and Minority Ethnic Populations**

Data from 2001 census on ethnicity, country of birth and religion of the populations of South Staffordshire PCT (and other council areas in Staffordshire) is attached as **Appendix 1** to this document.

The tables in this Appendix reflect the population of local Councils in Staffordshire. The population served by the PCT is covered by the following district councils :

- Stafford Borough,
- East Staffordshire District Council,
- South Staffordshire District Council,
- Cannock Chase District Council
- Lichfield District Council
- Tamworth District Council

and the figures below reflect the data from these five councils.

Tables in this Appendix indicate that between 93.9% and 98.1% of the population in areas served by the PCT are White, that between 1.65 and 4.1% of the population were born in other EU countries or elsewhere, and that between 0.8% and 4.8% of the population have an identifiable non-Christian

religion. The tables also show a range between the different district council areas served by the PCT

Data on ethnic breakdown of the PCT workforce is attached as **Appendix 2**

It is recognised that ethnicity has an effect on patterns of health and ill health – an extract from a mapping exercise undertaken by Keel University is attached as **Appendix 3**

## **STATEMENT OF STRATEGIC INTENT**

Working in partnership, the PCT aims to improve the health and well being of the responsible population, through:

- Securing and provision of safe high quality services delivered in the most appropriate setting, based on needs, with the patient/user as the focus. (***The PCT will ensure the provision, and access to, services to members of the community based on clinical need and irrespective of ethnic origin.***)
- Tackling the major determinants of ill health and promoting good health. (***The PCT will recognise the potential influence of ethnic origin in relation to health and ill health (see Appendix 4)***)

## **NATIONAL STRATEGIC CONTEXT IN THE NHS**

The following are key policy drivers and initiatives that provide some of the context within the NHS to support implementation of our Race Equality Scheme.

- The framework for the NHS on Equalities, **The Vital Connection**, introduces a range of indicators, standards and monitoring arrangements as well as national targets for the NHS from April 2000 on disability, tackling harassment, achieving a representative work force and board training on equality and diversity.
- **Working Lives: Programmes for Change - Positively Diverse** is a national organisational development plan that aims to change the culture of NHS – it encourages local action to create an environment where differences between staff are seen as normal and welcome.
- Guidance is available to set up **Black and Minority Ethnic Staff Networks**. The Positively Diverse programme is particularly useful in changing the culture of organisations in relation to employment of diverse staff.
- **Tackling Racial Harassment in the NHS** – Good Practice Guidance is one of the initiatives of **Improving Working Lives**. It provides guidance on dealing with racial harassment and what steps need to be taken to develop policies and procedures.

- **Looking Beyond Labels**, Working Lives: programme for change focuses on widening the employment opportunities for disabled people in the NHS.
- **Putting Race Equality to Work in the NHS, a resource for action** covers; getting started, involving the Board, auditing work in progress, assessing impact, training, employment, mainstreaming equality, involving local communities and action planning.
- **Equality Standards in Health and Social Care**, a scoping study in 2001 that compares 8 toolkits for developing Race Equality Standards with recommendations on what would be of most value in the development of such toolkits.

## **OUR COMMITMENT TO MEETING THE GENERAL DUTY**

South Staffordshire PCT will act positively to implement the general duty set out in this scheme in all its functions and obligations as outlined in our action plan. We shall endeavour to work in partnership with our local communities, social care districts, other agencies and partnerships to promote a more holistic and inclusive approach in delivering on this agenda for change.

## **DELIVERING ON THE RACE EQUALITY SCHEME**

Examples of what the Board needs to do includes:

- Have an executive and non executive lead
- Monitor the implementation of the scheme at Board level
- Set up an internal monitoring an implementation group
- Regular progress reports presented to the Board

This Race Equality Scheme will be delivered effectively via a number of channels. The PCT already has a range of activities and practices in place which promote and support the achievement of Race Equality. These include :

- Recruitment and Selection Procedures
- Monitoring Procedures relating to recruitment and selection
- Dignity and Respect at Work Policies
- Equality and Diversity Policies
- Training sessions for staff for enhancing awareness of equality and diversity issues

These activities and practices will be subject of review and updating to ensure that they are effective and are in line with the latest legislative requirements and best current practice.

