

Comparing policies to tackle ethnic inequalities in health: Belgium 1 Scotland 4

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Background: Ethnic-minority health is a public health priority in Europe. This study compares strategies for tackling ethnic inequalities in health from two countries, Scotland and Belgium. **Methods:** We compared the countries using the Whitehead framework. Official policy documents were retrieved and reviewed and two databases related to immigrant health policies were also used. Ethnic inequalities in health were compared using the UK and Belgian Censuses of 2001. We analysed the recognition of the problem, the policies and the services and described ethnic health inequalities. **Results:** Scotland has recognized the problem of ethnic inequalities in health, thanks to better data and the Scottish Government has come up with a bold strategy. Belgium is a later starter, unable to properly monitor ethnic inequalities. In addition, there is no clear government commitment to tackling either health inequalities or ethnic inequalities in health. Both countries provide health-care services to ethnic minority groups through the mainstream services, although ethnic minority groups have more choice in Belgium than in Scotland. Overall, ethnic health inequalities are lower in Scotland than in Belgium. **Conclusion:** Scotland has provided a more advanced and comprehensive response to tackling ethnic inequalities in health than Belgium. It has acknowledged that discrimination exists and that ethnic minority groups may have different needs. Belgium still assumes non-discrimination in health care and effectively denies the need for policy to tailor services to meet these needs. In Scotland, public organizations have been made accountable for promoting equality in health. This is an important contribution to European health policy.

Keywords: ethnic groups, migration, public policy, health inequality

Introduction

Improving the health status of ethnic minority groups is becoming a health priority internationally: it is an important component of the US Healthy People monitoring system and of the Acheson report in the UK.^{1,2} Europe is catching up with the US. The European Charter of Human Rights (Art. 21) prohibits discrimination based on sex, colour, ethnicity and language. Public-health related comparative research, such as the Migrant and Ethnic Health Observatory Project, is examining ethnic inequalities in Europe.³ In 2009, the European Commission released a policy paper aimed at supporting the member states in tackling health inequalities, including migrant or ethnic health inequalities.⁴

Tackling ethnic inequalities in health demands a comprehensive European strategy.⁵ However, differences in Europe for awarding citizenship to immigrant groups, political climates in relation to multiculturalism and health-care systems may lead to different policies and varying outcomes regarding ethnic inequalities. Recent European research suggests that particular minority groups face different risks of poor health status in different host countries, e.g. the Roma are in better health in Hungary than in Slovakia^{6,7} and Turks are in better health in Belgium than in the Netherlands.^{8,9}

We need to understand the reasons why there is inconsistent progress across Europe.^{10,11} Policy is likely to be critically important. Our aim was to compare two European countries

with different policy environments. We address the following question: in the contest to reduce ethnic disparity in health and health care, which is doing better, Scotland or Belgium?

Contextual information on Belgium and Scotland

Belgium and Scotland are similar in size, overall health status and in economic performance. Belgium and Scotland have, respectively, 10 and 5 million inhabitants, with high income (USD 36 200 and 33 500 per capita, respectively). Health-care expenditure is 10.3% of gross domestic product (GDP) in Belgium and about 10% in Scotland. Life expectancy is slightly higher in Belgium than in Scotland (79 years vs. 77 years).¹²

These two countries, however, differ strongly in two dimensions relevant to ethnicity and health: citizenship and the health-care system. Citizenship is mainly defined according to nationality in Belgium and according to birthplace and length of residence in Scotland.¹³ In Belgium, acquisition of nationality is linked to *jus sanguinis* (ancestry) and acquisition of nationality by place of birth is automatically provided only to the grandchildren of immigrants, although others can obtain it by naturalization. In Scotland, as in the rest of the United Kingdom, citizenship is linked to *jus soli*, place of birth. In Belgium, voting rights are granted to non-European citizens only after 5 years of residency and only for local elections.¹⁴ In Scotland, many immigrants from non-European countries obtain political rights (for parliamentary elections) more rapidly in Scotland than in Belgium.

