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(Accepted 26 June 1995)

Department of Health's requirement for mandatory collection of data on ethnic group of inpatients

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On 1 April the Department of Health introduced the mandatory collection of data on the ethnic group of patients admitted to hospital. Its coding was based on a national minimum standard for classifying ethnic groups, ostensibly using the categories in the 1991 census. In the census, however, one in four people from ethnic groups other than white, including many of mixed parentage, provided non-standard responses to the question on ethnic group. The Department of Health's standard does not include provision for respondents to write in a description of their ethnic group, and this has produced a flawed system out of step with current practice on collection of data on ethnic group. Different methods of analysis preclude comparison with census statistics, and the difficulties in aggregating more detailed local categories to the standard raise concerns about consistency of reporting and quality of the data.

The debate about the collection of ethnic group statistics by census and health agencies in the United Kingdom and North America has been wide ranging and comprehensive.^{1,2} In particular, attention has been drawn to the necessary interdependence of census and public health surveillance systems and the importance of including free text fields for members of ethnic groups, particularly the growing numbers of people of "mixed parentage" (with parents from different groups), who do not feel catered for by specified categories.³ It is therefore surprising and unsatisfactory that the Department of Health's recently introduced mandatory requirement for recording the

ethnic group of inpatients does not accord with this emerging consensus.

After the Department of Health attempted unsuccessfully to introduce the collection of statistics on ethnic group through general practice in 1992,⁴ the onus for such collection was shifted to secondary care and an implementation date was set for April 1993,⁵ coinciding with the general release of statistics on ethnic group from the 1991 census. However, the department did not write to health organisations about its implementation proposals until October 1993.⁶ This consultation delayed until 1 April 1995 the start of the collection and recording of data by provider units, as a mandatory part of the contract minimum dataset, on the ethnic group of all hospital inpatients and day cases.⁷

As indicated in the October 1993 circular, national uniformity for coding and classification of ethnic group is required, the notifications making clear that "the ethnic group categories used in the 1991 OPCS census will form the national minimum standard."⁸ One of the supporting arguments is that "these categories have already been tested as to public acceptability."

The specimen form for collection of data on ethnic group is similar to, but not identical with, the question in the 1991 census. For example, ethnic group is defined on the form as "how you see yourself, and is a mixture of culture, religion, skin colour, language, the origins of yourself or your family. It is not the same as nationality."⁶ In the census it was not defined, the belief being that respondents would answer according to their own perceptions of ethnic group. As in the census, patients are presented with a list of ethnic

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BMJ 1995;311:1006-9

group categories from which to identify their ethnic group, and the department's guidance states that the process of identifying the ethnic group will be based on the individual patient's own perception of their ethnicity.

Originally an "Asian-Other" category was included on the Department of Health's form. This generated much feedback in consultation exercises as the category had been manufactured by the Office of Population Censuses and Surveys and was not one publicly tested for acceptability and understanding when the census question on ethnic group was formulated. In the end the "created" group was not included on the form for national collection and the categories seem to be the same as those on the census form—but there is a notable exception.

Ethnic group categories on form and in census differ

The 1991 census asked respondents to describe their ethnic group by ticking the relevant box from the predefined categories of "White," "Black-Caribbean," "Black-African," "Indian," "Pakistani," "Bangladeshi," and "Chinese," or, if none was appropriate, by ticking either "Black-Other" or "Any other ethnic

group" and explaining their ethnic origin (including mixed origin) in the free text fields provided. In the form for use by the NHS, the "Black-Other" and residual "Any other ethnic group" categories do not make provision for answers to be written in. The Office of Population Censuses and Surveys's tests of public acceptability were based on the full version, with provision for writing in answers as an integral part of the classification.⁹ The Department of Health's requirement on this matter is that health purchasers and providers may seek additional information at their discretion—though this is not required as part of the national system—but that "local categories must be aggregated into the national minimum standard categories before they are reported."⁸ Guidance for national implementation and training material—including the issue of the collection of more detailed categories of ethnic group to meet local needs—was promised in October 1994 but not published until December 1994,¹⁰ only three months before the start of mandatory recording and probably in the wake of most providers' pilot schemes.