Progress will be reported to the Board on a regular basis.

## Extract from 2001 Census Key Statistics, Research Unit, Staffordshire County Council

**Note:** In the tables below the population of the PCT appears in the rows for Stafford Borough, East Staffordshire, South Staffordshire, Cannock Chase, Lichfield and Tamworth District Councils

### 5. Ethnicity, Country of Birth and Religion

- 5.1. England continues to have a diverse ethnic mix with over 9% of the population being non-white. The biggest ethnic cohort in England are black groups accounting for 2.3% of the population, closely followed by the Indian population at 2.1%. A higher proportion of population in the West Midlands Region are non-white, a total of 11.3% come from other ethnic groups. In contrast Staffordshire has a much lower proportion of non-white population at only 2.4%, this being only 21% of the average for the Region. Staffordshire Moorlands has the smallest proportion of non-white population in Staffordshire with only 0.8% (726 persons). In contrast East Staffordshire has the highest percentage of non-white population with 6.1% (6,323 persons).
- 5.2. The biggest ethnic group in Staffordshire is the Pakistani population at 0.6% (4,582 persons), of which 84% (3,862 persons) are concentrated in East Staffordshire, which accounts for 3.7% of the total population of this district. Mixed ethnic groups also account for 0.6% (4,952 persons) of the Staffordshire population, with the highest concentrations found in Stafford and East Staffordshire. The Indian cohort accounts for only 0.5% (3,653 persons) of the population of the County with the highest concentration located in South Staffordshire, with 0.7% (789 persons) of the population of this district being from this ethnic group. Only 0.3% (2,625 persons) of the population of Staffordshire are from black groups with the highest concentrations in Newcastle-under-Lyme and Stafford.

See Table 2 for full ethnicity figures for Staffordshire.

Table 2 Ethnicity (percentage)

	All people	White	Indian	Pakistani	Black	Mixed	Other
Staffordshire Moorlands	94,488	99.2%	0.1%	0.0%	0.1%	0.4%	0.2%
Newcastle-under-Lyme	122,030	98.0%	0.4%	0.2%	0.2%	0.6%	0.7%
Stafford	120,670	97.4%	0.6%	0.2%	0.5%	0.8%	0.5%
East Staffordshire	103,770	93.9%	0.4%	3.7%	0.6%	0.9%	0.5%
South Staffordshire	105,896	98.0%	0.7%	0.1%	0.3%	0.6%	0.3%
Cannock Chase	92,126	98.6%	0.3%	0.1%	0.2%	0.4%	0.4%
Lichfield	93,232	98.1%	0.6%	0.1%	0.3%	0.5%	0.4%
Tamworth	74,531	98.1%	0.4%	0.0%	0.5%	0.7%	0.3%
Staffordshire	806,744	97.6%	0.5%	0.6%	0.3%	0.6%	0.4%
West Midlands Region	5,267,308	88.7%	3.4%	2.9%	2.0%	1.4%	1.6%
England	49,138,831	90.9%	2.1%	1.4%	2.3%	1.3%	1.9%

