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Explaining levels of wellbeing in Black and Minority Ethnic populations in England

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Explaining levels of wellbeing in BME populations in England

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Executive Summary: Explaining levels of wellbeing in Black and Minority Ethnic populations in England

Introduction

Self-reported wellbeing, i.e., feeling good and functioning well, varies between different ethnic groups in the UK. Even controlling for the social and economic factors known to influence wellbeing, there appears to be a residual, non-random difference – with people from Black and Minority Ethnic (BME) communities reporting lower levels of wellbeing than their White counterparts. This report describes the findings of a review conducted to investigate the issue of ethnic disparities in wellbeing and possible drivers for this.

Methodology

The study was carried out using a mixture of interviews, a roundtable discussion and a desk-based review of the literature. A total of 14 semi-structured qualitative interviews were carried out, in person or by phone. Interviewees included academics, clinical staff, NHS leaders, local authority staff, and other opinion leaders, encompassing a range of expertise and backgrounds. In addition to the individual interviews, a roundtable discussion was held. Attendees included 11 invited experts representing a wide range of organisations, including think tanks, academia, the third sector and Public Health England.

What is subjective wellbeing?

‘Wellbeing’ in this report refers to self-reported, subjective wellbeing - how people think and feel about their own wellbeing, and includes aspects such as life satisfaction, positive emotions, and whether their life is meaningful. The collection of wellbeing data has gathered pace in recent years, as governments including that of the UK have sought to recognise and improve the wellbeing of their citizens.

How does wellbeing differ in BME populations?

Data on wellbeing in the UK is gathered through multiple sources, across which ethnic disparities have been evidenced. For example, the Understanding Society Survey gathers data on life satisfaction, and has recently published data based on an ethnicity boost sample that illuminates some of the key issues in wellbeing for ethnic minorities in the UK (Knies, Nandi & Platt, 2014). The study considered the broad question of life satisfaction, asking participants “overall, how satisfied are you with your life”. The findings of the survey indicate that life satisfaction is lower for people from BME groups, with a larger effect for people of second generation status. Importantly, it found that difference in life satisfaction holds when controlled for individual characteristics and neighbourhood factors. The Annual Population Survey also gathers ethnicity data, allowing for detailed analysis of wellbeing by ethnic group. The ONS published a summary of differences in wellbeing by ethnicity, which

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reports disparities for BME groups (ONS, 2013). With respect to life satisfaction, the White ethnic group reported an average of 7.4 out of 10, compared to 6.7 in the Black ethnic group, though some other ethnic groups reported similar or slightly higher averages. On the question of 'how worthwhile the things they do are' also, the White ethnic group reported a higher average than all other ethnic groups.

Why consider wellbeing?

There is a positive association between higher levels of subjective wellbeing and both health and longevity. High levels of wellbeing can add 4 to 10 years to life, a fact highlighted by the evidence review of how wellbeing affects health, which was published by the Department of Health in 2014 (Department of Health, 2014). The review detailed the impact of wellbeing across the life course, noting the links between wellbeing and child development, living well and ageing well, among others. In summary, the review reported that higher levels of subjective wellbeing increases longevity, is associated with good health outcomes, improves recovery from illness and supports ageing well.

What are the implications of these differences in wellbeing for BME populations?

Lower wellbeing is associated with poorer health and longevity. If therefore there is a difference in wellbeing for ethnic minority populations, this has serious implications. That the apparent differences hold when controlling for known factors influencing wellbeing such as employment, housing and household income, suggests there is a particular association between BME status and lower subjective wellbeing. The possible implications include poorer physical and mental health outcomes, with impact on life expectancy amongst other negative outcomes.

What explains the persistence of lower levels of wellbeing across the social gradient in BME communities and what are the implications of this?

The persistence of lower levels of wellbeing, both across different BME groups and across the social gradient, suggests a correlation between the experience of belonging to a BME group and experiencing lower levels of wellbeing. Research participants also highlighted the role of social determinants of wellbeing. With respect to the residual deficit in wellbeing for BME populations, interviewees pointed to likely explanations such as higher mental distress and experiences of exclusion, racism and discrimination.

Evidence of ethnic inequalities

The published literature revealed evidence of ethnic inequalities across every dimension of life which we explored and the findings corroborated the views expressed at the roundtable discussion and in the interviews conducted as part of this study. A study of treatment by employers demonstrated discrimination in 7 major British cities when job applicants were matched on education, skills and work history, but conveying different ethnic identities.

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BME applicants had to send 16 applications for a successful outcome compared with 9 for White applicants. National data showed little evidence of occupational progress among ethnic minorities between 1991 and 2001 when other factors such as education had been adjusted for. Within occupations, the largest earnings gaps were seen in managerial and professional groups confirming that BME people find it difficult to obtain high-ranking executive positions.

Ethnic disparities are reported throughout the criminal justice system and there is a disproportionately higher representation of young Black men among deaths of people in police custody. The racial inequalities in the enforcement of drug laws in the UK are especially stark when considered against the evidence that BME communities have lower rates of drug use than the White majority. Nationally only 5% of police officers are from a BME background.

In terms of educational attainment, ethnic minorities in England have become increasingly better qualified than their White British counterparts but continue to experience inequalities in education and the labour market. For example, diversity in the teacher workforce does not match the diversity of pupils in schools.

BME populations in England have a greater prevalence of illnesses such as diabetes and cardiovascular disease in comparison with their White counterparts. But one study of barriers to adopting healthy lifestyles in the African Caribbean community highlighted that advice on healthy behaviour has little relevance when set alongside the daily struggle against racism and discrimination faced by such families.

In access to health care too, ethnic variations are observed, with 'intrinsic' cultural differences such as language and literacy as well as organisational factors in health services offered as possible explanatory factors. Research on cardiovascular care has shown repeatedly that BME communities have poorer access to hospital care, although studies on health care seeking behaviour have found that they may have a greater likelihood of seeking immediate care compared with their White counterparts. General practice based studies have been more variable in their findings, with some arriving at a more positive conclusion, but others demonstrating clear ethnic disparities particularly in the treatment of cardiovascular disease. Variations by ethnicity are also a feature of mental health care in England, with evidence to demonstrate that Black men are more likely to be subject to sectioning under the Mental Health Act, held in seclusion on mental health units and physically restrained.

Despite these inequalities across a very wide spectrum of social dimensions, analysis of the Understanding Society survey data revealed that it is ethnic minority people, including those who were UK and non-UK born who expressed a stronger British identity than the White British majority, and this increased across generations.

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Are there differences in wellbeing between distinct BME communities, and/or between 1st, 2nd and 3rd generation individuals?

The Understanding Society Survey found that the association between ethnic minority status and lower wellbeing was larger for second generation respondents. Frustrated expectation to be treated in the same way as others born in the UK may offer one explanation. Ethnic penalties and discrimination in employment, for example, have clearly shown that the second generation face negative experiences similar to those of the first generation. Higher levels of wellbeing reported by BME than White British participants in the 'Determinants of Adolescent Social wellbeing and Health' study (DASH), are a notable contrast to the lower levels of wellbeing consistently reported by other studies. Possible drivers to explain this may be the impact of participation in family activities, or that young BME people are coping better or are more resilient to the effects of racism. Mental health improved with age in the study population, more so in male rather than female students, with cultural integration (friendship choices across ethnic groups) found to be associated with the lowest levels of mental health problems especially among some groups.

While the data indicates a shared experience of lower wellbeing for BME communities, there are nevertheless variations in the impact of everyday experiences on wellbeing in different communities. There may also be variations *within* BME communities, particularly in relation to migration – both migration patterns within communities and the history of migration of the BME population (whether an established or more recent community). Participants also pointed to differences in the country of origin translating into BME populations in the UK, such as social status or education.

A report from the Social Integration Commission (2014) entitled 'How integrated is modern Britain?' highlighted that residential segregation by ethnicity is increasing. The average Briton is reported to have 48 per cent fewer interactions with people of different ethnicities than would be expected if ethnicity was irrelevant. London was found to be even less ethnically integrated than the rest of Britain. White Londoners have one third the number of interactions with non-white Londoners than if their relationships reflected the ethnic make-up of the city.

How does the language of wellbeing resonate with cultural reality and language, especially in terms of population survey language?

While it was largely held that there would be differences in the cultural interpretations of the questions and concepts of wellbeing, the extent to which this impacts on reported wellbeing is debatable. Population surveys avoid using 'wellbeing' directly, and the language that is used is open to wide interpretation, which allows it to be understood through a framework of cultural reality.

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How do these questions apply to the NHS which has notably high proportions of BME representation among its staff?

The NHS has a highly ethnically diverse workforce, and also a specific focus on population health and wellbeing. Consequently, it may be reasonable to assume that the NHS would be concerned to promote the wellbeing of its staff and was therefore chosen as a useful case study for this research. The findings point to the fact that, far from being an exemplar for staff wellbeing, the NHS helps to illuminate the impact and consequences of lower wellbeing, as well as specific drivers for differences in wellbeing between different ethnic groups.

The ethnic diversity is not proportionately represented through the NHS hierarchy. A study of BME progression in the NHS in London exposed the stark contrast between London's demography, with 45% of the population and 41% of its NHS staff being made up of BME people, and BME representation of only 8% of Trust Board members and 2.5% of Chief Executives and Chairs in the NHS leadership. The London picture was reflected in every respect nationally, with BME representation being entirely absent from the Boards of some of the national English NHS bodies.

Ethnic discrimination has also been demonstrated in recruitment and career progression, resulting in an 'ethnic gradient' within the workforce, with BME staff being represented in larger numbers at lower pay grades and lower status roles among medical and non-medical employees. Recognition and reward for work is also inequitably distributed, as shown by a review of one example of performance related pay, the variation by ethnicity of Clinical Excellence Awards for consultant staff.

Furthermore, racism and discrimination against staff can take other forms. A 65% increase in racist verbal and physical attacks against staff by patients in the NHS was reported by one study in the 5 years up to 2013. A published report of an incident described how a hospital had acquiesced, when parents requested that their child was to be treated by a White doctor only.

An ongoing issue of concern is that inquiries to the GMC regarding doctors qualified outside the UK are more likely to be associated with higher impact decisions at each stage of the fitness to practice process. These associations were not explained by 'measured inquiry related and doctor related characteristics'. A 2014 report prepared for the GMC confirmed the persistent view among BME doctors and those who have qualified outside the UK that the GMC registration process and the fitness to practise investigations and their outcomes were less likely to be fair to them.

Examinations and assessments may also be areas prone to bias as was shown by a study based on the Membership of the Royal College of General Practitioners examination from

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2010 to 2012. A fourfold difference was found in the likelihood of failing the clinical skills test between BME graduates trained in the UK and their white UK colleagues. BME graduates trained abroad were even more likely to fail this exam. 'Subjective bias due to racial discrimination in the clinical skills assessment' was offered as the likely explanation.

Experiences of actual or perceived discrimination, barriers to progression and other inequalities, are broadly agreed to have an impact on staff wellbeing, but the extent of the impact is unclear and less well researched. However, research has demonstrated a clear link between the wellbeing of BME staff and patients' perceptions of care. If BME staff felt motivated and valued, patients were more likely to be satisfied with the service they received. Conversely, the greater the proportion of staff from a BME background who reported experiencing discrimination at work in the previous 12 months, the lower the levels of patient satisfaction in the study.

In recognition of the fact that patients from BME backgrounds rated their care from the NHS lower than that from the majority population, and that BME NHS staff rated their job satisfaction lower than staff from the majority community, a ten-point strategic NHS Race Equality Plan had been developed in 2004 but a decade later there is little evidence of progress in achieving its goals.

What recommendations for policy and practice could truly make a difference?

The impact on wellbeing of BME status in itself is supported by the findings of this research, and should drive changes in policy and practice which aim to address ethnic inequalities in wellbeing. In particular, it needs to be recognised that such action benefits not merely the BME community but the wellbeing of the country as a whole.

In considering strategies which could improve wellbeing and health in BME communities, we had difficulty in identifying specific actors, organisations and entities that could be recommended for actions, while others could be exempt from responsibility. The impact of ethnic inequalities appeared to be so pervasive and was evident across so many sectors and aspects of life that, in our view, a systematic cross-sectoral effort to address the structural and cultural barriers to equality is called for.

Against that background, urgent actions may include:

- 1) *A cross-Government drive to assess and to tackle institutional discrimination within their organisations and workforce as well as in other institutions within their sphere of influence*
- 2) *Zero tolerance towards organisations which do not collect appropriate ethnicity data needed to drive positive change*

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- 3) *Broader engagement in wellbeing from both the NHS and public health providers as well as a wider range of statutory agencies, including through action to address wellbeing per se, rather than as a measure of success of other interventions.*
- 4) *Engaging with existing community structures and leaders to deliver information and support in a language, style and model that is best suited to individuals and communities, adapting to meet their needs.*
- 5) *Improved engagement with communities, using appreciative enquiry to determine specialised and localised interventions particular to the communities and their environments.*
- 6) *More shared public opportunities to enable communities to meet and develop together.*
- 7) *Systematic analysis and reporting of data by the NHS on the extent of ethnic differences in the quality of care.*
- 8) *More and better research on the potential effects and determinants of ethnic inequalities in wellbeing.*

This Executive Summary is taken from:

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Introduction

Self-reported wellbeing, i.e., feeling good and functioning well, varies between different ethnic groups in the UK. Even controlling for the social and economic factors known to influence wellbeing, there appears to be a residual, non-random difference – with people from Black and minority ethnic (BME) communities reporting lower levels of wellbeing than their White counterparts. This discrepancy in wellbeing, which persists across the social gradient, is recognised, but has not previously been researched in detail. This report describes the findings of a research project conducted to investigate the issue of ethnic disparities in wellbeing and possible drivers for this. The project aimed to carry out a brief review of the existing data and literature on ethnic disparities in wellbeing and to gather the observations and views of key opinion leaders through a call for evidence, interviews and a roundtable meeting.

The findings of our review are described in this report. It summarises the determinants of wellbeing in BME populations and considers the main challenges and issues relevant to addressing disparities in wellbeing. Key questions, which were discussed in interviews and at the roundtable meeting, are used to frame the contents of the report. These are:

- How does wellbeing differ in BME populations, and what are the implications of this?
- What explains the persistence of lower levels of wellbeing across the social gradient in BME communities and what are the implications of this?
- What factors beyond the social gradient influence wellbeing in ethnic groups?
- Are there differences in wellbeing between distinct BME communities, and/or between 1st, 2nd and 3rd generation individuals?
- What are the differences in cultural interpretations of the questions and concepts of wellbeing, and what impact do these have on reported wellbeing?
- How does the language of wellbeing resonate with cultural reality and language, especially in terms of population survey language?

