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Ethnic Disparities in Health and Health Care:

**A focused review of the evidence  
and selected examples of good  
practice**



Report July 2004





Ethnic Disparities in Health and Health Care:

**A focused review of the evidence  
and selected examples of good  
practice**

Executive Summary

**Peter J Aspinall** Senior Research Fellow

Centre for Health Services Studies, University of Kent  
& Special Advisor to the London Health Observatory

**Dr Bobbie Jacobson** Director

London Health Observatory

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This report (the full document and summary) arises from a project commissioned by the Department of Health's Equality and Human Rights Group to produce an evidence-based review with a national perspective that addresses (i) ethnic differentials in health and healthcare and (ii) evidence of effective NHS and other action, including selective examples of good practice to illustrate each area. Rather than aiming for comprehensive coverage, the Department suggested a document that focuses on selective topics and population health priorities drawn from the NHS Plan, existing and developing National Service Frameworks, and other policy documents and which, collectively, are encompassed in the NHS's 10-point Race Equality Action Plan. We were not asked to review the evidence on other key areas (such as hypertension, stroke, disability, etc.), ethnic disparities in the wider determinants of health, and on some specific groups such as gypsy travellers and refugees and asylum seekers. Some of these topics are covered in other recent reviews.

The report addresses the following specific topics:

- Coronary heart disease
- Cancers
- Diabetes
- Mental health
- Sexually transmitted infections
- Communicable disease
- Population groups (older people, mothers and babies, and children and young people)
- Access to health services
- Health and lifestyle factors (tobacco use, alcohol consumption, exercise and physical activity, and diet and nutrition)

The full report, with references and detailed examples of good practice can be downloaded from the London Health Observatory website:

[http://www.lho.org.uk/Publications/Attachments/PDF\\_Files/Ethnic\\_Disparities\\_Report.pdf](http://www.lho.org.uk/Publications/Attachments/PDF_Files/Ethnic_Disparities_Report.pdf)

## 2 Understanding ethnic disparities and inequities – The challenges

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Equity of access to health care is widely interpreted as equal access for equal need and ethnicity is one of several characteristics - including, for example, age, gender, and socio-economic group - that may unfairly affect access. However, establishing that the provision of services across ethnic groups is inequitable is highly complex and difficult to determine.

- The absence or poor quality of ethnic group data collection in primary, secondary, and tertiary care frequently precludes even the most basic of audits of access to healthcare. The most recent data (2002-3) shows that only 68% of Hospital Episode Statistics records have a valid ethnic code, with 12% of records still using the 1991 Census classification for ethnic group. However, the fact that around one in ten trusts are managing to achieve a high level of coding (95% and over) demonstrates the feasibility of data collection that is of quality.
- For equity to be properly assessed, it is necessary to measure need for treatment, including severity of illness, appropriateness of treatment, and ability to benefit. This is often difficult to establish as few trials on interventions and the management of disease contain participants from minority ethnic groups. Some account may also need to be taken of different patient preferences for treatment.
- Differences in access by ethnic group need to be adjusted for the confounding effect of the socio-economic status of patients. Studies need to be large enough to permit adjustment for this and other confounding factors. Many datasets currently do not contain information on the social class or socio-economic group of patients, the area-based proxy of deprivation measuring an important yet different dimension from *individual-level* social class.
- Consequently, with the exception of some recent national surveys and a handful of research studies, few attempts have been successful in assessing whether there is equity of access to services based on patient ethnicity.
- Some of the factors affecting access to services and other dimensions of inequity - such as social class/socio-economic position and its life-course dimension - are now being investigated with greater rigour and should

enable more accurate measurements and assessment of their explanatory power to be undertaken in future health surveys and other studies.

- There has been widespread neglect of the impact of racial discrimination and racism on health and healthcare disparities across ethnic groups. Recent research has found strong independent associations between reported experience of racism and various health indicators which show reasonable consistency across different ethnic groups, making this a key area for further enquiry.
- While ethnic disparities in health continue to be attributed to genetic and non-specific "cultural" explanations in some areas of medical research, the emerging evidence base suggests that socio-economic factors and the experience of racism may be amongst the most important causes of these disparities.