Source: 2001 Census Key Statistics for Local Authority Areas, Office for National Statistics  
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- 5.3 Over 94% of the population of Staffordshire was born in England with a further 3.8% being born in the rest of the United Kingdom. This is a much higher proportion than for the West Midlands with only 89% being born in England and 3.3% being born in the rest of the United Kingdom. In total 2.9% of the population of Staffordshire were born outside the United Kingdom, this compares with 7.6% for the West Midlands and 9.3% for England.
- 5.4 East Staffordshire has the highest percentage in Staffordshire for persons born out the United Kingdom at 4.5%. The lowest proportion in the County is found in Staffordshire Moorlands with only 1.7% of the population being born outside the United Kingdom. Stafford has the lowest percentage of persons born in England in Staffordshire at 92.1% with Staffordshire Moorlands having the highest proportion at 96.4%. More details can be found in **Appendix F**.
- 5.5. For the first time the 2001 Census asked a question about religion. The population of Staffordshire is 80.1% Christian with other religions accounting for only 1.5% of the population, 11.7% of the population stated that they had no religion and 6.7% did not complete the question. The highest percentage of Christians in Staffordshire is in South Staffordshire (83.5%), closely followed by Staffordshire Moorlands (82.8%). The lowest proportion of Christians, in the County, is in Tamworth with 76.8% of the population belong to this faith, however, this is still much higher than the average for the West Midlands Region (72.6%) and England (71.7%). The largest none Christian faith, in Staffordshire, is Muslim with 6,081 persons belong to this faith, this equates to only 0.8% of the total population of the County. However, 68% of all Muslims in Staffordshire live in East Staffordshire, the group accounts for 4% of the population of the district. Other faith groups appear to be fairly evenly distributed throughout the County. Further information relating to religion and its distribution across the County can be found in Appendix F.

## Appendix F

Table F1 Country of Birth (percentage)

	All people	England	Scotland	Wales	Northern Ireland	Republic of Ireland	Other EU Countries	Elsewhere
Staffordshire Moorlands	94,489	96.4%	0.8%	0.9%	0.2%	0.2%	0.5%	1.0%
Newcastle-under-Lyme	122,030	94.5%	1.0%	1.2%	0.3%	0.3%	0.8%	1.9%
Stafford	120,670	92.1%	1.7%	1.7%	0.5%	0.6%	0.9%	2.4%
East Staffordshire	103,770	92.7%	1.4%	1.0%	0.4%	0.4%	0.7%	3.4%
South Staffordshire	106,896	95.5%	0.8%	1.2%	0.2%	0.4%	0.5%	1.3%
Cannock Chase	92,126	95.2%	1.5%	1.1%	0.2%	0.4%	0.5%	1.1%
Lichfield	93,232	94.1%	1.3%	1.4%	0.3%	0.5%	0.6%	1.7%
Tamworth	74,531	94.9%	1.1%	1.0%	0.4%	0.7%	0.6%	1.3%
Staffordshire	806,744	94.3%	1.2%	1.2%	0.3%	0.4%	0.6%	1.8%
West Midlands Region	5,267,308	89.1%	1.1%	1.8%	0.4%	1.0%	0.8%	5.8%
England	49,138,831	87.4%	1.6%	1.2%	0.4%	0.9%	1.4%	6.9%

Source: 2001 Census Key Statistics for Local Authority Areas, Office for National Statistics  
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Table F2 Religion (percentage)

	All People	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other	No Religion	Religion Not Stated
Staffordshire Moorlands	94,489	82.8%	0.1%	0.0%	0.0%	0.1%	0.0%	0.2%	9.8%	7.0%
Newcastle-under-Lyme	122,030	78.5%	0.1%	0.2%	0.1%	0.5%	0.1%	0.2%	13.1%	7.2%
Stafford	120,670	79.9%	0.1%	0.2%	0.1%	0.4%	0.3%	0.2%	12.1%	6.6%
East Staffordshire	103,770	77.5%	0.1%	0.2%	0.1%	4.0%	0.2%	0.2%	11.5%	6.3%
South Staffordshire	105,896	83.5%	0.1%	0.2%	0.0%	0.2%	0.5%	0.1%	9.2%	6.1%
Cannock Chase	92,126	80.8%	0.1%	0.1%	0.0%	0.2%	0.2%	0.2%	11.3%	7.2%
Lichfield	93,232	80.4%	0.1%	0.2%	0.1%	0.3%	0.3%	0.1%	11.9%	6.6%
Tamworth	74,531	76.8%	0.1%	0.2%	0.0%	0.2%	0.2%	0.2%	15.5%	6.9%
Staffordshire	806,744	80.1%	0.1%	0.2%	0.1%	0.8%	0.2%	0.2%	11.7%	6.7%
West Midlands Region	5,267,308	72.6%	0.2%	1.1%	0.1%	4.1%	2.0%	0.2%	12.3%	7.5%
England	49,138,831	71.7%	0.3%	1.1%	0.5%	3.1%	0.7%	0.3%	14.6%	7.7%

