Health Inequalities Early Years
The Equality and Human Rights Commission

1. Introduction.
The Equality and Human Rights Commission (EHRC) is the regulatory body for equality and anti-discrimination law in Scotland, England and Wales, working across the nine protected grounds set out in the Equality Act 2010: age, disability, gender, race, religion and belief, pregnancy and maternity, marriage and civil partnership, sexual orientation and gender reassignment. We are also one of Scotland’s two “A status”1 National Human Rights Institutions (NHRIs2). We share our human rights mandate in Scotland with our colleagues in the Scottish Human Rights Commission (SHRC).

We welcome the opportunity to give evidence to the Health & Sport Committee in its inquiry into early years health inequalities. We should however point out that in developing our submission we have struggled to locate research or administrative data about younger people from protected groups in Scotland’s health outcomes, and that this absence of data is a major concern.

2. Legislative base.
The Equality Act 2010 makes discrimination in employment and the provision of goods, facilities and services unlawful. The specific grounds of discrimination are those as set out above in the introduction.

Over 260 public bodies in Scotland are subject to the Equality Act General and Specific Duties including every Health Board, Local Authority and Government Department.

The General Duty requires that every Heath Board in Scotland pays due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good community relations.

The Specific Duties which also apply to every Health Board in Scotland require them, amongst other things, to

- assess the impact of their policies and practices on equality
- set equality outcomes and report on their progress
- report on the progress it has made to make the equality duty integral to the exercise of its functions

It should be noted that whilst age discrimination against people under the age of 18 is not prohibited by the Equality Act, discrimination on any of the other 8 grounds listed above is unlawful.

1 www.ohchr.org/Documents/Countries/NHRI/Chart_Status_NIs.pdf
3. Whose Inequality?

At the heart of any debate about the reduction of health inequalities in Scotland is the central question of how do we define "equality" and "inequality" and how these definitions impact on the conceptualisation of public health, and the resulting decisions that are made about how to reduce and prevent "inequality". This also has a major impact on how Scotland sets its priorities for research into health, and what factors of "inequality" it then decides to use as measures for progress.

The Scottish Government's Ministerial Taskforce on Health Inequalities\(^3\) adopted the definition of health inequality as being ""a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity". Health may also include people's ability to lead a socially and economically productive life." and focussed on developing a social model of health which would "describe the factors that influence people's health and wellbeing and that determine inequalities." We agree that this holistic vision of health – one which incorporates medical and social issues - is the significant step forward in defining the issues we need to address.

The Commission agrees that the impact of deprivation on Scotland's communities is stark and that particularly in the west of Scotland, poverty and deprivation have a demonstrable impact on life expectancy and quality. It is therefore understandable and justifiable that the Government should seek to direct its resources at a preventative agenda which seeks to improve the life chances and experiences of Scotland's most deprived communities. It is equally understandable that one such focus should be at a geographical level - "place based policy".

However the EHRC is concerned that the NHS in Scotland may not be paying sufficient regard to the needs of Scotland's ethnic minorities, disabled people and other groups whose identity also impacts on their life chances through discrimination and the particular susceptibility of some groups to certain conditions.

The EHRC is particularly concerned that by adopting a predominantly place based and deprivation based focus, the health needs of protected groups - who may (or may not) also experience deprivation but are not resident in deprived communities - may be left unaddressed. In particular we are concerned that by adopting a single focus for policy and its measurement - deprivation - the NHS may not be paying due regard to the need to eliminate discrimination and advance equality of opportunity on the basis of race, sex, faith or belief, sexual orientation, or disability.

This is important because the routes into, and out of, poor health as a result of deprivation differ from those which are caused by discrimination, culture or genetic predisposition. As one small example programmes which seek to reduce the incidence of CHD and cancer in later life which focus on alcohol reduction or smoking will have little impact on ethnic minority communities

\(^3\) http://www.scotland.gov.uk/Publications/2008/06/25104032/4
who tend to drink and smoke less than deprived white Scots but who have known predispositions to certain cancers and CHD through different causes.

4. Early year's health, "inequality groups" & "equality groups".
The most striking aspect of Government policy, research and monitoring data on health inequalities is that is almost entirely "equality blind". Almost all of the data that we have examined in preparing this submission suggests that the Government has a very strong interest in tracking, measuring and analysing "inequalities", that is health outcome by income deciles or postcodes, but factors such as race, gender or disability which are known to be determinants of poor health are generally absent.