### 3 The unequal burden of disease

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The review examines the unequal burden of disease in the aforementioned six key areas. For each disease area the evidence is reviewed for disease frequency, survival, mortality, and access.

#### 3.1 Coronary heart disease

- Prevalence data shows South Asians to have moderately higher rates than other groups.
- There are important differences in the burden of illness across the different South Asian groups, with Pakistani and Bangladeshi groups having the highest rates. Adjusting for occupationally-based social class accounts for some but not all of these differences; however, use of more sensitive measures (standard of living) substantially reduced the disproportionate risk of these groups.
- The latest data shows that the highest mortality ratios for CHD occur amongst those born in the Indian subcontinent, although standardised mortality ratios are not available for the different South Asian country of birth groups.

- Mortality data by ethnic group is not collected and incidence data are also not available.
- While the causes of higher CHD amongst South Asians can be in part attributed to known risk factors such as high blood pressure, blood fats, smoking, central obesity (the deposition of obesity around the trunk), and insulin resistance, socio-economic position is also key and likely to be of a greater magnitude than hitherto reported.
- Only one study has comprehensively assessed ethnic differences in equity of access with respect to invasive management (revascularisation), finding that South Asian patients were less likely than white patients to receive coronary revascularisation in relation to need. This was shown not to be due to any doctor-related bias, but to other unknown factors.

### Examples of Good Practice

The focus of examples is upon South Asian communities. They illustrate a variety of approaches towards systematic prevention of coronary heart disease and an achievement of a change of attitudes of both clients and professionals. While components of good practice are difficult to extract because of the lack of robust evaluations, some notable features are common:

#### CHD: The elements of good practice

- The development of a local evidence base through surveys and focus groups.
- Involvement of at risk communities and survivors of CHD.
- Multi-agency partnerships to deliver the programmes.
- The innovative use of a wide range of media, including audiocassette tapes, video drama, and pilot health programmes on community radio and TV.
- The creation of infrastructures for community involvement.
- Peer education schemes with accreditation.
- Training programmes for health professionals.



## 3.2 Cancers

- The very poor levels of ethnicity recording in cancer registry data mean that there is no reliable routine data on ethnic differences in cancer incidence. Our understanding of these differentials comes largely from research studies.
- South Asian cancer incidence rates (for all sites combined) are significantly lower than for non-South Asians.
- Research studies report a low incidence of colorectal cancer amongst South Asians but significantly higher rates of oral cancer amongst South Asians and nasopharyngeal cancer amongst the Chinese.
- Mortality ratios for lung cancer are elevated for men and women born in Scotland and Ireland but low in both genders in other migrant groups.
- Generally low mortality ratios for breast cancer are found in all the migrant groups but it should be noted that breast cancer is still the most important cause of death in these women.
- Despite being a common cancer, no studies of variations in prostate cancer rates between ethnic groups have been conducted in the UK. There is evidence from other countries that rates are substantially higher in the black groups.
- South Asian rates for childhood and early adulthood cancer were similar or higher than non-South Asian rates and were also significantly higher for some of the rarer cancers, including Hodgkin's disease in men, cancer of the tongue, mouth, oesophagus, thyroid gland and myeloid leukaemia in females, and cancer of the hypo-pharynx, liver and gall bladder in both sexes.

There have been no comprehensive studies of equity of access to cancer services for minority ethnic groups but the third of the national surveys of NHS patients suggests many areas of disadvantage.

### Examples of good practice

There is a dearth of examples from hospital treatment and care. Most examples are from preventative screening programmes.

### 3.3 Diabetes

- Many studies have reported a much higher prevalence of diagnosed non-insulin dependent diabetes among South Asians and a raised rate amongst black Caribbeans.
- The difference between the white and all minority ethnic groups in the rate of diagnosis of diabetes remains large once socio-economic factors have been taken into account.
- Age at presentation is significantly earlier amongst South Asians, placing them at greater risk of complications.
- Mortality directly associated with diabetes amongst South Asian migrants is around three and a half times that in the general population.
- Non-insulin dependent diabetes remains undiagnosed in up to 40% of Asian diabetics.
- Several studies report inadequate quality of health care for Asian and African-Caribbean diabetics and poor compliance arising from patients' lack of knowledge about the disease and its management through the inappropriateness of health information.