Belgium and Scotland have different welfare state types.¹⁵ The Belgian welfare state is categorized as social-democratic, whereas the Scottish welfare state is classified as liberal, according to the Esping–Andersen classification.¹⁶ Belgium emphasizes a social transfer approach, whereas the Scottish welfare state puts more emphasis on state-funded services. Allocation of resources in Belgian health care relies on a clear separation of providers and purchasers, whereas the National Health Service (NHS) in Scotland relies on a stronger relationship between the provision and the financing of health care. Most of the population (99%) is covered by compulsory health-care insurance in Belgium, while all legal residents in Scotland are entitled to full care from NHS Scotland. In Belgium, undocumented immigrants are entitled to health care under the 1996 law on Emergency Medical Aid. The entitlement of undocumented immigrants is undergoing revision in the UK but, basically, includes emergency care and the treatment of some infectious diseases.¹⁷

Scotland is an emigrant nation with a huge diaspora. Over the last 100 years, immigrants from many countries settled in Scotland (English, Irish, Italians, and Poles). Since the 1950s, a small but important non-European population has grown, principally with origins in Pakistan, India, and China. These populations are firmly established and make a major contribution to the business and public-service sectors. Scotland has a sizeable South Asian minority (1.09% of the population), the most important sub-groups being Pakistanis and Indians.¹⁸ In the last decade, Scotland has experienced considerable immigration from Eastern European countries. Although migration is difficult to estimate due to the lack of a comprehensive registration system, the General Register Office estimates a net intake of 20 000 per year, most of whom are coming from the new European Union (EU) member states such as Cyprus, the Czech Republic and Poland.

Belgium has long attracted immigration from southern European countries. In the 1960s and 1970s, a low-cost labour force was recruited from Turkey and Morocco and these groups became sizeable, particularly in metropolitan areas. They are still considered as ethnic minority groups, due to the prejudice they face on the labour, housing and educational markets.^{19–21} A third ethnic group, linked to Belgium's colonial history in the Congo, is growing. These three groups are considered as the main ethnic minority groups and, according to their nationality at birth, represent 4.1% of the population.²² This percentage, however, is an underestimate, as many children of immigrants have acquired Belgian nationality, although they mostly self-define as Turkish or Moroccan.²³

Methods

This research was a result of a scientific mission of a European COST action (COST-HOME-ISO603) comparing best practice in policies to reduce ethnic inequalities in health in Belgium and Scotland.

Our comparison used the framework developed by Whitehead. This analyses the stages and typology of action taken to tackle health inequalities and includes the following components: (i) recognition of the problem and its causes; (ii) policies to tackle inequalities; (iii) interventions and their underlying theories; and (iv) outcomes.^{24,25}

Under the auspices of the Cost-Home network, VL (a Belgian) visited Scotland for 2 months and met with several key stakeholders to discuss key policies. The comparison also used two international databases on immigrant policies, the Mighealthnet database (mighealth.net) and the Eugate project (www.eugate.org.uk/). We also searched the official websites of the Belgian

(www.inami.fgov.be/ and www.health.fgov.be) and Scottish health-care authorities (www.healthscotland.com/, www.isdscotland.org/). The list of accessed and analysed documents is given as supplementary file on the journal website. For the purpose of this research, policy was defined as statement of goals, objectives and means that create the framework for activity.²⁶

Ethnic health inequalities were compared through literature search as well as by comparing the UK Sample of Anonymised Records (based on the Scottish census) with the Belgian Census of 2001. The methodology has been described elsewhere.²⁷ The British census included a three-item question ('good', 'fairly good' and 'not good') and the Belgian census a five-item question ('very good', 'good', 'average', 'bad' and 'very bad'). Respondents who reported 'not good health' in Britain and 'bad' or 'very bad' health in Belgium were regarded as having poor health. We compared those in poor health to everyone else.

Mortality risk was also compared on the basis of previous published studies.^{28,29} In brief, the Belgian mortality study is based on all residents aged 24–54 in the census of 1991 ($n = 2\,096\,679$), followed for 58 months. The Scottish study was based on death certificates for residents aged 25+ between 1997 and 2003 ($n = 362\,029$), with the denominator computed on the basis of the 1991 and 2001 Scottish censuses.