Source: 2001 Census Key Statistics for Local Authority Areas, Office for National Statistics  
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## Appendix 2

### A Breakdown of the recorded ethnic origin of the PCT Workforce as at 31<sup>st</sup> December 2006

South Staffordshire PCT		
Ethnic Origin	Head Count	%
Asian Bangladeshi/BritBan	2	0.1%
Asian Indian/Brit Indian	11	0.6%
Asian Other	2	0.1%
Asian Pakistani/Brit Pak	3	0.2%
Black African	2	0.1%
Black Caribbean	7	0.4%
Black Other	1	0.1%
Chinese	1	0.1%
Mixed White/Blk African	1	0.1%
Mixed White/Blk Caribbean	4	0.2%
Not Stated	30	1.5%
Other Stated Origin	3	0.2%
White British/Mxd British	1740	87.3%
White Irish	14	0.7%
White Other	12	0.6%
XXX-Indian	1	0.1%
XXX-White	93	4.7%
No Data	67	3.4%
Grand Total	1994	100.0%

Source: PRISM Feb 2007

*Extract from Mapping Health Information for West Midlands PCTs – Ethnicity  
Faculty of Health, Department of Medicines Management, Keele University  
March 2005*

### **How ethnicity can affect health**

It is widely accepted that health is profoundly unequal and inequalities run throughout life, from before birth through into old age. Inequality exists between social classes, different areas of the country, between men and women, and between people from different ethnic backgrounds. In 1999, the White Paper Saving Lives: Our Healthier Nation focused on “the main killers”: cancer, coronary heart disease and stroke, accidents, mental illness. Inequalities in health between ethnic groups were highlighted, in particular:

- Death rates for coronary heart disease for those born in the Indian sub-continent are 38 per cent higher for men and 43 per cent higher for women than rates for the country as a whole.
- Stroke death rates in people born in the Caribbean and the Indian sub-continent are one and a half to two and a half times higher than for people born in this country - a differential that has persisted from the late 1970s.
- Women living in England born in India and East Africa have 40 per cent higher suicide rates than those born here.

More recently (July 2004), a focused review of the evidence and selected example of good practice was carried out by the London Health Observatory. The full report from this review is available online at

[http://www.lho.org.uk/Publications/Attachments/PDF\\_Files/Ethnic\\_Disparities\\_Report.pdf](http://www.lho.org.uk/Publications/Attachments/PDF_Files/Ethnic_Disparities_Report.pdf).

The key findings were:

1. The Policy Studies Institute Fourth National Survey of Minority Ethnic Groups showed that Pakistanis and Bangladeshis were 50% more likely to have described their health as fair or poor compared with whites. Caribbeans were also more likely than whites to have reported fair or poor health. In the 1999 Health Survey for England, Pakistani and Bangladeshi men and women reported worse general health than the general population: risk ratios for bad/very bad health, for men and women, were 2.9 and 3.6 (Pakistani) and 3.9 and 3.3 (Bangladeshi). Black Caribbean women (1.8) and Indian men (1.6) and Indian women (2.6) were also more likely to report bad/very bad health than the general population.
2. Studies show that coronary heart disease is moderately higher in South Asian groups than in the population as a whole. There is evidence that the poorest groups, of Pakistani and Bangladeshi origin, have the highest rates. The causes of the elevated rates in the South Asian groups are incompletely understood.
3. Mortality ratios for lung cancer are low in both men and women in migrant groups from E Africa, W Africa, Caribbean, and S Asia. Generally low rates of mortality from breast cancer are reported for women from migrants groups. Some studies report low uptake of breast and cervical screening amongst minority ethnic groups.
4. Many studies have reported a much higher prevalence of diagnosed non-insulin dependent diabetes among South Asians and Caribbeans. Mortality directly associated with diabetes amongst South Asian migrants is around three and a half times that in the general population; those born in the

Caribbean have a similar excess, recent data reporting a rate 3.5 times the national rate among men and a six fold excess amongst women. Diabetic nephropathy and end stage renal failure are significantly more common in South Asian diabetics than in white diabetics: relative risks of up to 14 have been reported in studies.