#### Examples of good practice

There are few published examples of best practice but examples are promised in the diabetes 'Delivery Strategy'.

#### Diabetes: The elements of good practice

- Research & consultation with community members to identify barriers to optimal self-care.
- The development of integrated, multi-professional services.
- The use of community-based diabetes specialist nurses to support primary health care teams and the employment of ethnic link-workers.

- Provision of accredited training for Asian diabetes support workers.
- The use of pictorial flashcards in a one-to-one education programme to increase knowledge of the condition and self-caring behaviour.

### 3.4 Mental health

- The evidence of differences in disease frequency of major mental illnesses across ethnic groups is mixed. Most is based largely on hospital treatment rates which do not necessarily reflect a true picture of mental illness in the wider community. Such research has reported that black Caribbean people are between three and five times more likely to suffer from psychotic illness – including schizophrenia – than other population groups.
- The EMPIRIC survey - a representative population-based survey - found that black Caribbeans do not have significantly higher rates of psychotic illness than other groups - although the rate of psychosis was estimated to be twice as high compared with the white group. Further research is needed to investigate the differences in rates between those for prevalence in the community and those for treatment.
- There were no marked differences in Common Mental Disorders (depression, anxiety, mixed anxiety and depression disorder, phobia, obsessive-compulsive disorder and panic disorder) between ethnic groups in the population survey. The exceptions to this were for Bangladeshi women where the rates were low and for Pakistani women where the rates were higher.
- For suicide there are marked differences by country of birth group, rates for men being elevated for those born in Scotland and born in Ireland, but low in the Caribbean, East African and Indian subcontinent groups.
- Rates of suicide amongst young Asian women are more than twice those of young white women.
- A recent systematic review of studies comparing use of mental health services by more than one ethnic group found higher rates of in-patient admission among black patients.

- A significant body of research also reports higher rates of compulsory psychiatric admission amongst the black groups compared with white and other groups. There is also evidence that black patients follow more coercive and complex pathways to specialist care, with ethnic variations in primary care assessments. The reasons for this overrepresentation of black patients are not clearly understood.

### Examples of good practice

Recent enquiry and policy reports have highlighted the important yet limited availability of good practice examples in the delivery of mental health services for members of black and minority ethnic groups. These have tended to be relatively small, substantially dependent upon a few champions, operated on limited funds that constrain their effectiveness and expansion, isolated initiatives mainly located in inner-city areas, and have not resulted in the innovative practice being shared across mainstream services.

#### Good practice in mental health: The elements of success

- Establishing trust between the project managers and the communities they serve.
- Strong leadership.
- A strong element of community care, according with a preference for treatment in this setting by members of black and minority ethnic groups.
- Open referral systems.
- Adequate provision of social workers and supervisory staff.
- Commitment to the maintenance of patient contact with their families and/or peer groups.
- A commitment to the eradication of fear in the therapeutic encounter.
- A focus on social inclusion with respect to relationships, education, and employment.

### 3.5 HIV and sexually transmitted infections

- Black and minority ethnic groups in the UK are disproportionately affected by HIV and sexually transmitted infections (STIs). Prevalence rates vary across the different groups with black-Caribbean and black-other groups especially affected by STIs.
- Factors underlying such variation are complex. They reflect differing patterns of migration, socio-economic position, and experiences of disadvantage and discrimination as well as variations in sexual attitudes, behaviour, and mixing and access to and use of health services.
- The number of new diagnoses of HIV infection in heterosexuals associated with the HIV pandemic in sub-Saharan African countries is high and continues to rise.
- Higher rates of undiagnosed HIV infection (and late diagnosis of long-standing HIV infection) now seen in heterosexual GUM (Genitourinary medicine) clinic attendees outside London could be due to the recent dispersal of migrant and refugee populations from countries with a high prevalence of HIV infection.
- Although the number of HIV and STI diagnoses amongst Asian ethnic groups continues to be low, caution is required as Asia is now the second-ranking world region of likely acquisition of newly diagnosed HIV infections in England & Wales.

