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Executive Summary

S1. Aims, objectives and methodology.
This report provides a summary of the present understanding of factors affecting the health of Black and Ethnic Minority (B&EM) populations. It explores issues related to access to health services and lists initiatives to remove barriers to health services for minority ethnic communities in the North West of England. It is expected that this report and the (electronic) data base attached will inform the planning of health services for Black and Ethnic Minority communities and act as a means by which knowledge, experience and views may be shared.

Box S.1 - Objectives of the project.

- To provide a summary of the present understanding of factors influencing the Health of Black and Ethnic Minority communities in The North West of England.
- To provide a list of initiatives to improve access to health services for Black and Ethnic Minority communities in the North West of England (electronic data base).
- To evaluate the awareness of Directors and Managers of Health Services (particularly Health Authorities) of the barriers to accessing health services which minority ethnic groups face.

Box S.2 - Research methodology

Publications from national and international sources, addressing the Health of Black and Ethnic populations and factors affecting access to health services were reviewed. This literature review was followed by interviews with Directors and Managers in Health Authorities, selected Hospital and Community Trusts, Community Health Councils and community representatives. These interviews were semi-structured in format and explored issues related to the demographic and socio-economic characteristics of local Black and Ethnic Minority communities, access to health services...
services and initiatives aimed at overcoming barriers to health services experienced by these communities.

S2. Reducing inequalities in Health.

Box S.3 - Statement from the Department of Health

“Tackling health issues involves a range of linked programmes, including measures on welfare to work, crime, housing and education as well as on health itself”

(Our Healthier Nation - DoH 1998)

The National Health Service (NHS) on its own, will have limited impact on reducing inequalities in health. This will require the commitment of a wide range of organisations in the public, private and voluntary sector. The NHS is expected to ensure that the factor over which it has most influence, namely the provision of medical care, is targeted to maximise its potential for reducing inequalities in health and life expectancy.

The expectation is that improving access to health services for Black and Ethnic Minorities will improve the health experiences of these groups and reduce the variations in health which exist between these groups and the White population. Ensuring equal access to health care (for equal need) would appear to be the most attainable (and the most just) equity goal for health services (see Section 1.2).

S3. Defining ethnicity.

The difficulties which arise in obtaining a clear definition of the term “ethnicity” need not exclude it from the list of exposures which deserve investigation as factors which influence health outcomes. Importantly, in the past its use allowed the identification of differences in health outcomes for groups defined in this way. The terms, race and ethnicity, are in reality, of social construction. Their significance is determined to a large extent by the society or more specifically the more powerful elements in the society. Of equal importance, is the understanding that it is not primarily “Race” or “Ethnicity” which determines health differentials but it is the social and economic consequences which arise directly or indirectly out of the classification, which supports the causal relationship with these health differentials (see Section 1.4).


Understanding the demographic and socio-economic characteristics of local Black and Ethnic Minority communities is an essential pre-requisite to planning appropriate health services for these communities. The ethnic description of the population based on the 1991 Census was not without its epidemiological, political and sociological uncertainties. This census estimated that there were three million people of minority ethnic origin living in England and Wales accounting for approximately 6% of the total population. The population of the geographical area defined as the North West Health Region was estimated to be 6,44,360 with the Black and Ethnic Minority groups numbering 245,658 or 3.8% of the total population. Residents identifying themselves to be of Pakistani (31.4%) ethnic origin represented the largest minority ethnic group, those
identifying themselves as Indian (22.7%) comprised the second largest. These two groups together accounted for over half of the total Black and Ethnic Minority population in the North West. All other groups recorded much lower percentages with no group recording more than 10% of the total B&EM population (see Chapters 2 and 3).

**S5. Black and Ethnic Minority ill health.**
The illness profiles of B&EM groups are distinctly different from that of the general UK population with variations occurring from birth to old age. In general terms, individuals from Black and Ethnic Minority communities have shorter life expectancies and poorer physical and mental health (Chapter 5). They must often struggle with a health service which is not adequately equipped to deal with or adequately sensitive to their particular language, cultural and religious needs.

**S6. Health service utilisation.**
Health service commissioners and providers must make adequate provision for the changing demographic characteristics of client populations. For the general UK population, the annual GP consultation rate was estimated from the UK wide Health and Lifestyles Survey to be 3.6 consultations per person per year. From the Health and Lifestyles Survey (of the Black and Ethnic Minority population) however, for African-Caribbeans it was estimated to be 4.2, for Indians 5.0, for Pakistanis 7.1 and for Bangladeshis 7.9 consultations per person per year. The Fourth National Survey reported similar findings. Minority ethnic groups were much more likely to have seen their GP in the month prior to this survey. One in eleven Caribbean, Indian and Bangladeshi respondents and more than one in ten Pakistani respondents saw their GP three or more times in the month preceding this survey as compared to about one in twenty for the White population (see Section 6.2).

It is estimated that in the North West of England the number of GP consultations to women, 16 - 74 years and of Indian sub-continent ethnic origin, will increase by 50% by the year 2001 compared to 2% for White women. Further, by the year 2001, first admissions to hospital will increase by 43% for these women while those for White women will decrease by 1.5% (see Section 6.2).

**S7. Improving access to health services.**
The progress which has been made towards improving access to health services appears to be as a result of the commitment and perseverance of a relatively small number of individuals in Health Authorities, Trusts and communities. Changes in organisational structures and procedures have not been shown to have brought about the improvements in access to services which they promised (see Section 7.6).
Health Authorities are not equipped for using epidemiologically based methods for assessing the health needs of local Black and Ethnic Minority communities. Initiatives aimed at assessing the health care needs of Black and Ethnic Minority communities have provided more qualitative than quantitative results (see Section 7.4).

Although restricted in its utility, much emphasis is still placed on demographic and socio-economic data available from the OPCS 1991 census in the planning of services for local Black and Ethnic Minority communities. Alternative sources of information are uncommon and include local surveys and databases held by community based organisations (see Sections 7.2.1 and 7.2.2). Information on the language skills of local communities is often based on subjective evaluations (see Section 7.2.3).

Ethnic monitoring in secondary care can provide important information on the morbidity and health service utilisation profiles of Black and Ethnic Minority populations. However, the information collected to date has been incomplete and under utilised. Introducing ethnic monitoring in the primary care setting will require solid support from Health Authorities (see Sections 7.3.2 and 7.8).

Initiatives aimed at improving access to health services for Black and Ethnic Minority communities in the North West of England have mainly focused on (see Section 7.14)

- obtaining better estimates of community characteristics and health care needs,
- providing information on services in mother tongue languages,
- providing appropriate interpretation services,
- providing clinics staffed by female personnel and
- using link workers as health promoters.

**S8. Recommendations for the North West.** (Details are provided in Chapter 8)

The Regional Office of the NHS

- should facilitate collaboration among organisations and individuals, in the North West of England, involved with Black and Ethnic Minority issues.

Health Authorities and Trusts

- should establish and support key posts (and key personnel) with responsibilities for Black and Ethnic Minority issues within their organisations.
- should review their procedures for measuring the progress made towards improving access to health services for Black and Ethnic Minority communities.
- must improve their understanding of the demographic, socio-economic and related characteristics of client communities.
- must match resources to health care need.
- must address racial prejudice.
• must ensure that contractual arrangements are met and that they provide benefits for clients.
• should recognise their potential, as the largest group of employers in the region, to address the inequalities in employment opportunities experienced by Black and Ethnic Minority communities.

Community Health Councils
• must improve their capabilities to represent the interests of Black and Ethnic Minority communities.

Health Authorities, Primary and Secondary Care services and communities
• should work together to implement and maintain ethnic monitoring so its full potential can be realised.

Health Authorities
• should support research into ways of improving the Health of Black and Ethnic Minority communities.

CHAPTER 1

Reducing inequalities in Health

1.1 A strategy to reduce inequalities in Health.
It is clear from past and recent pronouncements that the Department of Health (DoH) expects Health Authorities to vigorously pursue activities which will reduce the inequalities in health which exists among groups in the population (DoH 1992, 1996, 1998). It recognises however that it is -

Box 1.1 - Statements by the Department of Health

“The cumulative differential exposure to health damaging or health promoting physical and social environments that is the main explanation for observed variations in health and life expectancy, with health related social mobility, health damaging or health promoting behaviours, use of health services, and genetic or biological factors also contributing” (DoH 1996).

“Tackling health issues involves a range of linked programmes, including measures on welfare to work, crime, housing and education as well as on health itself” (DoH 1998).
It is therefore fair to say that the Department of Health also recognises that the National Health Service (NHS) on its own, will have limited impact on reducing these inequalities. Significant reductions will require the commitment of a wide range of organisations in the public, private and voluntary sector. However, the NHS is expected to play a pivotal role in initiating and sustaining this *multi-sectoral* collaboration. More so, it is expected to ensure that the factor over which it has most influence, namely the provision of medical care, is targeted to maximise its potential for reducing the variations in health and life expectancy.

The Department of Health has proposed that -

**Box 1.2 - Statement by the Department of Health (DoH 1996)**

“an important way of achieving the Health of the Nation targets is to improve the health of the least healthy groups closer to the levels attained by the most healthy groups”.

This identifies the intent to target resources and services to the least healthy groups in the population. It should be expected therefore that Black and Ethnic Minority communities would be key recipients of these services and resources since, as will be discussed in Chapter 5, their health experience is considerably less favourable than that of the population in general. The present interest in improving access to health services for Black and Ethnic Minorities may, at least to some extent, reflect this thinking.

The current strategy also requires that Health Authorities and General Practices develop local strategies for identifying the variations in health which exist among their populations and set in place interventions for reducing these variations. Further more, the Department of Health has advised that these interventions should be evaluated for effectiveness and cost-effectiveness and the mechanisms put in place to identify and measure changes in health occurring as a result of these interventions (DoH 1996).

The enthusiasm therefore, to improve access to health services for Black and Ethnic Minorities, with the intention of improving the health experiences of these groups and reducing the variations in health which exist between these groups and the White population, should be matched by the appropriate evidence of effectiveness and cost-effectiveness. Initially, of the ability of interventions to improve access and subsequently, of the ability of improved access to health services to improve health experiences.

**1.2 Access to Health Services.**

Statements related to equity in health care are common place in health reports, policy documents and policy statements and are often presented as an important principle, if not the central principle, governing the distribution of resources for improving and maintaining health. There is
often however, limited discussion of what “equity in health care” really means to the authors of these documents or the organisations which they represent. Further, the optimism with which these statements appear to be made are not usually supported with an equivalent degree of certainty in the ways in which this equity will be achieved or how progress towards this goal will be determined. It is essential therefore to pursue at least some discussion of concepts around “equity in health” not as a consequence of the statements made previously but because of the need to demonstrate that the choice of “ensuring equal access to health care” as a strategy to improve the Health of Black and Ethnic Minorities is not a step down from more desirable alternatives (see Box 1.3). On the contrary, it can be argued that it is the alternative which is most justifiable and even the most “just”.

In general, concepts of “equity in health care” are couched in the following three themes (Mooney 1994).

Box 1.3 - Equity in Health Care (Mooney 1994)

- Equality in health.
- Equality of use for equal need.
- Equality of access.

Each places different demands on those who aspire to use either of these goals, as the purpose behind their endeavours and also not unexpectedly on patients and on society in general.

In particular, the goal of ensuring “equality in health”, poses potentially insurmountable dilemmas as it takes the consequentialist view (Scrambler 1991) and requires that the provision of health care should be in such quantity, of such quality and directed in such a way that the commodity “Health” becomes evenly distributed among all persons. This however does not appear to be a realistic goal. Primarily, since the initial health potential of all individuals is not the same and even if it was, achieving this goal would require that all persons have the same desire for “health” and pursue “health” with the same level of enthusiasm.

The some what less idealistic and possibly more attainable goal of “equal use for equal need” is also not without its share of difficulties. Here the issues arise of firstly measuring “need” and then ensuring “use” of health care by persons and groups based on these assessed needs. Achieving this goal requires therefore a process which can in some way measure need objectively. As a starting point, this has led to the development of the concept of defining different categories of need; namely, normative, felt and expressed need (Bradshaw 1972). By classifying need in this way it is hoped that by separating out the subjective elements of the need complex, identified as felt and expressed need, it would be possible to objectively measure the normative need component (Figure 1.1).
Taxonomy of Need

This however, has also been found to be problematic as it requires subjective inputs on the part of the observers which itself diminishes the objectivity of the process. Further, some decision has to be made as to which components of this need can be satisfied for it is not all need which should be targeted but only those elements for which there is potential to benefit (Culyer 1991). Additionally, a definition of equity, which assumes that the goal is equal use for equal need, is ignoring not just variations in individuals’ preferences for health but variations in individuals’ preferences for health care (Mooney 1994).

The third goal - “equity of access” attempts to focus on the mechanisms and facilities through which health services are delivered. Unlike the previous two goals it is based on the principle that if the processes through which services are delivered are just, then the health outcomes which arise (what ever these may be) are also just (procedural justice). This appears to be the most realistic of the three goals since it makes no assumptions about the inherent health potential of individuals or preferences of individuals for health and health care.

1.3 Improving access to health services for Black & Ethnic Minority populations.
For health services in the United Kingdom, the difficult goals of maintaining and improving health and responding effectively and efficiently to ill health are further complicated by the reduced access to services experienced by Black and Ethnic Minority populations (B&EM). This has led to a number of proposals being put forward as strategies for addressing problems of access. One such list is shown in Box 1.4, items from which are discussed in subsequent chapters (Hopkins A., Bahl V. 1993).
Box 1.4 - Improving access to health services for B&EM communities

- development of an equal opportunities policy and programme;
- ethnic monitoring;
- needs assessment;
- appropriate health promotion clinics and protocols;
- service development;
- appropriate screening services;
- appropriate information;
- financial support for practices;
- joint commissioning;
- appropriate development of primary health care teams;
- inclusion of the needs of B&EM both in business and in service development plans.

1.4 Definition and Use of the term “Ethnicity”.

Although the word “ethnic” has been used on several occasions previously no attempt was made to provide a definition of the term. In this section, a definition and some discussion of the use of this term will be presented.

The word ethnic derives from the Greek word ethnos meaning nation but its present usage often carries connotations of being “different, foreign and marginal: not one of us” (Smaje 1995). It usually describes groups of people who are disadvantaged and experience discrimination due to differences that exist in the colour of their skin, their language, their culture, their religion and their historical or geographical origin (Essed 1991). The classification of people into ethnic groups however, is in no way uni-directional since both the classifier and the classified can play an active role in the process with distinctly different purposes and outcomes. One writer has addressed this distinction as described in Box 1.5.

Box 1.5 - Classification into ethnic groups (Mason 1990)

- **Ethnicity as identity** - the process by which people create and maintain a sense of group identity and solidarity which they use to distinguish themselves from others.
- **Ethnicity as category** - the external creation of categories which people impose on others.

A reflection of this distinction is the view that this process of categorising people into ethnic groups is based on defining either items of similarity or items of difference, with the choice of which of the two sets to be used, determined solely by the person or group doing the classifying. Persons wishing to classify themselves choose items of similarity and in this process establish or
re-affirm their identity. In contrast however, the process of categorising others is based on identifying differences which set these groups apart and establishing them as atypical, unusual and sometimes even bizarre.