We also present a case study considering the wellbeing of BME staff working in the NHS – as the organisation in England with an exclusive focus on population health and wellbeing, and a large employer with a highly diverse workforce, this is included to illuminate the themes raised in the evidence review and provide a detailed contextual example of wellbeing in practice.

The report presents the main drivers of differential wellbeing in BME populations, and concludes with both recommendations for policy and practice and for further research.

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Methodology

This research was carried out using a mixture of interviews, a roundtable discussion and a desk-based review of the literature. A total of 14 semi-structured qualitative interviews were carried out, in person or by phone. Interviewees included academics, clinical staff, NHS leaders, local authority staff, and other opinion leaders, encompassing a range of expertise and backgrounds. Participants were identified through recommendations, research and self-selection in response to open calls distributed through relevant networks. Questions broadly following the structure of this paper were asked to participants, who were also invited to share the elements of their work and expertise they felt were relevant to the issues under discussion. Most interviews were recorded and transcribed, with the permission of the participant.

In addition to the individual interviews, an expert roundtable discussion was conducted with 11 invited attendees representing a wide range of organisations, including think tanks, academia, the third sector and Public Health England. The discussion considered each of the questions presented as sub-headings in this paper.

Finally, the desk-based review included a range of grey and published literature gathered through a call for evidence, hand and electronic searches and through recommendations made by interview and roundtable participants.

The aim of the research was to identify the key factors associated with differential levels of reported wellbeing in BME communities and to gather the relevant data and evidence, with a view to presenting recommendations for both further research, and action to address these disparities.

The UK Office of National Statistics highlights that there is a lack of consensus on what constitutes an ethnic group and membership is usually self-defined. Ethnicity is diverse, encompassing common ancestry and elements of culture, identity, religion, language and physical appearance. The terms ethnicity and race are sometimes used interchangeably. In this study we focus on BME groups as defined by the censuses and national surveys. This has enabled us to draw on evidence from these important sources of data and information on ethnicity and wellbeing.

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What is subjective wellbeing?

‘Wellbeing’ in this project refers to self-reported, subjective wellbeing. This can include hedonic, evaluative, and eudaimonic elements, with most measures used to collect data on wellbeing including questions to evaluate all of these, as the view that wellbeing is composed of and best measured by a combination of all three is widely accepted. The ‘hedonic’ element refers to the importance of happiness and absence of unhappiness to wellbeing, while ‘evaluative’ measures consider life satisfaction overall, and ‘eudaimonic’ refers to broader definitions of ‘living well’ than simple emotion, such as feelings of worth (NEF, 2012).

The collection of wellbeing data has gathered pace in recent years, as governments including that of the UK have sought to recognise and improve the wellbeing of their citizens. This is rooted in a growing consensus that Gross National Product alone is not sufficient to measure the progress or status of a society – the wellbeing of its citizens is an equally important indicator. This is demonstrated at the global level, through the World Happiness Report 2012 which examines data on happiness gathered from different countries and concludes that there are broad societal and structural drivers of wellbeing (Helliwell, J. Layard, R. & Sachs, J. 2012).

The report is significant in identifying factors such as trust and equality in influencing wellbeing, an association which is borne out by the findings of our study.

Data on subjective wellbeing is gathered using various tools. For example, the Warwick Edinburgh Mental Well-being Scale (WEMWBS) has been developed to capture data on both hedonic and eudaimonic elements of wellbeing. A cross-cultural evaluation of the tool conducted with Chinese and Pakistani populations in the UK concluded that WEMWBS could be recommended for use in general population surveys (Taggart et al, 2013).

An analysis considering wellbeing data gathered using different measures in different national settings describes three overall ‘types’ of measure used to gather wellbeing data:

“measures of positive emotions (positive affect) including happiness, usually asked about the day preceding the survey; measures of negative emotions (negative affect) again asked

“A household’s income counts for life satisfaction, but only in a limited way. Other things matter more: community trust, mental and physical health, and the quality of governance and rule of law. Raising incomes can raise happiness, especially in poor societies, but fostering cooperation and community can do even more, especially in rich societies that have a low marginal utility of income. It is no accident that the happiest countries in the world tend to be high-income countries that also have a high degree of social equality, trust, and quality of governance”

(Helliwell, J. Layard, R. & Sachs, J. 2012).

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about the preceding day; and evaluations of life as a whole. Together, these three types of reports constitute the primary measures of subjective well-being” (Helliwell, J. Layard, R. & Sachs, J. 2013).

The question of defining what is meant by ‘wellbeing’ was consistently emphasised in our qualitative research. The roundtable discussion highlighted the variety of concepts and ideas included in ‘wellbeing’ such as community involvement, health and economic status. The shared view was that wellbeing was linked to both external conditions and to psychological resources such as resilience, self-esteem and optimism and consequently should be understood as more encompassing and far-reaching than just ‘happiness’. It also noted the view that reporting of wellbeing will be relational – with respondents comparing themselves to other people they consider similar to themselves in order to respond. This may be significant in terms of considering how people measure their own wellbeing in response to these questions.

Differences in reported subjective wellbeing between different communities have been ascribed to cultural bias, an issue which is explored in this paper. However, participants in the study emphasised that cultural bias is an insufficient explanation, and in fact some differences which may be cultural in root can be real differences, not just bias:

“There may be things that are cultural, but they actually have a very real impact on people’s wellbeing, so you can’t say or dismiss it as a bias.”

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How does wellbeing differ in BME populations?

In the UK, data on wellbeing is gathered through the Office for National Statistics (ONS) Annual Population Survey, which includes four questions on wellbeing:

1. Overall, how satisfied are you with your life nowadays?
2. Overall, how happy did you feel yesterday?
3. Overall, how anxious did you feel yesterday?
4. Overall, to what extent do you feel the things you do in your life are worthwhile?

These four questions are incorporated in the Public Health Outcomes Framework, which shapes local authority public health interventions, and includes four indicators on wellbeing to match each question (Department of Health, 2013).

At the national level, the figures for 2012 on these measures were (ONS, 2012):

Indicator	Definition	Value (%)
Life satisfaction	Percentage with medium/high rating of satisfaction with life overall	75.9
Worthwhile	Percentage with medium/ high rating of how worthwhile the things they do are	80.0
Happy yesterday	Percentage with medium/ high rating who rated their happiness yesterday	71.1
Anxious yesterday	Percentage with medium/low rating who rated how anxious they were yesterday	60.1

Source: Annual Population Survey, Office for National Statistics

Additional sources of wellbeing data in the UK include the Health Survey for England, which in 2010 and 2011 included questions on wellbeing. In 2010, the HSfE used the WEMWBS measures to assess subjective wellbeing, finding an association between increased household income and higher wellbeing (HSCIC, 2011). The 2011 survey further illustrated an association between poor mental and physical health and lower wellbeing (HSCIC, 2012).

Finally, the Understanding Society Survey gathers data on life satisfaction, and has recently published data based on an ethnicity boost sample that illuminates some of the key issues in wellbeing for ethnic minorities in the UK (Knies, Nandi & Platt, 2014). Understanding Society is a large scale project including some 30,000 UK households, with the ethnic boost sample designed to provide a minimum of 1000 adult respondents drawn from five BME groups.

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The study also considered information on the generational status of participants, providing invaluable insight into hypothesised differences between the experiences of first and second generation migrants with respect to wellbeing, considered in detail later in this report. The study considered the broad question of life satisfaction, asking participants “overall, how satisfied are you with your life”. The findings of the survey indicate that life satisfaction is lower for people from BME groups, with a larger effect for people of second generation status. Importantly, it found that difference in life satisfaction holds when controlled for individual characteristics and neighbourhood factors. This led the authors to conclude subjective wellbeing is lower for people from ethnic minorities, which they suggest is associated with feelings of belonging to an ‘out group’ or outsider status. They also found a weak correlation between the ethnic density of the neighbourhood in which people live and their wellbeing.

The Annual Population Survey also gathers ethnicity data, allowing for detailed analysis of wellbeing by ethnic group. The ONS published a summary of differences in wellbeing by ethnicity, which reports disparities for BME groups (ONS, 2013). With respect to life satisfaction, the White ethnic group reported an average of 7.4 out of 10, compared to 6.7 in the Black ethnic group, though some other ethnic groups reported similar or slightly higher averages. On the ‘worthwhile’ question also, the White ethnic group reported a higher average than all other ethnic groups. The ONS put forward possible explanations for these differences, including factors such as gender, where differences were too small to be explanatory. External factors such as unemployment, health status or educational status are all considered, as is ‘cultural bias’:

“The differences may in part be due to what can be described as ‘cultural bias’. This may be because people from different cultures may interpret the question scales differently or be more likely to give more extreme or moderate ratings when asked to make an assessment of their life in this way. However, although the research literature suggests there are some cultural differences in the patterns of observed responses, it is difficult to say to what extent this represents error in the data rather than genuine differences in how people feel, or how they assess their lives (OECD, 2013). This presents a challenging research agenda for the future.” (ONS, 2013).

This question, the extent to which differences are genuine, or related to bias, engendered the study reported here.

The New Economics Foundation analysed the data from the Annual Population Survey in a report which contains a chapter on ethnicity (NEF, 2012). Their summary conclusion is striking:

“Black, Arab, Bangladeshi, Pakistani and Indian people experience significantly lower wellbeing than White people in the UK. The differences are large in size, apply across multiple measures of wellbeing, and persist even after taking into account a number of

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factors known to affect wellbeing such as relationship status, labour market status, and home ownership” (NEF, 2012).

The analysis finds that these ethnic groups report lower wellbeing both on individual measures and on a composite of the four measures – on all four measures, 16% of Arab people, 17% of Black people, and 19% of Bangladeshi, compared with 25% of Chinese people and 27% of White people score well. In order to explore these differences, the NEF analysis controls for socio-economic factors known to influence wellbeing: age, gender, married or cohabiting, divorced or separated, number of children, reported religion, urban area, homeowner, disability, degree, full-time student, employed, unemployed. Controlling for these factors, a wellbeing deficit is still identified for people belonging to Bangladeshi, Pakistani, Arab, Black, and Indian groups:

“Two people who were identical in every other way (according to our model) would be likely to report different levels of wellbeing if one was White and the other was from one of the ethnic minority groups listed.” (NEF, 2012).

Differences for the Chinese and Mixed/Multiple groups, however, do not persist after controlling for these factors.

It should be noted that the NEF analysis did not control for household income, as this data was not available, though the report notes that exploratory analysis conducted by NEF using other available data suggests the findings do hold. The USS ethnicity boost sample research was however able to control for household income, and this found similar results.

This analysis lays the foundation for the research reported here, which aimed to explore the drivers of wellbeing in ethnic groups. For the purposes of this project we refer to ‘BME populations’ to include the groups identified by the NEF data: Bangladeshi, Pakistani, Arab, Black, and Indian groups. The differing findings for Chinese and Mixed/Multiple groups warrant further targeted research, and we make this recommendation at the conclusion of this paper.

Explaining levels of wellbeing in BME populations in England

Why consider wellbeing?

In February 2014, the UK Department of Health published an evidence review of how wellbeing affects health (Department of Health, 2014). The review details the impact of wellbeing across the life course, noting the links between wellbeing and child development, living well and ageing well, among others. In particular, it notes the positive association between higher levels of subjective wellbeing and both health and longevity, noting that high levels of wellbeing can add 4 to 10 years to life. In summary, the review finds that higher levels of subjective wellbeing increases longevity, is associated with good health outcomes, improves recovery from illness and supports ageing well. Enjoyment of life, in later years, is associated with survival: "Survival over an average of more than nine years was associated with greater enjoyment of life. Effects were large, with the risk of dying being around three times greater among individuals in the lowest (compared with the highest) third of enjoyment of life measures" (Department of Health, 2014).

Subjective wellbeing is therefore about much more than feeling happy. It is strongly associated with health, longevity and survival and so discrepancies in wellbeing have significant consequences. If there are differences in wellbeing between different populations, this may lead to inequalities across the health spectrum and in life expectancy.

The contribution of subjective wellbeing to health and longevity was the subject of a review, published in *Applied Psychology*, which found there are sufficient studies on health and all-cause mortality to conclude that high subjective wellbeing causally influences both health and longevity (Diener and Chan, 2011). Evidence reviewed included a 2008 meta-analysis which examined the association between positive wellbeing and mortality in both healthy and diseased populations; concluding that positive wellbeing is related to lower mortality in both populations (Chida and Steptoe, 2008). Positive moods such as joy and high life satisfaction predicted longevity in the healthy population and reduced death as well as renal failure rates in HIV patients.

Moods and emotions are consistently found to be associated with biological measures such as blood pressure and inflammation, as well as indicators of diseases such as artery wall thickening (Diener and Chan, 2011). There also seems to be a difference in the body's response to short-term and long-term positive and negative emotions (Segerstrom and Miller, 2004). Short-term positive and negative emotions produce adaptive bodily responses, which are not necessarily indicative of pathology. Long-term negative emotions such as chronic stress and depression however, can create physiological responses that are harmful. From an evolutionary perspective this can be explained with the fact that diverting resources in response to threats can potentially save a life by going into emergency mode. In the long term on the other hand, such bodily diversions can lead to failure in reproduction and repair following bodily damage (Barnett and Hamsworth, 1990).

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Experimental studies also demonstrated a correlation between a person's mood and health relevant physiological measures (Robles, Brooks and Pressman, 2009). In a skin recovery experiment for example, positive emotions led to a quicker skin recovery compared to negative emotions, demonstrating the effects of stress in skin recovery.

Furthermore, subjective wellbeing has a great impact on patients' quality of life through their perception of pain: In most studies positive emotions were related to lower pain and greater tolerance of pain (Pressman and Cohen, 2005). Additionally high subjective wellbeing predicts faster recovery, for example, in stroke patients and also increases the quality of life if a person is sick (Diener and Chan, 2011).