#### Examples of good practice

Whilst there are many well-documented HIV/AIDS prevention initiatives in the HDA's database, there are few community-based wider sexual health initiatives focussing on ethnic minority communities. There is some evidence to suggest that small group interventions delivered at the community level can be effective in influencing the sexual health and risk behaviours of members of black and minority ethnic groups.

Given cultural differences, however, such findings may not be transferable to the UK's African population where impact and outcome evaluations of interventions are needed. Reports of community-based projects addressing the wider sexual health needs of young people from minority ethnic groups are few, but suggest that targeted recruitment and training of educators from within the black and minority ethnic communities is a successful approach.

### 3.6 Tuberculosis and hepatitis B

- The highest tuberculosis rates are within the black African group, followed by the Pakistani, Indian, and Bangladeshi groups. Low rates have been found in the black Caribbean and Chinese groups. Tuberculosis incidence is strongly related to deprivation.
- A very high proportion of cases in England, Wales, and Northern Ireland in the minority ethnic groups were migrants.
- The health burdens of tuberculosis in London are reflected in both mortality and hospital admissions data, rates being substantially elevated amongst country of birth groups representing the main ethnic groups.
- Recent Health Protection Agency data shows that hepatitis B infections were relatively more common in South Asian children and adults over the age of 40 compared to the overall distribution by age group. The relatively more frequent childhood infections amongst South Asians resulted in a higher risk of chronic infection in South Asians.

#### Examples of good practice

There are few published community-based examples:

- The PHLS reported a radio-based media campaign to improve understanding of TB in minority ethnic communities involving a comedian of minority ethnic origin.
- TB leaflets have been produced in key community languages and are being disseminated via London's TB networks.

#### 4.1 Older people

- There has been very little explicit focus on the health and social care needs of ethnic minority older people in Britain. The frequently expressed perception is that they are small in numbers and 'look after their own'. However, the population of ethnic minority older people in London was predicted to triple between 1991 and 2011.
- The incomes of minority ethnic older people are lower and they are more likely to be disadvantaged in the housing market.
- Important socio-demographic differences across the different ethnic communities are revealed in some marked differences in social and economic position: more black Caribbean and African older men live alone than do men from other minority ethnic groups.
- The Older People's National Service Framework particularly highlights lack of readily accessible and fully appropriate mental health services, culturally biased mental health assessments, incorrect assumptions with respect to the willingness of families to act as primary carers for their older relatives, and the probability that black and minority ethnic older people are more likely to suffer discrimination in accessing services.

#### 4.2 Mothers and Babies

- As ethnic group is not recorded at birth registration, there is a paucity of data on birth outcomes by ethnic group. However, country of birth data shows that mothers of babies born in Pakistan had an infant mortality rate higher than babies of mothers born in any other country and double the overall infant mortality rate. Similarly, stillbirth and perinatal rates were significantly higher for these mothers.
- Studies have reported lower adjusted birthweight rates in first and second generation South Asian babies born in the UK, although the longer-term consequences of this distribution have not been established.

- Women from minority ethnic groups use antenatal services less intensively and a higher proportion book too late for screening to be useful.
- A recent systematic review has concluded that women of South Asian origin may be up to 70% less likely to receive prenatal testing for haemoglobin disorders and Down's syndrome than white women and some research suggests that such women might be less likely to be offered testing.
- The latest confidential enquiry into maternal deaths - a good indicator of the quality of maternity care - shows that the rate for Asian women was three times that of white women, with black women between. The reasons for these differences are likely to be complex.
- The latest infant feeding survey (for 2000) shows clear ethnic differences in the incidence of breastfeeding, mothers from ethnic minority groups being considerably more likely to breastfeed at birth compared with white mothers. With respect to duration of breastfeeding, Asian and black mothers were more likely to be breastfeeding than white mothers at ages up to 4 and 9 months, respectively.
- Data by ethnic group on the prevalence of smoking in pregnancy and rates of smoking cessation in pregnancy are not currently routinely reported, the limited research evidence suggesting that women in minority ethnic groups, especially Asian women, were less likely to smoke in pregnancy than white women.