Results

Recognition of the problem: Scotland one, Belgium nil

Recognition of ethnic inequalities in health and their causes would be made easier by (i) ethnic coding to allow official statistics to be analysed by ethnic group, and (ii) by publication of governmental reports.

Scotland counts its ethnic minority groups both by place of birth and by self-identification. Belgium counts its minorities according to nationality. Ethnic coding in Scotland is advancing in two directions. First, the 1991 and 2001 Scottish Censuses provided data on ethnic self-identification and the 2001 census is linked to mortality and NHS databases. Secondly, Information Services Division is promoting ethnic coding in all NHS records such as discharge episodes. The level of coverage is, however, rather low (16.8% for discharges) and greatly varies from one board to another: surprisingly, Glasgow, the board with the largest ethnic minority group, is not the best performer. The death certificate records the place of birth and other health records, including general practice ones, increasingly record ethnic groups.

In Belgium, ethnic coding is sparse. The Belgian Census had no question about ethnicity and the only available information is nationality or place of birth. Hospital discharge records do not provide information on either nationality or place of birth. Belgium has been surveying health and health care since 1997, but without any question about ethnicity. This situation is largely due to historical and legal considerations. Focusing on nationality is common in Europe and reluctance to collect such data appears to date back to the use of unprotected census data to target vulnerable populations for internment and deportation during the holocaust.^{30,31} The Belgian 1962 law on statistics is a legacy of this: it forbids the Institute of Statistics to collect data on religion, race, and ethnic origin.³² Although this law was aimed at protecting privacy, it is a major obstacle to ethnic coding. As a consequence, Belgian studies on ethnic inequalities in health have had to rely on place of birth or nationality as a proxy.^{33–35}

Research translates into policies, thanks to stock-take reports. In 2001, the Scottish Government commissioned a stocktaking report to assess ethnic inequalities in health care.

The resulting report identified areas in which NHS Scotland needed to take action to ensure that services were accessible to all. One important conclusion of this report was to call for a 'more strategic approach to ethnic minority health'.³⁶ In contrast, research efforts in Belgium have not led to any official acknowledgment, with the exception of a 1990 report of the Commissariat Royal à la Politique des Immigrés. Although the issue of discrimination on the labour and housing markets remains a high priority of public authorities, these topics have led only to non-governmental reports, such as those of the Centre for Equal Opportunities. These reports have not been endorsed by executive bodies and have not addressed health inequalities.

There is a great deal of research about ethnicity and health in Belgium. However, most of these studies have to rely on nationality and have not been endorsed by a public recognition. In Belgium, the topic is still mainly addressed by researchers and non-governmental organizations (NGOs), while in Scotland it is addressed by national reports or governmental bodies.

Policies: Scotland two, Belgium nil

Research can be translated into policy, a plan of action or decisions. Actions can include an official strategy, decisions creating statutory duties and rights and new institutional bodies.

In Scotland, an impetus was given to policymaking by both the Race Relations Amendment Act of 2000 and the Fair for All policy. The Act was unique in creating a legal duty for public services to promote race equality plans, known as Race Equality Schemes.³⁷ It came into force in 2002. Six months earlier, in 2002, the Scottish Executive Health Department issued a letter (effectively, policy) requiring NHS organizations to tackle ethnic inequalities in health and health care into five domains:³⁸ (i) to energize organizations to deal with minority health issues positively; (ii) to produce information about the population of each NHS board's area; (iii) to acknowledge and overcome barriers to access; (iv) to recruit ethnic minority staff; and (5) to consult minority ethnic communities.

As part of the implementation of the Fair for All policy, the Scottish Government created the National Resource for Ethnic Minority Health (NRCMH), whose initial job was 'to support the NHS Scotland services to deliver minority ethnic health agenda'.³⁹ In 2008, the Scottish Government moved the NRCMH into NHS Scotland's new Directorate of Equalities and Planning, integrating the issue of ethnic disparity with other equality strands such as age, gender, religion, sexual orientation and disability. This integration needs to be carefully monitored, as ethnic inequalities often require different approaches than, say, gender inequalities. Moreover, as these latter inequalities relate to individual characteristics, one possible impact of this institutional move would be to strengthen individual approaches to health inequalities at the cost of more community-based approaches.²⁵ The main change, however, is that the Centre have moved from being stand-alone organizations with short-term funding to being embedded in NHS organizational structures.