Interviews conducted with Local Authority representatives of two London boroughs as part of this study also highlighted the value of considering wellbeing. Both outlined that the twin burdens of mental ill-health and physical ill-health were of particular concern to their Local Authority, and the subject of intensive work. The role of wellbeing in driving both physical and mental health was recognised, and in one case explicit wellbeing data on residents is being collected, using the WEMWBS tool. As wellbeing is increasingly on the agenda of Local Authorities, in part through their new health responsibilities following the reform of local health services, it is particularly timely to explore wellbeing at the local and community levels.

Explaining levels of wellbeing in BME populations in England

What are the implications of these differences in wellbeing for BME populations?

Lower wellbeing is associated with poorer health and longevity. If therefore there is a difference in wellbeing for ethnic minority populations, this has serious implications. That the apparent differences hold when controlling for known factors influencing wellbeing such as employment, housing and household income, suggests there is a particular association between BME status and lower subjective wellbeing. This may be partly due to cultural bias or reporting differences, but surveys collecting wellbeing data have controlled for such differences and still found lower reported wellbeing in BME groups. Any genuine difference has implications for health and longevity and should therefore be addressed.

Good health is associated with higher levels of wellbeing. Therefore focusing policies on wellbeing could improve wellbeing as well as health outcomes (Department of Health, 2014). There are known health inequalities affecting BME populations. They also have a higher prevalence of a range of health conditions, for example, cardiovascular disease. This has been linked to various drivers such as socio-economic status. However, it is interesting to also consider whether lower subjective wellbeing may be an additional driver. What follows is a review of some of the evidence from the Health Surveys for England, describing health data for BME groups. The data is not exhaustive, but intended to illustrate the higher burden of some common non-communicable diseases or conditions in BME populations. This review was conducted as part of the study reported here, by Gopalakrishnan Netuveli, Professor of Public Health, Institute of Health and Human Development, University of East London and Mukil Menon, medical student, University of Malta.

Review of evidence from Health Surveys for England

Objective: To describe the prevalence of poor general health, mental health and a selection of cardio-vascular diseases in the BME groups in England in 1999 and 2004.

Data: Health Surveys for England are annual cross-sectional surveys. In 1999 and 2004 the surveys had a boost sample of ethnic minorities. As a comparison we used data for the general population from the 1998 and 2003 surveys where the modules for Cardio Vascular Disease (CVD) were included. We have used these data restricting it to those who are 16 years of age or more.

Ethnicity: For this analysis, we used the general population sample as the reference group. This sample did contain a small number of ethnic minorities. In 1999, the Black population was labelled Caribbean while in 2004 they were divided into Black Caribbean and Black African. For this analysis we combined these groups. Other groups are Indian, Pakistani, Bangladeshi, Chinese and Irish.

Health outcomes: Self-reported general health was dichotomised so that 1 represents those reporting worse than good health. We designate this variable as poor health. Mental health

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is indicated by GHQ caseness defined as a GHQ12 score of four or more. Self reports of doctor diagnosed hypertension, diabetes (excluding gestational), and heart attack were used as binary variables with 1 representing presence.

Control variables: age grouped as 16-64, 65-74, 75+; sex; social class, non-manual, manual, and never worked; smoking; and drinking.

Analysis: We present adjusted prevalence (%) for the outcomes for the general population and BME groups based on logistic regression models. Results are presented as tables. The numbers in the parentheses are the lower and upper limits of the 95% confidence interval which reflects the precision of the estimates (narrower the intervals better the precision). The odds ratio (OR) compares the risk in the particular BME group to the general population. If the risks are equal the OR will be one. To be statistically significant the 95% confidence interval (95% CI) of OR should not include one.

Poor Health

	Prevalence* %		OR (95%CI)**
	1999	2004	
General population	6.30 (5.97, 6.63)	6.46 (6.12, 6.80)	Reference
Black Caribbean/African	9.45 (8.34, 10.56)	9.67 (8.57, 10.78)	1.59 (1.38, 1.83)
Indian	11.30 (9.89, 12.71)	11.56 (10.12, 13.00)	1.97 (1.69, 2.31)
Pakistani	15.80 (14.03, 17.56)	16.13 (14.31, 17.95)	3.01 (2.58, 3.52)
Bangladeshi	17.64 (15.76, 19.52)	18.01 (16.06, 19.95)	3.49 (3.00, 4.07)
Chinese	5.96 (4.50, 7.42)	6.11 (4.62, 7.60)	0.94 (0.71, 1.24)
Irish	7.46 (6.45, 8.48)	7.64 (6.61, 8.68)	1.21 (1.03, 1.42)

*Adjusted for age, sex, social class, and smoking

** ORs are detrended

The prevalence of poor health increased slightly in the general population and all BME groups between 1999 and 2004. Except for the Chinese all other BME groups had a greater prevalence of poor health. While the Chinese were not different from the general population in reporting poor health, other groups were more likely to do so.

Mental health (GHQ caseness)

	Prevalence* %		OR (95%CI)**
	1999	2004	
General population	14.66 (14.15, 15.18)	12.12 (11.64, 12.60)	Reference
Black Caribbean/African	16.50 (15.08, 17.93)	13.69 (12.49, 14.90)	1.15 (1.04, 1.28)
Indian	16.48 (14.84, 18.11)	13.67 (12.24, 15.10)	1.15 (1.02, 1.30)
Pakistani	17.05 (15.26, 18.84)	14.16 (12.59, 15.74)	1.20 (1.05, 1.37)
Bangladeshi	16.37 (14.51, 18.24)	13.58 (11.95, 15.21)	1.14 (0.99, 1.32)
Chinese	9.35 (7.65, 11.05)	7.64 (6.22, 9.06)	0.60 (0.49, 0.73)
Irish	15.97 (14.44, 17.50)	13.24 (11.91, 14.56)	1.11 (0.99, 1.24)

*Adjusted for age, sex, social class, and smoking.

** ORs are detrended

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Prevalence of poor mental health as indicated by a GHQ score of four or more reduced in the general population and all BME groups between 1999 and 2004. Except for the Chinese and the Irish all other BME groups had greater prevalence than the general population and were more likely to have poor mental health. The Chinese had a lower prevalence and were significantly less likely to have poor mental health compared to the general population.

Hypertension

	Prevalence* %		OR (95%CI)**
	1999	2004	
General population	18.52 (17.99, 19.04)	22.98 (22.40, 23.56)	Reference
Black Caribbean/African	24.69 (23.18, 26.20)	29.96 (28.34, 31.58)	1.52 (1.38, 1.67)
Indian	18.81 (17.23, 20.38)	23.32 (21.52, 25.12)	1.02 (0.91, 1.15)
Pakistani	18.56 (16.73, 20.39)	23.03 (20.93, 25.14)	1.00 (0.87, 1.15)
Bangladeshi	13.53 (11.79, 15.27)	17.15 (15.07, 19.23)	0.66 (0.56, 0.78)
Chinese	13.19 (11.34, 15.05)	16.75 (14.54, 18.95)	0.64 (0.53, 0.76)
Irish	19.07 (17.61, 20.53)	23.62 (21.95, 25.28)	1.04 (0.94, 1.16)

*Adjusted for age, sex, social class, smoking and drinking

** ORs are detrended

The prevalence of hypertension increased 4 to 5% in the general population and all BME groups between 1999 and 2004. Except for the Bangladeshis and the Chinese all other BME groups had greater prevalence of hypertension. The Bangladeshis and the Chinese were less likely and the Black Caribbean/Africans were most likely to report doctor diagnosis of hypertension compared to the general population. Other groups were not different from the general population in this respect.

Diabetes

	Prevalence* %		OR (95%CI)**
	1999	2004	
General population	2.82 (2.60, 3.04)	3.48 (3.23, 3.72)	Reference
Black Caribbean/African	7.99 (6.94, 9.05)	9.62 (8.44, 10.80)	3.18 (2.71, 3.73)
Indian	8.65 (7.40, 9.90)	10.38 (8.95, 11.82)	3.49 (2.91, 4.18)
Pakistani	11.34 (9.65, 13.03)	13.47 (11.55, 15.39)	4.87 (3.99, 5.94)
Bangladeshi	11.17 (9.43, 12.90)	13.27 (11.28, 15.27)	4.78 (3.89, 5.87)
Chinese	4.68 (3.41, 5.94)	5.71 (4.20, 7.22)	1.73 (1.28, 2.34)
Irish	3.03 (2.38, 3.68)	3.73 (2.95, 4.50)	1.08 (0.86, 1.36)

*Adjusted for age, sex, social class, and smoking

** ORs are detrended

Prevalence of doctor diagnosed diabetes increased in the general population and all BME groups between 1999 and 2004. Except for the Irish all other BME groups had greater prevalence and were more likely to have diabetes than the general population. The Chinese

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had a lower prevalence and were less likely to have diabetes compared to other BME groups except the Irish.

Heart attack

	Prevalence* %		OR (95%CI)**
	1999	2004	
General population	2.51 (2.30, 2.73)	2.70 (2.47, 2.92)	Reference
Black Caribbean/African	1.94 (1.44, 2.44)	2.08 (1.57, 2.60)	0.76 (0.58, 0.99)
Indian	3.31 (2.33, 4.28)	3.54 (2.49, 4.59)	1.35 (0.97, 1.89)
Pakistani	4.43 (3.10, 5.76)	4.74 (3.32, 6.15)	1.88 (1.33, 2.68)
Bangladeshi	1.68 (0.89, 2.46)	1.80 (0.96, 2.64)	0.65 (0.39, 1.06)
Chinese	1.96 (1.31, 2.61)	2.11 (1.44, 2.77)	0.77 (0.54, 1.08)
Irish	2.59 (1.74, 3.44)	2.78 (1.82, 3.74)	1.03 (0.72, 1.50)

*Adjusted for age, sex, social class, and smoking

** ORs are detrended

The prevalence of heart attacks increased in the general population and all BME groups between 1999 and 2004. Compared to the general population, the Indian and the Pakistani groups had a greater prevalence of heart attacks while other BME groups had a lower prevalence. The increased risk of heart attacks in the Pakistani group and the lower risk in the Black Caribbean /African group were statistically significant.

Conclusion

These findings are illustrative of the higher burden of ill health in BME populations.

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What explains the persistence of lower levels of wellbeing across the social gradient in BME communities and what are the implications of this?

Lower levels of wellbeing are reported, as the data demonstrates, even when socio-economic factors are controlled for. This additional difference is seen for multiple ethnic groups, which suggests there is some difference linked to ethnic minority status that affects self-reported wellbeing. At the roundtable, participants agreed that the way in which 'BME' itself is defined and understood is vital, noting the variable experiences of different BME groups. The persistence of lower levels of wellbeing, both across different BME groups and across the social gradient, suggests a correlation between the experience of belonging to a BME group and experiencing lower levels of wellbeing.

Many participants in the project, both in interviews and at the roundtable, stressed the importance of looking beyond the affected communities to find the cause of differences in wellbeing, rather than ascribing 'fault' to communities or individuals themselves. The roundtable in particular emphasised the need to consider non-random external differences in experiences and drivers of wellbeing.

In the interviews, participants also highlighted the role of social determinants of wellbeing. With respect to the residual deficit in wellbeing for BME populations, interviewees pointed to factors such as higher mental distress and experiences of exclusion, racism and discrimination.

Suggested factors driving differing levels of wellbeing included the issue of networks, put forward by participants at the roundtable, who discussed the link between migration, especially recent migration, and smaller networks which are also potentially less diverse and incorporate fewer nodes at higher social or economic levels to facilitate access to progressing up the social gradient.

Issues of identity and belonging, particularly for first generation and recent migrants were also discussed at the roundtable, in particular for those first generation migrants who maintained a sense of belonging 'back home' rather than in their new environment.

Specific internal barriers were also identified, such as religious or cultural beliefs or understandings which would hold across the social gradient. These issues are considered in detail in the sections on language and cultural concepts of wellbeing.

The largest and most frequently cited issues, in most interviews and by participants at the roundtable, relate to experiences of racism and discrimination and the impact of this on communities. These experiences, discussed in detail in the next section, were generally agreed to hold and impact across the social gradient, and therefore to explain at least some of the additional discrepancy.

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What factors beyond the social gradient influence wellbeing in ethnic groups?

Given the residual difference in wellbeing after controlling for the impact of the social gradient, additional factors appear likely to also influence wellbeing. At the roundtable, factors such as stage in the life course and age were discussed, in relation to the different experiences and narratives of age and race-related discrimination faced by individuals from BME communities. This led to a discussion on the impact of migration pattern, considered in more detail in the next section. Language was also considered as a potential driver, though it was noted that there is not likely to be a straightforward correlation between English language capability and wellbeing, as the language spoken in the community and the extent to which language is shared is the determinant of individual connection and social networks, not English language per se (i.e. if most social connection is within a community speaking the language of the individual's country of origin, lack of English language ability may not limit social interaction).

The roundtable discussion also considered the possible positive drivers of wellbeing linked to BME status, including resilience and community, and emphasised the need to consider both positive and negative influences. This underlined the necessity to focus on factors that operate differently or exclusively on BME wellbeing, as compared to the majority population. Some interviewees cited factors such as unemployment and employment status (e.g. manual or professional), stigma and discrimination, gender, and health behaviours. The interesting feature of such drivers is that these also operate in White British communities. While the nature of the impact may differ, given the population level at which wellbeing data is gathered, such differences ought to average out. Where residual differences emerge there must be additional drivers.

One interviewee stated that such shared drivers would be put forward as an explanation out of discomfort with identifying issues such as race. This conclusion was reached by most interviewees and in the roundtable discussion, across broadly two vectors. Firstly, the combined influence of the markers of BME experience: "The history, migration, migration patterns, age, different cultures", and the "overlapping influences of ethnicity, religion, culture".

Secondly, and most significantly emphasised, was experiences of racism, exclusion and discrimination. At the roundtable discussion, participants discussed the impact of these drivers on individual's feelings of anxiety, connection to their community and ability to

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reach their potential – all markers of wellbeing. Participants also described the link between the societal mistrust generated by discrimination and racism, and further reductions in wellbeing, as well as the association participants had noted in their work and research between mistrust and lower wellbeing,

Experiences of race and ethnicity-related discrimination was the factor most frequently identified through the research as driving and influencing wellbeing in BME communities.