1.5 Issues of validity, reliability and usefulness.
Epidemiological methods for generating and testing hypotheses which describe exposure-outcome relationships can broadly be divided into four categories; cross-sectional studies, case-control studies, cohort studies and randomised control trials (Hennekens 1987). In each of these study designs, a definition of the exposure status, which allows some distinction of those who are exposed from those who are not, is required. The clarity, precision and sophistication of this definition, will determine to what extent those who are “truly” exposed will be distinguished from those who are partially or totally un-exposed. Research therefore, which seeks to establish differences in the health experiences (outcomes) of individuals classified as different in some ways (exposures) must at the outset determine how these differences will be identified and possibly quantified. In many instances these differences in exposure status are easily described, at least in general terms. Evaluating the different health experiences of men and women for example, provides little debate on most occasions, about how individuals’ sex / gender will be determined. Similarly, determining exposure to tobacco smoke provides a somewhat greater although not un-surmountable hurdle. On the other hand however, the use of terms such as “Race” or “Ethnicity” to describe exposures in a way that, for example, sex or smoking habit are used has not been as widely accepted by researchers (Ahmad 1994). Certainly, one reason for this has been the inability to objectively define these terms or to establish scientific criteria for the groupings which result from their use. Further, with regard to “ethnicity”, it has not been entirely agreed, by researchers, users of research data or most importantly the subjects of research, how this exposure should be defined and as a consequence how it should be measured or used in research. Some commentators go so far as to suggest that the analytical status of the concept of ethnicity is so questionable it should not be used at all (Sheldon & Parker 1992). Others suggest that research in ethnicity and health tends to highlight the negative aspects of the health of ethnic minority groups and this may damage their social standing and deflect attention from their health priorities (Bhopal 1997).

Equally however, the “vagueness” of this term need not exclude it from the list of exposures which deserve investigation as factors which influence health outcomes. Importantly in the past its use allowed the identification of differences in health outcomes for groups defined in this way (Marmot 1989).

While there is much disagreement about definitions and methods for exposure measurement in “Race and Health” or “Ethnicity and Health” research, there are some areas of agreement. Both these terms, race and ethnicity, are in reality, of social construction with their significance determined to a large extent by the society or more specifically the more powerful elements in the
society (Smaje 1995). Of equal importance, is the understanding that it is not “Race” or “Ethnicity” which determines health differentials but it is the social and economic consequences which arise directly or indirectly out of the classification, which supports the causal relationship with these health differentials (Smaje 1995, Essed 1991).

1.6 Defining ethnicity in the United Kingdom.
In the 1991 census, the Office of Population Censuses and Surveys (OPCS - now called the Office of National Statistics) made its first attempt at categorising the population of the United Kingdom into ethnic groups based on characteristics other than family and individual immigration histories. Previously, attempts to identify non-white populations relied on the use of data collected on country of birth and mother’s and father’s country of birth in the 1971 census, and on birth place in the 1981 census. In view of the way in which the non-white population had to a very large extent been constituted, through in-migration in the late 1950’s, the 1960’s and the early 1970’s (Layton-Henry 1992, Mason 1995), it might have been appropriate around those times to describe the demographics of the non-white population based on responses to questions about a person’s country of birth. However, as early as the mid seventies it was becoming clear that the United Kingdom born non-white population was becoming a significantly larger proportion of the total non-white population and other methods would be required. Questions related to country of birth although having the distinct advantage of being relatively simple and less prone to respondent bias could not be used however, to distinguish between white and non-white individuals who had been born abroad. Further, these questions could not allow the identification of the offspring of the immigrant population who would have fallen into the general category of “born in the UK”.

In the 1991 census, respondents were required to identify from a list of ethnic categories their own impression of the ethnic group to which they perceived themselves to belong or failing this to enter their ethnicity in one of two open categories (OPCS 1992). This list is shown in Table 1.1.

Table 1.1
Ethnic Categories - 1991 census

<table>
<thead>
<tr>
<th>White</th>
<th>Pakistani</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black - Caribbean</td>
<td>Bangladeshi</td>
</tr>
<tr>
<td>Black - African</td>
<td>Chinese</td>
</tr>
<tr>
<td>Black - Other (please describe)</td>
<td>Any other Ethnic Group (please describe)</td>
</tr>
<tr>
<td>Indian</td>
<td></td>
</tr>
</tbody>
</table>

Source: OPCS 1991 Census Questionnaire
This attempt at *ethnic* classification provided distinct advantages over the previous attempts in 1971 and 1981. It addressed, at least to some extent, the problem of classifying the offspring of immigrants who were born in the United Kingdom. It did however have several problems of its own some of which are listed in Box 1.6.

**Box 1.6 - Problems with the methodology used in the OPCS 1991 census.**

- Respondents were required to give their own impression of the ethnic group to which they perceived themselves to belong and this in itself introduced considerable subjectivity to the responses which were obtained.
- The choices which were offered to respondents tended to group individuals of widely differing religions, cultures and languages into single categories. Persons who would have classified themselves as Indian for example, would have included Punjabi Sikhs, Gujarati Hindus and Bengali Muslims.
- The classification created a dilemma for respondents of mixed ethnic origin - the only alternative being for them to categorise themselves as “Other”.
- For a significant number of individuals their own view of their ethnicity is not static but may change from time to time and depending on particular circumstances. This was clearly illustrated in the Validation Survey for the 1991 Census which showed that 12 percent and 22 percent of respondents classifying themselves as “Black Caribbeans or Black Africans” and “Other” respectively, classified themselves differently in this validation survey (Storkey 1994).

The *ethnic* description of the population based on the 1991 Census was therefore not without its epidemiological, political and sociological uncertainties. In the Fourth National Survey of Ethnic Minorities carried out by the Policy Studies Institute in 1994 (Modood 1997), an attempt was made to remove some of the subjectivity which was introduced by the way ethnicity was determined in the 1991 census. In this survey alongside the question on ethnic group membership (as in the 1991 census), questions about family origins were included. Respondents were asked to identify from a list the geographical origins of their parents. The view of these researchers was that questions about ethnic group membership was more a sociological enquiry and that questions about family origins would provide a better demographic classification. Further, they found that there was a very close relationship between the two with the overwhelming majority of respondents giving equivalent answers to both questions. Deviations however did occur with the largest differences being reported among Mixed, Other and Black Caribbean groups (Table 1.2).

<table>
<thead>
<tr>
<th>Table 1.2</th>
<th>Perceived group membership Vs. Family origins</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of respondents</td>
<td>White</td>
</tr>
</tbody>
</table>

Family origins: White, Black, Indian, Indian, Pakistani, Bangladeshi, Chinese, Other, Mixed.


### Group membership

<table>
<thead>
<tr>
<th>Group</th>
<th>100</th>
<th>1</th>
<th>1</th>
<th>1</th>
<th>1</th>
<th>2</th>
<th>1</th>
<th>55</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>81</td>
<td>69</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Black African</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Black British</td>
<td>13</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Black other</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Indian</td>
<td></td>
<td>8</td>
<td>97</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Pakistani</td>
<td></td>
<td></td>
<td>98</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td></td>
<td></td>
<td>95</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Chinese</td>
<td></td>
<td></td>
<td></td>
<td>98</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>British Asian</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Mixed</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
<td>7</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>25</td>
</tr>
</tbody>
</table>

Source: 4th National Survey of Ethnic Minorities

### 1.7 Summary.

Ensuring equality of access to health services (for equal need) would appear to be the only appropriate interpretation of the goal of providing equity in health care. Black and Ethnic Minority communities experience reduced access to health services and there are a number of strategies which have been proposed to reduce the barriers to health services which exist for these communities. The categorisation of individuals into *ethnic* groups remains a contentious issue.

There are epidemiological, sociological and political issues to be considered. The methodology applied in the 1991 census for determining ethnicity has introduced several limitations to the ways in which the data coming out of this census may be used. The Fourth National Survey of Ethnic Minorities provides the most recent data on the ethnic composition of the population of Britain. An attempt was made in this survey to reduce some of the subjectivity in determining ethnicity which was inherent to the OPCS 1991 census.

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### Chapter 2

**Black and Ethnic Minority Populations in England and Wales**

#### 2.1 Demography.

The 1991 census, estimated that there were 3 million people of minority ethnic origin living in England and Wales at the time of the census, accounting for approximately 6% of the total population (OPCS 1992) (Table 2.1 and Figure 2.1)

#### Table 2.1
Population of England and Wales - 1991 Census

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Population</th>
<th>% of Total Population</th>
<th>% of B&amp;EM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>54,889,000</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>51,874,000</td>
<td>94.5</td>
<td></td>
</tr>
<tr>
<td>B&amp;EM</td>
<td>3,015,000</td>
<td>5.5</td>
<td>100.0</td>
</tr>
<tr>
<td>Black - Caribbean</td>
<td>500,000</td>
<td>0.9</td>
<td>16.6</td>
</tr>
<tr>
<td>Black - African</td>
<td>212,000</td>
<td>0.4</td>
<td>7.0</td>
</tr>
<tr>
<td>Black - Other</td>
<td>178,000</td>
<td>0.3</td>
<td>5.9</td>
</tr>
<tr>
<td>Indian</td>
<td>840,000</td>
<td>1.5</td>
<td>27.9</td>
</tr>
<tr>
<td>Pakistani</td>
<td>477,000</td>
<td>0.9</td>
<td>15.8</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>163,000</td>
<td>0.3</td>
<td>5.4</td>
</tr>
<tr>
<td>Chinese</td>
<td>157,000</td>
<td>0.3</td>
<td>5.2</td>
</tr>
<tr>
<td>Other group - Asian</td>
<td>198,000</td>
<td>0.4</td>
<td>6.6</td>
</tr>
<tr>
<td>Other group - non Asian</td>
<td>290,000</td>
<td>0.5</td>
<td>9.6</td>
</tr>
</tbody>
</table>

Source: OPCS 1991 Census

Figure 2.1
Black and Ethnic Minorities
England and Wales 1991
Respondents identifying themselves as being of Indian ethnic origin constituted the largest ethnic group accounting for 1.5% of the total population and approximately 28% of the total Black and Ethnic Minority (B&EM) population. Those having reported themselves to belonging to the Black Caribbean, Pakistani and Other categories (both Asian and non-Asian) comprised the next largest groups, each accounting for approximately 0.9% of the total population and approximately 16% of the total B&EM population. All other groups, Black African, Black Other, Bangladeshi and Chinese, accounted for between 0.3% and 0.4% of the total population and between 5% and 7% of the total B&EM population (Table 2.1 and Figure 2.2).
The 1991 census also revealed that there were distinct differences in the age distribution of respondents from the B&EM population as compared to the White population. The B&EM population was shown to be a relatively young population with as many as 33% of this population under the age of 16 years and with as little as 3% aged 65 years and over, compared to 19% and 17% respectively for the White British population (Figure 2.3). This pattern of age distribution mainly reflected the immigration and fertility characteristics of B&EM groups. Significant differences in the age distribution of the various ethnic groups also occurred.

Figure 2.3
Specific Age Groups
- a percentage of the total population
The Black Caribbean group, being in general terms the first non-White immigrant population and therefore having a longer history within the United Kingdom, recorded age patterns closest to the White British population with 22% of its population under the age of 16 years and 6% aged 65 years and over. In contrast, the Bangladeshi group with its more recent immigration history and higher general fertility rate recorded 47% of its population under the age of 16 years of age and 1% above the age of 65 years (Table 2.2).

Table 2.2
Age Distribution of Ethnic Groups in Britain
Percentage of population in each age group - OPCS 1991 Census

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>&lt; 16 years</th>
<th>16 - 24 years</th>
<th>25 - 34 years</th>
<th>35 - 44 years</th>
<th>45 - 54 years</th>
<th>55 - 64 years</th>
<th>&gt; 65 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black Caribbean</td>
<td>22</td>
<td>15</td>
<td>22</td>
<td>10</td>
<td>13</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Black African</td>
<td>29</td>
<td>17</td>
<td>28</td>
<td>14</td>
<td>8</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Other Black</td>
<td>51</td>
<td>19</td>
<td>19</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Indian</td>
<td>30</td>
<td>15</td>
<td>18</td>
<td>16</td>
<td>10</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Pakistani</td>
<td>43</td>
<td>17</td>
<td>14</td>
<td>12</td>
<td>7</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>47</td>
<td>18</td>
<td>12</td>
<td>9</td>
<td>8</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Chinese</td>
<td>24</td>
<td>18</td>
<td>23</td>
<td>18</td>
<td>9</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Other Asian</td>
<td>24</td>
<td>15</td>
<td>22</td>
<td>22</td>
<td>11</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Other ethnic minorities</td>
<td>42</td>
<td>15</td>
<td>18</td>
<td>11</td>
<td>6</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>B&amp;EM</td>
<td>33</td>
<td>16</td>
<td>19</td>
<td>13</td>
<td>9</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>White</td>
<td>19</td>
<td>13</td>
<td>15</td>
<td>14</td>
<td>12</td>
<td>11</td>
<td>17</td>
</tr>
</tbody>
</table>

Source: OPCS 1991 Census
The Black Other category recorded the youngest population of all with 51% of the population in this group found to be under the age of 16 years and 1% aged 65 years and over. This was expected since the construction of the ethnic categories produced a dilemma for the United Kingdom born offspring of Black immigrants and those of mixed parentage many of whom would have found “Black Other” as the most appropriate way of categorising themselves.

2.2 Social characteristics
The results of the Fourth National Survey of Ethnic Minorities carried out by the Policy Studies Institute in 1994 and published in 1997 (Modood 1997), provides the most recent national data on the social characteristics of Black and Ethnic Minority communities in Britain.

Box 2.1 - Comment on the Fourth National Survey

In reviewing the results of this survey however, it should be noted that there were some differences, in the way ethnicity was classified in this survey as compared to the way in which it was classified in the 1991 census. In the Fourth National Survey, the ethnic group identified as Caribbean included persons born in the Caribbean as well as those born in the United Kingdom but having family origins in the Caribbean. The group identified as Indian excludes persons having a period of stay in East Africa; these persons were classified as African Asians.

2.2.1 Housing tenure. The results of the Fourth National Survey of Ethnic Minorities suggested that the housing tenure for the various ethnic groups in Britain was not unlike that seen in the 1991 census except for increasing owner occupation in all groups except for Pakistanis (Table 2.3).

Table 2.3
Housing Tenure in Britain
Percentage of each Ethnic Group in each category of Housing Tenure

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Own</th>
<th>Rent Local Authority Housing Assn.</th>
<th>Rent Housing Assn.</th>
<th>Rent Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>67</td>
<td>20</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Caribbean</td>
<td>50</td>
<td>33</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td>Caribbean - White</td>
<td>58</td>
<td>29</td>
<td>7</td>
<td>6</td>
</tr>
</tbody>
</table>
Housing tenure is often used as a proxy measure of socio-economic status with individuals living in owner occupied residences being considered to be better off financially than those living in rented accommodation (Whitehead 1992). However, there have been two important criticisms of this use of housing tenure. Firstly, it does not take into consideration varying preferences for home ownership and secondly, it ignores variations which occur in the quality of accommodations. The Fourth National Survey attempted to address these criticisms and reported that Indians, African Asians and Pakistanis expressed a greater preference for owner occupation than other ethnic groups and that Pakistani and Bangladeshi homes tended to be more likely to be lacking central heating, bathrooms and inside toilets (Lakey 1997).

2.2.2 Religion. Respondents in the Fourth National Survey were asked to identify whether they had an affiliation to a religion and if so to name that religion. There was little variation in the responses from White and Caribbean respondents; approximately thirty percent (30%) responding that they had no religion with approximately seventy percent (70%) responding that they were Christian. Most Indians, fifty percent (50%), reported that they were Sikh with the largest other religious group being Hindu (32%). Most African Asians reported that they were Hindu (58%). Almost all Pakistanis and Bangladeshis, over ninety five percent, reported that they were Moslem (Table 2.4).

<table>
<thead>
<tr>
<th>Religion</th>
<th>White</th>
<th>Caribbean</th>
<th>Indian</th>
<th>African Asian</th>
<th>Pakistani</th>
<th>Bangladeshi</th>
<th>Chinese</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>31</td>
<td>28</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>58</td>
</tr>
<tr>
<td>Hindu</td>
<td>0</td>
<td>0</td>
<td>32</td>
<td>58</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Sikh</td>
<td>0</td>
<td>0</td>
<td>50</td>
<td>19</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Muslim</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>15</td>
<td>96</td>
<td>95</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: 4th National Survey of Ethnic Minorities
Major differences were observed in the importance that religion was reported to play in the lives of respondents (Figure 2.4). Muslims were far more likely to report that their religion was a very important part of their lives (74%) while White Church of England followers were most likely to report that religion was not important in their lives (53%). Approximately one third of non-White Church of England followers and White and non-White Roman Catholic followers responded that their religion was very important, fairly important or not important to them.