#### 4.3 Children and young people

- The 1999 Health Survey for England (HSE) shows that Indian, Chinese, and especially Pakistani and Bangladeshi children are less likely than children in the general population to report any long-standing illness. Psychological health scores were generally similar across minority ethnic groups and the general population.
- Compared with the general population, Irish girls were more likely, and Indian, Pakistani, Chinese and Bangladeshi children were less likely, to report ever having smoked.



- Compared with the general population, Indian and Chinese children were much less likely to report having drunk alcohol and reported rates of alcohol use were especially low amongst Pakistani and Bangladeshi children.
- Differences in physical activity levels across the ethnic groups were not marked, the largest - for sports and exercise - being the lower rates in Indian, Pakistani, Bangladeshi and Chinese children compared with the general population.
- Further analysis of the HSE data showed marked differences between the ethnic groups in overweight and obesity. African-Caribbean girls were more likely to be overweight and African-Caribbean and Pakistani girls were more likely to be obese than girls in the general population. Indian and Pakistani boys were more likely to be overweight.
- Respiratory symptoms were more common in the general population and the black Caribbean and Irish groups than in the Indian, Pakistani, Bangladeshi and Chinese groups, Bangladeshi children being least likely to have respiratory symptoms.
- The 1999 HSE also reported that the prevalence of major non-fatal accidents amongst children was highest in the general population and in the black Caribbean group, as were minor accident rates.

## 5 Lifestyle factors

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### 5.1 Tobacco

Data from national surveys on the prevalence of tobacco use amongst minority ethnic groups all show substantial differences between minority ethnic groups and the white group in smoking patterns.

- In the 1999 HSE self-reported smoking prevalence amongst Bangladeshi men was 44% (but only 1% in Bangladeshi women) vs. 27% of men in the general population and 17% in Chinese males.
- These surveys consistently report high prevalences of pan (paan or betel) use amongst Bangladeshi males and females.

- The national surveys omit some groups with very high smoking levels. The Turkish community in London have a reported smoking prevalence of 55-74% amongst men and 45-59% of women.

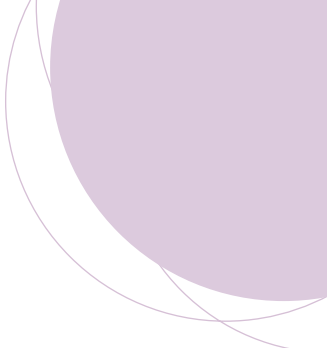
### Examples of good practice

There is a general lack of evaluated smoking cessation services specifically targeted at minority ethnic groups. The latest evidence on the monitoring of NHS smoking cessation services in England shows that the proportion of people setting a quit date by ethnicity is below the population size of the different ethnic communities. Recent survey evidence suggests that the time spent on developing services for all smokers may be detracting from that available for developing methods of attracting groups of smokers that the Department of Health has stated should be prioritised, including minority ethnic groups.

National initiatives include the NHS Asian Tobacco Campaign, which has utilised the minority ethnic press, radio and TV stations, and the NHS Asian Tobacco Helpline available in appropriate languages.

#### Smoking: The elements of good practice

- The training of bilingual peer educators to run smoking cessation services.
- The use of community-based stop smoking clinic services sited in youth, community, and neighbourhood centres.
- The use of trained community pharmacists, practice nurses, and health visitors to provide smoking cessation services in local pharmacies, drop-in and day centres for homeless people, and people's homes.
- The communication of best practice to the team through training.
- Working with Muslim communities during Ramadan through the involvement of Imams.



Only two *comprehensive evaluations* of smoking cessation interventions amongst minority ethnic groups have been identified. An intervention aimed at the Turkish community - comprising a 10-minute play, poster and media campaign, and a series of purpose-designed leaflets - resulted in a small reduction (2.9%) in smoking prevalence, mainly amongst light smokers, people not in full-time employment, and men with a high awareness of the campaign.