The decision to omit free text or written answers has a complex effect on use of statistical output from the 1991 census as denominator data for the Department of Health's hospital episode statistics. The Office of Population Censuses and Surveys assigned one of 35 codes to answers to the ethnic group question; this full classification incorporates the seven predefined categories in the question and a further 28 derived from the written descriptions given in the boxes for "Black-Other" and "Any other ethnic group" and from any forms on which several boxes had been ticked. The codes for the free text responses were then mapped back to the categories in the census question by using a complex algorithm to form a 10 category output classification, as used in most of the statistical tables on ethnic group (figure).¹¹ To accommodate the respondents who had used the free text fields to indicate that they were East African Asian or Indo-Caribbean or were from the Indian subcontinent or had other Asian origins, a 10th category not present in the original question, "Other group-Asian," was created.

Comparison with census statistics is precluded by methods of analysis

Although use of the 10 category classification of the Office of Population Censuses and Surveys to analyse responses to a question on ethnic group is important for comparability with statistics resulting from the 1991 census, comparability can be achieved only by following the same method of analysis as used for the 1991 census. As there are no supplementary free text fields in the question used by the Department of Health to collect information on ethnic group, results from the form cannot be comparable with the output classification in the census. Firstly, the department's national minimum standard classification will greatly overestimate the size of the "Black-Other" group: in the 1991 census classification many of the free text codes were mapped back to other output categories like "Other groups-Asian." This category is almost 19% smaller in the published census tables than the "Black-Other" count in the summary classification (as on the census form).

Secondly, in the census output classification the "Other groups" category has been broken down into "Other groups-Asian" and "Other groups-Other." The "Other groups-Asian" category (which accounted in 1991 for 6.6% of all people in ethnic minority groups in Great Britain) cannot be derived from the Department of Health's classification since this category was composed entirely of free text codes derived from write in answers in the census. When the two "Other"

OPCS's algorithm for redistributing write in answers to output categories

Categories encompassed by output classification

White	0 26-29 33	Indian	3	Other Group - Asian
Black Caribbean	1 8 20	Pakistani	4	11-13 23-25
Black African	2 10 22	Bangladeshi	5	Other Groups - Other
Black Other	7 14 15 17	Chinese	6	9 16 18 19 21

output categories are combined, the census output category for Great Britain is more than 6% smaller than the "Any other ethnic group" summary category (as on the census form). Finally, the "Black-African" category was 2% larger after free text answers were included.

In both the "Black-Other" and "Any other ethnic group" categories these net differences mask differing compositions. Table I clearly shows that in the analysis framework devised for the census the "Other ethnic groups" output category loses the Irish, Greek, Turkish, and Other European groups (they go to the White group) but gains some answers from the free text of the "Black-Other" category. Without the free text fields, these four groups will be coded as "Other" and the profile of this group will differ from that in the 1991 census. Finally, the "Black-Caribbean" and "Black-African" groups both have free text groups mapped to them from the "Black-Other" and "Any other ethnic group" categories.

The effect of all these differences can be seen by comparing the ethnic grouping of residents of Great Britain in the summary classification on the census form (before allocation to output categories) with the output classification as used in census tables (table II). Although the differences between the census classification and proposed health service classification are not substantial in the case of the "White," "Black-Caribbean," and "Black-African" categories, they have a

major effect on the size and composition of the "Black-Other" and "Other ethnic groups" categories and also deny the use of the census output category of "Other-Asian."