In Belgium, there is no explicit federal government policy to address (ethnic) health inequalities. The subject is still left to research teams and NGOs to address. The King Baudouin Foundation (FRB) and the Centre for Equal Opportunities and Opposition to Racism (www.diversite.be) have been the two main bodies campaigning against health inequality, supporting studies and providing recommendations to government bodies. Although the Centre is a public body, it makes non-binding recommendations.

Despite the lack of a comprehensive policy on health inequality, Belgium has been keen to provide health-care services to immigrants who do not have compulsory health-care insurance. The law allows undocumented immigrants to

access all care (and not only emergency care) through the local municipality's social services.⁴⁰ However, the application of this law remains patchy with only 14% of undocumented migrants being effectively entitled.⁴¹

Interventions: Scotland three, Belgium one

Both countries provide health-care services to ethnic minority groups through the mainstream services. However, Belgian patients may have more choice than Scottish patients, thanks to a higher density of physicians and the lack of gate-keeping to access consultants.⁴² International comparisons of patient satisfaction with general practitioners (GPs) suggest that Belgian patients are happier than patients in the UK.⁴³ As ethnic minority groups are more vulnerable and rely more heavily on general practice, more choice might empower them when their expectations are not met. This kind of power is greater in Belgium than in Scotland. This potential benefit needs examination.

Both countries provide interpreting services. In Belgium, 81 intercultural mediators are employed in 62 hospitals (out of 215), with a budget of €2.4 million.⁴⁴ In Scotland, the budget amounts to €3 million, for a country with half the population of Belgium and with a lower percentage of ethnic minority groups. Scotland is committed to providing interpretation services on a large scale and according to need. Whereas Belgium has limited these services to hospitals, interpretation services are also available in general practice in Scotland. Cultural sensitivity is not only a matter of language. Ethnic minority groups have difficulties in navigating health-care systems and may feel that their expectations are not being met. NHS Scotland has developed some innovative approaches to improving the link between the NHS and ethnic minority groups. The Minority Ethnic Health Inclusion Project (MEHIP), for example, provides ethnic minority groups with link workers who provide information and advice on services as well as helping them to talk to health professionals. In Belgium, cultural mediators do interpret in about two-thirds of their interventions, but they are also involved in culture brokering, helping patients to navigate the health-care system.

How does Scottish Government policy become daily routine of the health services? Two vehicles are used to evaluate the impact of the Health Department Letter: 'Checking For Change' and 'Equity Impact Assessment'. 'Checking for Change' is a self-monitoring toolkit to help NHS organizations identify outcomes for race equality and processes to achieve outcomes, for each of the above-mentioned objectives.⁴⁵ The Equity Impact Assessment holds the NHS boards accountable. Whereas Scotland may have the advantages of the command-and-control approach, local and voluntary initiatives spring up more easily in Belgium. Because of the statutory separation between funding and provision in Belgium, many NGOs or non-profit organizations receive public funding. For example, Medimmigrant is an innovative NGO that provides advice to health-care providers on the implementation of the legislation for undocumented immigrants.⁴⁰ Medimmigrant is a good example of a Belgian strength: many small NGOs, often with public funding, are actively and creatively seeking to provide services to ethnic minority groups. This is not to say that no such initiative may spring up in Scotland: the Scottish Glasgow Anti Racist Alliance (GARA; <http://www.gara.org.uk/>) and Nari Kallyan Shango (NKS; <http://www.nkshealth.co.uk/html/index.htm>) are examples of such initiatives

Ethnic Health inequalities: Scotland four, Belgium one

In Scotland, most ethnic groups had better subjective health than White Scottish, with the exception of Pakistanis and other

Table 1 Risk of not good health and of long-term limiting illness by ethnic or nationality group in Scotland and Belgium among those aged 25+, UK Sample of Anonymised Record and Belgian Census 2001: odds ratios^a