This experience was linked by one interviewee to the concept of ‘weathering’, a concept proposed by the US academic Arline T. Geronimus. The theory holds that the stressors associated with being Black in a predominantly White society has a ‘weathering’ impact, increasing the burden of ill health and accelerating age-related health deterioration. Geronimus has conducted various studies to explore this theory, finding that racial differences in health persist and are unexplained by poverty, with association between a greater ‘weathering’ impact and ‘high-effort’ coping (Geronimus et al, 2005). This resonated with the interviewee’s experiences:

“Being a Black person, no matter how educated you are, is bad for your health because you have to assimilate, and assimilation costs you something, in terms of your health. You have to be able to be in situations, the higher up the ladder you go, where there are fewer and fewer people like you, so there’s fewer

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and less people to support you, who look like you, who live in your neighbourhood, who eat your food, who are able to understand where you're coming from as a Black person. So you have put up with and tolerate all those stresses and strains as well as getting to that place in the first place, which takes a lot out of you, because to become a Black person in the high level positions takes a lot out of you anyway. So the point is, this weathering effect, not being able to get the food that you want, not be able to be who you are, not being able to see yourself on TV, not being able to see yourself in magazines, not being .. you know, all the things that White society takes for granted, you have to live a life where you are almost a second class citizen, and you just have to live with that. What this woman says is, it has a weathering effect on you. It actually wears you down, wears you out."

Participants in this study were unanimous, that these experiences influence wellbeing, though it was noted that it is difficult to measure and capture the impact of such experiences in wellbeing research (Saamah Abdallah, interview). It was also widely agreed that the impact was caused by both structural discrimination and personal racism. Some participants attributed this to unconscious or unintentional bias, though others disagreed:

"and it's to do with the Blacker you are or the Blacker you're perceived to be, the more alien and foreign you are, and the more different you are the less like me you are, the less I want you in my space. And people use this term unconscious bias a lot, personally I don't think it exists. That's my personal view. I know people love to use it because it's such a get out clause isn't it, though. I just don't buy it at all. I don't buy it."

That structural, societal and systemic factors of racial discrimination drive lower wellbeing was the conclusion reached by both interviewees and roundtable participants. The factual basis of these experiences is borne out by data on inequalities along ethnic lines that people in the UK experience, across health, education, employment, policing and other social boundaries, as well as in the wider societal discrimination that persists in this country. The following sections consider discrimination in different aspects of society. The hard evidence of inequalities demonstrated in this review underline the very real drivers of disparities in wellbeing, going far beyond any 'cultural interpretation' differences to underscore real differences in wellbeing. The literature reviewed here underscores the reality to the discrimination and racism highlighted by project participants as drivers of lower wellbeing, and provide a solid explanation for why wellbeing should be lower for BME groups.

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Evidence of ethnic inequalities

Key facts on ethnic inequalities

Around two-fifths of people from ethnic minorities live in low-income households, twice the rate for White people (The Poverty Site, 2013).

In 2009, the 'average White household' owned approximately £221,000 in assets, while Black Caribbean households owned £76,000, Bangladeshi households £21,000 and Black African households £15,000 (The Great Debate UK, 2011).

A child from a Black Caribbean background is 3 times more likely to be permanently excluded from a school than the school population as a whole (Children's Commissioner, 2010).

Being Black and male has a greater impact on levels of numeracy than having a learning disability (Equality and Human Rights Commission, 2010).

A Black or minority ethnic University graduate is more than twice as likely to be underemployed (Equality Challenge Unity, 2011).

Evidence of ethnic inequalities exists across many dimensions of society and bears out the views expressed across the roundtable and interviews conducted in this research. People from BME groups experience discrimination that underlies challenges in important aspects of life, and consequently provides a solid evidence base for the witnessed disparities in subjective wellbeing.

The 'Britishness' of BME people in England

England has a long history as a country of multiple populations. Around 14% of the UK population define themselves as of minority ethnicity but twice this proportion (around 29%) were born in or have parents or grandparents born in a country outside the UK. Thus even the apparently homogenous White majority is more diverse than is assumed. (Nandi & Platt, 2012). Despite this historic heterogeneity in the UK, immigrants, and the term usually refers to Black and ethnic minority people in the popular and political discourse, are perceived not as core to the make-up but as additional to the population, in contrast with other countries where they may be viewed as part of the national picture. Furthermore, immigrants are viewed as a threat not only to the economy but also to the continuation of cultural tradition. A glaring example of this lay in the observation of a commentator writing in the Daily Mail, that "the 2011 census revealed that the indigenous British had become a minority in their own capital" (Professor Paul Collier, Daily Mail, 2013). This ignores the facts that there is no census category for 'indigenous' people, and British either by birth or by acquired citizenship still make up the majority in London, thus instigating Hugh Muir of the Guardian (Hugh Muir, The Guardian, 2014) to ask "how long do you have to be in Britain before claiming the right to call it yours?"

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Against this background, national identity and connection with the notion of Britishness is generally viewed as an indicator of social cohesion and whilst the national identification of ethnic minorities is the focus of much debate and speculation, the identification of the White majority as British has been assumed. Nandi and Platt's analysis of the Understanding Society longitudinal household survey data firmly rebuts this assumption (Nandi & Platt, 2013). Ethnic minority people, including those who were UK and non-UK born expressed a stronger British identity than the White British majority and this increased across generations. The minority participants in the survey held strong ethnic and national identities, demonstrating that the two are not mutually exclusive. Furthermore, the probability of having a 'separated' identity decreased in the UK born generation of minorities. It was also striking that all the Muslim groups, of whatever ethnicity, were particularly likely to identify more strongly as British. There were between 10 and 25 per cent who were 'marginalised' in identity terms across the minority groups, and this was most likely in the Caribbean group. The authors explain that although this group is recognised as being socially, geographically and in employment terms the most 'assimilated', it may include a section that feels alienated by a society still strongly stratified along racial and ethnic lines.

Contrary to expectation, the study also revealed that 'White' British people born outside the UK, despite assimilation into the White population, had a lower sense of British identity than those maintaining a minority identity. Also, with the exception of those born in Northern Ireland, individual country identities (England, Wales, Scotland) are prioritised over a British identity. These findings firmly disprove popular perceptions about majority and minority populations and their likely expressed identity and national connection.

Discrimination in employment

The likelihood of being rejected for a job following an interview or an assessment varies considerably by ethnicity, as revealed by a study of the Understanding Society survey data (Saggar & Nandi, 2012). Over a third of certain Black and minority ethnic (BME) groups such as Caribbeans and Africans reported that they fell into this category. Less than 30 per cent of their White counterparts reported a similar experience, as did the Indian, Bangladeshi and Pakistani groups. Of those turned down, about one fifth perceived discrimination as the basis of their rejection, with the Caribbean group reporting the highest percentage of discrimination (31%). The other minority ethnic groups reported rates ranging from 17% to 24%. Race or ethnicity was reported as the reason for the rejection by 6-16% of most minority ethnic groups. In addition, the authors highlight that these data do not reveal the number of people who do not even apply for jobs in the belief that discrimination will prevent them from being appointed to the posts.

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An analysis of 2011 Census data to assess ethnic differences in employment among 25 to 49 year old men and women in England and Wales found that the White ethnic groups had the highest rate of employment compared with other ethnic groups (Nazroo & Kapadia, 2011).

Indian men and Black Caribbean women had a similar rate of economic activity to that of the White ethnic group, probably explained by increasing levels of education. For unemployment, Pakistani men had rates that were one and a half times the rate for White British men, and Black Caribbean men had rates almost three times as high. Pakistani women's unemployment rate was more than three times White British women's, and for Black Caribbean women, unemployment was more than twice the rate for White British women.

'Ethnic minorities in the labour market', a report by Ken Clark and Stephen Drinkwater highlighted that there was little evidence of occupational progress among ethnic minorities between 1991 and 2001 when other factors such as education had been adjusted for (Clark & Drinkwater, 2007). Their analysis concluded that the only group to experience notable advancement was Black Caribbean men. Higher education graduates also appeared to have increasing difficulty in obtaining professional or managerial jobs, with this being greatest for women, especially Black Caribbeans and Black Africans. Moreover, Labour Force Survey data showed wide differences in earnings between the White group and ethnic minority men in particular, the largest differences being observed among the Black Africans, Pakistani and Bangladeshi groups and the lowest in the Chinese, Black Caribbeans and Indians. Within occupations, the largest earnings gaps were seen in managerial and professional groups confirming that BME people find it difficult to obtain high-ranking executive positions.

A plethora of evidence is now available to demonstrate the 'ethnic penalties' in employment in the UK and the poorer outcomes for BME groups in terms of rates of unemployment, the level of work attained and rates of pay, which persist even after differences in the groups such as age profiles and levels of education are controlled for. But, to demonstrate that discrimination is the key factor underlying such differences, other plausible factors that may contribute to the gap in labour market outcomes (for instance a lack of established contacts with potential employers among ethnic minority groups) need to be ruled out. Field experiments have now been developed to assess variations in treatment by employers which can be reliably attributed to discrimination. Such a study carried out on behalf of the Department of Work and Pensions (Wood, Hales, Purdon, Sejersen, & Hayllar, 2009) tested differences in employer call-back for an interview to applications for formally advertised job vacancies in 7 major British cities. The applicants were closely matched in terms of education, skills and work history, but conveying different ethnic identities. A high and statistically significant level of net discrimination of 29 percent in favour of White names over equivalent applications from ethnic minority candidates was found. In summary, 16 applications from ethnic minority applicants had to be sent for a successful outcome compared with 9 for White applicants. The level of racial discrimination was found to be

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high across all ethnic groups and for both genders. Public sector employers were found to be significantly less discriminatory than the private sector, but this was thought to be explained not by more positive attitudes in the sector but by the greater use of standard application forms in the public sector (79 percent vs 6 percent) which allow personal details of applicants to be detached before the sifting process, and. The authors of this study concluded that 'there are no plausible explanations for the difference in treatment found between White and ethnic minority names other than racial discrimination'.

Law enforcement

An authoritative report published by Release, the national centre of expertise on drugs and drugs law, and entitled 'The numbers in Black and White: ethnic disparities in the policing and prosecution of drug offences in England and Wales' examined racial differences in rates for stop and search, arrest, prosecution and sentencing (Eastwood, Shiner & Bear, 2013). It confirmed that the policing and prosecutions of drug possession offences in England and Wales is disproportionately focussed on Black and minority communities and that the enforcement of drug laws in the UK appear to provide a significant basis for racial inequalities. In 2009/10 the overall search rate for drugs was 10 searches per 1000 people across the population as a whole, 7 per 1000 for White people, 14 per 1000 for mixed race people, 18 per 1000 for Asians and 45 per 1000 for those identifying as Black. In summary, Black people were 6.3 times more likely and Asians were 2.5 times more likely than White people to be stopped and searched for drugs. In London, the rate of drug searches rose to 34 per 1000 across the population as a whole, and to an alarming rate of 66 per 1000 for Black people. When drugs searches were excluded from the data for all 'reasonable suspicion' searches, the rates did fall for BME people but nevertheless remained higher than for White people with the disproportionality for Black people dropping to 5 times and halving for the Asian community when compared to the rate for White people. These injustices are all the more glaring, when set against the evidence that Black and Asian communities have lower rates of drug use than the White majority.

Disproportionately higher representation of young Black men among deaths of people in police custody and a recent disclosure by the Independent Police Complaints Commission of its investigations into the deaths in unexplained circumstances of several Black and Asian men following their contact with the police, has concerned the Government sufficiently to order an urgent inquiry (David Leppard, The Sunday Times, 2014). Past reports including one published in 2009 by the now defunct Mental Health Act Commission highlight discrimination in the way that BME men, including those with mental illness, are handled when restrained by the police (Mental Health Act Commission, 2009).

Ethnic disparities were exposed by the research throughout the criminal justice system. For example, Black people also faced harsher sanctions for drug possession offences and were subject to court proceedings, found guilty and were subject to immediate custody at

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substantially greater rates than White people. Black people in London who were caught in possession of cocaine were charged, rather than cautioned, at a much higher rate than their White counterparts.

Nationally only 5% of police officers are from a BME background (compared with 14% of the population) (Daniel Boffey, *The Observer*, 2014). In London BME police officers make up 10% of the force, although 55% of Londoners are BME people.

The killing of Stephen Lawrence in an unprovoked racist attack in London in 1993, and the Macpherson report published following the 1998 public inquiry into the police investigation of the murder was perhaps the most significant milestone in recent decades in exposing the police as 'institutionally racist'. The reputation of the police was further damaged earlier this year, when the conduct of undercover officers in undermining the investigation was exposed (Sean O'Neill, *The Times*, 2014).

Education

'In space, race doesn't matter' was the poignant title of an article in the *Guardian* newspaper profiling Maggie Aderin-Pocock, the highly acclaimed expert in physics and astronomy and presenter of the BBC TV programme *The Sky at Night*, who also happens to be from a Black background (Emine Saner, *The Guardian*, 2014). Her progression to a world leading space scientist in a highly competitive academic discipline is inspirational. Yet she, like many other BME people, is evidently at risk of being typecast, as demonstrated by the *Daily Mail* diarist Ephraim Hardcastle's assertion on 19 March 2014, following the appearance on the TV programme *Newsnight*, of Aderin-Pocock and her astronomer colleague Dr Hiranya Peiris, that their contribution to a discussion about a book on the 'Big Bang' origins of the universe could only be explained by the programme editor's keenness on diversity (*The Voice*, 2014).

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A study of evidence from the 2011 Census shows that ethnic minorities in England have become increasingly better qualified than their White British counterparts (Lymperopoulou & Parameshwaran, 2014). The groups with the highest proportion of people with degree level qualifications were the Chinese (43%), Indian (42%) and Black African groups (40%). In contrast, 25% of people with a White background had no qualifications. The Indian and Pakistani groups increased their degree level qualifications by 27 and 18 percentage points respectively, between 1991 and 2011. Proportions of people without any qualifications declined by 19 and 16 percentage points in the Bangladeshi and Pakistani groups between 2001 and 2011. Likely explanations may be wider and improved access to higher education, particularly among women and previous policies aimed at raising the attainment of ethnic minority pupils in schools.

Despite the narrowing of the educational attainment gap between some ethnic groups and the White majority, the authors of the study caution that ethnic minority groups continue to experience inequalities in education and the labour market. The Bangladeshi and Pakistani groups were, for example, more likely to have no qualifications than White British people.

