New data on health patterns since 1998

Since the Acheson Report’s publication in 1998, four significant population representative sources of data have become available, that add to the overall picture of health patterns among ethnic minority groups. The first of these is the 2001 census variables on ethnicity. In the England and Wales 2001 census, Pakistani and Bangladeshi men and women in England and Wales reported the highest rates of ‘not good’ health in 2001 (ONS, 2005). Pakistanis had age-standardised rates of ‘not good’ health of 13 per cent (men) and 17 per cent (women).

The age-standardised rates for Bangladeshis were 14 per cent (men) and 15 per cent (women). These rates, which take account of the difference in age structures between the ethnic groups, were around twice those of their White British counterparts. Chinese men and women were the least likely to report their health as ‘not good’.

Second, the ethnicity data in the ONS Longitudinal Study have been used to describe patterns of morbidity and mortality (Harding and Rosato, 1999; Harding and Balarajan, 2000, 2001) as well as test complex hypotheses about intergenerational changes in the associations about ethnicity and health. For example, for South Asians and Black Caribbean poor health has persisted across generations, and for Black Africans health has worsened (Harding and Balarajan, 2000). Among mothers of Black Caribbean, Black African, Indian, Pakistani and Bangladeshi ethnicity, mean birthweights of infants of migrant mothers were similar to those of infants whose mothers were born in the UK, contrary to the expectation that UK-born minority ethnic mothers would have higher birthweight babies than migrant mothers (Harding et al., 2004). In terms of social mobility, between 1971 and 1981 there was some upward social mobility among South Asian and West Indian migrants, but most minority ethnic groups remained socially stable, and relatively disadvantaged compared with the majority population (Harding and Balarajan, 2001). Social disadvantage persists across generations of ethnic minorities. Evidence from the life-course literature shows that the accumulation of disadvantage across the life course results in poorer health trajectories. This suggests that an increase in health inequalities among ethnic minorities and migrants can be expected (Harding and Balarajan, 2001).

Third, the EMPIRIC (Ethnic Minority Psychiatric Illness Rates in the Community) study (Sproston and Nazroo, 2002), a quantitative and qualitative survey of rates of mental illness among different ethnic groups in England, published its findings. This study showed that Black Caribbean people do not have a significantly higher prevalence of psychotic illnesses compared to the White majority group, whereas they do show much higher rates of first contact with treatment services for such illnesses. In contrast to studies on rates of contact with services, the EMPIRIC study indicated a twofold higher rate for Black Caribbean people compared with the White group. This difference was not significant for men or the total Black Caribbean population and was not significant at the level of estimated rates of psychosis. Even if Black Caribbean people are more vulnerable to psychotic illnesses, the discrepancy between the data from psychiatric services and the general population suggests that they are also treated differently in the UK. Possible explanations suggested by the EMPIRIC study are racism by psychiatrists and in the community, misunderstanding of cultural expressions of distress, differential responses by police and social and treatment services and social inequality. However, why such factors should operate for Black Caribbean people and not for other ethnic minorities is not clear. The EMPIRIC results are important in illustrating how ethnic group influences a person’s pathway through the health services.

Fourth, there have been two large-scale population surveys of adults and children, representative of minority ethnic groups across England – the Health Survey for England in 1999 (Erens et al., 2001) and in 2004 (Sproston and Mindell, 2006). Both surveys reveal a complex distribution of health among the major ethnic groups. While some minority ethnic groups have significantly higher rates of disease (for example, cardiovascular disease among Pakistani and Bangladeshi groups, tuberculosis and sexually transmitted infections among Black African groups), other minority
ethnic groups like the Chinese have better health than the majority White population. The two surveys are especially useful for looking at trends in patterns of health by ethnic group since the Acheson Report. Although a gap of five years is a relatively short time for analysing changes in population health, the rare availability of such population-representative data on ethnic minorities in 1999 and in 2004 makes it useful to see if there has been any narrowing of the health gap between ethnic groups living in England.

As may be expected, the trends by ethnicity are complex. For some health conditions, there is little change. Among the general population and all minority ethnic groups, there was no change in the prevalence of bad or very bad self-reported general health between 1999 and 2004. The pattern for age-standardised prevalence of doctor-diagnosed diabetes among minority ethnic groups relative to the general population was the same in 2004 as in 1999, among both men and women. Overall, the patterns for obesity by ethnic group in 2004 were similar to those in 1999, although for most groups the absolute levels of overweight and obesity have increased.

For other health indicators, there is some narrowing of the health gap (for example, smoking among Irish and Black Caribbean men, and physical activity among Bangladeshi and Chinese men). However, there is also a worrying increase in poor health for some minority ethnic groups. The levels of long-standing illness and limiting long-standing illness were significantly higher for Pakistani women in 2004 than they were in 1999. There was a general increase in the prevalence of cardiovascular disease (CVD) in all minority ethnic groups between 1999 and 2004. This increase was non-significant except for Pakistani men where the prevalence of CVD doubled significantly between the two surveys.

The prevalence of hypertension was higher in 2004 than in 1999 in most minority ethnic groups, although many of the increases were not statistically significant. There was a notable reduction in regular physical activity participation among Pakistani men between 1999 and 2004. Mean C-reactive protein generally did not change for different minority ethnic groups between 1999 and 2004 except for Pakistani men, in whom a significant increase was found in the proportion of informants with high levels. Between 1999 and 2004, mean ferritin increased significantly in Pakistani and Irish men, and in Black Caribbean and Bangladeshi women. Black Caribbean women showed significant increases in both mean LDL cholesterol, and in the prevalence of raised LDL cholesterol, which is an important risk factor for cardiovascular disease.