	Not good health ^b Odds ratio (95% CI)	Long-term limiting illness Odds Ratio (95% CI)
Scotland:		
White Scottish (ref)	1	1
Black	0.91 (0.71–1.15)	0.89 (0.73–1.08)
Indian	0.893 (0.65–1.23)	0.84 (0.65–1.09)
Pakistani and other SA	1.52 (1.28–1.80)	1.49 (1.29–1.72)
Chinese	0.76 (0.54–1.06)	0.67 (0.51–0.88)
Belgium:		
Belgian (ref)	1	1
Turkish	2.79 (2.36–3.29)	1.31 (1.15–1.49)
Moroccan	2.47 (1.17–2.80)	1.25 (1.14–1.37)
Other African	2.23 (1.58–3.16)	1.29 (1.02–1.63)
Congolese	0.71 (0.38–1.33)	0.89 (0.67–1.18)

a: Controlled for age and sex.

b: The British wording is 'Over the last twelve months would you say your health has on the whole been: Good?; Fairly good?; Not good?'. The Belgian wording is 'Would you say your health is on the whole: Very good? Good? Fairly good? Bad? Very bad?'

Table 2 Risk of mortality by ethnic or nationality group in Scotland and Belgium

	No. of deaths men	No. of deaths women	Mortality risk men	Mortality risk women
Scotland: ^a				
White Scottish (ref)	152 456	171 488	100	100
Indian	473	419	88**	97
Pakistani	171	110	71**	63**
Chinese	67	71	72**	75**
Belgium: ^b				
Belgian (ref)	27 892	14 726	100	100
Turkish	173	76	80**	76**
Moroccan	297	145	64**	84**
Other African	275	181	98	1.41**

** $P < 0.01$; * $P < 0.05$.

a: SMR, indirect standardization. Source: ref. 28.

b: Cox Hazard Rate, direct standardization. Source: ref. 29.

South Asians (table 1). In Belgium, most non-Belgians groups had poorer subjective health than Belgians. The same pattern applied to long-term limiting illness. In Scotland, Chinese, Indians and Blacks had a lower risk of long-term limiting illness than White Scottish, while Pakistanis had a higher risk. In Belgium, Turks, Moroccans and other North African groups had a higher risk of long-term limiting illness than Belgians. If we compare the ethnic minority group most at risk in Scotland (Pakistanis) with the non-national minority group most at risk in Belgium (Turks), we find, however, that these two groups faced similar health disadvantages. Caution is however required particularly because of cross-cultural validity of self-rated health: indeed the Black (Scotland) and the Congolese (Belgium), two comparable groups, both had a lower risk of not good health.

In both countries, the mortality risk was lower among ethnic minority groups for both men and women (table 2). However, women from other North African countries than Morocco had a higher risk of mortality than Belgian women.

In table 3 we have summarized the main findings in this paper, in terms of context, policies and ethnic health inequalities.

Discussion

Main findings

On three of the four key components, Scotland has provided a more comprehensive response than Belgium, while on interventions, both countries scored on different aspects. Firstly, Scotland has recognized the problem of ethnic inequalities in health, including the need to collect better data; secondly, it has come up with a bold strategy; thirdly, this strategy has led to significant changes in the planning and provision of services. Belgium is a later starter, and has been unable to monitor ethnic inequalities. Although several studies have been undertaken, Belgium needs, in the first place, to obtain reliable data on its ethnic groups. There is, moreover, no clear executive commitment to tackling inequalities by national health-care organizations. While Scotland has acknowledged that discrimination exists and requires solutions, Belgium still relies on the assumption that there is no discrimination in health care and that needs are not different among ethnic minority groups.