Diversity in the teacher workforce does not match the diversity of pupils in schools. While 17% of pupils in the UK are from BME backgrounds, only about 7% of teachers are (Daniel Boffey, The Observer, 2014). A report published earlier in 2014 revealed a substantial variation by ethnicity in the proportion of applicants accepted by teacher training institutions (UCAS, 2014). Only 17.2% of Black African and 28.7% of Black Caribbean applicants were accepted for teacher training in 2013, compared with 46.7% of White applicants. For postgraduate courses for a certificate in

Key facts on ethnic inequalities

In 2011-12, 47% of Black males between the ages of 16 and 24 were unemployed, as opposed to 20% of White males of the same age group (Commons Library Standard Note, 2013).

In 2010, the rates of admission for mental health care for 'other Black' group were six times higher than average (Care Quality Commission, 2011).

Black people are seven times more likely to be stopped and searched than White people and Asian people at twice the rate (Runnymede Trust, 2012).

For every one African Caribbean male undergraduate at a Russell Group university, there are three African Caribbean males aged 18–24 in prison (Runnymede Trust, 2012).

Ethnic minority households are around 3 times as likely to become homeless than the majority White population (Office of the Deputy Prime Minister, 2005).

The infant mortality rate amongst Black groups was double that of White groups in 2006 (8 deaths per 1000, compared to 4 deaths per 1000) (National Perinatal Epidemiology Unit, 2007).

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education in history in 2013, the acceptance rate was 10% for Black African, Caribbean and mixed race applicants, but 26% for White applicants. Black and Asian teachers are less well represented among head teachers and deputy head teachers than their White counterparts, and discrimination was cited as a major barrier to securing leadership posts in one survey of BME teachers (McNamara et al, 2008).

Adopting healthy lifestyles

African Caribbean communities have a greater prevalence of obesity and 'lifestyle-related' illnesses such as diabetes, hypertension and strokes in comparison with their White counterparts (Nazroo, 2001). There is also evidence that the African Caribbean community is comparatively socio-economically disadvantaged when compared with the White population. It would therefore not be surprising if this resulted in health inequalities between the 2 groups. Yet, studies exploring the determinants of health in the African Caribbean communities have implicated behavioural factors while other factors such as social class, poverty or social discrimination have been inadequately controlled for (Ochieng, 2013). A qualitative study which explored the perceptions of Black families in England, to barriers to healthy lifestyles highlighted that the participants could identify behaviours (such as exercise) and social characteristics (such as a healthy neighbourhood and functioning family and social dynamic) which were consistent with the existing national healthy lifestyle advice, but also emphasised other issues which related to values and experiences specific to the African Caribbean community, such as the need for healthy nutrition advice to include foods associated with an African Caribbean diet. Importantly, participants in the study argued that policies to improve healthy lifestyles needed to address the wider determinants of health such as racism, discrimination and the need for appropriate education and employment. The commonly accepted notions of healthy lifestyles which focused on individual behaviours were regarded as irrelevant, against a background of daily struggles in relation to other priorities.

Racism and discrimination were cited as major barriers to healthy lifestyles, with racism permeating nearly all aspects of the participants' lives and excluding them from the labour market, as well as other types of socio-economic life chances. Boys and men were thought to suffer significant racism in terms of employment opportunities, and this was emphasised as limiting the choice of men to maintain a healthy lifestyle. The study reported the women participants as repeatedly raising concerns about the ill-treatment of the men in their families and community, and that the men were consequently a source of considerable grief and anxiety for the women.

Furthermore, the study exposed the hostility of the participants towards healthy lifestyles advice based on White British values and beliefs and omitting any mention of African Caribbean foods for example, which was perceived as a mechanism to impose social control and conformity to dominant preferences. Instead, a healthy lifestyle was described as one

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which encouraged community empowerment, harmony and understanding within and with other ethnic groups.

Although this particular study focused on one BME group, it is likely that other groups share similar experiences.

Variations in access to health care: the example of cardiovascular services

Health itself is a strong determinant of wellbeing (Department of Health, 2014). Interventions to improve wellbeing may therefore include measures to improve health care for those who need it. The BME population has a higher burden of ill health than the White population. Yet, studies on hospital care have shown repeatedly that BME communities have poorer access to health care. In patients with heart disease, those of south Asian origin have previously been reported to be less likely to undergo specialist investigation than those of white European origin. An observational study in 2003 by Barakat and colleagues comparing the presentation and treatment of Bangladeshi and white patients admitted with acute myocardial infarction (MI) in east London found no ethnic difference in the interpretation of symptoms as being potentially MI and in the time from onset of chest pain to arrival in hospital (Barakat et al, 2003). However, once the patients were in hospital, it took almost twice as long on average (42.5 vs 26 minutes) for the Bangladeshi patients compared with the White patients to receive thrombolysis, despite a greater proportion of the Bangladeshi patients being male, suffering from diabetes mellitus or having had a MI previously, which should have resulted in a greater suspicion of MI. An inability to communicate effectively with their health care providers has been offered as a likely explanation in the absence of any other plausible factors (Khunti & Samani, 2003).

Of particular concern is the fact that there were no ethnic differences in identifying pain as cardiac, in a study of variations in health seeking behaviours and attitudes among patients in London carried out almost 2 decades ago (Chaturvedi, Rai & Ben Schlomo, 1997). Indeed, the South Asians in that study were found to be more anxious than the Whites about pain and Hindus and Sikhs reported a greater likelihood of seeking immediate care compared with their White counterparts, indicating that barriers to care were unrelated to their recognition of the seriousness of the symptoms. The conclusion was that the explanation must lie with doctors' difficulties in arriving at a diagnosis in ethnic minority patients or in ethnic variations in management of cardiovascular disease.

It is acknowledged that some general practice based studies have arrived at a different and more positive conclusion. One 2004 study of cardiovascular services reported that South Asian patients had higher rates of angiography, consistent with more equitable access to specialist cardiac services (Jones, Ramsay, Crook & Hemingway, 2004). However, a 2008 study has shown that the management of hypertension in ethnic minority groups remains

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suboptimal particularly in individuals with cardiovascular comorbidities, compared with White patients with similar clinical histories, and despite the introduction of pay for performance for GPs (Millett, Gray, Bottle & Majeed, 2008). And persistent ethnic disparities in the management of diabetes were reported as recently as in 2010 by researchers who carried out a 10-year study, although the disparities were starting to be addressed especially among the South Asian group (Verma et al 2010).

Discrimination in Mental Health Services

Variations by ethnicity are also a feature of mental health care in England. A systematic review of the literature demonstrated that black people are overrepresented among in-patients and Asian patients use in-patient facilities less often than do White patients (Bhui et al, 2003). There is compelling evidence to demonstrate that Black men are more likely to be subject to sectioning under the Mental Health Act, held in seclusion on mental health units, physically restrained and discriminated against because of misconceptions of being dangerous or having a propensity for violence. A recent report published by Time to Change, the anti-stigma and mental health campaign run by charities Mind and Rethink Mental Illness, describing the results of a mental health survey of ethnic minorities in England highlighted the 'dual discrimination' - discrimination in everyday life due to their illness as well as racial discrimination faced by the majority of respondents (Time to Change, 2013). Furthermore, about half the respondents had faced discriminatory behaviour from mental health staff, leading the authors to conclude that 'discrimination is everywhere'.

The Care Quality Commission's 2010 Count Me In survey showed that BME people continue to be over-represented in mental health inpatient services and may have increased since the first survey in 2005 (making up 22% vs. 20% of in-patients), despite Government targets to reduce their over-representation in these services (Care Quality Commission, 2010). Poverty and deprivation are likely to be among the root causes of mental ill health leading to higher rates of admissions, but everyday racism, fear of racial discrimination, and lack of information about services are also cited as major and persistent barriers to mental well-being in BME communities.

In addition, there is a paucity of reliable information on the prevalence of mental illness in BME children and factors which could promote their mental well-being, despite this group deserving to be prioritised if mental ill health in adulthood is to be reduced. Data that is available suggests a higher prevalence of conduct disorders among boys from Black backgrounds, and self-harm among South Asian women aged 16 to 24 years (Race Equality Foundation, 2014). Yet children from these backgrounds are less likely to engage with services which could intervene early and prevent a deterioration of their illness.

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Difficulties in drawing conclusions from research into inequalities in health care

A particular difficulty in drawing conclusions about practical steps which could be taken to address inequalities in health care stems from the focus of much of the research being confined to exploring the differential uptake of services or 'receipt' of care (Szczepura, 2005). There are fewer papers reporting research on process, including barriers to accessing care and factors influencing these; and very little peer reviewed literature on the evaluation of interventions to improve access. Assessments of 'access' which focus only on uptake of care ignore the other essential dimensions of equity; the provision of appropriate information, timeliness and sensitivity of care and the ability to use the service with ease and having the confidence to know that care providers would treat you with respect.

Factors influencing access to health care by BME groups have been summarised by Szczepura as falling into 2 groups - 'intrinsic' cultural differences and language and literacy, and ignorance due to 'newness' of the user, for example, a recently arrived migrant. Organisational factors include poor provision of services for 'ethnic diseases' such as haemoglobinopathies which only affect minority communities, poor staff training, and poor linguistic and cultural competence among health care providers. Location may be another barrier, although a less convincing one, as many BME populations live in inner city areas which are also home to some of England's most prestigious hospitals and health care services (Zaman & and Patel, 2011).

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Are there differences in wellbeing between distinct BME communities, and/or between 1st, 2nd and 3rd generation individuals?

While the data indicates a shared experience of lower wellbeing for BME communities, there are nevertheless variations in the impact of everyday experiences on wellbeing in different communities. There may also be variations *within* BME communities, particularly in relation to migration – both migration patterns within communities and the history of migration of the BME population (whether an established or more recent community). Roundtable participants also pointed to differences in the country of origin translating into BME populations in the UK, such as social status or education.

Heterogeneity is likely to be the main explanation for differences between communities in levels of wellbeing, but variations in levels of integration, the degree of assimilation and cultural and community separateness were also acknowledged as factors which may differ between communities (Saamah Abdallah interview).

“There is no reason to assume that one ethnic group will have similar rates of health and wellbeing – there are bound to be intra-ethnic differences.”

Such distinctions between BME communities influence the nature and degree to which factors such as exclusion and discrimination operate on that community, and therefore the impact on wellbeing. One African Caribbean participant, stated:

“Black African, Black African American and Black African Caribbean people, get the brunt of it. Then after that I would say Bangladeshi people, people from Bengal, and those parts of the Indian subcontinent. And then there’s your Indians and so on, followed by your Chinese and other Asians. We are not all treated the same, we do not have the same health issues we do not have all the same exclusivity/ inclusivity issues, therefore the same health issues.”

A report from the Social Integration Commission (2014) entitled 'How integrated is modern Britain?' highlighted that residential segregation by ethnicity is increasing. The average Briton is reported to have 48 per cent fewer interactions with people of different ethnicities than would be expected if ethnicity was irrelevant. Apart from the mixed ethnic group, all ethnic groups have around 40 to 50 per cent fewer social interactions with others than would occur if there was no segregation. Despite its high levels of diversity, London was found to be even less ethnically integrated than the rest of Britain. White Londoners have one third the number of interactions with non-white Londoners than if their relationships

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reflected the ethnic make-up of the city. Black and Asian Londoners have more interactions with those of other races but less than two thirds of the numbers expected. The British educational system also demonstrated signs of social segregation by social grade and ethnicity with the school system being rated by the OECD as the fourth most segregated for recent migrants.

Different historical experiences and legacies would also drive the disparities between BME communities. Participants at the roundtable highlighted the likely influence of the drivers of migration e.g. educated people seeking economic enhancement and those escaping poverty, war or persecution. The legacy of slavery and colonialism was also highlighted in respect of the ongoing and current influence of these structures in affected communities.

The issue of migration patterns could also drive differences between generations. Besides, the concept of wellbeing itself is new, and less well recognised by older generations:

“I think you could see a difference between generations definitely because I think the whole concept of well-being is a fairly recent one. In the public domain I think well-being has been highlighted in the last few years, so people haven’t been used to framing their life in that way necessarily.”

More widely reported, was the impact of the varied experiences of different generations of migrants. This was reported in many interviews, and by the roundtable. One participant considered the issue through her own experience as a second generation African Caribbean woman. She described the experiences of animosity and hostility that faced first generation immigrants in her own family, and the long term impact on wellbeing she felt this had created, contrasting this with the different experiences of second and third generation migrants, which are more nuanced depending on cultural markers and events, the level of diversity in the area of residence, and community structures such as schools:

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Other participants though suggested that they would expect wellbeing to be lower in second and third generations:

“...I think that if you looked back at the first generation like my mother’s generation, well actually me really because I wasn’t born here. But if you look at her generation they all came over here very starry-eyed didn’t they? They were all, ‘the motherland and the mother country’ etc. and they came over and they were hit with this thing, no Blacks, no dogs, no Irish thing, but they kind of got on with it and worked very hard and were what I would call acquiescent and submissive, is what I would say they were. Compared to what we have now, which is their children. So they came over, worked hard, worked in our hospitals and our underground and a lot of them are dead now or have gone back to the West Indies. But their children and their children’s children have lived in this society and have become increasingly more disenfranchised, more, I suspect if you look at the statistics, and I think it was the last time I looked, every single boy killed last year in London was a Black boy, stabbed. So they are more disenfranchised, disengaged, disillusioned, disrespectful, every ‘dis’ I can think of they have become, because they have not seen that they are an integral part of this society.”

This was also linked to a perception of more recent migrants remaining connected and ‘rooted’ to home, whereas second and third generations are more likely to feel disconnected from both the country of their heritage and the UK.