Aggregating local categories to the national standard

An additional difficulty arises if providers decide to meet local needs by collecting data in greater detail than is required by the national standard, as is suggested in the national implementation guidance. Providers in Lambeth, Southwark, and Lewisham Health Commission, for example, may include the Vietnamese, a community of over 6000 people (as defined, albeit imprecisely, by residents living in households headed by a person born in Vietnam), larger than either the "Pakistani" or "Bangladeshi" ethnic groups. In the 1991 census just under two thirds of Vietnamese described their ethnic origin as "Chinese" and a third gave free text responses that were assigned to the "Other-Asian" category. There are no means by which providers can then aggregate their local categories into the national minimum standard categories. Many members of the Vietnamese community would tick the "Vietnamese" ethnic group option rather than the "Any other ethnic group" category and the Chinese count would also fall, although it seems likely that a considerable proportion of the ethnic Chinese from Vietnam would continue to describe themselves as Chinese.

The procedures as outlined by the NHS Executive place a substantial burden on providers to set up collection systems that are compatible with the national minimum standard. The provision of a discretionary right to introduce more detailed categories, while welcome in itself, creates the potential for inconsistent recording of the nine minimum standard categories.

Necessary interdependence of census and hospital data

Where census data are used as the denominator and data from the NHS collection system are used as the numerator, the resultant proportions and rates will be of questionable validity for some groups. Given the interdependence of census data and data used for surveillance of public health, priority should be given to standardising data collection systems, the content and format of questions, and the algorithms used to derive output classifications. Faced with the need for compatibility with census data, the department may have felt forced to compromise, perhaps anticipating problems in asking provider staff to code and assign free text fields using the Office of Population Censuses and Surveys's algorithm, although pilot projects in some trusts had shown that this was feasible.¹² Alternatively, producing an output classification directly comparable with the 1991 census would have involved the Department of Health in collating original data that contain written in answers—a substantial processing task and one that would have raised complex confidentiality issues in the transfer of person based information.

Under the mandatory system, hospital episode statistics on ethnic groups will only be comparable with census data (before free text responses were reassigned) in a single published table of counts for all people (not broken down by age and sex) at local authority level.¹³ Only the "White," "Black-Caribbean," "Indian," "Pakistani," "Bangladeshi," and "Chinese" groups will be reasonably compatible with census output data, assuming that providers have correctly aggregated data from any more detailed categories that they have introduced.

In addition to pitfalls at the data collection stage,

TABLE I—Composition of the Black-Other and Other groups for Great Britain in the 1991 census full and output classifications¹³

Code for free text responses*	Description	Full classification	Output classification (as in published tables)
Black-Other:		219 091	178 401
7	British	58 106	58 106
8	Caribbean Island, West Indies, or Guyana	3 093	
9	North African, Arab, or Iranian	6 471	
10	Other African countries	927	
11	East African Asian or Indo-Caribbean	1 271	
12	Indian subcontinent (not elsewhere stated)	4 005	
13	Other Asian	24 854	
14	Other answers (non-mixed origin)	44 940	44 940
15	Black/White	24 687	24 687
16	Asian/White	69	
17	Other Mixed	50 668	50 668
Other groups:		520 709†	487 740
9,11,12	Black-Other (non-mixed origin)		11 747
13	Other Asian		24 854
16	Asian/White (Black-Other mixed origin)		69
18	British; ethnic minority indicated	16 170	16 170
19	British; no ethnic minority indicated	13 971	13 971
20	Caribbean Island, West Indies, or Guyana	3 532	
21	North African, Arab, or Iranian	58 720	58 720
22	Other African countries	3 325	
23	East African Asian or Indo-Caribbean	6 110	6 110
24	Indian subcontinent	41 333	41 333
25	Other Asian	119 961	119 961
26, 27, 28, 29	Irish,‡ Greek, Turkish, Other European	59 006	
30	Other answers (non-mixed origin)	41 725	41 725
31	Black/White	29 882	29 882
32	Asian/White	61 805	61 805
33	Mixed White	3 776	
34	Other Mixed	61 393	61 393

*Codes 7-14 and 18-30 indicate non-mixed origin; codes 15-17 and 31-34 indicate mixed origin.

†The full classification codes for Other groups sum to 520 709, although the published census figure is 521 166.

‡Estimated as 11 050 (after having been excluded because of processing fault).