Broadly, health inequalities are lower in Scotland than in Belgium. Belgium has higher inequalities in self-rated health and in long-term limiting illness than Scotland. Nevertheless, the ethnic minority groups most at risk, in Scotland and in Belgium, face similar disadvantages. This is consistent with recent studies on diabetes: in Belgium, Turks had five times the risk of diabetes of Belgians;⁴⁶ in Scotland, South Asians have three to four times the risk of non-South Asians.⁴⁷

Limitations of this work

As with many international comparisons, this comparative work has limitations, related to measurement of ethnicity and the concept of policy. Ethnicity is not understood in the same way in the two countries and we had to rely on different concepts to make our comparison. Because many children of immigrants have Belgian nationality, our comparison may have compared immigrants and their offspring in Scotland with, mainly, immigrants in Belgium. Moreover, the ethnic groups in Belgium are not the same as the ethnic groups in Scotland. Such differences may also contribute to explain the comparison of ethnic inequality, particularly because of the difficulty in collecting valid self-reported health in a multicultural ethnic setting.⁴⁸ Indeed, we observed that the ethnic group 'black' in Scotland had similar levels of long-term limiting illness and of not good self-rated health as the group described as 'Congolese' in Belgium: it is thus important to acknowledge the limitation of such cross-cultural and cross-country comparison. This is, however, the only information currently available in both censuses.

Better comparable measures are needed to compare ethnic inequalities in health and in the use of health-care or preventive services.³ Indeed, it is possible that differences on the ground may not match the differences in policies, particularly if local initiatives are more likely to pop up in Belgium.

Secondly, the concept of policy is variable. Although Scotland, like the rest of the UK, tends to have explicit policy documents and strategies, this is not so in the Belgian context, which does not necessarily mean there is no policy. The policy could be embedded in law or implicit in rules, regulations and practices. We also focused on the country level because health care and preventive individual care remain funded and organized according to country-level regulations or institutions, both in Scotland and in Belgium.

Table 3 Comparison of steps taken in Scotland and Belgium to tackle ethnic inequalities in health: context, policies and ethnic health inequalities

	Scotland	Belgium
Ethnic minority groups Context: citizenship Context: health care	Pakistanis, Indians and Chinese Citizenship is linked to residency (<i>jus soli</i>) Strong, free at delivery and tax-funded bureaucratic health-care system Good horizontal and vertical equity	Turks, Moroccans and Congolese Citizenship is linked to nationality (<i>jus sanguinis</i>) Providers' autonomy and weak public health-care institutions Good horizontal equity (equal provision for equal needs), but poor vertical equity (share of out-of-pocket payments) Low, not developing
Measurement of ethnic inequalities in health	Moderate, moving ahead	
Recognition of the problem	Governmental recognition Fair For All Avoiding discrimination is replaced by legal duty for public services to provide equal opportunities NHS Scotland has a Directorate for Equality and Planning.	Researchers and NGOs only Discrimination policy is not mainstreamed. Equity is mainly addressed from an individual and financial perspective No public accountability for equity
Policies		
Interventions	Free interpreter services for health care	Interpreter services in some hospitals
Ethnic health inequality	Most ethnic minority groups had better self-rated health than white Scottish Risk of mortality is, however, lower in most ethnic minority groups.	Most ethnic minority groups had poorer health status than Belgians Risk of mortality is, however, lower in most ethnic minority groups
Main weakness or limitation	Policies and laws are hard to implement	Ethnicity policy is stalling because it is a hotly debated political issue, within and between Belgium's main communities
Main strength	The issue of ethnic inequality is addressed in law, policy and public-service processes and structures	Patient choice may help ethnic minority groups to change provider when their expectations are not met

Conclusion

First, there is a need for sharing of best practice in tackling ethnic inequalities in health. Our analysis hints that best practice may be more likely to be found in countries where the government has been committed to equal opportunity. Second, implementing ethnic equity requires laws, policies and plans. Several European countries have taken some steps towards developing policies to reduce health inequalities.⁴⁹ In Scotland, the approach to ethnic inequality in health has been backed by political and legal powers within the NHS itself. This comparative analysis led by an independent visitor has discovered good practice that Scotland is contributing to European health policy and health care.

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Key points

- Scotland has provided a more advanced and comprehensive response to tackling ethnic inequalities in health than Belgium.
- Scotland has recognized the problem of ethnic inequalities in health and has come up with a bold strategy.
- Both countries scores on services with Belgium providing more choice to patients and Scotland making health-care organizations more accountable.
- Best practice may be likely to be found in countries where the government is committed to equal opportunity.

