An urgent need for primary care to engage with social and structural determinants of health

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In *The Lancet Public Health,* Ruth Watkinson and colleagues[1] report on ethnic inequalities in health among older adults (ie, those aged >55 years) by use of the large, nationally representative, English cross-sectional General Practice Patient Survey (GPPS). They estimated the association between ethnicity and health-related quality of life (HRQoL) in 18 ethnic groups (including Gypsy or Irish Travellers), adjusting for age and stratifying by sex. The study showed marked ethnic and sex inequalities in health-related quality of life (HRQoL) and its domains, and in key proximal determinants of health, namely the presence of long-term conditions or multimorbidity, experience of primary care, degree of local service support provision, and patient self-confidence in management of own health. Adjustments for area-level social deprivation did not generally alter the observed ethnic and sex inequalities in HRQoL.

Ethnic inequalities in mortality and morbidity have been documented for decades in the UK. Researchers have called for robust national data to fully understand how these inequalities develop within and across ethnic groups over the life course.[2] The COVID-19 pandemic has drawn attention to the continued absence of robust data to understand the greater vulnerability of some groups to poorer health outcomes than others. Watkinson and colleagues[1] show the important role of diverse inequalities, with sex, ethnicity, and age being key dimensions. For example, relative to the HRQoL of their White British peers, there were larger inequalities among women than men for many ethnic groups, but in the Gypsies or Irish Travellers ethnic group, both sexes experienced large relative disadvantage, while both Chinese men and women experienced relative advantage. Younger age groups (ie, those aged 55–64 years and 65–74 years) in some ethnic groups had better relative outcomes, such as Black African men and Chinese women.

Watkinson and colleagues[1] highlight an urgent need to address ethnic inequalities in the prevalence of long-term conditions, particularly diabetes and hypertension. Others have shown that cardiovascular disease mortality has been declining across most ethnic groups, but ethnic inequalities related to specific issues persist, such as low levels of diagnosis, an absence of culturally appropriate services, and poor cardiovascular risk management.[3,4] The prevalence of type 2 diabetes is alarmingly high in some ethnic minority groups, such as Black Caribbean and Black African groups, and is diagnosed approximately 10–12 years earlier in these groups than in White Europeans. The onset of type 2 diabetes can trigger the onset of other long-term conditions.[5]

Intersectional life-course perspectives provide novel opportunities to understand inequalities in healthy ageing and premature morbidity.[6] Intersectionality refers to the simultaneous experience of multiple forms of discrimination (eg, based on gender, ethnicity, and socioeconomic position). The analyses by Watkinson and colleagues[1] were limited by the absence of robust data to understand the dynamic interplay between age, sex, ethnicity, individual socioeconomic position, and area-level deprivation. Individuals from ethnic minority groups are more likely to live in deprived areas, and the concordance between individual socioeconomic position and aggregate area-level social deprivation measures, such as the Index of Multiple Deprivation score, classified by ethnicity, is not sufficiently understood. The so-called healthy migrant effect complicates interpretation of ethnic differences in health outcomes, as migrants tend to be younger and healthier than UK-born individuals from the same ethnic group. This migrant health advantage is largest among those with activity-limiting health conditions in low-skilled occupations. In addition, ecological determinants of health, such as local ethnic density and support from faith-based organisations, might influence ethnicity-specific experiences in deprived areas, including care-giving and community cohesion.[7] Nonetheless, combining the ecological measure from the Index of Multiple Deprivation with the GPPS enhanced the value of these datasets for future analyses.[1] Given the residential patterning of ethnic minority groups, hierarchical and spatial analyses could provide nuanced insights into variations between different regions or practices in terms of area-level social deprivation, sex, and ethnicity to inform targeted policy and practice interventions.

We strongly support the recommendation by Watkinson and colleagues[1] for high quality longitudinal data to increase our understanding of ethnic inequalities

in health. A life-course perspective is central to understanding ageing and premature morbidity. In the UK, ethnic differences in the risk of cardiometabolic disease are present in childhood, with ethnic minority groups disproportionately exposed to cumulative and multiple adversities,[8] including racism.[9] Such contextual factors at multiple ecological levels, together with qualitative studies on lived experiences of social and structural determinants in health, need to be incorporated into longitudinal datasets. This combination would facilitate an improved understanding of intersectional life-course influences as fundamental drivers of inequalities and would strengthen causal inferences.

Despite biases, such as the absence of data on ethnicity-specific survey non-response rates and the social determinants of health, Watkinson and colleagues[1] present strong evidence of ethnic inequalities in HRQoL, the presence of long-term conditions, and poor experiences of primary care. There seems to be inadequate support from local services to manage long-term conditions in ethnic minority groups. Although constrained by the availability of granular data, the report[1] reinforces the need to consider the intersectional influences of sex and ethnicity on inequalities in healthy ageing.

The findings of the study[1] are important to drive transformative changes in health care that engage with the ethnic inequalities in the social and structural determinants of health. There are examples of emerging, novel, and theoretically underpinned approaches, but many community-led interventions are disconnected from primary care services.[10] Connecting communities to health-care and other social care systems by decision makers has the potential to ensure that communities have a say in shaping culturally accessible services for both the prevention and management of ill health.

We declare no competing interests.

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