An impact evaluation of the London-wide Ramadan Campaign aimed at Muslim communities - involving community outreach workers, information and awareness raising, referral to local tobacco cessation services, and the encouragement of contact with language specific help-lines – showed a significant increase in knowledge of where to obtain help with tobacco cessation. Self-reported quit rates were 61% for those with a last attempt to give up since the beginning of Ramadan and 23% for those with a last attempt to give up before the beginning of Ramadan. Success was associated with the amount of help received.

## 5.2 Alcohol

There are substantial differences in reported prevalence of alcohol consumption across minority ethnic groups and compared with the white population.

- Rates are highest amongst white (92%) and Caribbean men (87%), lower amongst Indian (66%) and Chinese (68-73%) men, and substantially lower amongst Bangladeshi and Pakistani men (3-8%).
- The national surveys report prevalences of <1% and 2% for Pakistani and Bangladeshi females but 51% for Chinese women and 74% for Caribbean women. Reported prevalence levels for Indian women show inconsistencies, lying in the range 18-35%.

### Examples of good practice

There is a lack of documented good practice on *reduction of alcohol consumption* amongst minority ethnic groups. In addition, little is reported on *drug misuse*, one example, cited as good practice in NHS support materials, showing that outreach work by members of the minority ethnic community, the use of a video project to gather views, the use of bilingual, volunteer 'community interactors' to teach drug education to families, and the use of community organisations and businesses through a multi-agency forum all contributed to the success of the project.

### 5.3 Physical activity

- According to the 1999 HSE, the highest age-standardised ratios relating to the current guideline for recommended participation in physical activity were found amongst black Caribbean (1.13) and Irish men (0.97), lower ratios being found amongst Indian (0.86), Chinese (0.62), Pakistani (0.70), and Bangladeshi (0.55) men.
- Age-standardised ratios were highest amongst black Caribbean (1.21) and Irish (1.15) women but much lower amongst women in other groups (Chinese, 0.74, Indian, 0.67, Pakistani, 0.63, and Bangladeshi, 0.35).
- These differences are also reflected in figures for participation in vigorous activity in the past four weeks. Specific ethnic/age subgroups in the South Asian population reveal some important differences.

### 5.4 Diet and nutrition

- The 1999 HSE reported that consumption of fruit and vegetables six or more times a week was highest in the Chinese group, especially amongst women. Proportions were markedly lower in some of the other groups, especially Pakistanis and Bangladeshis.
- There is other evidence that Bangladeshis have a poor diet, including high consumption levels of red meat, adjusted high fat scores, and low fibre score.

### Examples of good practice

There is a paucity of good practice examples on exercise and diet. There is some evidence for the effectiveness of exercise on prescription (EoP) schemes for South Asian women - although such schemes are few in number - but conflicting evidence about the effectiveness of EoP schemes in the wider community. Factors contributing to the success of these schemes for South Asian women include specific consideration to their needs with respect to the use of local facilities, the employment of bilingual and sympathetic staff, low costs, the provision of childcare facilities, and establishment on a long- rather than short-term basis. There is some evidence for the effectiveness of brief behavioural counselling in general practice on the consumption of fruit and vegetables amongst adults in ethnically-mixed inner city areas.

### 6.1 Preventative services

- South Asian groups, especially Bangladeshi women, have a much lower uptake of potentially life-saving *cervical cancer smears*, though more recent studies have reported similar rates to the general population in other minority ethnic groups.
- A lack of accessible information, poorer knowledge about the service, language barriers, inadequate surgery premises, and concerns about sterility may be contribute to lower uptakes.
- Evidence with respect to the uptake of *breast screening* amongst minority ethnic groups is inconclusive but there is some evidence that rates are lower than amongst white women, especially for the South Asian groups.
- Evidence also suggests that, amongst those at risk of pregnancy, Pakistanis and Bangladeshis have a much lower use of contraception compared to white women. The reasons for this are complex.
- Evidence on the uptake of *immunisations for children* is poor but the few research studies indicate that minority ethnic groups have similar or higher rates than the white group, although findings are inconsistent for the orthodox Jewish community.