2.2.3 Marital status. For adults under sixty years of age marriage was most common among Indians, African Asians, Pakistanis and Bangladeshis (over 70%) and least common among Caribbean adults (less than 40%). Being single was most common among Caribbean and Chinese adults (41% and 34% respectively) and approximately equally uncommon among the other ethnic groups. White and Caribbean adults were more likely to be living as married (9% and 10% respectively) than any of the other ethnic groups among whom this was uncommon (Figure 2.5).
2.2.4 Mixed ethnicity partnerships.

For half of Caribbean men who were born in the United Kingdom and who had a partner that partnership was with a White individual. For Caribbean women it was approximately thirty percent (30%) while for Indian and African Asian men and women it was nineteen percent (19%) and ten percent (10%) respectively. There were very few partnerships involving Pakistanis and Bangladeshis, and Whites (Figure 2.6).

Figure 2.6
Mixed ethnicity partnerships
Percentage British born with White partner
2.2.5 *Family units with children*. Family units of White couples were the least likely to include children (48%) while those of Pakistani and Bangladeshi couples were most likely (79%). Family units of never married Pakistani and Bangladeshi, and Indian and African Asian women very rarely included children (1% and 4% respectively) while those of never married White women included children in sixteen percent of cases. Family units of never married Caribbean women were by far the most likely to include children (47%) (Figure 2.7).

**Figure 2.7**

*Family units with children*

Mothers aged 20 - 59 years

By marital status and ethnic group
2.2.6 Family size. At the time of interview, present family sizes were largest for Pakistani and Bangladeshi families with thirty three percent (30%) and forty two percent (42%) of these families, respectively, having four or more children. Few White, African Asian and Chinese families had families with four or more children (approximately 3%) while an intermediate number of Indian and Caribbean families (11% and 7% respectively) had four or more children (Figure 2.8).

**Figure 2.8 - Number of children per family** At time of interview - By ethnic group
2.2.7 Adult child living in the same household. Respondents of Indian, Pakistani and Bangladeshi, African Asian ethnic origin who were past or approaching retirement were much more likely to have an adult child living in the same household (over 60%). White elderly were the least likely to have an adult child living in the same household (Figure 2.9). This situation has important relevance for the availability of family members to provide home help for the most elderly in the future.

Figure 2.9 - Adult child living in the same household  By ethnic group
2.2.8 Unemployment. The unemployment rate for men as defined by the proportion of economically active men without work was significantly higher for minority ethnic men in general, than White men. Chinese, African Asian and White men were the least likely to be unemployed (9%, 14% and 15% respectively) while Caribbean, Pakistani and Bangladeshi men were the most likely (31%, 38% and 42% respectively) (Figure 2.10).

Figure 2.10
Unemployment rate among men
By ethnic group
For Caribbean men under thirty five years of age with no qualifications equal to or above O-level standard the unemployment rate was an alarming sixty one percent. For Pakistani and Bangladeshi men under thirty five years of age, only after attaining qualifications of A-level or higher were they able to attain employment levels with White men of the same age group. At no educational level did Caribbean men attain the same employment rate as White men (Figure 2.11).

**Figure 2.11 - Rate of male unemployment**
By highest British qualification. Men - under 35 years
2.2.9 **Self employment.** For men in paid employment, Chinese and those with family origins in the Indian subcontinent and East Africa were the most likely to be self-employed (approximately one third). Caribbean and Bangladeshi men were the least likely (14% and 17% respectively). For women in paid employment, only Chinese women approached rates of self employment close to those of their male partners (Figures 2.12 & 2.13).

**Figure 2.12 - Self employment**

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>None</th>
<th>O-level or equivalent</th>
<th>A-level or higher</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>19%</td>
<td>13%</td>
<td>15%</td>
</tr>
<tr>
<td>Caribbean</td>
<td>61%</td>
<td>28%</td>
<td>28%</td>
</tr>
<tr>
<td>Indian / African Asian</td>
<td>18%</td>
<td>20%</td>
<td>18%</td>
</tr>
<tr>
<td>Pakistani / Bangladeshi</td>
<td>45%</td>
<td>43%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Source: 4th National Survey of Ethnic Minorities

Percentage of individuals economically active. By gender and ethnic group

**Figure 2.13**
2.2.10 *Earnings*. Bangladeshi men reported, by far, the lowest level of wages with forty one percent earning less than £116 per week. Pakistani men reported the second highest percentage of men in this wage category (< £116 / week) (13%), still considerably lower than the proportion for Bangladeshi men. African Asian and White men recorded the highest proportions (25% and 15% respectively) in the highest earnings category (> £500 / week) (Table 2.5).

### Table 2.5
**Male employees earnings**

<table>
<thead>
<tr>
<th>Percentage of male full-time employees</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Weekly Earnings</strong></td>
</tr>
<tr>
<td>&lt; £116</td>
</tr>
<tr>
<td>£116 - £192</td>
</tr>
<tr>
<td>£193 - £289</td>
</tr>
<tr>
<td>£290 - £385</td>
</tr>
<tr>
<td>£386 - £500</td>
</tr>
<tr>
<td>&gt; £500</td>
</tr>
</tbody>
</table>

Source: 4th National Survey of Ethnic Minorities

**2.3 Summary.**

A thorough understanding of the age and sex distribution, and the social and economic characteristics of client populations is an important requirement for determining the health care
needs of these populations and for planning and delivering health services which are appropriate to these needs. There are for example, distinct relationships between the number of elderly individuals in the population and the need for hip replacement surgery or the number of women of child bearing age and the need for family planning and maternity services. There is little debate therefore about the need for sound demographic data. What is sometimes not as clear is the importance of social and economic data to the health care planning process.

However, just as age and sex determine health care need, so does command over material resources. Economic status determines living and working conditions and a myriad of other factors which have a direct or indirect effect on health. Poor housing, for example, directly affects both physical and mental well being, impacting on the incidence of allergies, asthma, respiratory infections, household accidents and depression among occupants (Whitehead 1992). Further, economic status determines the ability to access health services. In a practical way, having the use of a family car makes using health services significantly easier. Clearly therefore, an understanding of the economic characteristics of client populations, provided by information on housing tenure, car ownership, employment and employee earnings, is also important to health care planning.

Somewhat less apparent though, is the requirement for information on social characteristics such as religion, marital status and partnerships but these as well have their impact on health care need, health care delivery and health service utilisation. Religion can determine utilisation of family planning services and fertility or the need for circumcision services. It can also determine the format and focus of interventions. Marital status influences timing of pregnancies and fertility. The ethnic composition of partnerships determines family cultural norms and health beliefs.

The OPCS 1991 census provides regional and district estimates of the demographic and some social and economic characteristics of minority ethnic populations and as a result, in the first half of the present decade, extrapolations from national statistics were considered somewhat unnecessary. However, as the decade progressed this data source would have become less useful as demographic and social characteristics changed and data from other surveys such as the Fourth National Survey of Ethnic Minorities, with more recent and more varied information, became available. Although however, use of information from these other sources at the regional and district level are limited by the way study populations were selected they remain to a large extent, the only estimates of some demographic, social and economic characteristics. An appreciation of the findings of these surveys can therefore provide a useful addition to the data from the OPCS 1991 census.

There are clearly important differences in the demographic, social and economic characteristics of the B&EM population compared to the White British population and among the various minority ethnic groups as well. These differences determine to a significant extent the distinct
health care needs of each ethnic group as well as the capacity of each of these groups to access and use health services.

Chapter 3

Black and Ethnic Minority populations in the North West of England

3.1 Demography.

The population of the geographical area defined as the North West Health Region was estimated in the 1991 OPCS census to be 6,444,360 with the Black and Ethnic Minority groups numbering 245,658 or 3.8% of the total population. Table 3.1 gives a description of the ethnic composition of this population.

Table 3.1

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Population</th>
<th>Percentage of Total Population</th>
<th>Percentage of B&amp;EM Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Groups</td>
<td>6,444,360</td>
<td>100.0</td>
<td>-</td>
</tr>
<tr>
<td>White</td>
<td>6,198,702</td>
<td>96.2</td>
<td>-</td>
</tr>
<tr>
<td>B&amp;EM</td>
<td>245,658</td>
<td>3.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Black-Caribbean</td>
<td>21,721</td>
<td>0.3</td>
<td>8.8</td>
</tr>
<tr>
<td>Black-African</td>
<td>9,379</td>
<td>0.1</td>
<td>3.8</td>
</tr>
<tr>
<td>Black-Other</td>
<td>16,160</td>
<td>0.3</td>
<td>6.6</td>
</tr>
<tr>
<td>Indian</td>
<td>55,690</td>
<td>0.9</td>
<td>22.7</td>
</tr>
<tr>
<td>Pakistani</td>
<td>77,111</td>
<td>1.2</td>
<td>31.4</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>14,903</td>
<td>0.2</td>
<td>6.1</td>
</tr>
<tr>
<td>Chinese</td>
<td>17,572</td>
<td>0.3</td>
<td>7.2</td>
</tr>
<tr>
<td>Asian-Other</td>
<td>8,993</td>
<td>0.1</td>
<td>3.7</td>
</tr>
<tr>
<td>Other-Other</td>
<td>24,129</td>
<td>0.4</td>
<td>9.8</td>
</tr>
</tbody>
</table>
Residents identifying themselves to be of Pakistani (31.4%) ethnic origin represented the largest minority ethnic group, those identifying themselves as Indian (22.7%) comprised the second largest. These two groups together accounted for over half of the total Black and Ethnic Minority population. All other groups recorded much lower percentages with no group recording more than 10% of the total B&EM population. Residents identifying themselves as Black Caribbean (8.8%) comprised the largest of the smaller *ethnic* groups (excluding “Other-Other”) with those identifying themselves as Asian-Other (3.7%) comprising the smallest.

This ethnic distribution of the B&EM population of the North West was distinctly different from that seen for Britain as a whole (Table 3.2); Black Caribbeans, Black Africans and Other Asians
were considerably under represented in the North West as compared to Britain; Pakistanis and Chinese were considerably over represented.

Table 3.2
Ethnic Distribution of the B&EM population
Percentage of the total B&EM population

<table>
<thead>
<tr>
<th></th>
<th>Britain</th>
<th>North West</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black Caribbean</td>
<td>17</td>
<td>9</td>
</tr>
<tr>
<td>Black African</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Other Black</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Indian</td>
<td>28</td>
<td>23</td>
</tr>
<tr>
<td>Pakistani</td>
<td>16</td>
<td>31</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Chinese</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Other Asian</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Other ethnic minorities</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

Source: OPCS 1991 Census

3.2 Age Distribution of the population of the North West

As seen for B&EM populations in the United Kingdom in general, this population in the North West was found to be, on average, younger than the White population. The age distribution of the Black Caribbean population resembled most closely that of the White population with somewhat similar population proportions in the younger age groups. In the older age groups however, the similarity disappeared with the White population recording progressively larger proportions of its population in the 65-74, 75-84 and 85+ age groups (Figure 3.1). As suggested in Chapter 2, this pattern of age distribution for the Black Caribbean ethnic group reflects the earlier immigration history of this population and a general fertility rate closer to that of the White population.

Figure 3.1
In contrast, the group designated as Black-Other which had the youngest population with the largest proportion under 5 years of age (20%) and with more than 60% of its members below the age of 20 years. It has been suggested that this group represents to a considerable extent the offspring of Black immigrants and mixed parents. The group Other-Other also contained a particularly young population with 17.5% of the population under the age of 5 years and over fifty percent under the age of 20 years. A similar pattern, although less pronounced, was observed for the other ethnic groups, with significantly larger proportions of the populations in the younger age groups as compared to the White population.

For all Black and Ethnic Minority groups the proportion of the population at retirement age or older was considerably lower than that for the White population. This was most pronounced in the Bangladeshi population which recorded less than 0.1 percent of its population over the age of 85 years. Further, in this, the very oldest age group, only Black-Caribbeans (0.2%) and Chinese (0.3%), reflecting earlier migration into the North West, approached the 1.5% seen in the White population.

These age distribution differences seen for the B&EM populations were also demonstrated in the proportion of Black and Ethnic Minorities who comprised the various age groups in the total population. Where as B&EM groups made up 7.0% and 7.2% of the 0-4 and 5-14 years age groups respectively, these groups only comprise 0.3% and 0.4% of the 75-84 and 85+ age groups (Figure 3.2).

**Figure 3.2**
3.3 Social characteristics.

Information on the social characteristics of the B&EM populations at a regional level are often restricted to what is available from the national census. Data from the other major national surveys, such as the Health and Lifestyles Survey (B&EM) or the National Survey of Ethnic Minorities, often do not retain their statistical validity when broken down by region. Assumptions have to be made about the applicability of national data at this level and often therefore national rates are applied to regional populations with the assumption that these represent a valid estimate of the situation at the regional level. The following reports on some of the findings from the OPCS 1991 census. In other chapters national rates from surveys other than the 1991 census are applied to the population of the North West to make estimations and projections.

3.3.1 Country of Birth of the B&EM population. By reviewing responses on country of birth from the 1991 census, it was possible to determine what proportion of respondents were born in the United Kingdom. For B&EM populations in general, those born in the UK accounted for over half of all Black and Ethnic Minorities (53%) in the North West (Table 3.3). As expected the largest proportion born in the UK was for the Black-Other (92%) and the Other-Other (68%) groups since these groups (see Chapter 2) comprised mainly persons born to earlier immigrant populations. The Ethnic Minority group with the smallest proportion born in the UK was the group labelled Asian-Other (29%) and this might be because this group contained the relatively recently immigrated Vietnamese population (Layton-Henry 1992).

<table>
<thead>
<tr>
<th>Country of Birth</th>
<th>Black and Ethnic Minority Population - North West of England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percentage not born in the UK</td>
</tr>
<tr>
<td>Total Population</td>
<td>4</td>
</tr>
<tr>
<td>White</td>
<td>3</td>
</tr>
<tr>
<td>B&amp;EM</td>
<td>47</td>
</tr>
</tbody>
</table>

Table 3.3

Source: OPCS 1991 census
The immigration policies seem unlikely to change significantly in the near future thus it can be expected that by the time of the 2001 census, significantly larger proportions of the B&EM population would have been born in the United Kingdom. This and the effect of increasing numbers of offspring of mixed ethnic group parents is likely to result in increases in the Black-Other, Asian-Other and Other-Other categories making these categories a greater proportion of the total B&EM population.

3.3.2 Fertility patterns. Table 3.4 shows the child / women ratio for the ethnic groups which comprise the B&EM population in the North West. This ratio gives an indication of the fertility characteristics of the population, notwithstanding in some what general terms. For the White population, for every 1000 women of child bearing age there were 314 children four years of age or younger while for Black and Ethnic Minority groups there were 535 (1.7 times higher). Black-other, Other-other, Bangladeshi and Pakistani groups recorded the highest ratios and only Chinese and Black-Caribbean groups recorded ratios lower than those for Whites.

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Women 15-44 years</th>
<th>Children 0-4 years</th>
<th>Child / Women ratio per 1000 women</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>1,320,200</td>
<td>414,194</td>
<td>314</td>
</tr>
<tr>
<td>BEM</td>
<td>58,418</td>
<td>31,239</td>
<td>535</td>
</tr>
<tr>
<td>Black-Caribbean</td>
<td>5,276</td>
<td>1,616</td>
<td>306</td>
</tr>
<tr>
<td>Black-African</td>
<td>2,256</td>
<td>982</td>
<td>435</td>
</tr>
<tr>
<td>Black-Other</td>
<td>3,768</td>
<td>3,219</td>
<td>854</td>
</tr>
<tr>
<td>Indian</td>
<td>14,039</td>
<td>5,596</td>
<td>399</td>
</tr>
</tbody>
</table>

Source: OPCS 1991 Census
There were at the time of the 1991 census 2,548,384 households in the North West Region with 64,637 (2.5%) of these, the homes of B&EM individuals and families. The pattern of housing tenure for these groups was not unlike that seen in the rest of England and Wales with a significantly lower proportion of homes of B&EM being either owned or in the process of being bought (64.8%) as compared to the homes of White individuals; a significantly lower proportion being rented from the Local Authority (17.3%); a significantly higher proportion being rented from private landlords (10.4%) or Housing Associations (5.8%) (Table 3.5).