References

- 1 Gordon D, Shaw M. *Inequalities in health: the evidence presented to the Independent Inquiry into Inequalities in Health*. Bristol: The Policy Press, 1999.
- 2 U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*, 2nd ed. Washington, DC: U.S. Government Printing Office, 2000.
- 3 Bhopal R. Chronic diseases in Europe's migrant and ethnic minorities: challenges, solutions and a vision. *Eur J Public Health* 2009;19:140–3.
- 4 Commission of the European Communities. *Solidarity in Health: Reducing Health Inequalities in the EU*. 1–11. 2009 Brussels, Commission of the European Communities. Brussels; 2009.

- 5 Bhopal RS. Ethnicity, race, and health in multicultural societies foundations for better epidemiology, public health and health care. Oxford: Oxford University Press, 2007.
- 6 Kolarcik P, Geckova AM, Orosova O, et al. To what extent does socioeconomic status explain differences in health between Roma and non-Roma adolescents in Slovakia? *Soc Sci Med* 2009;68:1279–84.
- 7 Voko Z, Csepe P, Nemeth R, et al. Does socioeconomic status fully mediate the effect of ethnicity on the health of Roma people in Hungary? *J Epidemiol Community Health* 2009;63:455–60.
- 8 Deville W, Uiters E, Westert G, Groenewegen P. Perceived health and GPs consultation among ethnic minorities compared with the general population in The Netherlands. In: Westert G, Jabaii L, Schellevis F, editors. *Morbidity, performance and quality in primary care*. Oxon: Radcliffe Publishing, 2006, 85–96.
- 9 Lorant V, Van Oyen H, Thomas I. Contextual factors and immigrants' health status: double jeopardy. *Health Place* 2008;14:678–92.
- 10 Rafnsson SB, Bhopal RS. Large-scale epidemiological data on cardiovascular diseases and diabetes in migrant and ethnic minority groups in Europe. *Eur J Public Health* 2009;19:484–91.
- 11 Norredam M, Nielsen SS, Krasnik A. Migrants' utilization of somatic healthcare services in Europe—a systematic review. *Eur J Public Health* 2009; Epub ahead of print.
- 12 OECD Health Data 2008 [computer program]. Version 5.0. Paris: CREDES-OECD, 2008.
- 13 Kraler A. The legal status of immigrants and their access to nationality. In: Baubock R, editor. *Migration and Citizenship*. Amsterdam, NL: Amsterdam University Press, 2006, 33–66.
- 14 Baubock R. *Migration and citizenship*. Amsterdam, NL: Amsterdam University Press, 2006.
- 15 Bambra C. Going beyond The three worlds of welfare capitalism: regime theory and public health research. *J Epidemiol Community Health* 2007;61:1098–102.
- 16 Esping-Andersen G. *The three worlds of welfare capitalism*. Princeton, N.J: Princeton University Press, 1990.
- 17 Romero-Ortuño R. Access to health care for illegal immigrants in the EU: should we be concerned? *Eur J Health Law* 2004;11:245–72.
- 18 Scottish Executive: Office of the Chief Statistician. *Analysis of Ethnicity in the 2001 Census*. Edinburgh: Scottish Executive, 2004.
- 19 Lorant V, Van OH, Thomas I. Contextual factors and immigrants' health status: double jeopardy. *Health Place* 2008;14:678–92.
- 20 Kesteloot C, Cortie G. Housing Turks and Moroccans in Brussels and Amsterdam: the difference between private and public markets. *Urban Stud* 1998;35:1835–53.
- 21 Timmerman C, Vanderwaeren E, Crul M. The second generation in Belgium. *Int Migr Rev* 2003;37:1065–90.
- 22 Centre pour l'égalité des chances et la lutte contre le racisme. *Migration - rapport 2007 2008*.
- 23 Phalet K, Swyngedouw M. National identities and representations of citizenship: A comparison of Turks, Moroccans and working-class Belgians in Brussels. *Ethnicities* 2002;2:5–30.
- 24 Whitehead M. Diffusion of ideas on social inequalities in health: a European perspective. *Milbank Q* 1998;76:469.
