Special Article

Ethnic minorities, health provision and the 1976 Race Relations Act

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Summary: The present anti-racial discrimination legislation in the United Kingdom is embodied in the 1976 Race Relations Act. In essence this Act attempts to avoid any form of direct or indirect discrimination on the basis of racial or ethnic origin. However, health professionals are acutely aware that there are important racial differences in disease, some of which are, in fact, not racial but merely associated with social deprivation, poor housing and, of course, the incapacity to speak English.

These new findings present the medical profession, in the climate of scarce resources, with the challenge of meeting these needs without discriminating in favour of, or against, individuals on the basis of their race. This is because there are few provisions in the 1976 Act to allow for such discrimination, even when it is for an ethnic group's advantage. The dilemmas this raises for health professionals who are involved in planning services for ethnic minorities are discussed.

Introduction

The increase in the ethnic minority population since strict immigration control was introduced has been due, in the main, to subsequent generations born in Britain.^{1–3} In 1984–86 the ethnic minority population of Great Britain was around 2.43 million or 4.5% of the total population resident in private households.^{1,2} Of this population, approximately 52% are from the New Commonwealth including Pakistan (NCWP), while the Afro-Caribbean population is 26%.¹ Although some 43% of the ethnic minority population have been born in the United Kingdom, this varies with the group; over half of the Afro-Caribbean population but less than a third of the Asian community were born in the UK.¹

The 1980s has been a decade of prolific growth into studies that highlight the health needs of the resident ethnic minority population both with regard to the inequality in health between some minority groups and the white indigenous population, and also the need for a transcultural approach to the provision of services.^{4,5} Whether racial characteristics as such are the reason for the inequality in health or not, ethnic identification has been used as a convenient targeting mechanism in a number of studies.^{6–11} In addition, with the forthcoming census in 1991 and the introduction of

questions relating to ethnic origin, this type of convenient labelling will increase as more sophisticated geographic mapping techniques will become available.

These new challenges will lead to changes either by modifying present services or by the setting of new priorities. Such changes will inevitably, in many cases, reallocate resources in favour of providing health care for certain ethnic minorities groups where specific needs are identified. Health policies that prioritize resources for some population groups must, by definition, discriminate against others. Since, in the present context, this will be done on the basis of racial/ethnic origin, it is prudent that all health professionals who are involved in such a process should be aware of the present legislation with regard to racial discrimination which is embodied in the Race Relations Act 1976.¹² The Act was introduced to promote non-discriminatory access to employment, education, housing and other services by addressing specific problems of adverse racial discrimination evident in British society. It attempts to be wide reaching in the prevention of disadvantage and stereotyping, but it may now inadvertently be a barrier to the general movement towards improving and positively targeting resources towards ethnic related health needs.

The aim of this article is to review the 1976 Race Relations Act and consider examples of potential

conflict that health professionals may encounter with the statutory requirements of the Act, in attempting to provide specific services to meet the health needs of ethnic minorities resident in the United Kingdom.

Race Relations Act 1976

Legislation against racial discrimination was first passed in 1965 and its scope broadened in 1968.^{13,14} The 1968 Race Relations Act extended the powers of the enforcement agency to the Race Relations Board and set up a new agency, the Community Relations Commission, which was to encourage 'harmonious community relations'.¹⁴ By the mid-1970s it was clear that stronger legislation was needed and in 1976 the Race Relations Act provided not only a wider definition of discrimination but created a new agency, the Commission for Racial Equality (CRE), which assumed the functions of the previous two. The CRE also had increased powers of investigation and a power to issue Non-discrimination Notices. The 1976 Act made it unlawful to treat one person less favourably than another on racial grounds, that is on grounds of colour, race, nationality, ethnic or national origin. This applies to employment, education and housing, and the provision to the public of goods, facilities and services. This then was the 3rd Act to be introduced since 1965 and to date there has been no systematic attempt by Parliament to update or modify it. The Race Relations Act does not apply to Northern Ireland, where different anti-discrimination legislation applies.