### Table 3.5

<table>
<thead>
<tr>
<th>Housing Tenure in the North West of England</th>
<th>Households in each housing category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>House Ownership</td>
</tr>
<tr>
<td>All Households</td>
<td>2,548,384</td>
</tr>
<tr>
<td>Owner</td>
<td>643,849</td>
</tr>
<tr>
<td>Buying</td>
<td>1,095,119</td>
</tr>
<tr>
<td>Rent-private</td>
<td>155,851</td>
</tr>
<tr>
<td>Rent-HA</td>
<td>91,402</td>
</tr>
<tr>
<td>Rent-LA</td>
<td>530,746</td>
</tr>
</tbody>
</table>

There were also significant variations in housing tenure among the groups which comprise the B&EM population, some reflecting variations seen in Britain as a whole and others somewhat unique to the North West. In general the pattern of housing tenure for B&EM in Britain (OPCS 1991) reflects the complex and combined effects of several factors over many years. These include migration history and immigration policies, racial prejudice, changes in the labour market and housing availability and housing policies. For the first immigrants, public housing was not an option since migrants did not qualify for public housing and accommodation needed to be found elsewhere. This left two alternatives, private rental or owner occupation. While most Black Caribbean and Black African immigrants chose or were limited to renting from the private housing market, most immigrants from South Asia, mainly Indians and Pakistanis, took the
alternative and became owner occupiers. With time, Black Caribbean and Black Africans, moved out of private rentals and into properties owned by Local Authorities and Housing Associations while Indians and Pakistanis continued their trend towards owner occupation (Layton-Henry 1992, Phillips 1987).

This sequence has largely determined the pattern of housing tenure for these groups; Indians, Pakistanis, Black Others, Black Africans and Black Caribbeans, in the North West. Indians and Pakistanis recorded the highest home ownership (owned outright or in the process of being bought); 82.3% and 79.9% respectively, while Black Other, Black African and Black Caribbean recorded the lowest with 34.9%, 36.1% and 44.8% (respectively) of homes in this category. Further, with respect to accommodation in houses owned by the Local Authorities or Housing Associations, Black Caribbeans, Black Africans and Black Others recorded the highest proportions 48.1%, 48.2% and 51.4% respectively while Indians and Pakistanis recorded the lowest, 9.8% and 9.6% (Table 3.6 & 3.7).

Table 3.6

<p>| Housing Tenure of the B&amp;EM Population in the North West |
| Number of Households |</p>
<table>
<thead>
<tr>
<th>Owner / Buying</th>
<th>Rent-private</th>
<th>Rent-HA</th>
<th>Rent-LA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black Caribbean</td>
<td>1,011</td>
<td>3,536</td>
<td>4,547</td>
</tr>
<tr>
<td>Black African</td>
<td>199</td>
<td>1,048</td>
<td>1,247</td>
</tr>
<tr>
<td>Black Other</td>
<td>200</td>
<td>1,076</td>
<td>1,276</td>
</tr>
<tr>
<td>Indian</td>
<td>3,924</td>
<td>7,827</td>
<td>11,751</td>
</tr>
<tr>
<td>Pakistani</td>
<td>4,481</td>
<td>8,241</td>
<td>12,722</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>315</td>
<td>1,595</td>
<td>1,910</td>
</tr>
<tr>
<td>Chinese</td>
<td>1,046</td>
<td>2,521</td>
<td>3,567</td>
</tr>
<tr>
<td>Asian-Other</td>
<td>251</td>
<td>1,164</td>
<td>1,415</td>
</tr>
<tr>
<td>Other-Other</td>
<td>731</td>
<td>2,743</td>
<td>3,474</td>
</tr>
</tbody>
</table>

Source: OPCS 1991 Census

Table 3.7

Percentage in each category of Housing Tenure

<table>
<thead>
<tr>
<th>Owner / Buying</th>
<th>Rent-private</th>
<th>Rent-HA</th>
<th>Rent-LA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black Caribbean</td>
<td>44.8</td>
<td>6.3</td>
<td>10.1</td>
</tr>
<tr>
<td>Black African</td>
<td>36.1</td>
<td>14.0</td>
<td>12.6</td>
</tr>
<tr>
<td>Black Other</td>
<td>34.9</td>
<td>12.5</td>
<td>15.3</td>
</tr>
<tr>
<td>Indian</td>
<td>82.3</td>
<td>6.2</td>
<td>2.2</td>
</tr>
<tr>
<td>Pakistani</td>
<td>79.9</td>
<td>9.9</td>
<td>2.3</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>67.5</td>
<td>15.7</td>
<td>4.8</td>
</tr>
</tbody>
</table>
Housing tenure for the ethnic groups described above, followed to a large extent trends for these groups in Britain in general. There were however, some major differences in the pattern of housing tenure for Bangladeshis in the North West. For this group home ownership was significantly more common in the North West (67.5%) as compared to all Bangladeshis in Britain (44.5%) and as a result significantly fewer were renting Local Authority housing (10.0%) than in Britain in general (37.0%).

3.3.4 **Overcrowding.** Of all households in the North West, there were 1.6% where there were more than one but less than one point five (1.5) persons per room in the household and 0.3% where there were more than one point five (1.5). For households of Black and Ethnic Minorities the pattern was very different with 12% (almost 9 times higher than for White households) of these households recording more than one but less than one point five (1.5) persons per room and with 4.6% (23 times higher than for White households) recording more than one point five (1.5) (Table 3.8 & Figure 3.3).

### Table 3.8
**Overcrowding in Households - North West of England**

<table>
<thead>
<tr>
<th>Persons per room</th>
<th>Persons per room</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 1 to 1.5</td>
<td>&gt;1.5</td>
</tr>
<tr>
<td>Total</td>
<td>1.6</td>
</tr>
<tr>
<td>White</td>
<td>1.4</td>
</tr>
<tr>
<td>B&amp;EM</td>
<td>12.0</td>
</tr>
<tr>
<td>Black-Caribbean</td>
<td>2.1</td>
</tr>
<tr>
<td>Black-African</td>
<td>5.4</td>
</tr>
<tr>
<td>Black-Other</td>
<td>2.9</td>
</tr>
<tr>
<td>Indian</td>
<td>12.6</td>
</tr>
<tr>
<td>Pakistani</td>
<td>23.7</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>26.6</td>
</tr>
<tr>
<td>Chinese</td>
<td>7.9</td>
</tr>
<tr>
<td>Asian-Other</td>
<td>8.2</td>
</tr>
</tbody>
</table>
For all groups which comprise the B&EM population in the North West, the household occupancy was higher than that for White households. There were however considerable variations among B&EM groups. Black Caribbeans recorded levels of household occupancy closest to those of White households, 2.1% and 0.7% respectively for households with more than one but less than one point five (1.5) persons per room and households with more than one point five (1.5) persons per room. For South Asian households the picture was very different. Bangladeshis in particular, were resident in households which recorded high occupancy ratios with 26.6% (19 times higher than for White households) having more than one but less than one point five (1.5) persons per room and 18.9% (95 times higher than for White households) having more than one point five (1.5) persons per room. This level of overcrowding found to be experienced by the B&EM population is in part due to less adequate housing facilities but also reflects the younger age distribution of this population and higher fertility rates. It was not totally surprising therefore that the Black Caribbean ethnic group recorded overcrowding patterns close to that of the White population and the Bangladeshi group the least similar.

Figure 3.3

3.4 Summary
The importance of demographic, social and economic data to health needs assessment, health care planning and health service delivery was discussed in Chapter 2. The main source of regionally specific information on these variables remains the 1991 OPCS census. The Black and Ethnic Minority population represents 5.5% of the total population in the North West. Individuals of Pakistani ethnic origin comprise the largest of the ethnic groups and accounting for 31.4% of the total B&EM population. The B&EM population is a “young population” with larger proportions of this population in the younger age groups as compared to the White population. Over fifty percent of the total B&EM population was born in the United Kingdom. Ninety two percent of individuals categorising themselves in the OPCS 1991 census as “Black Other” were born in the United Kingdom. Fertility was highest among women from Bangladeshi and Black-Other ethnic groups. Home ownership was lowest among Black Caribbean, Black African and Black Other ethnic groups. Overcrowding in households was highest among Bangladeshis.

CHAPTER 4

Young People from B&EM Populations
in the North West of England

4.1 Introduction.
This chapter has been included in this report primarily for two reasons. Firstly, young people represent the vast majority of the B&EM population in the North West. Secondly, they represent the future for “Black people” in this country - their achievements have the capacity, unlike at any time in the past, to impact on British society as no previous indigenous minority ethnic population has had.

The factors which affect the health, the health needs and access to health services for B&EM populations in the North West of England (and in the United Kingdom as a whole) are changing with every generation. Increasingly a larger percentage of this population is being born in the United Kingdom, 53% of the total B&EM population in the North West at the time of the 1991 census (OPCS 1992), and this in itself has secured some advantages for B&EM youth over their fore-parents. This chapter reviews how this and other issues impact on the health and well being (in its widest context) of young people from B&EM communities in the North West.

4.2 Demographics of the Young B&EM Population in the North West.
The OPCS 1991 census showed that the age structure of the B&EM population was distinctly different from that of the White British population with the demographic pattern of B&EM showing relatively fewer persons over the age of 65 years and relatively larger numbers in the younger age groups. This younger demographic pattern can be illustrated further by reviewing the proportions of the population for each ethnic group, comprising persons 0 to 24 years of age (Figure 4.1).

Figure 4.1

Only the Black Caribbean population had a proportion of 0 - 24 year olds similar to that of the White British population. Black other, Bangladeshi, Pakistani and Indian populations recorded significantly higher proportions (71%, 66%, 62% and 51% respectively).

One important consequence of these differences in the demographic profiles of the various ethnic groups, is that this pattern will determine the future growth of the various ethnic populations in the North West. There will be wide variations by the year 2001 in the number of women of child bearing age (15 - 44 years) in the different ethnic groups (Figure 4.2).

Figure 4.2
By the year 2001, the Black Other, Pakistani and Bangladeshi populations in the North West, will see significant increases in the size of their child bearing populations (women 15 - 44 years); Black Other and Bangladeshi populations realising an almost 50% increase and the Pakistani population a 39% increase. Black Caribbean and Indian populations will see smaller increases, 4% and 15% respectively. At the same time, the White British population will realise a 4% decrease.

If the present fertility rates of the various ethnic groups remain the same, it can be expected that the ethnic composition of the population of the North West will change considerably during the 21st Century. In particular, young people of Black and Ethnic Minority ethnic will comprise a significantly larger proportion of the total young population.

4.3 Family life
There is little dispute that family structure and family life has a profound effect on the social development of young people. It is within this setting that values and attitudes are to a large extent developed, decisions about right and wrong are made (though not necessarily reflecting those of the family unit), life goals are set, levels of potential determined and emotional support provided (Elder 1995). Further, the family remains an important source of the physical means (including financial resources) with which young people can seek to attain their full potential.

It is not possible to make judgements about the quality of family life in an individual family based on whether that family is a married couple family unit, a lone mother family unit, a lone father family unit or any of the other family type. However, there is a general agreement that the married couple family unit provides, a more beneficial environment for children (Wojtkiewicz 1993). Of much concern therefore, is the significant differences which exist in the family structures for the various ethnic groups in Britain. Data from the 1% sample of anonymised records from the 1991 census showed these differences quite clearly (Table 4.1).

<table>
<thead>
<tr>
<th></th>
<th>Married Couple</th>
<th>Cohabiting Couple</th>
<th>Lone other</th>
<th>Lone Father</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black Caribbean</td>
<td>34</td>
<td>8</td>
<td>54</td>
<td>3</td>
</tr>
<tr>
<td>Black African</td>
<td>61</td>
<td>3</td>
<td>33</td>
<td>4</td>
</tr>
<tr>
<td>Other Black</td>
<td>41</td>
<td>9</td>
<td>49</td>
<td>2</td>
</tr>
<tr>
<td>Indian</td>
<td>92</td>
<td>-</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Pakistani</td>
<td>91</td>
<td>-</td>
<td>8</td>
<td>1</td>
</tr>
</tbody>
</table>
Bangladeshi  89  3  8  1  
Chinese      88  -  11  1  
Other Asian  88  1  9  3  
Other Ethnic Minorities  63  6  30  2  
White        78  6  16  1  

Source: OPCS 1991 census

Of the different ethnic groups, children of Black Caribbean, Black Other and Black African ethnic origin were the least likely to be in a married couple family unit (34%, 41% and 61% respectively); fifty seven percent (57%), fifty one percent (51%) and thirty seven percent (37%) were in lone other or lone father family units. Children of Indian, Pakistani, Bangladeshi and Chinese ethnic origin, on the other hand were the most likely (92%, 91%, 89% and 88% respectively) to be in married couple family units. For the North West, this suggests that at the time of the 1991 census, some 9,000 Black children were being brought up in households in which, according to present understanding, they have comparatively reduced chances of achieving their full potential. Of even greater concern is the expectation, as discussed in Section 3.2, that this number will increase dramatically in the 21st Century should marital and fertility patterns remain the same.

The initial immigrants brought their language, religion and culture with them when they came to the UK. Their offspring however, have a somewhat different history. Most were born in the UK. At the time of the 1991 census, 97% of African-Caribbean, 95% of Indian, 88% of Pakistani and 67% of Bangladeshi children under the age of 16 years had been born in the UK and into a society decidedly different from the one into which most of their parents were born. For parents of each generation and of all ethnic groups, there is often difficulty in relating to the “youth culture” of the subsequent generation. However, for many B&EM families there is the added complexity introduced by the differences in the birth histories (and as result possibly language, values and culture) which exist between parents and offspring. There are certainly clear differences in language preference which occur as a consequence of these differing birth histories. In the Health and Lifestyles Survey-B&EM (HEA 1993) for example, 51% of young adults of Indian ethnic origin reported that English was their main spoken language while in contrast only 8% of the eldest adults in this group reported the same. Furthermore, it is not inconsistent to expect that in the under 16 years age group, a percentage much greater than 51%, would report that English is their main spoken language. This difference in language preference and ability to communicate opinions, emotions and ideas in English will inevitably have considerably impact on parent-child communications.

4.4 Education.

Many early immigrants from non-English speaking countries were faced with the problem of not being able to understand the language which was predominantly spoken and written in this country. This is illustrated in surveys which have reviewed the language abilities of minority
ethnic groups. (The older age groups in these surveys would have comprised to a large extent these early immigrants.) Particularly among women and Bangladeshis, ability to speak and read English has been repeatedly found to be low (Table 4.2) (Rudat 1994, Modood 1997).

Table 4.2
Percentage reporting not being able to speak English

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Women 50 - 74 years</th>
<th>Men 50 - 74 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indian</td>
<td>53</td>
<td>14</td>
</tr>
<tr>
<td>Pakistani</td>
<td>85</td>
<td>33</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>79</td>
<td>49</td>
</tr>
</tbody>
</table>

Source: Health and Lifestyles Survey (B&EM)

For the present generation of young people from B&EM communities this particular disadvantage is rapidly becoming less important. This new generation mainly born into an English speaking society and educated in English schools now see English as their first language (in some cases their only language) with fewer being able to communicate in the mother tongue of their parents. Language ability however is only one of the many hurdles along the education path of B&EM and while this barrier has to a large extent been removed others still remain. These include a wide range of factors of varying severity and origin; many determined by the geographical location of B&EM groups within multiply-deprived areas.