Differences between first and second generation experiences of subjective wellbeing were explored in the Understanding Society Survey ethnicity boosted data, which found that the association between ethnic minority status and lower wellbeing was larger for second generation respondents typically, and noted differences between drivers for each group (Knies, Nandi & Platt, 2014). For first generation, the impact of using contemporaries in the country of origin as a reference and differences between expectation and reality in their neighbourhoods are cited. For second generation, the frustrated expectation to be treated in the same way as others born in the UK, and higher sensitivity to ethnic inequalities and discrimination are key. Studies to explore the ethnic penalties and discrimination in employment have clearly shown that the second generation face experiences similar to those of the first generation (Wood, Hales, Purdon, Sejersen & Hayllar, 2009)

The issue of generational status is particularly interesting in the context of the DASH study – Determinants of Adolescent Social wellbeing and Health, a longitudinal study investigating wellbeing and ethnic differences in adolescents. The total DASH sample of 6,643 adolescents aged 11-13 years included more than 80% ethnic minorities. The sample was recruited through 52 schools in 10 London boroughs. 63% of ethnic minority participants were UK born, 87% have at least one foreign born parent, 51% reported speaking a foreign language at home, and 42% attended a place of worship at least once per week. Ethnic diversity in friendships was more common than ethnic homogeneity. The study focused on a range of longitudinal social, psychosocial, and health measures, aimed to understand the

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emergence and evolution of ethnic differences in physical and mental health. In addition, it hoped to identify key time points when interventions to reduce ethnic inequalities in health could be most effective, and offer insights into improving health outcomes for the whole population. The DASH study found higher reported wellbeing for BME adolescents compared to their White counterparts (Maynard, Harding & Minnis, 2007).

Two of the researchers leading the DASH study were interviewed as part of this project. They outlined that their findings indicate higher levels of wellbeing and better reported mental health for ethnic minority children, which, they observed, may indicate generational differences, though with the caveat that the downstream effects are not yet known. The social determinants and adversity impacting BME people, such as unemployment, racism and other operators, are still prevalent, but the DASH findings suggest that young people might be coping better or be more resilient to the effects. The impact of migration was also suggested, with first generations having experienced more adversity and hardship, while second or third generation people may experience more social mobility.

The DASH findings throw additional light on the role of migration history and generational status as a driver worthy of more detailed research. Though it should be noted that participants at the roundtable meeting discussing the DASH findings, observed that given the particular ethnic density and integration of the London boroughs where the research was conducted, such positive findings may be reflective of the protective effects of concentration found by other studies, but may not be replicated in all areas (Knies, Nandi & Platt, 2014).

Higher levels of wellbeing reported by BME than White British participants in the DASH study merit further analysis, as they are a notable contrast to the lower levels of wellbeing consistently reported by other studies. Possible drivers to explain this are reported in multiple papers discussing the DASH study findings (please note sample sizes and distribution vary). The impact of participation in family activities was considered in one paper, and reported to vary by ethnicity, with all minority groups more likely to visit family and friends with a family group than the White UK participants. Differences were also found in the likelihood of eating family meals, between both different ethnic minority groups and the White UK group. Independent of both family type and socio-economic status, in multivariate analyses all adolescent minority groups demonstrated better wellbeing than the White UK group (Maynard & Harding, 2010a).

Perceived parenting was also evaluated, finding that between the ethnic groups, minorities had relatively better mental health compared with Whites, even in environments of low levels of parental care and greater individual autonomy. Despite heterogeneity reported in perceived parenting, low care and high control scores were associated with poorer mental health within each ethnic group in the 11 to 13-year-olds sample (Maynard & Harding, 2010b).

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The impact of cultural integration was also considered. Mental health improved with age in the study population, more so in male rather than female students, with cultural integration (friendship choices across ethnic groups) found to be associated with the lowest levels of mental health problems especially among Black Caribbean and Black African male students (Nigerian/Ghanaian origin). This effect was sustained irrespective of age, ethnicity and other potential explanatory variables (Bhui, Lenguerrand, Maynard, Stansfeld & Harding, 2012).

Racism was additionally found to influence wellbeing, to a greater extent than ethnic density or deprivation in schools or neighbourhoods. Interestingly, higher levels of wellbeing were recorded for Nigerian/Ghanaian boys, despite this groups' reporting of racism increasing with age. Experiences of racism were associated with wellbeing reducing with age (Astell-Burt, Maynard, Lenguerrand & Harding, 2012).

The DASH findings indicate the need for further research into the links between generational status and wellbeing, as well as the internal and external differences in experiences of younger versus older people from ethnic minorities that influence wellbeing.

In terms of variations in wellbeing *within* BME communities, there is a paucity of published literature on gender differences, or on those with dual-minority status such as individuals who are from a BME background and have a disability, or belong to the Lesbian, Gay, Bisexual or Transgender group. It is possible that such groups face even greater marginalisation and discrimination than BME counterparts without the additional characteristics.

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What are the differences in cultural interpretations of the questions and concepts of wellbeing, and what impact do these have on reported wellbeing?

Given that wellbeing is 'self-reported' the way in which individuals understand their own wellbeing and their interpretation of the questions asked to ascertain it will have an impact on the way they report. It is therefore possible that differences in wellbeing shown up by the data might be attributable to the way in which individuals report their wellbeing, rather than differences in levels of wellbeing itself. If people from different cultures understand the questions and concepts of wellbeing differently, this may explain differences in level of reported wellbeing.

The roundtable discussed this issue at length, starting from an agreement that wellbeing is a useful measure in enabling the capture of immaterial factors outside social and economic measures that are significant in their impact on people, although there are challenges to capturing and understanding wellbeing objectively. The influence of environments and experiences on both wellbeing and how it is understood were noted. The idea of 'objective' wellbeing raised a mixture of views from participants, as some felt that Quality of Life (QOL) measures were more reliable to avoid the impact of cultural bias, as these were felt to be more objective. Others stated the view that wellbeing is itself a subjective experience so it was important to have measures that captured the experience of wellbeing. One participant described wellbeing as the 'experience of quality of life'.

Many participants in the project raised questions over the cultural and linguistic resonance and understanding of 'wellbeing' in itself as a concept. One roundtable participant noted translation problems, stating that the closest word he could identify in Hindi or Sanskrit literally translates as 'good state' and does not accurately capture the concept being measured. Interviewees noted the broad range of definitions and understandings, influenced by community and culture. For example, one observed that in her work with Traveller communities, wellbeing had been demonstrated to be interlinked with cultural understandings of community and bound in traditions and lifestyles which directly influence wellbeing. Others observed the impact of religious belief and the influence of concepts such as forbearance, detailing the different ways in which individuals' understanding of happiness is influenced by cultural and religious beliefs – such as the difference between self-actualisation, deferred gratification and wellbeing as in individual or group state. The impact of family on wellbeing was also noted, with interviewees stating that the wellbeing of the family would be a key determinant in the individual's assessment of their own wellbeing for people from many groups:

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“I think family is a big one for everybody, to be honest. I can’t think of a group where family isn’t at the forefront. And then you have things like religion which will come into play for a lot of the groups. I don’t know how important things like finances would be. I can’t think of a group where their whole way of being isn’t about family: supporting them, making a life for them.”

Davinia-Louise Green, interview

The differences in the understanding of wellbeing were also thought to be affected by wider influences such as family networks and proximity and environmental factors. The roundtable participants also felt that it was vital not to expect differences to hold across communities, as wider experiences would also have an impact on individuals.

Overall though it was felt that the framing of questions and cultural concepts would play a role, but a wide range of other influencing factors were cited as being more important than cultural markers. It was also noted that the tools used to assess wellbeing were not framed around concepts of ‘wellbeing’ as such, as the term itself does not feature in wellbeing measures. This is considered in detail in the following section.

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How does the language of wellbeing resonate with cultural reality and language, especially in terms of population survey language?

While it was largely held that there would be differences in the cultural interpretations of the questions and concepts of wellbeing, the extent to which this impacts on reported wellbeing is debatable. Population surveys avoid using 'wellbeing' directly, and the language that is used is open to wide interpretation, which allows it to be understood through a framework of cultural reality.

In the two main data sources demonstrating lower wellbeing in BME groups, the survey language used is, in the Annual Population Survey:

1. Overall, how satisfied are you with your life nowadays?
 2. Overall, how happy did you feel yesterday?
 3. Overall, how anxious did you feel yesterday?
 4. Overall, to what extent do you feel the things you do in your life are worthwhile?
- (ONS, 2012)

And in the Understanding Society Survey:

"Overall, how satisfied are you with your life" (Knies, Nandi & Platt, 2014).

This language would seem to allow space for personal and cultural concepts and differences such as the role of family or religion to be accounted for – the different ways individuals may understand 'happy' can still be captured by the question 'how happy did you feel yesterday'. Nevertheless, potential differences in how individuals might measure their happiness, or other concepts used in wellbeing survey questions, was felt to be a relevant issue.

At the roundtable, participants noted that wellbeing relates to the lives people lead and the environment in which they live, and that the understanding of and answers to population survey questions will be influenced by these factors. One participant noted that 'wellbeing' or 'happiness' may itself be maladaptive in situations of struggle or suffering.

The difficult experiences of particularly first generation migrants were also pointed to as illustrative of why 'happiness' may not resonate with some individuals:

"You know, if you look at my grandparents, when I was a kid they looked so old, compared to 50/60 year old people now, because of what they were doing to bring up their children and put them through school. Encountering so much animosity in this country, and dealing with so many hardships. You know, I've so rarely seen my grandmother smile, and I think that's because she went through so much. If you asked her if she was happy, I'm 100% certain that she would say no and that's because of the life she's actually had. For her, it's a case of getting through until she actually goes."

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Further, the concept of wellbeing is often tied to the idea of community and the extent to which an individual feels connected to or part of the community. This was felt to be especially challenging for BME people who may perceive themselves to be part of multiple communities, and understand the language of community in more varied or challenging ways:

“I’d look at the Black community as my community, and then the area in which I live as my immediate community. But I don’t necessarily feel... I don’t think there is a Black community anymore, as such. So there’s no connection, and I don’t really have any ties within my immediate community in the area in which I live. I think community is a weird word for people, and it can mean so many different things for different people... For a lot of BME groups, I think the first thing is their own ethnic background community, maybe the first instinct would be to think about their peers, or the Black or South Asian people around them. Maybe, I don’t know. Maybe, if I asked some of my friends about community, they would say, oh, there are not that many Black people around here, maybe. That might be the first thing that came out of their mouths.”

The extent to which different understandings of the language used in measures of wellbeing influence the subjective values people assign to their wellbeing is an element to be considered in an analysis of ethnic differences in wellbeing. However, that lower levels of wellbeing are reported consistently by different BME groups in comparison to White groups, despite their heterogeneity, makes clear that cultural and linguistic differences cannot be a full explanation. Indeed, as such differences are reported by varied BME groups including groups with English as a first language and second and third generation groups with UK schooling and learning, where linguistic differences will be minimal in comparison to the White population, then it is clear that language cannot be the driver of differences, and instead that there are real differences in wellbeing.

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How do these questions apply to the NHS which has notably high proportions of BME representation among its staff?

The NHS has a highly ethnically diverse workforce, and also a specific focus on population health and wellbeing. Consequently, it may be reasonable to assume that the NHS would be concerned to promote the wellbeing of its staff and was therefore chosen as a useful case study for this research. The roundtable, in addition to exploring the determinants of wellbeing at the population level, also considered whether the NHS was an exemplar in promoting wellbeing across its ethnically diverse population. A number of focussed interviews with NHS staff, representing clinicians, senior leaders and individuals with a specific and specialised interest in issues around diversity, and BME NHS staff, provided further evidence as to how the NHS promotes wellbeing among its ethnically diverse workforce. The findings point to the fact that, far from being an exemplar for staff wellbeing, the NHS helps to illuminate the impact and consequences of lower wellbeing, as well as specific drivers for differences in wellbeing between different ethnic groups.

In a review published in 2010, Dr Saima Latif explored previous efforts to address health inequalities in the NHS (Latif, 2010). Sir Donald Acheson's *Independent Inquiry into Inequalities in Health* was a turning point in highlighting the role of ethnicity as a focus for health policy for the first time (Acheson, 1998). The 2008 Department of Health review (Department of Health, 2008), *High Quality Care for All*, also referred to as 'the Darzi review', provided a long term vision for the NHS which would remedy health inequalities, but did not address ethnicity as an important factor. Furthermore, the 2010 '*Marmot Report*', on health inequalities (Marmot, 2010), reported on socioeconomic inequalities but largely left out ethnic inequalities and the systemic barriers that BME people face while accessing health services.

This report sets out two intersecting factors to address health inequalities; greater collection of ethnicity data, and better adherence to legal obligations such as the Race Relations Amendment Act 2000. Recent initiatives to better understand and tackle health inequalities are weakened by the lack of baseline data on ethnicity. This lack of data remains a central and perhaps convenient barrier to addressing the problem of health inequalities.

Diversity in the NHS

The ethnic diversity of the NHS workforce was widely noted by project participants, who also commented on lower diversity at senior levels. The diversity is due to a range of factors including targeted programmes of overseas recruitment to fill gaps in the workforce. Recent statistics compiled by the Health and Social Care Information Centre and reported by the Guardian newspaper detail the reliance of the NHS on staff from outside the UK (Haroon Siddique, The Guardian, 2014).

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Of all staff for whom data was available in the NHS and community health services, 11% are foreign nationals, while 14% of professionally qualified clinical staff and 26% of doctors are from outside the UK. As shown by the table below, overall, 40% of doctors in the NHS are from a BME background. The contribution of staff recruited overseas to the NHS is significant and has been documented – the Runnymede Trust has produced two books detailing the contribution of Caribbean and Asian staff respectively, for example. However, this diversity is not proportionately represented through the NHS hierarchy. Lord Nigel Crisp, an interviewee in this project, recently asked a question in the House of Lords on the number of Executive Directors of Nursing in the NHS who describe themselves as BME (House of Lords Daily Hansard, 2014). Based on data from September 2012, the Department of Health responded that 5 (just under 3%) of 195 nursing directors were identified as BME. The ensuing debate acknowledged the need to address this issue, with Lord Hunt of Kings Heath concluding “18% of the NHS workforce in England is from a BME background and 14% of the population of England is from a BME background. As 2.6% of nursing directors comes from a BME background, that shows that there is a very long way to go.”

At the roundtable, ethnic differences in seniority, specialisms and role were recognised, and participants noted drivers including overt discrimination – favouring ‘people like me’ as well as more discreet drivers through ‘closed shop’ practices. These issues were elucidated in more detail by interviewees and are confirmed by the research evidence.