### 6.2 Primary care

- Our ability to assess equity of access to *primary care services* is severely limited by the lack of comprehensive ethnic monitoring data - not currently mandatory - in this setting but clearly needed to meet the requirements of the Race Relations (Amendment) Act 2000. An opportunity was lost to require such collection in the new General Medical Services contract. There is no centralised reporting of the ethnic group data that is collected in primary care, although a few notable national PCT development sites, such as Lambeth and Central Liverpool PCTs, have demonstrated the feasibility of systematically undertaking 'patient profiling', including ethnicity, country of birth, religion, and language.

- Evidence from large-scale national surveys shows that while South Asians and African-Caribbeans are more likely than the white group to have consulted their GP, and at least as likely after differences in their health have been taken into account, the Chinese are consistently shown to be under-utilisers of this service.
- The first of the NHS national surveys of patient experience - reported for general practice in 1999 - showed differences in the quality of services received across most measures (that is, poorer for respondents from minority ethnic groups), although the findings have not been adjusted for age and other factors. The second of these surveys, conducted in PCTs and reported in 2004, also showed marked differences in the various domains investigated, reflecting a less positive patient experience amongst members of minority ethnic groups, especially South Asian respondents. An analysis of ethnic differences in London PCTs (serving a higher proportion of ethnic minority respondents) and non-London trusts elsewhere in England showed similar patterns. Importantly, the differences between the ethnic groups remained after taking into account differences in age, gender, educational status, and other factors.

### 6.3 Hospital care

Little data is available on the utilisation of hospital inpatient and other hospital care by ethnicity as the completeness and quality of ethnic coding on Hospital Episode Statistics (HES) is generally too poor to merit analysis - with around 30% of records currently lacking valid ethnic coding - and ethnic data collection is not mandatory in outpatient, A & E, and community settings.

- Evidence suggests that the Chinese may under-utilise hospital casualty, outpatient department, and inpatient services.
- The findings of the Acute Inpatient Survey, 2001/02 undertaken for former CHI, indicate that members of minority ethnic groups may be receiving a poorer quality service. However, when the results were subjected to multivariate analysis, the effect of the significantly lower scores for minority ethnic groups compared with white British respondents was substantially reduced and, in many cases, disappeared. Among the South Asian patients the scores remained significantly lower than those for white British patients in the domains of prompt access, involvement and choice of care.

- In the former CHI outpatient survey there were significant ethnic differences in the scores for all domains, comprising access, coordination, information, environment, and relationships. With the exception of Irish and African patients, large ethnic differences persisted in all domains even after adjusting for other explanatory factors, with most groups - especially South Asian and Chinese respondents - expressing significantly more negative views than the white British group.
- In the A & E survey conducted for CHI, large differences from the white British patients persisted for most minority ethnic groups after adjusting for other explanatory factors. The South Asian, mixed, and other white groups all expressed significantly more negative views than the white British group, although differences were less consistent for Caribbean, African, and Chinese patients. While adjustment for other explanatory variables eliminate some of the differences from the white British patients, experiences of access and waiting and safe, high quality, coordinated care remained more negative than for the white British group.
- Although the quality of HES data is poor, utilisation rates of hospital inpatient care have been assessed through the use of Proportional Admission Ratios (PARs), a method with known shortcomings. A pan London analysis showed significantly lower revascularisation (coronary artery bypass graft/percutaneous transluminal coronary angioplasty) rates amongst Bangladeshis compared with Indians and Pakistanis. A more recent analysis of PARs by former CHI again showed that revascularisation rates for Bangladeshis were consistently lower than those for Pakistanis and Indians.

#### 6.4 Other health services (e.g. health visiting, dental services, and paramedical services)

- There are no comprehensive sources of data on the use of other services such as *physiotherapists, psychotherapists, health visitors or district nurses, social workers, home helps, and meals on wheels*.
- Survey evidence indicates that there was no marked variation across the different ethnic groups, although in general white respondents were more likely to have utilised most of these services.
- Ethnic minorities are less likely to visit the dentist than the white group, rates being particularly low for Bangladeshis and for Pakistani and

Bangladeshi children. Language barriers, costs, and a lack of information may be responsible. However, several studies show that being a member of a minority ethnic group does not necessarily mean poorer oral health.