There is little controversy over the relationship between achievements during compulsory schooling, higher education or vocational training and the potential for employment. Equally, employment improves the prospects for improving or maintaining social positioning and gaining command over material resources. This applies to all ethnic groups but for Black and Ethnic Minorities in particular, improving social status and gaining command over financial resources may be the only mechanism by which social disadvantage may be overcome or counteracted (Braodbent 1994).

Figure 4.3
The successes of B&EM youth at compulsory education however, has been variable; some groups attain significantly higher levels of achievement than the general population and others attain significantly lower levels. The Youth Cohort Study (Department for Education and Employment 1994) reviewed the achievements of 16 years olds and reported that only 21% of the Black pupils and 24% of Pakistani / Bangladeshi pupils attained 5 or more GCSE grades A to C. This compared to 51% for Other Asians (including Chinese), 45% for Indian and 43% for White pupils (Figure 4.3). How these achievements, both high and low, relate to factors within the social and economic structure of the different ethnic communities and to factors within the society in general has not been clearly defined. What is certain however is that they do have a profound effect and the lower achievements of Black, Pakistani and Bangladeshi youths can be attributed to some extent to these factors (Plewis 1987, Lavin & Crook 1990, Broadbent 1994). Improving the prospects for these groups therefore will require addressing the wider social and economic issues as well as the system of education which presently exists.

In spite of the relatively lower achievements by Black and Pakistani / Bangladeshi pupils in compulsory education (as compared to White pupils) a greater percentage participate in post-compulsory education as compared to White pupils (Department for Education and Employment 1994) (Table 4.3). This has been suggested however to be related, at least to some extent, to the limited employment opportunities available to young B&EM adults (see Section 4.5).

Table 4.3
Participation in post compulsory full time education.
Percentage in each age group

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>16 year olds</th>
<th>17 year olds</th>
<th>18 year olds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pakistani / Bangladeshi</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Ethnic Minorities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indian</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Asian</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In 1991, the North West would have seen approximately (applying these rates) 140,000 sixteen, seventeen and eighteen year olds in post compulsory education, of these less than one in fifteen pupils would have been of B&EM groups, by the year 2001 (applying these rates) this will have increased to one in every ten pupils, an increase of 40%. These circumstances will require some fundamental changes in the educational system so as to accommodate the interests, competence, cultures and religious practices of this expanding minority ethnic population.

### 4.5 Employment.

In general, employment opportunities for young people from B&EM ethnic backgrounds are less than for the White British population. The Labour Force Survey of Spring 1995 showed this quite clearly with wide variations among the various ethnic groups, in unemployment rates for the 16 - 24 years age group, being recorded (Table 4.4) (ONS 1995).

**Table 4.4**  
*Unemployment Rates 16 - 24 year age group*

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Percentage unemployed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>39</td>
</tr>
<tr>
<td>Indian</td>
<td>23</td>
</tr>
<tr>
<td>Pakistani / Bangladeshi</td>
<td>39</td>
</tr>
<tr>
<td>Other ethnic minorities</td>
<td>27</td>
</tr>
<tr>
<td>White</td>
<td>14</td>
</tr>
</tbody>
</table>

Source: Labour Force Survey Spring 1995

Unemployment rates for young Black, Pakistani and Bangladeshi adults were almost 3 times higher than for young White adults while for Indian and other ethnic minorities it was almost twice as high. In 1991, this would have represented approximately 15,000 sixteen to eighteen year olds requiring employment in the North West but not getting jobs, seven percent of whom would have been from B&EM groups. In the year 2001 (applying the same unemployment rates to the projected population), the position will have worsened for B&EM, with these groups accounting for at least 10% of the unemployed, even though for sixteen to eighteen year olds taken as a whole, the number of unemployed would have decreased. The argument here is that if
nothing is done to redress the inequality of employment opportunity presently faced by B&EM and the disparity in unemployment rates for the various ethnic groups remains the same, then relative to the White population, the situation for B&EM groups will worsen due to the changes which are expected in the demographics of the population in the North West.

4.6 Crime and Drug Use.
The perception that a relatively large proportion of crimes is perpetrated by persons from minority ethnic groups, in particular Black groups, still exists in the minds of many (Smith 1984). This perception would appear to be stimulated, at least to some extent, by the negative stereotypes of minority ethnic groups in the mass media and supposedly confirmed by the over representation of persons of African Caribbean descent in prison (Hood 1992). There is evidence however, that supports the view that the criminal justice system is permeated by systematic and institutional racism. This evidence proposes that persons of African Caribbean origin are more likely to be arrested and charged than their White counterparts for similar offences and if convicted are likely to receive harsher sentences (Gordon 1993). The results of the “Young people and Crime” study (Graham 1995) by the Home Office did not support the view that Black groups are responsible for a disproportionate number of crimes. On the contrary it reported that there was no significant difference in the proportion of young people aged 14 to 25 years from Black groups, compared to White persons of the same age, admitting to have ever committed an offence. Further, it suggested that the rates of admitted offending among Indian, Pakistani and Bangladeshi groups were significantly lower than among both Black and White groups (Figure 4.4).

Figure 4.4

In stark contrast to this perception of B&EM groups as the perpetrators of crime is the realisation that these groups are to a relatively greater extent the victims of crime as revealed in the British Crime Survey. In this survey, both for household offences and personal offences, B&EM groups were more likely to be victims of crime than White groups.

As with crime, the commonly held views about illicit drug use among the various ethnic groups, highest among young Black groups and very low among Indian, Pakistani and Bangladeshi groups, are unsubstantiated and at the very least unhelpful. For young Black people the stigma of being represented in this way could only add to the disadvantage which they already face. For Indian, Pakistani and Bangladeshi youth, the recognition and attention which this issue deserves could well be neglected.

In the Home Office survey “Young People and Crime” (Graham 1995), 37% of White respondents admitted to ever having used any type of illicit drug compared to 24% of Black
respondents and 20%, 14% and 6% of Indian, Pakistani and Bangladeshi respondents respectively (Table 4.5).

Table 4.5
Cumulative participation in Drug Use.
Young People 14 - 25 years

<table>
<thead>
<tr>
<th>Drug</th>
<th>White</th>
<th>Black</th>
<th>Indian</th>
<th>Pakistani</th>
<th>Bangladeshi</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td>34</td>
<td>22</td>
<td>18</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Heroin</td>
<td>1</td>
<td>&lt;1</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Methadone</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Cocaine</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Crack</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>9</td>
<td>&lt;1</td>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Any Drug</td>
<td>37</td>
<td>24</td>
<td>20</td>
<td>14</td>
<td>6</td>
</tr>
</tbody>
</table>

Source: Home Office Research Study 145 - Young people and Crime

This evidence contrasts sharply with some of the commonly held views about the prevalence of drug use and the ethnic preference for the various types of drug. The prevalence of ever-use of heroin and / or methadone, for example, was reported to be higher among Black, Indian and Pakistani respondents than among White respondents. The prevalence of ever-use of “crack cocaine” was reported to be three times higher among Indian respondents than among White respondents and 50% higher than among Black respondents. If these drug use prevalence ratios for England and Wales are applied to the 1991 census population and the 2001 population projection for the North West, then it becomes evident that whereas the number of white 14 to 25 year olds having ever-used any illicit drug would have decreased by 10% by the year 2001, the number of B&EM individuals of the same age group having ever-used any illicit drug, would have increased by 27% (Figure 4.5).

Figure 4.5

Problems of drug misuse are not limited to any one ethnic group and interventions to reduce misuse and the consequences of misuse must target all ethnic groups. Further, intervention strategies and resource allocation must take into consideration the demographic changes which are occurring and which will determine the numbers of young persons in the various ethnic groups involved in drug misuse (as proposed above).

4.7 Racism.
The specific forms racism takes are determined by the economic, political, social and organisational conditions of society (Mason 1995). This principle applies as well in the North West as it does in the United Kingdom as a whole. In this region racism therefore exists in its many forms; from racially motivated violence to individuals from minority ethnic groups (ONS 1996) to the less discernible institutional racism exhibited for example in the way B&EM are treated by the criminal justice system (see Section 4.6).

The old colonial model of race exploitation and cultural oppression rationalised with pseudoscientific race theories is loosing ground and in the process cultural elements of racism are becoming more prominent (Essed 1992). Race inferiority is increasingly reformulated as cultural deficiency, social inadequacy and technological underdevelopment (Rodney 1982).

Therefore for young people of B&EM origins the challenge of over coming racism exists today as it did for previous generations. There is however a distinct difference. The open display of racist feelings has certainly diminished to some extent but has been replaced by the requirement that B&EM individuals measure up to the ideal of White middle class culture and values which are constantly presented as the norm and positive standard. In this way racism is increasingly taking the form of cultural inferiorization (Essed 1992).

4.8 Summary.
Young people represent the vast majority of the Black and Ethnic Minority population in the North West of England. Although less affected by the language deficiencies of their fore parents they still face tremendous barriers to attaining their full potential. Family, economic, social and political circumstances are often not in their favour. Improving educational achievements and command over material resources will be one path to overcoming social disadvantage.

Chapter 5

Illness profile of Black and Ethnic Minority Populations in Britain

5.1 Introduction.
The illness profiles of B&EM groups are distinctly different from that of the general UK population with variations occurring from birth to old age. In general terms, B&EM individuals have shorter life expectancies and poorer physical and mental health (DoH 1992, Smaje 1995), and must often struggle with a health service which is not adequately equipped to deal with or adequately sensitive to their particular language, cultural and religious needs.
National data on the general health of the population is for the most part provided by the General Household Surveys, the Health and Lifestyles Surveys and Census data analyses. For the B&EM population, the census data was the main source of comparable information until the completion of the Health and Lifestyles Survey (B&EM) in 1993 (HEA 1994) and the Fourth National Survey of Ethnic Minorities in 1994 (Nazroo 1997). These surveys have given a better insight into the perceived health of minority ethnic groups at a national level and has also allowed more valid comparisons to be made with the general UK population.

5.2 General Health.
In the UK wide Health and Lifestyles Survey, 47% of the adult population (16-74 years) defined their health status as very good as compared to 43% for African-Caribbeans, 45% of Indians, 37% of Pakistanis and 35% of Bangladeshis in the Health and Lifestyles Survey of the Black and Ethnic Minority population. Further, whereas 2% of respondents in the UK wide survey reported that their health was very poor, 6% of African-Caribbeans, Indians and Pakistanis and 9% of Bangladeshis reported their health as being very poor in the B&EM survey. These responses suggested that with respect to the perception of their own general health, persons from minority ethnic groups considered their health to be worse than did the general UK population.

The rate at which self perceived general health was reported to decline with age was also significantly greater for the B&EM population. This was evident for both men and women as shown in Figures 5.3 and 5.4 which depicts the age and sex specific prevalence of reported poor general health for the different minority ethnic groups and the general UK population.

The findings of the Fourth National Survey of Ethnic Minorities was to a large extent consistent with those from the Health and Lifestyles Survey. Minority ethnic groups were found to report fair or poor health significantly more frequently than the majority White population. Pakistani and Bangladeshi respondents reported the worst self assessed general health and were fifty percent (50%) more likely to describe their health as fair or poor than the White population. Pakistanis and Bangladeshis also reported greater limitations to their activities as a result of poor health, than the other ethnic groups (Table 5.1).

<p>| Table 5.1 |
| Activities limited by ill health (Percentage of 16 to 74 year olds) |</p>
<table>
<thead>
<tr>
<th>Activity</th>
<th>White</th>
<th>All ethnic minorities</th>
<th>Pakistani &amp; Bangladeshi</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vigorous activities</td>
<td>19</td>
<td>18</td>
<td>24</td>
</tr>
<tr>
<td>Moderate activities</td>
<td>6</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Several flights of stairs</td>
<td>12</td>
<td>15</td>
<td>22</td>
</tr>
<tr>
<td>One flight of stairs</td>
<td>4</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Walk &gt; 1 mile</td>
<td>7</td>
<td>13</td>
<td>23</td>
</tr>
<tr>
<td>Walk 1/2 mile</td>
<td>4</td>
<td>9</td>
<td>17</td>
</tr>
<tr>
<td>Walk 100 yds</td>
<td>2</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Carrying groceries</td>
<td>8</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>Bending, kneeling, stooping</td>
<td>9</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>Bathing or dressing</td>
<td>3</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>

Source: The Health of Britain’s Ethnic Minorities

5.3 Specific diseases.
Past research has often failed to focus on the diseases which contribute most to the burden of ill health among minority ethnic groups (Ahmad 1994). Emphasis has often been on diseases where the relative risk of disease in B&EM groups relative to the White population has been shown to be high. This approach tended to limit research into the impact of diseases with lower relative risks for B&EM and which unfortunately were often those with high attributable risks. Tuberculosis provides a valid example of a disease where there was great interest in researching issues of ethnicity based on the finding that the relative risk of this disease in the population of immigrants from the Indian Subcontinent (ISC) was between ten and thirty times (30) higher than in the general UK population (MRC Cardio-Thoracic Epidemiology Group 1992). This disease accounts however, for only 1% of all deaths in immigrants from the Indian subcontinent over 20 years of age (Smaje 1994).

5.3.1 Mental Health.
The prevalence and incidence of mental illness among B&EM groups has been an area of disagreement for some time. In particular, the somewhat widely held view that African-Caribbeans are more prone to psychotic illnesses, more specifically schizophrenia, has been contested by some researchers (Mason 1995, Balarajan and Raleigh 1995). These disagreements on the occurrence of mental illness are not completely unexpected however and may be due to some extent to the very nature of mental illness itself. Whereas, most other disease processes generally have clearly defined objective measures by which diagnoses are made, diagnoses of mental illnesses are more inclined to be based on the subjective evaluations of psychiatrists. Further, these evaluations depend to a greater extent on the results of interviews with patients and...
less on investigative procedures than do evaluations of physical illnesses. As a consequence there is therefore greater room for variations in diagnoses among different psychiatrists. Diagnoses of mental illness in minority ethnic groups are considered to be further complicated by language difficulties, cultural differences between psychiatrists and patients, ethnocentric assumptions about behaviour, beliefs and deviance and straight forward racist stereotypes (Mason 1995).

There are however some observations which in recent times (see Box 5.1), have been presented with increasing frequency and are now being advanced as valid (some more so than others) by the majority of researchers and writers in the field of B&EM health.

**Box 5.1 - Mental Health of the Black and Ethnic Minority population.**
- Admission rates to psychiatric hospitals for African-Caribbeans are higher than for the general population (Coker 1994, Cochrane & Bal 1989).
- Diagnoses of schizophrenia among persons admitted to psychiatric hospitals are 3 to 6 times higher among African-Caribbeans than among the white population (Coker 1994, Cochrane & Bal 1989).
- Diagnoses of depression and anxiety are less likely among African-Caribbeans than among the general population (Lloyd 1993).
- African-Caribbeans are more likely to be subjected to harsh and invasive types of treatment including intramuscular injections and electro-convulsive therapy, more likely to be placed in secure units, to be described as aggressive and to be hospitalised compulsorily under the Mental Health Act (Dunn & Fahey 1990, Davies 1996, Bhat 1996).
- Caribbean-born people have lower rates for suicide and parasuicide than the general population (Burke 1976, Soni Raleigh 1992).
- Diagnoses of schizophrenia among persons admitted to psychiatric hospitals are 3 times higher among Asian males than among the white population (Coker 1994, Bhat 1996).
- Suicide rates among women from the Indian Sub-continent and men and women from East Africa are higher than those for the general population (Soni Raleigh 1992, 1990).
- Suicide rates among Asian women 15-24 years are more than twice the national rate and 60% higher in Asian women aged 25-34 years (Soni Raleigh 1992, 1990).
- Psychiatric patients from B&EM groups make less use of psychiatric services (Donovan 1992, Kareem 1989).
- The ethnicity of a patient influences the clinical predictions and attitudes of practising psychiatrists (Lewis 1990).