Ethnic discrimination in the NHS recruitment process was first publicised by a landmark study in 1993, when researchers found that identical applications for medical posts were twice as likely to be shortlisted if they were made with an English name than with an Asian name (Esmail & Everington, 1993). Two decades later, the situation appears no better. A study published recently has revealed that White doctors are almost three times more likely to be successful in applying for hospital jobs than doctors from ethnic minorities (Jaques, 2013). In 2012, 13.8% of White applicants to senior hospital doctor jobs in England were successful in securing the role they applied for, compared with 4.8% of doctors from BME backgrounds. Black or black British applicants were the ethnic group least likely to secure hospital doctor jobs (2.7% success rate), followed by doctors of mixed ethnicity (3.5%), and Asian and Asian British doctors (5.7%). White doctors were also more likely to be both shortlisted for jobs and appointed to roles once they had been shortlisted.

In his seminal 2014 report considering BME progression in the NHS in London, Kline has exposed the stark contrast between London's demography, with 45% of the population and 41% of its NHS staff being made up of BME people, and the NHS leadership in London, which has BME representation of only 8% of NHS Trust Board members and 2.5% of Chief Executives and Chairs (Kline, 2014). Furthermore, the London picture was reflected in every respect nationally, with BME representation being entirely absent from the Boards of some of the national English NHS bodies.

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Data from the Health and Social Care Information Centre which shows the ethnic composition of the NHS workforce, demonstrates that an 'ethnic gradient' exists even within the workforce, with BME staff being represented in larger numbers at lower pay grades and lower status roles among medical and non-medical grades of staff.

NHS Hospital & Community Health Service (HCHS): Medical and Dental staff by grade and Ethnicity¹

England at 30 September 2013

	All Staff	Total ethnic minority groups	Total ethnic minority groups %
All staff	108,732	40,653	40.4%
Consultant (including Director of Public Health)	41,220	13,230	33.9%
Associate Specialist	3,273	1,766	56.9%
Specialty Doctor	6,607	3,675	60.2%
Staff Grade	506	273	58.2%
Registrar Group	40,492	16,374	44.4%
Senior House Officer	1,298	665	55.6%
Foundation Year 2	6,252	2,150	37.8%
House Officer and Foundation Year 1	6,525	2,002	34.7%
Other Doctors in Training	61	23	42.6%
Hospital Practitioner/ Clinical Assistant	1,459	293	21.8%
Other Staff	1,512	356	25.4%

- Staff from minority ethnic groups represent 40.4% of medical and dental staff.
- Groups with the highest proportion of staff from minority ethnic groups (all above 50%): Associate Specialist 56.9%, Speciality Doctor 60.2%, Staff Grade Doctor 58.2% and Senior House Officer 55.6%. These are groups just below the level of consultants
- Only 21.8% of Hospital Practitioner/ Clinical Assistants are from ethnic minority groups

¹ Copyright © 2014, Health and Social Care Information Centre Provisional Monthly Workforce Statistics
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NHS hospital and community health services: Non-Medical staff in England by pay band and ethnic group as at 30 September 2013²

	All Staff	Total ethnic minority groups	Total ethnic minority groups %(1)
England	1,075,035	148,396	14.4%
Band 1	41,168	6,322	16.2%
Band 2	174,336	21,449	12.9%
Band 3	143,074	15,845	11.6%
Band 4	92,481	8,864	10.0%
Band 5	244,092	49,717	21.3%
Band 6	187,994	26,966	15.0%
Band 7	115,540	12,406	11.1%
Band 8a	37,985	3,728	10.2%
Band 8b	17,143	1,388	8.4%
Band 8c	9,164	592	6.7%
Band 8d	5,017	270	5.7%
Band 9	1,474	68	4.8%
Unknown	16,040	1,748	11.7%

- Staff from minority ethnic groups represent 14.4% of non-medical staff.
- High representation of ethnic minority groups in staff with pay band 5 (21.3%).
- Low representation of ethnic minority groups in staff with pay bands 8c (6.7%), 8d (5.7%), and band 9 (4.8%).

The data presented here conclusively demonstrates ethnic minority under-representation at senior levels of the NHS.

Progression and recognition

As a large and complex employer, the NHS operates with a defined hierarchy offering career progression and recognition. Barriers to progression were identified by all study participants, in particular noting the issue of the lack of ethnic diversity in the senior leadership, as well as challenges at all levels to staff attempting to further their careers. The impact of this lack of progression was identified as significant for BME staff within the NHS.

Overall, ethnic minority NHS staff were felt to be pushed towards less popular specialisms and roles, and to face more stagnation as routes of progression were closed off. The direct impact of this, as well as the more indirect but no less pervasive impact of the perception of differential treatment or progress based on ethnicity, was identified as both significant and

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pernicious. The extent to which these issues arise out of discrimination was widely considered by participants, who largely noted that discrimination was a major driver of these differences. For example, Carol Baxter noted that:

“Racism is always there and is the biggest cause. People like to work with/ promote and sponsor people who look like them. People in senior positions would like to push forward their own. The other reason this happens is because BME people don’t have sponsors there/ people to push you forward - so it’s not always deliberate. But it’s never that easy to know what is deliberate racism and what isn’t.”

Lord Nigel Crisp, former Chief Executive of the NHS, was also interviewed as part of this project, and described his work on the NHS Race Equality Plan, a ten-point strategic plan developed in 2004 by Lord Crisp as Chief Executive of the NHS, designed to foster recognition of the value of race equality in the NHS and to promote action to achieve it (Crisp, 2004). Lord Crisp stated that the Plan emerged out of two observations:

“First, that patients from BME rated their care from the NHS lower than that from the majority population, and secondly, that BME staff rated their job satisfaction lower than staff from the majority community and something needed to be done about it as a health issue. Whilst of course, there are legal issues, and social justice issues, and moral issues and employment issues, actually, I addressed it as a straightforward health issue. We weren’t doing as well for this part of the population.”

The Race Equality Plan was made up of elements including improved data collection and mentoring support for BME staff. Lord Crisp conceded that it had achieved some successes but that there were also limitations particularly on improving BME representation at senior levels:

“I think you need more senior level push and determination on this, to make it happen. If there isn’t a

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tradition of people going into the higher posts, then you need to have more people making sure that they are pulled through. There needs to be more determination to make it happen, to make that change happen."

This view was widely echoed by participants in the study.

An objective measure of recognition may be considered to be performance related pay (PRP). Our purpose in relation to this aspect of our analysis and review, was not to comment on whether PRP is an effective method for rewarding outstanding performance in the NHS, but, given that PRP is offered in the NHS, to assess whether it is equitably distributed across the ethnically diverse staff in the organisation. We focused our review on the Clinical Excellence Awards, a scheme whose existence dates back to 1948 even if its title and processes may have undergone some changes over time. It is aimed at recognising 'excellence' and is generally recognised as a scheme for 'performance related pay' for NHS consultants (Abel & Esmail, 2006). A study of the fitness for purpose of the scheme published in 2006 concluded that despite changes in the name, discrimination by race and gender has persisted over time (Abel & Esmail, 2006). In 2011, the Department of Health for England's Advisory Committee on Clinical Excellence Awards (ACCEA), which implements the scheme reported as it has done in previous years that BME applicants have a lower success rate at all levels of national awards, with a particularly marked difference in 'Gold' awards (ACCEA, 2012). However, the proportion of successful BME awardees is reported to be 'comparable with the proportion of BME applicants'. But a key concern which the report fails to draw attention to is the under-representation of BME applicants. It may be reasonable to suggest that proportions of BME awardees at each level should be more comparable to proportions of consultants from BME backgrounds. Of particular concern is the fact that no assertive action appears to have been taken to eliminate BME under-representation in applications or lower levels of BME success in securing awards despite this being reported year after year. BME women probably face the dual disadvantage of gender and ethnicity and are likely to have proportionately the lowest level of awards, but the persistence of these inequalities over several decades highlights that there is no demonstrable concern to rapidly investigate or correct these injustices.

Discrimination in the NHS

Data published by the BBC in December 2013, gained through Freedom of Information requests to NHS trusts, demonstrates a 65% increase in racist verbal and physical attacks against staff by patients in the NHS in the past 5 years (BBC, 2013). The BBC story carries a quote from Dean Royles, CEO of NHS Employers, who stated:

"We should be proud of the contribution that staff from Black and minority ethnic backgrounds make to the NHS. We know from research that diversity is important for

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patient care and that a diverse workforce is a more productive workforce. Therefore, it is right that any signs of inequality or discrimination - factors which can significantly affect motivation - are taken seriously” (BBC, 2013).

Racism against staff takes a number of forms. Nadeem Moghal, an associate medical director reflected in a recent BMJ article on an incident at a hospital where parents requested their child was to be treated by a White doctor only (Moghal, 2014). Instead of confronting these parents and denying their request, a decision was taken to meet their demand. According to the specifications of the Macpherson report, this was an example of institutional racism, discriminating against the ethnic minority staff in the hospital (Macpherson A recent, 1999). Moghal argues that this kind of acquiescence will continue to happen unless leaders decide to change their attitudes and behaviour towards ethnic minority colleagues and peers.

Discrimination was identified in a number of forms by project participants. Many roundtable participants pointed to the disproportionate rates of complaints and disciplinary actions faced by BME staff. A study which evaluated whether country of medical qualification is associated with 'higher impact' decisions at different stages of the UK General Medical Council's (GMC's) 'fitness to practise' process concluded that inquiries to the GMC concerning doctors qualified outside the UK are more likely to be associated with higher impact decisions at each stage of the fitness to practice process (Humphrey, Hickman and Gulliford, 2011). These associations were not explained by 'measured inquiry related and doctor related characteristics'. A recent report prepared for the GMC (Bridges, Ahmed, Fuller and Wardle, 2014) and aimed at exploring doctors' perceptions of fairness in GMC policies and practice confirmed the persistent view among BME doctors and those who have qualified outside the UK that the GMC registration process and the fitness to practise investigations and their outcomes were less likely to be fair to them.

Particularly damning were the conclusions of two studies published in the British Medical Journal in 2014 which concluded that, if a 'UK equivalent' pass mark had been applied to the Professional and Linguistics Assessment Board (PLAB) examinations which international medical graduates need to clear to be able to practise in the UK, most doctors who are serving the NHS would not have been allowed to enter the workforce at that level of performance (McManus & Wakeford, 2014) (Tiffin, 2014). These conclusions may lead to international medical graduates who already have a history of facing discrimination being further stigmatised. Yet, international evidence suggests that the relative performance of international medical graduates does not translate into detectable differences in patient mortality, but likely 'contextual difficulties in communication, ethics and team working' (Peile, 2014).

A valid question is why the UK admits doctors whose performance falls below 'UK equivalent' standards into UK practice? Esmail argues that dishonesty is at the heart of the

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decision not to achieve self sufficiency in terms of training enough doctors to staff the NHS, but instead, to make up the shortfall with overseas graduates and then to ignore their need for greater support to be able to achieve satisfactory levels of performance (Moberly, 2014).

Sub-standard training and education does not offer a plausible explanation for the fourfold difference between BME graduates trained in the UK and their White UK colleagues in the likelihood of failing the clinical skills test, a part of the Membership of the Royal College of General Practitioners (MRCGP) examinations (Esmail & Roberts, 2013). Black and minority ethnic graduates trained abroad were even more likely to fail this test. The study, based on data from the examination for the years 2010 to 12 concluded that differences in likelihood of failing the test were likely to be the result of 'subjective bias due to racial discrimination in the clinical skills assessment' exam. A judicial review brought by the British Association of Physicians of Indian Origin (BAPIO) against the RCGP and the GMC concluded that the exam was lawful but that the time had come for the RCGP to take action on the huge differences between the UK and the international medical graduates taking the exams. In dismissing the case, the judge leading the review nevertheless acknowledged that BAPIO had won a moral victory if not a legal one (The Courier.co.uk, 2014).

The links between race, racism and complaints and the impact that has on staff both directly affected, and those aware of such incidents and made insecure by them, were highlighted at the roundtable. In an interview with Carol Baxter, who leads on equality and diversity for the NHS at NHS Employers, she noted that in the past the issue of racism and abuse from patients would have been the major issue for BME staff, but that this would be less common and less blatant now, though harassment and bullying remain significant issues within the NHS. Discrimination through increased disciplinary procedures was an ongoing issue, linked with differing perceptions and reactions driven by unconscious bias – for example, differing perceptions of lateness in staff of different ethnicities. She drew attention to the variable drivers of discrimination for migrant staff, with broader issues such as cultural interpretations and knowledge of NHS expectations and systems being important, compared to non-migrant BME staff, for whom the major issue is race.

The impact on staff wellbeing

Experiences of actual or perceived discrimination, barriers to progression and other inequalities, are broadly agreed to have an impact on staff wellbeing, as noted above for example in the official response to the BBC story on racism against NHS staff. In the recent Lords debate mentioned earlier, Lord Crisp also acknowledged this association:

“This is a hidden problem, with fewer than 3% of nursing directors coming from Black and minority ethnic backgrounds. This underrepresentation, which is mirrored elsewhere in the NHS, is particularly important because it affects morale, and staff morale in turn, as noble Lords will know, inevitably affects patient care and outcomes. In other words, this is a health

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issue and not just an equal opportunities one.” Lord Crisp speaking in the House of Lords (House of Lords Daily Hansard, 2014).

This view was echoed at the roundtable, where participants also noted that differential or discriminatory treatment of patients would have an impact on staff from the same ethnic background who witnessed it.

In his interview, Aneez Esmail was asked what the impact of barriers to BME staff progressing was on the wellbeing of staff:

“I think this is the million dollar question really, on one level I think people knuckle down and are very committed to it, but I can’t help feeling you will get more out of them if they feel recognised and valued, so absolutely. You have to get someone to talk through that you know. But I’ve seen it ruined, I’ve seen people become bitter and twisted, I’ve seen massive settlements in court about it, and it doesn’t augur well for how things are when that happens. It leaves a sour taste in your mouth and you do your work but not enthusiastically and if you could get that enthusiasm... But many people have never had problems and they’re fine and you’ve got to put this into perspective”

This view – that these issues impact on staff wellbeing, but the extent of the impact is unclear, was also displayed by other interviewees:

“In terms of wellbeing, it would be the stress and the harassment and bullying part of it which would affect the most”

“Well I don’t know the figures now, but certainly the figures did show us that people from that group of staff were less happy and we also know if people are less happy, they are less likely to give good service and to be feeling well. I think it is their perception of inequality, and I think if they think that the organisation isn’t for them, and that they are the second class citizens in it, then that will affect people’s well being. You know all the stuff on equality and how equity affects life expectancy, amongst other things.” Lord Crisp, interview

Further study may be useful to explore in greater detail the impact of wellbeing on NHS staff, in particular around health and life expectancy, to ascertain if there are differences even after adjustments are made for other factors.

