Briefing

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5. The health of minority ethnic communities

Who are Britain's minority ethnic groups?

In the UK as a whole, about one person in sixteen is from a minority ethnic group. In London, that figure is nearer one in four, while in the boroughs of Brent and Newham about half of all residents come from a minority ethnic group.

The largest minority ethnic groups in Britain are those from South Asia, the Caribbean and Ireland. There are also significant numbers of Chinese, African and Eastern European people in the UK. In London, there are 33 communities comprising more than 10,000 people born outside the UK. An estimated 250,000 refugees live in the UK, about 85 per cent of whom reside in Greater London.

Are minority ethnic groups more or less healthy than average?

On average, people from minority ethnic groups are more likely to experience ill health than white people. There are, however, wide variations between and within communities. Pakistani, Bangladeshi, Irish and black African-Caribbean people have higher levels of general ill health than the white British population, whereas Indian, African-Asian and Chinese people have levels of ill health closer to, or better than, the UK average (Nazroo, 1997).

Asian people living in England and Wales are 60 per cent more likely to have heart disease than white people and are up to five times more susceptible to diabetes. Black African-Caribbean people are five times more likely than average to have high blood pressure and twice as likely to die of stroke under the age of 65. Babies born to Pakistani women are twice as likely to die in the first week as those of British-born mothers.

This is the fifth in a series of King's Fund occasional briefings, for information only.

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Are there particular health problems for minority ethnic groups?

On the whole, people from all ethnic groups in Britain have much the same illnesses. Heart disease, cancer and mental health problems are the most important causes of avoidable death and serious illness regardless of ethnic group.

However, some health problems are specific to particular groups of people. Sickle cell disorders, for example, affect about 10,000 people in the UK, and almost all sufferers are black African or Caribbean. For many people from those groups, sickle cell disorders can cause disabling episodes of pain on a regular basis.

Wide variations are reported in levels of mental ill health. Black African and Caribbean people are between three and six times more likely than white people to be diagnosed with schizophrenia, while Asian women are more likely than average to have depression. The suicide rate among Asian women aged 15–24 is twice the national average.

The health of refugees is shaped to a large extent by their experiences of fleeing persecution and seeking asylum in the UK. Refugees may be particularly at risk of anxiety, stress and torture injuries, many of which have been neglected for some time because of poor access to health services.

What causes ethnic variations in health?

Ethnic groups with the worst general health are also the poorest financially. Across the UK, it is well known that poverty and ill health are inextricably linked. People living on low incomes and in deprived areas are more likely to be ill for longer and die younger than those in more privileged circumstances (Acheson, 1998).

The ethnic groups with the worst health are also those who live in the most deprived localities and on the lowest incomes. Pakistani, Bangladeshi and black African and Caribbean people have the worst health and lowest average incomes of all ethnic groups in the UK (Nazroo, 1997).

A recent Joseph Rowntree Foundation study found that 60 per cent of Pakistani and Bangladeshi people live in households with less than half the national average income, compared with 16 per cent white, 20 per cent Caribbean, 22 per cent Indian, 28 per cent Chinese and 31 per cent African people (Platt and Noble, 1999). Other studies show that people from minority ethnic groups are more likely than white people to live in sub-standard or overcrowded homes.

Income alone, however, does not explain why black people and people from minority ethnic groups are more often ill than white people. Racism in society acts as a major hurdle both to health and wealth. Black African men, for example, are three times more likely to be unemployed than white men even though they are more likely to have a higher educational qualification. Being a victim of crime, or living in fear of crime, are also common causes of avoidable ill health that disproportionately affect people from minority ethnic groups.

Are health services able to deal with this?

People from minority ethnic groups often experience difficulties getting the support they

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need from health services. Rates of primary care use are similar for all ethnic groups, but satisfaction with that service is often lower and rates of referral to hospital are below average among minority ethnic groups (Nazroo, 1997). Asian women, for example, often find it hard to register with a female GP, yet they rate being able to do so more highly than women from most other ethnic groups. In the 1998 National Patient Survey, 17 per cent of people from minority ethnic groups were registered with a single-handed practice, compared with 7 per cent of white people, giving them less choice of doctor.

People from minority ethnic groups may be discouraged from using health services because of a lack of confidence, a shortage of appropriate information, insensitivity to cultural or social needs, stereotyping or previous negative experiences of health care. A study of sickle cell services in London, for example, found that many people are given little help to manage their own pain and experience patronising attitudes from health workers in hospitals (Maxwell and Streetly, 1998).

The NHS is dominated by Western medical practices, not all of which are relevant to the needs and preferences of a growing number of people. Differences in mental health care, for example higher rates of compulsory treatment and drug therapies instead of 'talking' treatments, may reflect the assumptions of health workers as much as real differences in need. Negative experiences of the NHS not only damage individuals but create and sustain mistrust among the community as a whole.

Many health authorities, NHS trusts, primary care groups and individual health workers do provide specialist services to meet the needs of specific ethnic groups. Those services often exist, however, outside mainstream health care and rely on precarious, short-term funding. In the case of refugees, it often takes a major effort from within a community for their health needs to be met by local NHS services.

What needs to be done to tackle ethnic inequalities in health?

There are three broad areas of work in which the health of people from minority ethnic groups can be improved in tandem with that of the rest of the population:

1. Tackle the root causes of ill health

Efforts to reduce levels of poverty and social exclusion in society as a whole should have a beneficial effect across the board. The Government has made progress with initiatives like the Working Families' Tax Credit, the minimum wage and Sure Start. This process, however, is one that needs stable, long-term investment. It requires a co-ordinated programme of action across government, including the Department of Health, aimed not just at helping individuals to move out of poverty but at regenerating whole neighbourhoods and empowering whole communities. It must ensure that reducing exclusion among minority ethnic groups is a major priority and not just a byproduct of a larger enterprise.

2. Tackle the effects of racism in the UK

Eradicating racism, whether institutional or individual, should be a major priority for government, along with society in general. Public services have a big role to play. As employers, organisations like the NHS should ensure they provide genuine equality of opportunity in recruitment, retention and development of people from every background. As service providers, they

need to ensure equal access to services, to make harassment and discrimination as difficult as possible, and to work together to promote community safety in high-risk areas.

3. Improve access to appropriate health care

Access to health care is not simply achieved by providing facilities in a given locality. For services to be accessible, they need to understand how, when and where people use them. They need to communicate proactively with people from social groups with high levels of unmet need and to utilise the wealth of experience and knowledge within those communities to provide the best possible support for their health.

It may be necessary to develop specific services for some minority ethnic groups, and to make other services more accessible. Primary care services need to reach out to groups with a high risk of ill health, like refugees, young families and people isolated in their homes. This will require efforts to recruit and retain key staff in the most disadvantaged areas of the country. NHS Direct could do more to promote its services among minority ethnic groups, as could NHS screening services. Mental health care should be provided in a way that is relevant to the needs and preferences of each ethnic group. Where people do not speak English, for example, counselling services need to be provided in their own languages. There should be targeted and protected investment in advocacy and interpretation services wherever the need is identified.

There is a long way to go before we know how effective all of these measures might be. To ensure significant change is achieved, and knowledge is pooled, the Department of Health should invest in a National Service Framework for tackling inequalities, with an emphasis on black and minority ethnic health, for which the entire NHS will be accountable.

References and further reading

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Note: This information was accurate at the time of going to press