**5.3.2 Coronary Heart Disease (CHD) in the General Population.**
In England and Wales, Coronary Heart Disease (CHD) remains the major cause of death both before and after the age of 65 years, with approximately 150,000 persons (80,000 men and 70,000 women) dying each year from this cause (Donaldson & Donaldson 1993).
From an international perspective, this puts England and Wales among the territories with the highest rates of death from this disease with the CHD death rate in England and Wales being more than twice the rate in the United States and more than ten times the rate in Japan (Figure 5.5) (WHO 1987).

In 1985, mortality from CHD peaked in England Wales, when 163,104 CHD deaths were recorded (Davies & Davies 1993). From this time onwards however, rates have been declining slowly but as shown in Figure 5.6 more so among men than among women. It has also been suggested by several researchers that this decline has been more so among the better off members in the society than among the poor (Whitehead 1992, OPCS Monitors quoted in Davies & Davies 1993).

5.3.3 CHD and the B&EM population.

Much of the data which is presently available on the mortality experience of B&EM populations is based on work carried out by Balarajan and Bulusu (Balarajan & Bulusu 1990). They reviewed the mortality experience of immigrant populations using death registration data which records the country of birth of the deceased and population denominators obtained from the 1981 census in which respondents were asked to name their country of birth. The ethnic categories in the analyses which they carried out were therefore related only to country of birth and were to some extent different from the ethnic categories used in the 1991 Census. Further, these analyses, also as a consequence of the way in which ethnic groups were defined, excluded non-White individuals who were born in the United Kingdom. In this review of immigrant mortality, individuals from the Indian subcontinent (ISC) recorded the highest standardised mortality ratios for coronary heart disease with death rates being 46% higher among women and 36% higher among men from this part of the world as compared to the total female and male populations respectively. Both male and female immigrants from Ireland and male immigrants from the African Commonwealth recorded similarly higher mortality from CHD. For women born in the African Commonwealth, there was no statistically significant difference in the recorded mortality from CHD compared to the general female population. Men and women from the Caribbean Commonwealth both recorded statistically significant lower mortality from CHD (Figures 5.7 and 5.8).

Figure 5.6
Figure 5.7
Figure 5.8
This early description of the varying mortality from CHD among the various ethnic groups suggested a much greater risk of death from CHD for immigrants from the Indian subcontinent (ISC). This finding has also been reported for individuals from this geographical region in several other countries (Collins 1996, Seedat 1996). Such evidence of increased risk of CHD among immigrants from the ISC which is based on the analysis of mortality data has since been substantiated by findings from studies which have looked at CHD morbidity. A review of ischaemic electrocardiograph (ECG) abnormalities among the mainly Punjabi community in West London, for example, reported a prevalence of abnormal ECGs (suggesting ischaemia) in 17% of 40 - 60 year olds in this population as compared to a prevalence 12% in European men (McKeigue 1993).

However, while there is clear evidence that the risk of CHD varies among ethnic groups and is particularly high in immigrants from the Indian subcontinent, the reasons why these variations occur have not been adequately determined. The following reviews some known risk factors for CHD and considers the impact of each of these in determining the variations in risk which have been observed.

5.3.3.A Diet. The association between raised total plasma cholesterol, raised low density lipoprotein (LDL) cholesterol and lowered high density lipoprotein (HDL) cholesterol and increased risk of CHD and the extent to which diet plays a role in determining these levels has been well established (Oxford Textbook of Medicine 2nd Edition). Opinions vary however, as to the effect of diet in explaining the increased risk of CHD seen among persons from the Indian subcontinent. This has been due to some extent to the conflicting evidence coming out of studies which have examined the fat composition of South Asian diets and the levels of total plasma cholesterol among South Asians as compared to White British (Potts & Simmonds 1994, Saukat & Cruickshank 1993). It has been suggested, that whatever the average level of cholesterol in South Asians, small increases may have long term effects and the threshold at which cholesterol concentration becomes important may vary among ethnic groups (Saukat & Cruickshank 1993). On the other hand, the HDL concentrations observed among African-Caribbeans has been shown to be consistent with the recognised reduced risk of CHD in this population (Beckles 1986, Saukat & Cruickshank 1993).

Research into the possible role of South Asian diets in increasing risk to CHD has also centred around the use of clarified butter (ghee) in cooking since ghee contains a high concentration of cholesterol oxides which are known to be both inflammatory and atherogenic in animal studies (Jacobson MS. 1989).

5.3.3.B Glucose tolerance, Insulin secretion and Diabetes. The established association between diabetes and CHD and the increased prevalence of diabetes in the ISC population has left investigators with the task of deciding to what extent the increased risk of CHD in this population is attributable to diabetes. Some researchers have suggested that the increased risk is
entirely attributable to the increased incidence of diabetes in this population (Woods 1989) while others have suggested that the degree of glucose intolerance may merely be a marker for defects of insulin secretion and action (Cruickshank 1991). Some studies have revealed positive correlations between levels of insulin and cholesterol and low density lipoproteins and negative correlations with high density lipoprotein concentrations suggesting that insulin resistance increases the risk of CHD (Hughes 1990). The increased levels of insulin and C peptide in response to a glucose load seen in South Asians compared to White British and African-Caribbeans has therefore given weight to the argument that the increased risk of CHD in this population may be due to this disordered insulin response (Knight 1992, Cruickshank 1991). Further, the finding that in general, abnormal glucose metabolism is not associated with increased insulin secretion or increased plasma levels in African-Caribbeans is in keeping with the observation that this group reports the lowest mortality from CHD amongst all ethnic groups in the UK.

5.3.3.C Smoking. Cigarette smoking is well documented in numerous research studies as a dose related factor for CHD with the level of risk increasing with the number of cigarettes smoked per day. Of similar importance is the finding that ex-smokers exhibit reduced risk, with the risk of CHD declining rapidly after quitting to approximately half in about a year. Earlier impressions of the smoking rates among South Asians had been based on responses to the General Household Surveys of 1978 and 1980 which suggested that smoking prevalence was low among South Asians, 2 1/2 times lower than in White British (Balarajan & Yuen 1986). This led to the conclusion by some researchers that smoking could not explain the increased risk of CHD seen in this population (Shaukat & Cruickshank 1992). However subsequent local surveys and the recently completed Health and Lifestyles Survey of the B&EM population has challenged these earlier findings.

In the Health and Lifestyles Survey of the B&EM population smoking rates among South Asian women were found to be considerably lower than rates among women in the general UK population, for all age groups. Further, among women of African-Caribbean ethnic origin the smoking rate for the total 16 to 74 years age group (17%) was significantly lower than for women from the general UK population (29%). However, in the youngest age group of 16 to 29 year olds, there was no significant difference between rates for African-Caribbean women (30%) and that for the general UK population (31%). Among men, rates were found to be considerably closer than previously reported, to the smoking rates for the general UK male population and for some sub-groups they were significantly higher. Among the total 16 to 74 years age group Bangladeshi men recorded the highest smoking prevalence (42%) and there was no significant difference among the smoking rates for African-Caribbean (29%), Pakistani (30%) and UK (29%) men. Smoking rates among Indian men (20%) were lowest for all groups (Figures 5.9 & 5.10). Based on this recent information, there clearly needs to be a review of the role smoking plays as a risk factor for CHD among South Asians.
5.3.3.D Haemostatic factors. The role of the pre-thrombotic state and defects in the fibrinolytic system as predisposing factors for CHD among minority ethnic groups have also been researched. Of particular interest is the proposed relationship between Factor VIIc and post-prandial triglyceridaemia since high levels of circulating triglycerides in the blood are in turn related to insulin resistance which is of specific relevance to the South Asian population as described earlier (Miller 1989). Further, it has been observed that the time taken to break down thrombin varies among ethnic groups with rate of break down being slowest among Gujerati Indians and fastest among African-Caribbeans (Miller 1988). Both of these findings are consistent with the observed ethnic differences in CHD mortality.

5.3.3.E Body size and morphology. Studies in the UK have suggested that there is no significant difference in the prevalence of obesity between White British and first generation immigrants from South Asia and the West Indies (Bose 1995, Shaukat & Cruickshank 1992). These studies however used body mass index as a measure of obesity. Subsequent studies comparing the anatomical distribution of body fat, however, have suggested that South Asians have significantly more truncal fat as compared to White British (Bose 1995). This tendency towards truncal adiposity has been shown to be associated with the risk of CHD with this increased risk being mediated through effects on insulin secretion and action (Cruickshank 1991).

5.3.3.F Physical exercise. The role of physical exercise in reducing obesity, improving general health and reducing risk of CHD has prompted much research into the level of leisure time physical activity among UK residents. The Health and Lifestyles survey reported low participation in leisure time exercise among persons of ISC ethnic origin as compared to the general UK population. This finding has been supported by local research in Bradford which recorded even lower levels than the national survey (Knight 1993).

5.3.4 Diabetes and Black and Ethnic Minority populations.
Diabetes mellitus is a syndrome resulting from a variable interaction of hereditary and environmental factors, and is characterised by abnormal insulin secretion, inappropriately elevated blood glucose levels, and a variety of end organ complications including nephropathy, retinopathy, neuropathy, and accelerated atherosclerosis (Oxford Textbook of Medicine 2nd Edition).

Current classification distinguishes the following subclasses:
1. Insulin dependent diabetes (IDDM).
2. Non-insulin dependent diabetes (NIDDM)
3. Diabetes associated with certain conditions and symptoms
5. Impaired glucose tolerance.

The subclasses which pertain mainly to Black and Ethnic Minorities are non-insulin dependent diabetes (NIDDM) and gestational diabetes. In general, non-insulin dependent diabetes occurs in persons over the age of 30 years most of whom are obese (90%) and with variable insulin levels associated with insulin resistance. Gestational diabetes defines the situation where glucose intolerance develops or is discovered during pregnancy, often during the 2nd and 3rd trimesters, and usually disappears or becomes sub-clinical following the end of the pregnancy.

5.3.4.A Non-insulin dependent diabetes. Early research undertaken by Balarajan and Bulusu suggested that for specific B&EM populations, the mortality from diabetes was far greater than that for the White population (Balrajan & Bulusu 1990). This particular study however (as discussed previously) was based on data collected at death registration and was therefore only able to focus on persons whose place of birth was outside of the United Kingdom. Since information on country of birth and not ethnicity is collected at the time of death registration, studies such as these do not reflect the disease experience of the children of immigrant populations who were born in the United Kingdom. Further, it has also been established that mortality data under reports the extent of diabetes related death in Britain (Cruickshank 1989). These estimates, by Balarajan and Bulusu, of the increased mortality from diabetes experienced by B&EM, may therefore considerably underestimate the importance of this disease as a cause of death for B&EM populations. It does however, clearly illustrate, the significantly greater risk of the major complications of diabetes, which males from the Indian subcontinent, the Caribbean and the African Commonwealth and females from the Caribbean, experience.(Figure 5.11).

Figure 5.11

Mortality data alone, often do not represent the full extent of the impact of diseases on the population and this is particularly true for chronic diseases. Some other measures of the occurrence of these diseases and the non-fatal complications resulting from them are therefore required. In the case of diabetes, there have been several studies which have attempted to estimate the prevalence of this disease in ethnically defined populations, in various communities, in the United Kingdom. The results of these studies have consistently demonstrated the greater prevalence of this disease in B&EM communities (Cruickshank 1980, Dhawan 1994, McKeigue 1991, Simmons 1989, Simmons 1992, Simmons & Powell 1994, & 1994, Mather H. & Keen H 1985).
The reasons for this increased risk among B&EM population, have not been completely elucidated but there are suggestions that it may represent the expression of a genetic predisposition when the appropriate environmental factors are present - the thrifty genotype theory (Williams 1993, McCance 1992). The evidence proposing that the increased risk of diabetes in the B&EM population, is due to a genetic predisposition is impressive and among the South Asian population in particular, insulin resistance and altered insulin secretion and the relationship of these with genetically determined factors has been the focus of much research (Dhawan 1994, Gelding 1994, Knight 1992, Knight 1992, Proietto 1995, McKeigue 1991, Gelding 1994, Sacks 1996).

The importance of environmental factors however, in determining whether this genetic predisposition to abnormal insulin secretion and the subsequent development of inappropriately elevated blood glucose levels, is expressed, cannot be undervalued. Epidemiological studies have documented the role of increasing age, greater obesity, longer duration of obesity, unfavourable body fat distribution and physical activity as major risk factors for NIDDM (Simmons 1992, Virtanen 1994, Harris 1995, McKeigue 1991) The evidence from these studies not only helps to fill some of the gaps in the understanding of the aetiology and pathogenesis of this disease but more importantly identifies additional targets for public health interventions aimed at reducing the occurrence of this disease and its complications.

5.3.5 Cancer and the B&EM Population.
Cancer remains an important cause of death in the UK and is second only to CHD among the leading causes of death. Early research, once again by Balarajan and Bulusu, into the impact of these conditions among UK immigrants suggested that the mortality from all cancers taken together, was significantly lower for most B&EM groups than it was for the general population and for only the Irish born population was mortality from all cancers taken together found to be higher.

5.3.5.5 Specific cancers. With respect to mortality from cancer of the breast, rates were found to be lower for women born in the Indian subcontinent, the Caribbean Commonwealth and the African Commonwealth, while for women born in Ireland there was no statistically significant difference from the mortality rates seen for women from the general population. With respect to cancer of the cervix, mortality was significantly lower for women born in the Indian subcontinent and the African Commonwealth, while for women born in Ireland and the Caribbean Commonwealth, mortality from cancer of the cervix was not significantly different from that observed for women from the general population. For both men and women born in the Indian subcontinent, the Caribbean Commonwealth and the African Commonwealth mortality from cancer of the lung was lower than for the general population while for both men and women born in Ireland it was significantly higher.
Among the minority ethnic population, mortality from cancer of the liver and intrahepatic bile ducts was shown to be higher for men in all groups and not significantly different for women in all groups. With respect to cancer of the lip, oral cavity and pharynx mortality was shown to be higher among men born in Ireland and all groups of minority ethnic women except women born in the Caribbean Commonwealth (Figures 5.12, 5.13, 5.14 & 5.15).

The are some limitations in using this pioneering work to describe the present mortality experience of B&EM populations in the UK and even more so the incidence of cancer among these groups. Clearly, the data relate to a period some time in the past when predisposing factors for cancer may have been very different. Further, the study reviewed the mortality of immigrants who, at the time to which the data relates, represented the majority of the adult B&EM population. Presently however, a greater percentage of B&EM population are being born in the UK and are therefore being exposed to environmental and lifestyle factors increasingly similar to that of the general UK population. Some researchers suggest that the pattern of morbidity and mortality from cancer is progressing to one which approaches a pattern between that which is seen in the “home” country of immigrants and that which is experienced by the general UK population - the migrant effect (Balarajan and Raleigh 1995, Smaje 1995). This proposal is consistent with some of the changes in lifestyle factors which have been reported in the Health and Lifestyles Survey (B&EM) and which have been a source of concern for public health practitioners - in particular, the reported increase in the prevalence of smoking among men from the ISC and the change to more western diets.

Chapter 6

Use and Experience of Health Services

6.1 Introduction
There is relatively little information on variations in the use of health services, both primary and secondary care services, by minority ethnic groups and this is due to the limited availability of
data on the ethnicity of health service users. Ethnic monitoring of users of secondary care which was introduced in April 1995 should have provided substantial data on the use of at least hospital based services. However, only recently has levels of ethnic monitoring reached a point where some useful conclusions can be made from these data. Ethnic monitoring in primary care is in its infancy and useful information at a national or regional level will not be forthcoming for some time yet.

The Health and Lifestyles Survey (B&EM) and the Fourth National Survey of Ethnic Minorities both explored issues related to the use and experience of health services by B&EM individuals. The following describes some of the findings from these surveys and makes some estimations for the North West of England and some projections for the future.