- 25 Whitehead M. A typology of actions to tackle social inequalities in health. *J Epidemiol Community Health* 2007;61:473–8.
- 26 Buse K. *Making health policy*. Maidenhead: Open University Press, 2005.
- 27 Portet M, Mitchell R, Ch.Swine FP, Lorant, V. Caring, employment and health among adults of working age: evidence from Britain and Belgium. *Eur J Public Health* 2009;20:52–7.
- 28 Fischbacher CM, Steiner M, Bhopal R, et al. Variations in all cause and cardiovascular mortality by country of birth in Scotland, 1997–2003. *Scott Med J* 2007;52:5–10.
- 29 Deboosere P, Gadeyne S. Adult migrant mortality advantage in Belgium: evidence using census and register data. *Population* 2005;60:655–98.
- 30 Morning A. Ethnic classification in global perspective: a cross-national survey of the 2000 census round. *Pop Res Policy Rev* 2008;27:239–72.
- 31 Seltzer W. Population statistics, the Holocaust, and the Nuremberg trials. *Pop Dev Rev* 1998;24:511–52.
- 32 Loi du 4 juillet 1962 relative à la statistique publique, Moniteur Belge, (1962).
- 33 Anson J. The migrant mortality advantage: a 70 month follow-up of the Brussels population. *Eur J Pop* 2004;20:191–218.
- 34 Levecque K, Lodewyckx I, Vranken J. Depression and generalised anxiety in the general population in Belgium: a comparison between native and immigrant groups. *Journal of Affect Disord* 2007;97:229–39.
- 35 Lorant V, Depuydt C, Gillain B, et al. Involuntary commitment in psychiatric care: what drives the decision? *Soc Psychiatry Psychiatr Epidemiol* 2007;42:360–5.
- 36 NHS Scotland. Fair For All: everyone is entitled to fair access to health – this is the founding principle of the NHS Improving the Health of Ethnic Minority Groups and the Wider Community in Scotland, 2002.
- 37 Commission for Racial Equality. *The law, the duty and you: The race relations act and the duty to promote race Equality*. London, 2003.
- 38 Fair for all: working together towards culturally-competent services. *NHS HDL(2002)51, Scottish Executive: Health Department*, 2002.
- 39 NHS Scotland — NRCEMH. *Annual Report of the steering committee and the director of the national resource centre for ethnic minority health*, 2003.
- 40 Platform for international cooperation for Undocumented migrants. *Undocumented and seriously ill: residence permits for medical reasons in Europe*. Brussels: Picum, 2009.
- 41 Observatoire Européen de l'accès aux soins de Médecins du Monde. *Enquête européenne sur l'accès aux soins des personnes en situation irrégulière*, 2007.
- 42 OCDE. *OECD Economic Surveys: Belgium 2005*. Paris: OCDE, 2005.
- 43 Grol R, Wensing M, Mainz J, et al. Patients in Europe evaluate general practice care: an international comparison. *Br J Gen Pract* 2000;50:882–7.
- 44 Verrept H. *Intercultural Mediation at Belgian Hospitals*, 2009.
- 45 National Resource Centre for Ethnic Minority Health. *Checking for change: a Building blocks approach to Race Equality in Health*, 2007.
- 46 Vandenhede H, Deboosere P. Diabetes type 2 in Belgian women of Turkish and Moroccan origin: an important health issue. *Chaire Quetelet*, 2008.
- 47 Fischbacher CM, Bhopal R, Steiner M, et al. Is there equity of service delivery and intermediate outcomes in South Asians with type 2 diabetes? Analysis of DARTS database and summary of UK publications. *J Public Health (Oxf)* 2009;31:239–49.
- 48 Hunt SM, Bhopal R. Self report in clinical and epidemiological studies with non-English speakers: the challenge of language and culture. *J Epidemiol Community Health* 2004;58:618–22.
- 49 Mackenbach JP, Bakker MJ. Tackling socioeconomic inequalities in health: analysis of European experiences. *Lancet* 2003;362:1409–14.