TABLE II—Comparison of ethnic group counts for Great Britain in the summary and output classifications¹³

Ethnic group	No in classification		Difference (%)
	Summary classification (as on census form)	Output classification (as in census tables)	
White	51 810 555	51 873 794	0.12
Black-Caribbean	493 339	499 964	0.01
Black-African	208 110	212 362	2.04
Black-Other	219 091	178 401	-18.57
Indian	840 255	840 255	0
Pakistani	476 555	476 555	0
Bangladeshi	162 835	162 835	0
Chinese	156 938	156 938	0
Other groups	521 166	487 740	-6.4

using 1991 census data as the denominator is compounded by the delays in introducing ethnic monitoring, which has started four years after the census was taken; the inability at present to revise census data for ethnic groups between censuses; underenumeration in the census¹⁴; and inconsistencies in reporting in the "Black" and "Other" groups as identified by the census validation survey.^{15 16}

Lack of provision for non-standard responses

In addition to these analytical difficulties, the Department of Health's data collection procedures are unsatisfactory from the viewpoint of the patient. Most national census data collection systems now rely on respondents to identify their ethnic group. Self identification has become a cardinal feature of official statistical procedures to collect data on ethnicity or race. Because of the growing population of people of mixed parentage and the ideological and practical drawbacks to forcing people into standard ethnic group or racial categories, national census agencies have provided respondents with the opportunity to write in a description of their ethnic or racial group.

The importance of providing for non-standard responses to the ethnic question on census schedules can be gauged from the 1991 census, where 219 091 people (7.1% of ethnic groups other than "White" in the summary classification before allocation to output categories) ticked the "Black-Other" free text box and 521 166 people (16.9%) the "Other groups" free text box. In other words, about one in four people from ethnic groups other than "White" expressed a wish to describe their ethnic group.

Survey evidence corroborates these findings. Of the 548 residents from ethnic minority groups in South East London Health Authority who responded to Healthquest South East, 17% did not feel that one of the listed ethnic groups (which were the same as the census with the addition of a "Vietnamese" category and the exception that "Black-Other" did not offer a write in response) best described them and wrote in their own descriptions for the "Other" group.¹⁷ In the United States, where the race question in the 1990 census had 14 specific categories and two residual categories, about 9.8 million people (3.9% of respondents or 20% of those in racial groups other than "White"), could not or would not describe their race in any one of the standard categories and marked "Other race." This figure represents a 45% increase in the numbers who identified themselves in this way in the 1980 census.³

The potential lack of provision for patients unable to use one of the standard ethnic group categories (other than a residual "Other ethnic group") is a serious shortcoming (in provider units that choose not to use their discretionary right) which will compromise the principle of self identification at the expense of bureaucratic expediency. Providing for people to define their ethnic group in their own terms if they wish acknowledges the way in which people perceive, identify, and articulate membership. The "reification" of race or ethnic origin without such acknowledgement may give rise to social groups which are artefactual, with no real meaning. People of mixed parentage and from other

backgrounds who feel that they have not achieved official recognition by being given either a recordable identity that accords with their view, or the means to state such an identity, may feel frustrated and marginalised by finding their needs not met, especially when such processes as the national census and the requirements of other official bodies have created a growing awareness of issues of ethnic self identification and an expectation of provision for doing so accurately. People from mixed ethnic or racial backgrounds will be left in the awkward position of having to choose which ethnic group they identify with most. Commentators have drawn attention to the shifts that acknowledge the importance of growing numbers of people of mixed parentage and those who do not feel able to fit into one of the standard ethnic categories.¹⁸ Starr, for example, has emphasised the particular difficulty of "social classification—that is, the classification of people, their activities, and their attributes... because people typically have their own conceptions of membership."¹⁹

The Department of Health's compromise may be viewed as a setback at a time when census agencies are making greater efforts to accommodate non-standard ethnic group and racial responses. Given the important implications for determining the ethnic origin of the increasing numbers of people who choose not to fit into one of the standard predefined categories, write in answers should be reintroduced while there is still time for local implementations to do so.

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(Accepted 26 June 1995)