5. With respect to mental health, the EMPIRIC survey found that Black Caribbeans do not have significantly higher rates of psychotic illness than other groups. Although the rate of psychosis was estimated to be twice as high in the Black Caribbean group compared with the white group, the difference was not statistically significant. Moreover, though rates were low for Bangladeshi women and high for Pakistani women, there were no marked differences in Common Mental Disorders (depression, anxiety, mixed anxiety and depression disorder, phobia, obsessive-compulsive disorder and panic disorder) between the groups.
6. The most recent statistics from the Public Health Laboratory Service's Communicable Disease Surveillance Centre provide important information on incidence of sexually transmitted infections by ethnic group. For many STIs, including HIV/AIDS, incidence is higher in the Black groups. The reasons are complex and include differences in patterns of population mixing and in access to services.
7. Across all the national surveys, there are substantial differences between minority ethnic groups and the white group in smoking patterns. For example, self-reported smoking prevalence amongst Bangladeshi men was 44% in the 1999 HSE vs. 27% of men in the general population and 17% in Chinese males. However, there are some significant inconsistencies in reported rates across surveys.
8. The national surveys also show substantial differences in reported prevalence of alcohol consumption compared with the white population (for example, the fourth national survey found that only 4% of Pakistani men reported drinking more than once a week compared to 69% of white men) and also variations across the different ethnic groups. Again, there are inconsistencies.
9. According to the 1999 Health Survey for England, Bangladeshi men and women were least likely to eat fruit six or more times a week (15% men, 16% women) and Pakistani men (7%) and women (11%) least likely to eat vegetables with this frequency.
10. Bangladeshi men and Pakistani and Bangladeshi women were much less likely to participate in vigorous physical activity than other groups.
11. With respect to women's health, analysis of statistics on stillbirths and infant deaths, registered in England and Wales, shows that in 2000 babies of mothers born in Pakistan had an infant mortality rate of 12.2 per 1,000 live births. This rate was higher than babies of mothers born in any other country and doubles the overall infant mortality rate (5.5 per 1,000 live births). Evidence also suggests that ethnic minority women, especially Pakistani and Bangladeshi women, may have unmet family planning needs, use of contraception amongst those at risk of pregnancy being lower.
12. With respect to children's health, on measures of self-reported health for children aged 2-15, the 1999 Health Survey for England reported that Indian, Chinese, and especially Pakistani and Bangladeshi children were less

likely than children in the general population to report any longstanding illness.

Findings on the prevalence of childhood accidents in different ethnic groups vary across national surveys and research studies. The 1999 Health Survey for England reported that annual major, non-fatal, accidents amongst children aged 2-15, were highest in the general population and in the Black Caribbean group, as were minor accident rates, although showing greater variation across groups. African-Caribbean girls are more likely to be overweight and African-Caribbean and Pakistani girls are more likely to be obese than girls in the general population. Indian and Pakistani boys are more likely to be overweight.

13. Surveys and other studies have reported wide variations by ethnicity in the use of treatment and preventive services. Whilst South Asians and African Caribbeans are more likely than the white group to have consulted their GP, for example, and at least as likely after differences in health have been taken into account, studies consistently show the Chinese to be under utilisers of this service. Studies report the under use of dental services in the Bangladeshi population.
14. There are examples of good practice in a wide range of health care Interventions for minority ethnic groups, but a paucity of robust evaluations based on randomised controlled trials.

**Source :**

Mapping Health Information for West Midlands PCTs – Ethnicity  
Faculty of Health, Department of Medicines Management, Keele University  
March 2005