The Act established two main categories of discrimination, that is, direct and indirect discrimination, the former being simply when a person on racial grounds treats another less favourably than he or she would treat others. Indirect discrimination was a novel concept borrowed from the United States.¹⁵ It occurs when a person applies a 'requirement or condition' which has a significantly disproportionate adverse impact on one racial group in comparison with others and cannot be shown to be justifiable on non-racial grounds.

However, the defining of a racial group was a difficult problem only partly addressed by the Act. The Race Relations Act 1968 did not provide for discrimination on the grounds of nationality but merely national origins,¹⁶ but the 1976 Act defines racial grounds as meaning colour, race, nationality and national and ethnic origin. Clearly these are not scientific terms. It would be difficult to define 'race' for example, as the boundaries of racial types are elastic. In the absence of statutory provision, the courts have provided some guidance on interpretation; Jews or Sikhs may be a racial group – although religion is not covered, obviously a

discriminator may act on the basis of his perception of the victim's racial group which may or may not coincide with religious adherence. Similarly, gypsies, while frequently identified by a nomadic way of life, may suffer discrimination on the basis of perceived racial identity.^{17,18}

Provision of health services

General application of the 1976 Act

The 1976 Act did not address itself directly with health services, although different sections of the Act deal with major subject areas in which racial discrimination is rendered unlawful. These can be summarized as:-

- 1) Employment (Sections 4–16)
- 2) Education (Sections 17–19)
- 3) Housing (Sections 21–23)
- 4) The provision of goods, facilities and services (Section 20)
- 5) Advertisements (Section 29)

Health professionals who are engaged in providing health care for an ethnic minority population will find that their activities, while potentially associated with any of the above, are most likely to relate to the provision of goods, facilities and services (Section 20). In this section the Act makes it unlawful for anyone who is concerned with such provision to the public, or a section of the public, to discriminate by refusing or deliberately omitting to provide goods etc, or discriminate with regard to their quality or the manner in which they are provided.

Exceptions to the Act

The exceptions to the Act give partial recognition that direct discrimination on racial grounds may be acceptable in providing a benefit to a group suffering inherited disadvantage, i.e. provision to permit compensatory measures on the grounds of race to off-set 'inherited' disadvantage such as the lack of recognized qualifications obtained in the UK. Section 35 allows provision to be made for the special needs of racial groups in education, training and welfare. Sections 37 and 38 permit the provision of training and encouragement for racial groups to take jobs in which their group has previously been under-represented.

Access to facilities, services or benefits to be restricted, or to be allocated first, to members of a particular racial group in question is permitted, provided it can be shown that members of that racial group have a special need in those areas which are not, by such a restriction, a preferential treatment (Section 35). Any public or private body or person whose activities touch on these areas

may, consequently, make use of such provision.

The somewhat vague terms would encompass anything from the establishment by a health authority of birth control classes taught in Punjabi, to special circularization of predominantly black areas of the city by a Housing Association concerning vacancies in its accommodation.^{19,20}

Giving some definition to its breadth, however, is not easy, particularly since the various terms are not themselves defined and there are no reported judicial decisions as to how they should be interpreted. Of importance to medical provision is the term 'welfare' (Section 35). Bullock and Stallybrass (1977) suggest that the term 'welfare' in welfare legislation refers generally to government support for the poor, and particularly free or subsidised supply of goods or services in health and education.²¹ However, before it meets the requirements of Section 35 for exclusion from unlawful discrimination it must be designed to cater for the 'special needs' of the racial group targeted. As a result, the provision of a generic welfare benefit, such as free dental treatment to all Asians, is unlikely to meet the 'special needs' criterion given that non-Asians may have similar general needs for dental treatment. It is suggested therefore that the welfare benefit provided must be related to the more specific needs of a particular racial group and that these needs must be sufficiently distinct (in both qualitative and quantitative terms) to be considered 'special'.