In addition to these population representative surveys, there has been a large-scale epidemiological study of Gypsies and Travellers (Parry et al., 2004). Results of this quantitative survey show that Gypsies and Travellers have significantly poorer health status and significantly more self-reported symptoms of ill health than other UK-resident, English speaking ethnic minorities. Furthermore, their social circumstances are more disadvantaged compared with other ethnic groups: Gypsy and Traveller children are among the ethnic groups most eligible to receive free school meals.

Explanations for inequalities As well as documenting patterns of difference, there has been significant progress in establishing explanations of the patterns of health inequalities by ethnic group. A lifecourse approach has shown how the accumulation of socioeconomic disadvantage over time is related to higher risks of mortality among South Asian groups (Harding and Balarajan, 2001). The independence of the relationship between health and the experience of racism has been convincingly demonstrated (Karlsen and Nazroo, 2002). This is conceptually significant, since racism has often been assumed to be an aspect of deprivation, without a separate ill effect on health. Serious attempts to reduce behavioural risk factors for heart attack and stroke have shown the need to adopt differential strategies that emphasise different risk factors among different ethnic groups, especially in relation to alcohol use in the White population and weight in the Black Caribbean population (Dundas et al., 2001).
General and specific policies

The two types of recommendations considered by the Acheson Inquiry to reduce ethnic inequalities in health – general initiatives to tackle poverty and those specifically targeted at minority ethnic people – have their own strengths and weaknesses. The task of assessing whether such policies are contributing towards the narrowing of inequalities between ethnic groups is hampered by the relative lack of robust, nationally representative data sets with appropriate measurement of ethnicity and authoritative analysis. It is only in the past few years that it has become possible to investigate ethnic inequalities in health and their structuring through social and economic disadvantage (Nazroo, 2003). Our assessment of the pattern of inequalities by ethnicity makes reference to population-representative data that have been published since the Acheson Inquiry. The inquiry confined itself to its tightly defined brief in terms of evidence surveyed and scope of recommendations. This left a number of features of ethnic minorities in Britain that were not addressed, such as religion and language, yet they may be relevant to health inequalities.

Anti-poverty and regeneration policies of the past decade have often been locality based (for example, Sure Start, New Deal and Health Action Zones). While community ownership of state-funded policies has merit as a means of promoting engagement, the extent to which the population of impoverished people can be reached with locality-based initiatives is a problem in terms of promoting equity. The difficulties of reaching people of minority ethnicity in poverty differ from those of reaching the general population because of geographic and demographic factors. The overwhelming concentration of minority groups in London and other big cities is such that rural poverty is not currently a significant issue for this group. Despite the concentration of minority ethnic groups in cities, there is little evidence of the development of neighbourhood ghettoes (Dorling and Thomas, 2004). Data from the 2001 census show that even in localities with the highest concentration they are nonetheless a minority: in Tower Hamlets 33 per cent of the population is of Bangladeshi origin; in Leicester 26 per cent is of Indian origin. The highest proportion of all minorities in England and Wales can be found in London, with the exception of those of Pakistani origin, who are concentrated in greatest numbers in the West Midlands and Yorkshire and Humber. So the issue of the reach of locality-based policies is problematic for minority ethnic groups, as for the ethnic majority. Anti-poverty policies are greatly needed among those minorities who suffer disproportionate levels of unemployment and material deprivation compared with others: within socioeconomic class grouping there is a minority ethnic disadvantage, particularly for people of Bangladeshi and Pakistani origin (Nazroo, 1998). The youthful age structure of minorities, especially those who migrated more recently, can exacerbate poverty because of the greater number of dependants per household.

A study by the Centre for Analysis of Social Exclusion at the London School of Economics (Hills and Stewart, 2005) has surveyed the evidence on the impact of government policies aimed at alleviating poverty, inequality and social exclusion since the Labour government was elected in 1997. The study concluded that ethnicity was generally a sub-focus within social disadvantage, rather than the focus of specific policies. While there was a narrowing of the gap between ethnic groups in GCSE attainment (General Certificate of Secondary Education taken during the fifth year in secondary school), other dimensions of socioeconomic disadvantage such as lack of labour market participation continued to show a strong association with ethnic minority groups.

Policies specifically targeted at minority groups might offer some hope of addressing carefully defined and specific local problems with greater success than general policies; the devolution of commissioning to Primary Care Trust level makes this a current possibility. However, targeted policies are by no means a panacea and can reinforce ill-founded assumptions of homogeneity and immutability about the targeted group, which may in turn further disadvantage people who have atypical health needs. The definition of a health priority for a particular ethnic group may be used, albeit inadvertently, as a summary of that group’s needs, which may subsequently feed into a stereotyped way of treating that group.
Conclusion

The inequity of material deprivation, with well-documented ill effects on morbidity and mortality rates, can be compounded by forms of exclusion that are peculiar to minority ethnic groups. However, some minority ethnic groups are doing better in terms of wealth and health than the ethnic majority, while others are doing considerably worse and within ethnic groups such as ‘South Asian’ or ‘Black African’ there can be considerable divergence between sub-groups. The danger of having interventions targeted at specific minorities is that the policy is prescriptive about the culture in question and this reinforces the idea that minority cultures are bounded and static (Bradby, 2003). There is also a danger that new minorities, arriving as illegal immigrants, refugees and asylum seekers, whose culture has not yet been recognised by public services, may be excluded.

Health policy should seek to embed the protection of minority ethnic health into mainstream healthcare delivery, but how this can be done with the current patchy research database and the absence of good monitoring data remains unclear (Aspinall et al., 2003; LHO, 2003). The widening health gap for some minority ethnic groups, most notably for Pakistani men, suggests that the recommendations from the Acheson Report on reducing inequalities in health between ethnic groups are not currently effective at the population health level.

References