- South Asian women, especially Bangladeshis, are less likely to have visited an *optician* than white women and, amongst men, African-Caribbeans and Bangladeshis are the least likely to have used opticians.

## 6.5 Good practice: Generic examples across the health settings

### 6.5.1 New health services and settings

- Research suggests that walk-in centres - where patients can be seen without an appointment - could be more attractive to minority ethnic groups but findings from national evaluations are awaited.
- There are barriers to accessing out-of-hours services for members of minority ethnic groups, including lack of awareness of out-of-hours interpreting services.
- NHS Direct is now an integral part of the health service but, there is evidence that people from minority ethnic groups are either less aware of the service or use it less.
- Initial evaluations of one new technology, the use of touch-screens that provide health information in appropriate languages, show much promise and may have utility in other parts of the NHS where language is an issue.

### 6.5.2 Bilingual advocacy (e.g. link workers)

- Link worker and bilingual health advocacy (including interpreting) programmes have beneficial effects in a range of settings, including antenatal and infant care.
- The community mothers' programme, a particular type of intervention, has been used successfully with the travelling community in Ireland and a need for further replication of this model with hard to reach communities has been identified.



- Given that interpreting skills continue to be a scarce resource in the NHS, a wide range of practice has been tested from remote interpreting on a shared line to the innovative use of telephone conferencing technology.
- A rapid access remote interpreting service has been successfully introduced for the Turkish community and other examples of good practice include PCT-based advocacy and interpreting services - including out-of-hours services – that are operated on an open referral system.

## 7 Conclusions and implications for action

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### What we know - Ethnic disparities in health:

- Experience of racism has an adverse effect on indicators of both mental and physical health
- Socio-economic factors account for a much greater proportion of ethnic differentials than thought hitherto – but they do not explain all the differences observed
- There is both ethnic and gender heterogeneity in patterns of disease and lifestyle; the new census has offered potential for increasing our understanding of ethnic differences in white minority groups, for example, the Irish, hitherto largely invisible.

### What we don't know:

- There is a paucity of reliable information and research in many key areas, especially cancers.
- We are hampered by a lack of good monitoring and an inconsistent approach to NHS ethnic monitoring; the primary care information base needs most attention.
- The lack of monitoring means very limited information on whether the NHS is providing equitable access to services in relation to the needs of minority ethnic groups.

### Good practice: what can we learn?

- Examples of good practices are limited and inconsistently reported, although some elements of effective initiatives are emerging.
- Most good practice has developed in inner city areas where there is high concentration of minority ethnic communities. There is a risk that communities living elsewhere may not benefit to the same extent.
- Few examples of good practice appear to have been developed with white ethnic minority groups such as Irish and Turkish groups although there may be biases in reporting.
- Few were found that relate to outreach services, especially in primary care settings.
- There is no central repository of updated easily accessible good practice for all; examples are often poorly documented and scattered across many disparate databases.

The systematic collection of a minimum dataset on these examples relating to their organisation, staffing, funding, duration, and objectives and findings from internal and independent evaluations is needed.

- Examples of good practice are mostly based on reports of process rather than outcomes; the short-term nature of many such initiatives prevents entry into the mainstream.

### Research issues:

- The issue of inclusion of minority ethnic groups in clinical trials and other research is an important one for the NHS. Minority ethnic groups are under-represented in research studies, including clinical trials, in Britain. Other countries have shown that this situation can be remedied.
- NHS research strategy should review how the evidence base for effective action to tackle ethnic differentials in health can be improved in poorly researched areas. Cancers and lifestyle interventions should be high priorities.
- A research programme addressing our lack of knowledge on the relationship between mixed race/ethnicity and health is needed.



Working with the NHS in London

**London Health  
Observatory**

11-13 Cavendish Square  
London W1G 0AN

t 020 7307 2828

f 020 7307 2825

e [enquiries@lho.org.uk](mailto:enquiries@lho.org.uk)

w [www.lho.org.uk](http://www.lho.org.uk)