6.2 General Practice services
An important finding from both the Health and Life Styles Survey (B&EM) and the Fourth National Survey of Ethnic Minorities was that registration with a General Practitioner (GP) was almost universal among B&EM individuals with only a very small percentage of persons reporting that they had not been registered with a GP. Previously, a similar GP registration ratio had also been recorded for the general population in the United Kingdom wide Health and Lifestyles Survey.

Although there were comparable GP registration rates for all ethnic groups comparisons made in these surveys of the frequency of use of GP services by the various ethnic groups revealed that important variations in GP attendance existed among these groups. In both the Health and Life Styles Survey (B&EM) and the Fourth National Survey of Ethnic Minorities, B&EM individuals were found to utilise GP services much more frequently than the majority White population. This finding was not unexpected as this had already been established by earlier researchers (Blakemore 1983, Balarajan 1989, Mc Cormick 1990). More significant however, was the estimation of the extent to which this frequency of usage exceeded that for the UK population in general, the variations which occurred among the groups which made up the B&EM population and the increases which occurred in GP services usage among the older age groups of the B&EM population.

For the general population, the annual GP consultation rate was estimated from the UK wide Health and Lifestyles Survey to be 3.6 consultations per person per year. From the Health and Lifestyles Survey (B&EM) however, for African-Caribbeans it was estimated to be 4.2, for Indians 5.0, for Pakistanis 7.1 and for Bangladeshis 7.9 consultations per person per year (Figure 6.1).
Only for African Caribbeans and Indians, do the GP consultation rates approach that for the UK population; for Pakistanis and Bangladeshis they are approximately twice as high.

When the pattern of GP service usage for the different age groups in the B&EM population are compared with the corresponding age groups in the general UK population, larger differences in GP consultation rates among the older age groups, as compared to the younger age groups, for the B&EM population, are revealed. This is illustrated (as an example) in Figure 6.2 for women 16 to 74 years of age.

**Figure 6.2**

The Fourth National Survey reported similar findings. Minority ethnic groups were much more likely to have seen their GP in the month prior to this survey with about one in eleven Caribbean, Indian and Bangladeshi respondents and more than one in ten Pakistani respondents seeing their GP three or more times in the month preceding this survey as compared to about one in twenty for the White population (Table 6.1) (Nazroo 1997).

**Table 6.1**

<table>
<thead>
<tr>
<th>Number of visits to the General Practitioner</th>
<th>Percentage of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the month prior to survey</td>
<td></td>
</tr>
<tr>
<td><strong>White</strong></td>
<td><strong>Caribbean</strong></td>
</tr>
<tr>
<td>0</td>
<td>66</td>
</tr>
<tr>
<td>1 - 2</td>
<td>30</td>
</tr>
<tr>
<td>3 - 5</td>
<td>4</td>
</tr>
<tr>
<td>&gt; 5</td>
<td>0.6</td>
</tr>
</tbody>
</table>

Source: Fourth National Survey of Ethnic Minorities

These differences in GP consultation rates for the various ethnic groups which are outlined above have important implications for the provision of GP services in general but more so for the provision of GP services for B&EM groups.

The following is a comparison of the estimation of the number of GP consultations (as an example) by 16 - 74 year old women (White and ISC) in the North West of England which would have occurred in 1991 and a projection for GP consultations for the year 2001. Estimations for 1991 were made using data from the OPCS 1991 census and estimated GP consultation rates from the Health and Life Style Surveys. Projections for the year 2001 were made using relatively crude population projections from the 1991 census and the same GP consultation rates used in the 1991 estimations.
These calculations indicate that the absolute number of GP consultations to the population of White women in the North West of England is far in excess of those to women from the ISC (in 1991 - 12.6 million GP consultations for White women compared to approximately 300,000 for women from the ISC) (Table 6.2). This is not unexpected since women from the ISC represent only 2% of women in this age group.

### Table 6.2
**GP consultations in the North West of England**
**Women 16 - 74 years**
**Estimations for 1991 and 2001**

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>Indian</th>
<th>Pakistani</th>
<th>Bangladeshi</th>
<th>Indian Sub Continent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 2001</td>
<td>12,800,000</td>
<td>131,000</td>
<td>284,000</td>
<td>47,000</td>
<td>461,000</td>
</tr>
<tr>
<td>Year 1991</td>
<td>12,600,000</td>
<td>95,000</td>
<td>186,000</td>
<td>30,000</td>
<td>311,000</td>
</tr>
<tr>
<td>Increase</td>
<td>200,000</td>
<td>150,000</td>
<td></td>
<td></td>
<td>150,000</td>
</tr>
<tr>
<td>% Change</td>
<td>2%</td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

It is expected however, that the number of GP consultations to women in this age group and in these ethnic groups (White and ISC) will increase from the 1991 level to a significantly higher level by the year 2001. This prediction is based on the understanding of the changes which will occur in the demography of the population over the ten year period and on the assumption that the differences in age specific GP consultation rates for the various ethnic groups will not change dramatically during this time. Thus, where as there will be an expected 2% increase in GP consultations for White women, by the year 2001, the equivalent increase for women of the ISC ethnic origin will be approximately 50% (Figure 6.3).

### Figure 6.3
Further, the total increase in GP consultations for all women in this age group in the North West of England, is expected to be approximately 350,000. As many as 43% of these projected extra consultations will be provided to women of the ISC ethnic origin (Figure 6.4).

### Figure 6.4

#### 6.3 Hospital services.

Evidence from the Fourth National Survey of Ethnic Minorities suggested that overall B&EM men were less likely than White men to have been admitted to hospital in the year prior to this survey. This difference was however related to age and in the age group 55 to 74 years rates of hospital admission among South Asians exceeded those for White men (Table 6.3). Among women, hospital admission rates for Pakistani, Bangladeshi and Caribbean women exceeded
those for White women. This excess admission rates at least for Pakistani and Bangladeshi women appeared to be related to the higher fertility rates among these groups (Table 6.4).

Table 6.3
Hospital in-patient stays in the past year by age and gender
Percentage of respondents

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>Caribbean</th>
<th>Indian</th>
<th>African</th>
<th>Asian</th>
<th>Pakistani</th>
<th>Bangladeshi</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 - 24 yrs</td>
<td>4</td>
<td>12</td>
<td>4</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>25 - 34 yrs</td>
<td>9</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>35 - 54 yrs</td>
<td>9</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>55 - 74 yrs</td>
<td>14</td>
<td>11</td>
<td>16</td>
<td>17</td>
<td>20</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>&gt; 74 yrs</td>
<td>24</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>10</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

|                |       |           |        |         |       |           |             |
| **Women**      |       |           |        |         |       |           |             |
| 16 - 24 yrs    | 15    | 10        | 8      | 5       | 9     | 20        |             |
| 25 - 34 yrs    | 19    | 18        | 17     | 19      | 17    | 12        |             |
| 35 - 54 yrs    | 8     | 16        | 9      | 6       | 17    | 12        |             |
| 55 - 74 yrs    | 9     | 8         | 10     | 16      | 21    | 9         |             |
| > 74 yrs       | 20    | *         | *      | *       | *     | *         |             |
| **Total**      | 13    | 11        | 11     | 11      | 15    | 15        |             |

|                |       |           |        |         |       |           |             |
| All respondents| 11    | 10        | 10     | 9       | 11    | 10        |             |

Table 6.4
Hospital in-patient stays for Childbirth in the past year by age and gender
Percentage of respondents

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>Caribbean</th>
<th>Indian</th>
<th>African</th>
<th>Asian</th>
<th>Pakistani</th>
<th>Bangladeshi</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Women</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 - 24 yrs</td>
<td>5</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>10</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>25 - 34 yrs</td>
<td>10</td>
<td>7</td>
<td>12</td>
<td>11</td>
<td>16</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>35 - 44 yrs</td>
<td>&lt;1</td>
<td>2</td>
<td>&lt;1</td>
<td>&lt;1</td>
<td>8</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>11</td>
<td>13</td>
<td></td>
</tr>
</tbody>
</table>

Source: Fourth National Survey of Ethnic Minorities

The evidence from both surveys suggest that although B&EM respondents in general, considered their health to be worse than the White population and visited their general practitioner more frequently they were less likely to be admitted to hospital. There are several possible conclusions which can be drawn from these findings. Two are presented here. Firstly, minority ethnic
individuals perceived their health to be poor and therefore presented more frequently to their general practitioners who after clinical assessment considered the level of ill health not to require hospital admission. Secondly, minority ethnic individuals perceived their health to be poor and therefore presented more frequently to their general practitioners who for reasons of communication or other difficulties did not recognise the severity of these patients’ illnesses.

The percentages of respondents reporting to have been admitted to hospital for at least one night in the year prior to the Fourth National Survey provides an estimate of first time for the year hospital admission rates. If these first time for the year admission rates are applied to the population of the North West of England, assuming that these rates apply equally well in this region, then some idea of past and future use of hospital services can be obtained.

For the purposes of illustration, as was done previously for GP consultations, these rates were applied to the 1991 census estimations of the population of White and Indian subcontinent women in the age group 16 to 74 years, in the North West of England and to population projections for these age groups for the year 2001. This calculation suggested that a minority of hospital admissions in 1991, were to women from these minority ethnic groups with approximately fifty times as many first admissions occurring to White women as to women from the Indian subcontinent - approximately 270,000 and 5,550 admissions to White women and women from the Indian subcontinent respectively (Table 6.5). This rather rough estimation of first hospital admissions is not inconsistent with records of actual admissions to hospitals in the North West since the Regional Office of the NHS Executive recorded approximately 300,000 admissions for all women in the age group 16 to 74 years in 1996.

When these first time for the year hospital admission rates are applied to the projected population for the year 2001 the results suggests that first admissions for White women will fall by approximately 1.5% by the year 2001 while first admissions to women from the Indian subcontinent will increase by 43% (Figure 6.5).

<table>
<thead>
<tr>
<th>Year</th>
<th>White</th>
<th>Indian</th>
<th>Pakistani</th>
<th>Bangladeshi</th>
<th>Indian Sub</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>266,000</td>
<td>2,500</td>
<td>4,600</td>
<td>850</td>
<td>7,950</td>
</tr>
<tr>
<td>1991</td>
<td>270,000</td>
<td>2,000</td>
<td>3,000</td>
<td>550</td>
<td>5,550</td>
</tr>
<tr>
<td>Increase</td>
<td>-4,000</td>
<td>500</td>
<td>1,600</td>
<td>300</td>
<td>2,400</td>
</tr>
<tr>
<td>% Change</td>
<td>-1.5%</td>
<td></td>
<td></td>
<td></td>
<td>43%</td>
</tr>
</tbody>
</table>

Table 6.5
Hospital (first) admissions in the North West of England
6.4 Summary.
Information on the use of health services is considerably limited. At the regional and local level it is sometimes necessary to make assumptions about health service utilisation based on the results of national surveys. The use of health services both primary and secondary differ considerably for the various ethnic groups. General Practice consultation rates for Black and Ethnic Minority groups exceed those for the general United Kingdom population. Rates for Bangladeshis are highest among minority ethnic groups. Hospitalisation rates for Black and Ethnic Minority men are less than for White men. Hospitalisation rates for Pakistani, Bangladeshi and Caribbean women exceed those for White women. The excess admission rates for Pakistani and Bangladeshi women may be related to their higher fertility rates.

The question which projections of health service utilisation (although quite crude) place before health service planners is whether due consideration is being taken of the demographic changes which are occurring in the population of the North West of England. It is likely that the ethnic mix of the population will change considerably in the future with minority ethnic groups accounting for a larger proportion of the total population. The needs of these minority ethnic communities are different in quantity and character and therefore appropriate changes in the way health services are delivered will be required.

Chapter 7
Part 1
Awareness of barriers to the use of NHS services experienced by Black and Ethnic Minority groups

7.1 Introduction
It was proposed that this review would evaluate the awareness of Directors and Managers in Health Authorities, of the barriers to accessing health services which minority ethnic groups faced. This would require more than a confirmation from them that they were aware of what national and international research suggested about this issue. The strategy therefore was to attempt to evaluate whether these Directors and Managers had in place the structures and procedures which would have been required to determine:-
7.1.1 Methodology for the investigation.

The methodology applied to achieve the study objectives was in the form of semi-structured interviews, administered over a number of visits to Health Authorities. The interviewer used a questionnaire (see appendix 1) to facilitate but not rigidly direct discussions around issues related to Black and Ethnic Minority health, use of and access to health services.

Interviews were carried out in all but three Health Authorities in the North West of England. These three Health Authorities did not take up the invitation to participate in this review. The Director of Public Health in each Health Authority was contacted in writing to explain the purpose of the review and to request an interview with the Director of Public Health or anyone the Director thought appropriate. Interviews were therefore carried out in some Health Authorities with Directors of Public Health and in others with persons identified by Directors. Interviewees from Health Authorities included five (5) Directors of Public Health, seven (7) Consultants or Senior Registrars in Public Health Medicine, thirteen (13) Managers (from various departments) and two (2) Health Visitor Managers. Interviews required responses under the following nine headings (see Box 7.1).

Box 7.1 - Topics explored in interviews

- **The population** - the demographic and socio-economic characteristics of the Black and Ethnic Minority population.
- **The service** - the characteristics of the health services provided to Black and Ethnic Minority communities.
- **The consultation** - the processes through which communities were consulted about their health needs and levels of satisfaction with health services.
- **The needs assessment** - the mechanisms by which health needs were assessed with particular reference to epidemiological health needs assessment.
- **The quality assessment** - the processes through which the quality of services were judged.
- **The needs** - the health needs of Black and Ethnic Minority communities
- **The living environment** - the physical characteristics of Black and Ethnic Minority neighbourhoods
- **The contracts** - the contractual arrangements with health care providers which addressed Black and Ethnic Minority issues.
The community - the social dynamics of Black and Ethnic Minority communities

The following summarises the responses from Directors and Managers within Health Authorities. It includes comments on these responses as they relate to an understanding of the level of awareness among Directors and Managers of the barriers to health services experienced by Black and Ethnic Minority communities within their respective Health Districts.

7.2 The Population - the demographic and socio-economic characteristics of the Black and Ethnic Minority population:

7.2.1 Demographic data.

It was considered that a most basic requirement for Directors and Managers in the Health Authorities would be an understanding of the composition of minority ethnic groups within their respective Health Districts - their ethnicity, their spoken and written languages and their socio-economic characteristics. Interviews began therefore with an exploration of what Directors and Managers knew about their minority ethnic populations, what their sources of information were and whether these information sources were limited in any way.

All Health Authorities interviewed depended to some extent on reports available from the OPCS 1991 census for data on the characteristics of their minority ethnic populations. In each instance the shortcomings of this source were clearly expressed and comments such as the following were common during interviews (see Box 7.2).

Profound frustration with the limited utility of OPCS data was expressed in four Health Authorities. Concern centred around the limited utility of this data source in defining ethnic populations with the level of precision and to the detail required for fine tuning initiatives and for planning services at the community level. In the same Health Authorities minority ethnic issues appeared to have been approached with greater diligence and notable efforts were made to add to the information which was available from the OPCS 1991 census. In two Health Authorities, there was what would have been considered as complacency had a less measured view been taken. In these Health Authorities, ethnic issues were not viewed as major priorities and therefore tackling the problem of obtaining recent and appropriate population data had not been given much thought.

7.2.2 Socio-economic data.

There are specific socio-economic circumstances which either directly or indirectly affect the health potential of populations (see Section 2.3) and there is little doubt that an understanding of the way in which these are distributed within the population gives some insight into what the level of the health service needs of the population may be and the ways in which these needs may be satisfied. Interviews therefore aimed to establish whether specific locality based information related to these socio-economic circumstances was available. Further, if it was, what the sources of this information might have been and whether the advantages and the disadvantages of using
these sources had been considered. In particular, emphasis was placed on the availability of information on employment, occupation, housing conditions, family size, car ownership and housing tenure.