Impact of staff wellbeing on patients

We also asked interviewees what impact staff wellbeing might have on patients. That there is a link between the wellbeing of staff and the care and outcomes patients receive is broadly accepted. For example, the Department of Health’s review of wellbeing policy states the following:

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“Wellbeing of staff working in the health service can affect service delivery. There is a strong relationship between staff wellbeing and performance outcomes, with evidence demonstrating a causal link. How patients experience care can be just as important as the actual medical treatment they receive. Staff wellbeing is important in its own right (for example in relation to stress, bullying, and harassment) and it can improve the quality of both patient experience and their health outcomes.” (Department of Health, 2014)

This view was echoed in a recent paper on staff engagement in the NHS which reported: *“Trusts with high levels of unsatisfied staff and staff who intended to leave their jobs had lower levels of patient satisfaction, and vice versa”* and that *“Patient satisfaction rates were consistently higher in trusts with better rates of staff health and wellbeing, as measured by injury rates, stress levels, job satisfaction and turnover intentions. Individual staff wellbeing is best seen as an antecedent rather than as a consequence of patient care performance”* (The Point of Care Foundation, 2014).

This underlines the importance of staff wellbeing in ensuring good standards for patients, a view outlined by Carol Baxter in her interview, who stated that:

“In those areas in which staff report harassment and bullying, patient experience is worse). This is the case that we use when looking to improve these issues within the NHS- if your staff aren’t happy then your patients won’t be well looked after because they are demotivated and they won’t be able to give the job their best.”

She did however also sound a note of concern, very similar to that made by the roundtable meeting in relation to taking care not to blame affected BME populations with lower levels of wellbeing:

“I get a bit worried about the issue of unhappy staff meaning patient care is poor because it could be used to blame the victims”

The important point is that if staff wellbeing is affected by systemic or structural issues, and the impact of this wellbeing deficit is a reduction in patient care standards, then the responsibility for this lies in the system and structure, not the affected staff.

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Umesh Prabhu, on the other hand, argued that in his experience as a specialist in patient safety, staff wellbeing and prevalence of racism and discrimination directly impact on patient safety. He described poor leadership, bullying cultures and discrimination creating an atmosphere in which mistakes are not openly admitted and dealt with and concerns are not raised, with direct implications for patient outcomes and safety.

Research carried out by Michael West, and reported by Roger Kline in his recently published study confirms that there is a very clear link between staff treatment and patient satisfaction – where staff are treated well, patients report better experiences of care (Kline, 2014):

“Research suggests that the experience of black and minority ethnic (BME) NHS staff is a good barometer of the climate of respect and care for all within the NHS. Put simply, if BME staff feel engaged, motivated, valued and part of a team with a sense of belonging, patients were more likely to be satisfied with the service they received. Conversely, the greater the proportion of staff from a BME background who reported experiencing discrimination at work in the previous 12 months, the lower the levels of patient satisfaction.” (West et al, 2012)

A recent example provides an interesting case in point. Wexham Park Hospital in Slough was investigated by the Care Quality Commission and judged to have a number of failings, including on staffing, with staff reporting a culture of bullying and harassment preventing them from identifying failures (CQC, 2013). Subsequent to the investigation, a number of BME staff at the hospital published an open letter detailing their view that patient safety was being undermined by discrimination against ethnic minority doctors, identifying issues including harassment and harsher discipline (The Voice, 2013). However, the eventual CQC report does not acknowledge the letter or the issues raised.

Another important adverse consequence for patient care which may result from discrimination against BME staff is that BME applicants may not even be appointed to posts, even if they are the most skilled for the job. Furthermore innovation is likely to be stifled in organisations which do not value diversity of staff backgrounds and opinions.

How to address these issues

“I think the NHS knows that happy staff means happy patients, but what the NHS need to do more of is to find out the things that are making staff unhappy and to look more at the unconscious biases that exist with the services that make BME staff unhappy. That is a harder nut to crack- they know in theory, but addressing the solutions is where the challenge is at right now, the knowledge is already there.” (Carol Baxter interview)

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The need to address racism and discrimination within the NHS is incontrovertible. Recognition of these problems has been longstanding, but successful solutions have thus far remained out of reach. Speaking of her work on the Breaking Through programme, an earlier scheme to promote the progression of BME staff in the NHS, Yvonne Coghill argued that this scheme and others had achieved limited success due to the NHS leadership failing to understand race and the issues faced by BME staff. A system-wide recognition and prioritisation of these issues is therefore an essential first step.

Specific recommendations supported by our research are that:

- 1) Equality in recruitment, career progression, rewards and recognition need to be recognised as urgent priorities for action.
- 2) The NHS must undergo a cultural change to increase understanding of and commitment to equality and diversity, with a focus on the benefits of diversity to staff, patients and the NHS system. This must include all levels and branches of the NHS system as well as the wider medical community including the GMC and Royal Colleges.
- 3) System-wide accountability and engagement is necessary, so staff are encouraged to identify issues, middle managers are skilled to support and work with a diverse workforce, and senior management are accountable for delivering equality, in recruitment, progression and across the board.
- 4) Better training and induction programmes for BME staff recruited from overseas is needed, to support understanding and adaption to the NHS environment and culture and ensure that healthcare staff are enabled to deliver high quality care and reach their potential.
- 5) An improved NHS leadership, committed to embracing change and equality is essential: *“The whole NHS language has to change. It is not blame, it is not bullying, it is not inspection, it is not. It is working together. It is putting patients at the heart of everything we do, it is about good leadership, it is about a sense of belonging, it is about fair and open culture, supportive learning culture. And that is a type of leader I would appoint at every level.”* (Umesh Prabhu interview).
- 6) Systematic analysis and reporting of data by the NHS on the extent of ethnic differences in the quality of care.
- 7) More and better research on the potential effects and determinants of ethnic inequalities in wellbeing.

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What recommendations for policy and practice could truly make a difference?

The differences in self-reported wellbeing for BME populations in England as well as the grim picture in terms of ethnic variations across the important aspects of life and society exposed by the literature, suggest the need for urgent cross-sectoral action in both policy and practice. Action is needed to address both wellbeing and the institutional racism and discrimination which drives lower wellbeing for BME populations.

Szczepura's review highlighted the contrast between the US Agency for Healthcare Research and Quality and the UK's NHS in its commitment to address well-recognised ethnic inequity in access to health care (Szczepura, 2005). The US Agency has been required to produce an annual National Healthcare Disparities Report that will consider "disparities in health care delivery as it relates to racial factors" plus an annual National Health Care Quality Report; with both reports using a common framework because it is recognised that "disparities often present as inequalities in quality", so that poorer access in terms of inferior quality care is also exposed. It is intended to use both reports to monitor service performance and progress towards improved healthcare delivery for disadvantaged groups.

In the UK, the Race Relations Amendment Act 2000 introduced a statutory duty upon the NHS and other UK public sector organisations to "have due regard to the need to eliminate unlawful discrimination", and to ensure that every new action or policy considers the implications for racial equality. But the collection of ethnic monitoring data remains neglected, and a consistent message from studies on access, i.e., the need for better ethnic monitoring data in the NHS, and for greater use to be made of these data in health care planning to justify its collection, is ignored. Szczepura concluded that:

"the slow implementation of ethnic monitoring data recording in the NHS means that, unlike the USA, it has not been possible to develop a UK overview of disparities in service access for BME populations or to monitor these nationally (Szczepura, 2005). At the same time, there is evidence from the 2001 and earlier censuses that health disparities exist in the UK and that levels of long term illness are higher in most BME groups than in the general population, especially for older age groups. Furthermore, in terms of service quality indicators, analysis of responses to the patient satisfaction surveys undertaken on behalf of the NHS shows distinct differences for ethnic minority groups. But, UK data on ethnic minority groups and disparities in health and quality of care has not been integrated, unlike the initiative set in motion by the Department of Health and Human Sciences in the USA".

Recommendations to achieve better wellbeing among BME communities require actions within the NHS, as well as across sectors, to more widely recognise and address wellbeing as a social issue. Most importantly, action to address racism, discrimination and exclusion as a public health issue, is justified by the findings of this project, as there is:

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“... a strong enough argument that racism, however you will define it, is a social factor impacting on the wellbeing of individuals from minority groups – must be considered a public health issue. It’s a toxic effect, in terms of health and wellbeing of individuals. It needs to be tackled in much the same way as other toxic factors in the environment are seen as being linked to health conditions.” (SP Sashidharan interview).

The impact on wellbeing of BME status in itself is supported by the findings of this research, and should drive changes in policy and practice which aim to address ethnic inequalities in wellbeing. In particular, it needs to be recognised that such action benefits not merely the BME community but the wellbeing of the country as a whole.

In considering strategies which could improve wellbeing and health in BME communities, we had difficulty in identifying specific actors, organisations and entities that could be recommended for actions, while others could be exempt from responsibility. The impact of ethnic inequalities appeared to be so pervasive and was evident across so many sectors and aspects of life that, in our view, a systematic cross-sectoral effort to address the structural and cultural barriers to equality is called for.

Against that background, urgent actions may include:

- 1) *A cross-Government drive to assess and to tackle institutional discrimination within their organisations and workforce as well as in other institutions within their sphere of influence*
- 2) *Zero tolerance towards organisations which do not collect appropriate ethnicity data needed to drive positive change*
- 3) *Broader engagement in wellbeing from both the NHS and public health providers as well as a wider range of statutory agencies, including through action to address wellbeing per se, rather than as a measure of success of other interventions.*
- 4) *Engaging with existing community structures and leaders to deliver information and support in a language, style and model that is best suited to individuals and communities, adapting to meet their needs.*
- 5) *Improved engagement with communities, using appreciative enquiry to determine specialised and localised interventions particular to the communities and their environments.*
- 6) *More shared public opportunities to enable communities to meet and develop together.*

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- 7) *Systematic analysis and reporting of data by the NHS on the extent of ethnic differences in the quality of care.*
- 8) *More and better research on the potential effects and determinants of ethnic inequalities in wellbeing.*

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What further research is needed to understand the differing levels of wellbeing in BME populations?

This project set out to gather and review the existing data and evidence around differing levels of wellbeing in BME populations, in order to establish what is currently known about these issues and what is not yet known – that is, what further research is needed to understand these differences fully. Many suggestions for further research were raised in this project, both within the existing literature, by participants in interviews and the roundtable, and by the report's authors.

Below are some of the most pertinent suggestions for further research, which need to be considered seriously by those bodies with a responsibility to protect and improve public health, as more research data is essential to enable effective action to be taken to address disparities in wellbeing.

Questions for further research:

- *Generational differences in wellbeing over time, in particular to assess whether the results found in the DASH study hold for young people entering adulthood.*
- *The correlation between self-efficacy and wellbeing, and how this differs between ethnic groups.*
- *The association between religious belief and wellbeing.*
- *Whether there are differences in who is responding to wellbeing surveys, and in responses based on how surveys are conducted and the role of the researcher.*
- *Links between age and self-reported wellbeing, and whether these differences hold across different ethnic groups.*
- *Links between ethnic minority status and feelings of belonging and identity, and how this impacts on wellbeing.*
- *Objective data on experiences of discrimination and how this influences self-reported wellbeing.*
- *Qualitative research into how people of different ethnic groups experience and understand wellbeing, happiness, anxiety and other relevant concepts. The extent to which different understandings of the language used in measures of wellbeing influence the subjective values people assign to their wellbeing.*
- *Further research on the ethnic density of neighbourhoods and potential mediators contributing to wellbeing, building on the Understanding Society Survey and other research.*
- *Qualitative research with Chinese and Mixed/Multiple samples to explore what protective factors are operating in these groups to prevent similar differences in wellbeing as for other ethnic groups.*
- *Further research into the value of measuring and improving wellbeing, drawing on existing data around measuring wellbeing at work and the business case for developing this.*

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Susie Sykes, Senior Lecturer in Public Health and Health Promotion, London South Bank University. 7th October 2013.

The Lord Crisp KCB, Crossbench Peer, House of Lords, 9th October 2013.

Davinia-Louise Green, UK Breast Health Promotion Manager, Breast Cancer Care, 9th October 2013.

Professor Seeromanie Harding, Programme Leader, MRC/CSO Social and Public Health Sciences Unit, University of Glasgow, 10th October 2013.

Ursula Read, Career Development Fellow, MRC/CSO Social and Public Health Sciences Unit, University of Glasgow, 10th October 2013.

Saamah Abdallah, Senior Researcher, Well-being, New Economics Foundation, 14th October 2013.

Anonymous, clinical leadership role in NHS, 16th October 2013.

Aneez Esmail, Professor of General Practice, University of Manchester, 24th October 2013.

Carol Baxter CBE, Head of equality, diversity and human rights, NHS Employers, 4th November 2013.

Professor Sashi Sashidharan, Honorary Professor and Co-director of Centre for Research in Ethnicity & Mental Health, University of Warwick, 18th November 2013.

The Lord Patel KT, Crossbench Peer, House of Lords, 3rd December 2013.

Yvonne Coghill OBE, Senior Programme Lead - Inclusion & Coaching, NHS Leadership Academy 17th December 2013.

Dr. Jane Kennedy, Research Business Manager at London Borough of Newham, 16th January 2014.

Anonymous, London Local Authority public health lead, 16th January 2014.

Roundtable discussion (held 31st October 2013), participants:

Heema Shukla, Consultant in Public Health, Public Health England (Chair).

Professor Angela Harden, Professor of Community and Family Health, Institute for Health and Human Development (IHHD), University of East London.

Professor Gopal Netuveli, Professor of Public Health, Institute for Health and Human Development (IHHD), University of East London.

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Dr. Frank Keating, Senior Lecturer, Department of Social Work, Royal Holloway University of London.

Matthew Parsfield, Project Developer, Connected Communities Team, RSA Action and Research Centre.

Jo Moriarty, Research Fellow, Social Care Workforce Research Unit, King's College London.

Saamah Abdallah, Senior Researcher, Well-being, New Economics Foundation, 14th October 2013.

Frances Clarke, Community Worker, Community Links.

Nat Lievesley, Researcher, Centre for Policy on Ageing.

Jacqui Stevenson, Acting CEO, African Health Policy Network.

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