Implications for targeting ethnic high risk groups

In an atmosphere of limited resources and an increasing need to justify health care provision and procedures, it can be tempting to restrict services simply to those sections of the population most in need. Therefore, for example, if finances for haematology screening are limited, then the establishment of special haematology screening units for sickle cell disease and thalassaemia will be positive discrimination in favour of ethnic minority groups, possibly at the expense of the White majority. Similarly, screening for hypertension in Afro-Caribbeans and screening for hyperlipidaemia and dental caries in Asians would mean a diversion of resources in favour of one group and, therefore, by definition away from another group.

Occasionally the linkage between screening and the provision of a service by way of medical treatment or by way of access to such treatment may be so transparent that the two processes are not obviously distinct. If this view is correct, and judicial opinion has yet to suggest otherwise, a Community Dental Officer, for example, who screens only Asian schoolchildren for dental disease in some schools with a view to resultant

treatment, discriminates unlawfully *vis-à-vis* the screening itself. Where, however, treatment is not a necessary consequence of such screening the latter activity (not in itself constituting a service) would not be unlawful in terms of the Act. It may be difficult to argue, however, that screening was not preliminary to (and a *sine qua non* of) treatment in which case it interrelates with treatment and therefore would be rendered unlawful.

Iron-deficiency anaemia has been shown to have a high prevalence among Asian children, either because of their diet or their poor socio-economic circumstances.^{22,23} If, therefore, dietary advice and counselling was offered simply to Asians, rather than those on a specified dietary regime, this would constitute direct discrimination in terms of the Act, and justification on medical grounds would not constitute a relevant defence.

If Asian children were to be more prone to acquire hepatitis B infection, would it be appropriate for a medical officer in a predominantly Muslim community to offer from a mobile clinic, a hepatitis B vaccination to all children at the local mosque? It would appear that if no other services were provided to the rest of the community the result may indirectly discriminate against all other Asians and non-Asians as the 'condition and requirement' imposed, i.e. to attend the mosque.

In the absence of judicial opinion the examples given are simple hypotheses on the interpretation of the 1976 Race Relations Act. However, as our knowledge of the health requirement of the ethnic minority population increases, the solution for health services will be constrained by the legal profession's interpretation of this legislation. Therefore the issue of identification by cultural factors, religious background, skin colour and facial characteristics may be justified and it could be argued that the 'welfare' element is paramount. It would be safe to conclude, therefore, that Section 35 of the Act may be successfully invoked. The most problematic area will be where the needs of a particular racial group are not so evidently distinct from those of the broader community. In such instances the defence of 'justifiable', in respect of indirect discrimination, or of exemption by meeting a distinct significant welfare need, in respect of direct discrimination, may be difficult to sustain. It is unlikely that health professionals will be able to provide services as they see fit and be given blanket exception under Section 35 of the Act.

Conclusion

The Race Relations Act in 1976 was designed to counteract adverse racial discrimination. To date it remains the only safeguard for ethnic minorities

against arbitrary rules and practices as well as individual acts based on racial grounds leading to significant disadvantage. It is unfortunate that these safeguards may appear to hinder many who are attempting to improve health provision for this community. Presently there is little case law to guide health authorities as to the actions that are permissible but it is hoped that by increasing the awareness of those engaged in this field to the contents of the Race Relations Act, it will prevent naive attempts to help the ethnic minorities population which, although commendable in their motives, will possibly result in the opposite of the desired effects. Consequently, codes of practice which must reflect the requirements of the Race Relations Act 1976 are important, since there is a distinct danger that both health researchers and practitioners may find, not only that aspects of

their work are unlawful but that the law courts, through piecemeal judicial precedent, fail to clarify the boundaries of legitimacy.

Self-regulation has a role to play when determining health needs and providing appropriate services for a multi-racial society. For self-regulation to work, all those involved in this area should be aware of the present legislation and the areas of potential conflict that can arise in health provision. In addition, where race and cultural dimensions are explored, associations, health boards, ethical committees and editors of medical journals should impose strict codes of conduct in their respective fields. Therefore, it is preferable for the professional bodies to anticipate rather than respond to real and potential difficulties, and self-regulation should complement the 1976 Race Relations Act.

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