For example, the Scottish Health Survey 2011: Volume 2 - Children, the primary driver of data on the issue, reports solely on outcomes from the perspective of age, gender and deprivation. However across all of the areas that it tracks there are known disproportionalities for some equalities groups - in accidents, obesity, diet and participation in physical exercise - which cannot be tracked by this survey. If no monitoring is taking place how can NHSScotland demonstrate that it is actually eliminating discrimination, advancing equality in health outcomes or tackling health inequalities as it is required to do.

This lack of research into equalities in health is compounded by the slow progress Scottish Health Boards are making in monitoring patients characteristics. In a recent publication "Improving ethnic data collection for equality and diversity monitoring" (ISD Feb 2014) the NHS confirms that acute inpatient and day case discharges monitoring of ethnicity can fall as low 25% of all patients in some boards. Ringfenced funding for the Equality & Diversity Information Project, previously based at NHS National Services Scotland, which aimed to support NHSScotland improve on this situation was discontinued a few years ago and it is unclear how NHSNSS now support Health Boards in improving on this data collection.

Overall the impression is that NHS in Scotland approaches equality monitoring as "additional information" which may or may not be collected and may or may not be analysed. There is a very clear bias towards data on deprivation and the continued absence of equalities data makes the job of understanding and addressing equality issues all the more difficult. Put simply from the data presented we cannot tell if the NHS in Scotland is making progress on eliminating discrimination or taking opportunities to advance equality as they are required to do. This data gap applies as much to children's services as it does to adults.

Planning for an Equally Healthy Scotland.
In discussions with health professionals, and particularly in the health inequalities field, the Commission has noted two particular trends which directly impact on the poor health of equality groups over and above the predominant issue of data discussed above. These are "place" and "discrimination."
"Place"
In 2011 the Commission in Scotland published a review of place base policy entitled "Hard to Reach - Easy to Ignore?" (EHRC/ Herriot Watt University 2011). This research set out to establish if there was any evidence to support a contention that investment in anti-deprivation on a place- based basis was of benefit to equality groups. In the research we specifically focussed on benefits to ethnic minority groups and disabled people as these were two areas where some data was evident.

The conclusions of the report were that place-based policies could be beneficial to some sections of the community but' without specifically targeting a "one size fits all" or open door approach, had little or no impact on equality groups

Whilst we do not dispute that place-based policies have their advantages, they do run a real risk of further disadvantaging some minority groups who either do not happen to live in the area targeted or whose health behaviours do not conform to the majority. So for example it is well known that Scotland's Asian community has a high predisposition to CHD (indeed as high as the most deprived communities in Scotland) but also that they are far less likely to live in social housing. Equally the reasons for the high incidence of CHD may differ strikingly from white Scots.

"Discrimination"
In recent years the Scottish Government Health Directorates have made some notable advances in practice and policy towards "discrimination". Firstly through the development of the Fair For All programmes and then through the establishment of an Equality & Planning Unit to drive forward policy.

Whilst we agree wholeheartedly that discrimination has no place in healthcare, reports of individuals experience of discrimination are relatively rare. Undoubtedly there are serious issues of access - for example Gypsy Travellers being refused access to GP services or people with communication needs being denied interpretation - but the Commission is concerned that unless due regard is paid to equalities in the planning, shaping and monitoring of policy, well meaning local initiatives are unlikely to have any major impact on the health of Scotland's equality groups.

As we have noted in this submission we feel that infrastructure surrounding equality remains poor and underdeveloped. The types of administrative data which we can use to identify issues and track interventions is simply unavailable at a macro level and is significantly overshadowed by the amount of data on "inequality. The NHS has made significant progress in recent years in trying to integrate issues of equality, inequality and human rights into its impact assessment processes and should be commended for this. However it

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5 http://ije.oxfordjournals.org/content/early/2010/07/24/ije.dyq118.full?sid=acb3eb6e-1b3b-46f5-bcb0-26c455cb020c
would unfortunate if this work was constrained by the absence of critical data which could be used to identify issues and evaluate interventions.

Conclusion.

Whilst there is much to praise about Scotland's preventative approach to health inequalities there is still insufficient evidence to suggest that the NHS in Scotland's approach to date is leading to a reduction in unequal health outcomes for all communities. The Commission would be happy to expand on these concerns in evidence to the Committee if they so wish.

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March 2014