All interviewees agreed that socio-economic characteristics represented important determinants of health and that they provided an important starting point for health service planning. However, the universal response throughout the North West region was that the major (and often the only source) source of information on these socio-economic circumstances was the 1991 OPCS census - the limitations of which have been discussed in Section 1.6 of this review. Clearly, there were substantial gaps in the locality based information related to these socio-economic variables available to Health Authorities. Only in situations where local surveys had been carried out (for example in the case of the Yemeni population in Liverpool) were there information sources to supplement the OPCS 1991 census data.

7.2.3 English language proficiency.
Inability to speak and read English has been recognised as an important barrier for some minority ethnic groups. This affects the capacity of these minority ethnic groups to know what NHS services are available, to use these services appropriately and as a consequence to obtain the benefits available from these services. Therefore, an appreciation by Directors and Managers in Health Authorities of the English language literacy of the minority ethnic population can be considered essential to understanding local issues of reduced access to health services. In all Health Authorities (certainly to some extent due to the difficulty in obtaining this type of information), the estimation of English literacy at the local was limited or non-existent. Often Directors and Managers depended on national estimates or on the subjective views of health care workers and community representatives. Three Health Authorities directly referred to sources of information provided by Local Authorities or endeavoured to estimate English Language and “mother tongue” language proficiency themselves through surveys or reviews of databases held by various organisations. Two Health Authorities used the level of utilisation of Local Authority translation / interpreting services to determine language capabilities of communities.

The importance of having information on the language capabilities of client populations cannot be overstated in a service which for the most part is English language based. The inadequacy of appropriate information sources therefore required addressing. The use of national language proficiency data (such as the Health and Lifestyles survey of Black and Ethnic Minority population and the Fourth National Survey of Ethnic Minorities) provided a starting point for understanding the local situation however variations do exist across the country, across regions and across districts. Using these national estimations to plan services locally could therefore account for some of the anomalies in the level of provision of interpreters and non-English publications which existed (see Section 7.11). Similarly, subjective views of community representatives and even health and social care workers could at times miss the mark. However,
of greater concern was the use of data on the utilisation of interpreters at primary and secondary care institutions as a measure of the level of language proficiency of communities. This approach not only ran the risk of under-estimating the prevalence of the inability of individuals to speak and read the English Language but also could easily foster a false sense of achievement among health service planners.

**Box 7.4 - Improving English language proficiency data.**

In the Wirral survey of Ethnic Minority groups specific questions of language ability were asked. However since the study sample had not been randomly selected it was not possible to make estimations for the general minority ethnic population.

The Liverpool survey of the Yemeni population provided a particularly good estimate of the English Language capabilities of this population. In the initial survey questions about ability to speak and read English were asked and this was followed up in the second survey with questions related to the ways in which limited English language abilities impacted on access to health services.

The Salford and Trafford Health Authority collected information on English language proficiency as part of the initiative to provide a “Profile of Black Communities in Salford”.

### 7.2.4 Demographic data on Ethnic sub-groups.

All Health Authorities recognised that important differences exist among the various ethnic sub-groups which comprised the rather broad classifications provided by the OPCS 1991 census (see Section 1.6). Indians in the 1991 census for example, included Punjabi Sikhs, Gujerati Hindus and Bengali Muslims. In general, these sub-groups were identified in Health Districts in the North West through networks within the communities and estimations of the size of these groups and their social and economic characteristics depended largely on the knowledge and experience of community workers and their relationships with community organisations. A common comment however by interviewees on the difficulty in obtaining information form community based organisations was that often these organisations considered the information which they held on their members as confidential and were therefore reluctant to share this information with the Health Authority.

**Box 7.5 - A comment on obtaining demographic information.**

There is a certain level of distrust among some community organisations for statutory organisations. They are willing to give only the barest of details on their members.

District Health Visitor.
Collaborating with community organisations required considerable efforts in developing trusting relationships with members of these organisations.

**Box 7.6 - Rebuilding relationships with community organisations.**

*The Wirral Health Authority had a particularly good example of how relationships with community organisations could be re-established. Health Authority personnel ensured that they took on board the issues which these organisations considered important and backed up their verbal commitment with resources.*

7.2.5 **Population projections and health service planning.**

With respect to Black and Ethnic Minority population projections and health service planning for the future there was no detailed reference to any structured analysis of how the minority ethnic population would change in the next decade or later and how this would impact on service provision. There were some expectations around the ageing of the population but almost universally the principal comment was that resources were geared at coping with the immediate issues and that there was little time to consider planning into what was considered the very distant future. There was no Health Authority where present initiatives were reported to be entirely influenced by long term projections of changes in minority ethnic population demographics or needs.

**Box 7.7 - Long term planning of Health Services**

*The West Pennine Health Authority did report that their plans for future development of their link-worker and interpreting services was based on their recognition of the on-going practice of brides being brought in from the Indian subcontinent thereby continuing the need for these services.*

7.3 **The service** - the characteristics of the health services provided to Black and Ethnic Minority communities.

7.3.1 **Catchment populations for health service providers.**

Interviewees were very confident that information was readily available on the types of hospital services which were offered in each Health Authority - for example the number of hospitals, the numbers of beds for each speciality and the number of staff in each speciality. However, details of the catchment population for each of these hospitals were not and as a consequence, the ethnic composition of catchment populations were unknown. This meant that an essential requirement for determining the level of services provided to minority ethnic populations was therefore also unavailable.

7.3.2 **Ethnic monitoring in secondary care services.**

In April 1995, a directive from the Department of Health instituted the ethnic monitoring of clients using hospital in-patient services. This initiative was aimed at determining the frequency
and types of services being used by the various ethnic groups within the population. The reasoning behind this initiative was to facilitate not only the estimation of service utilisation by minority ethnic groups but also after comparison with catchment population demographics to evaluate under-utilisation and in effect access to hospital services. The unavailability of ethnicity specific catchment population information would however have made this difficult, if not impossible, even with completed ethnic monitoring details.

Ethnic monitoring of hospital inpatients was admitted by all Health Authorities to have been difficult to institute. As a result, at the time of interview, the level of monitoring was variable among the hospitals within Health Authorities and also within the different specialities in individual hospitals. Efforts on the part of Health Authorities to ensure that this requirement for ethnic monitoring was met, were variable and not always consistent with the level of ethnic monitoring which was taking place. It was reported that much depended on the willingness and capabilities of hospital authorities and staff. The result was that in effect ethnic monitoring was yet to provide the wealth of information for determining access to services and utilisation of services which it promised (Ethnic monitoring is discussed further in Section 7.8).

### 7.3.3 Physical access to Health Services.

In light of the relatively lower level of car ownership among minority ethnic groups, physical access to health services has been considered to be an important barrier to access to health services for these groups (HEA 1994, Modood 1997). Some understanding therefore of the ways in which various communities arrived at locations where health services were being provided and the difficulties which arose in getting there, was considered to be useful in determining whether Directors and Managers in Health Authorities appreciated the extent to which physical access played a part in reducing access to health services. On no occasion did interviewees report that Health Authorities had initiated an investigation of the ways in which clients physically accessed health services for the sole purpose of determining difficulties minority ethnic groups might have been facing in getting to these services. However, on several occasions as a result of plans to re-locate or re-configure hospital services attempts had been made to estimate travelling times, travel routes and travelling costs to specific hospitals. Examples are provided in Box 7.8.

**Box 7.3 - Examples of initiatives aimed at improving data on local B&EM populations.**

*The Liverpool Health Authority* estimated its Yemeni population by doing a census of family units using “snowballing” techniques. This initiative stands out for several reasons. Firstly, it represents a direct attempt by the Health Authority to estimate the size and social characteristics of a client group which was unidentifiable from the census data. Secondly, it utilised resources within the community itself and within the academic sector in Liverpool to complete the census. Thirdly and most importantly it re-enforced
the necessity of gaining the confidence of communities, in this instance the Yemeni community, which allowed the census to proceed.

**The Wirral Health Authority** have sought to estimate its ethnic community by reviewing membership at the Wirral Multi-cultural Centre - a community based project from which Health and Social services are provided.

**The Ethnic Health Unit at the West Pennine Health Authority** has supplemented its understanding of the characteristics of its minority ethnic population and the way the demographics of this population is changing with the results of a census carried out by the Oldham Local Authority.

The Salford District Health Authority in collaboration the Salford Community Health Council and the Salford Family Health services Authority completed in 1993 a “Profile of Black Communities in Salford. This profile was based on interviews with community representatives and local health care professionals. It provided estimations of the size of the various ethnic groups in Salford as well as socio-economic and language characteristics of this population.

**Box 7.8 - Assessing difficulties in physical access to health services.**

In the **Bury and Rochdale Health District** as part of the Acute Services review estimations of travelling times, travel routes and travelling costs to specific hospital services within the Health District have been carried out. This review targeted all communities and did not provide specific information about minority ethnic groups.

In the **Wirral Health District** the re-location of Breast screening services to the Clatterbridge Hospital prompted a review of potential clients’ views of the physical accessibility of this institution.

**The West Pennine Health Authority** has completed a general review of public transport services to hospital services within the Health District. The Authority subsequently used place of residence as a proxy for ethnicity to determine the physical accessibility of these services for minority ethnic group. This was in recognition of the strong association between ethnicity and the geographical location of place of residence within the Health District.

In the **Salford and Trafford Health District**, the closure of the the Ladywell Hospital prompted a general review of transportation services to alternative hospitals.
In the Stockport Health District, the subjective view that public transport to the Stockport Healthcare NHS Trust was difficult for some communities, prompted a joint initiative between a local bus company and the Stockport Health Authority to improve the service to this hospital.

7.3.4 Information on General Practitioners.
An important consideration was whether minority ethnic groups had available to them General Practitioners (GPs) who belonged to the same ethnic groups as themselves or were able to speak the mother tongue languages of their clients. One way of assessing whether Health Authorities had available to them information which would allow some exploration of this issue was to determine what information Health Authorities held about the GPs in their respective localities. It was not ubiquitous in the North West for Health Authorities to obtain from their GPs information on ethnicity and languages spoken. However in some instances there were Health Authorities which not only collected this information but also attempted to make this information easily available to clients. A particularly good example was provided by the Stockport Health Authority.

Box 7.9 - Into Health - an initiative in Stockport

The Stockport Health Authority in collaboration with Stockport Healthcare NHS Trust established a drop-in information centre within the shopping precinct in Stockport city centre - appropriately named “Into Health”. Here individuals could obtain information on the GPs who were available within Stockport, their ethnicity, the languages which they spoke and any particular medical interests which the GP might have.

7.3.5 Information on Dentists.
There were no examples within the North West Region of similar information, as for general Practitioners, being available to Health Authorities (and as a consequence to the population) for Dentists. This was of particular concern in view of the results of repeated national surveys which showed that the level of dental caries was highest and the use of dental services the lowest among minority ethnic groups (HEA 1994, Nazroo 1997).

7.4 The Needs Assessment.
To determine whether there are barriers to the use of health services requires at the very least some idea of the need for particular services. Clearly need must be weighed against utilisation before any useful statements about access or barriers to access can be made. Therefore, a crucial part of the interview of Directors and Managers of Health Authorities was geared at determining the extent to which progress was being made in determining the health care needs of minority ethnic communities.

The various strategies used to assess the health care needs of communities are summarised in Box 7.10.
Box 7.10 - Strategies for assessing Health Care Needs.

**Corporate** needs assessment, in general terms, uses the knowledge and experience of health care workers and significant others within communities to piece together a picture of health needs. Often, the challenge lies in finding ways to reduce the potential for bias which is an inherent weakness of corporate needs assessment since the opinions obtained are clearly dependent on the individuals whose views have been canvassed.

**Comparative** needs assessment aims to match service requirements among like communities. Clearly difficulties arise when attempting to compare communities which are different with respect to demographic, socio-economic and ethnic characteristics (for these have a profound effect both on health needs and health service usage) and in the assessment of the need for newly developed or non-traditional services.

**Epidemiological** needs assessment takes a somewhat more objective approach to health needs assessment and requires reasonable estimates of the age and sex specific prevalence and incidence of ill health and the demographic characteristics of the communities concerned.

The corporate and comparative approaches although providing useful additional information on health needs cannot substitute for an epidemiologically based evaluation of needs. The focus of the interview therefore was to determine not only how progress was being made towards health needs assessment in general but specifically whether epidemiologically based methods were being employed.

As discussed in Section 7.2.1 detailed demographic data on minority ethnic groups was not readily available to most Health Authorities and therefore an important requirement for this epidemiological approach was already missing. Further, information at the local level, on the prevalence and incidence of ill health among minority ethnic groups was very limited. With the two key components for an epidemiological approach to needs assessment severely lacking there was little progress in Health Districts towards needs assessment along these lines. Two examples of attempts at epidemiological approaches to the health care needs assessment of minority ethnic communities are provided in Box 7.11.

Box 7.11 - Examples of epidemiologically based health needs assessment.

*The West Pennine Health Authority,* with funding from the Department of Health Ethnic Health Unit, endeavoured to complete an epidemiological needs assessment of minority ethnic communities in the Health District. This initiative was expected to involve local residents, to underpin the revision of National Health Service contracts and to inform the Local Authority decision making process. Results were mainly qualitative.
The Liverpool Health Authority commissioned a “Health needs assessment of Black and Ethnic Minority communities” which was completed in December 1995. This survey represented a concerted attempt on the part of the Health Authority to assess the health care needs of its diverse ethnic minority population. The resulting report was particularly strong in its qualitative statements about health needs and barriers to accessing health care experienced by minority ethnic groups. However it was much less forthcoming with respect to actually quantifying these health care needs.

7.5 The consultation - the processes through which communities were consulted about their health needs and levels of satisfaction with health services.

There was interest, in all Health Authorities, in establishing and maintaining links between Health Authorities and communities. All interviewees expressed a need for consulting and working in collaboration with communities and community based organisations. Whether this interest was fuelled by a realisation of the limitations of objective methods for determining the health needs of communities or their levels of satisfaction with the services which were being offered or by a real desire to incorporate communities in the decision making process, was uncertain. Consultation with communities was afforded at various levels and through various mechanisms within the NHS organisation and there were good examples of initiatives to involve communities in deliberations on service provision and service evaluation. These approaches provided three models which are described in Box 7.12.

Box 7.12 - Approaches to consultation with communities.

Model 1
The Wirral Health Authority considers the Wirral Multi-cultural Organisation, a community based, Health and Social Services supported organisation as the focus for consultations with the minority ethnic communities within the Wirral Health District. Meetings are held quarterly (as well as extra-ordinary meetings at various times) to discuss issues related to the health of minority ethnic groups within the Wirral Health District. These meetings are attended by the Director of Public Health for the Wirral Health Authority thereby allowing direct access to senior management personnel within the Health Authority.

Model 2
The Liverpool Health Authority has established a Health and Race monitoring group which incorporates community and Community Health Council representatives and senior management personnel of the Health Authority. The group is chaired by a community leader and the agenda for meetings are set by the members of the group. Meetings are held monthly when issues related to the health of minority ethnic
groups are discussed. Proposals are taken from this meeting to executive meetings of the Health Authority through a Neighbourhood commissioning manager who represents the Health Authority within the group.

Model 3

The Wigan and Bolton Health Authority has established a permanent middle management post within its commissioning department to address issues related to the health of minority ethnic groups within the Health District. The post holder, a minority ethnic person himself, has forged strong links with communities, community organisations and community leaders. His position within the Health Authority provides access to senior management personnel and this affords him the opportunity to place issues related to the health of minority ethnic groups on the agenda of the Health Authority. In effect, he acts as a link between communities and the Health Authority.

The extent to which consultations with communities influenced policies and practices could not be evaluated from the interviews. However, it was hoped that some idea of the ways in which Directors and Managers sought to ensure that the views of communities would be heard at senior levels within the Health Authority, could be obtained. Where the consultation process was more formalised (Model 2) minutes of meetings of the Health and Race Monitoring Group were routinely circulated to senior levels of the organisation. The onus was therefore on the individual who prepared these minutes to provide an adequate account of the discussions which had taken place and on senior managers to read these minutes. Where a less formalised approach at consultation was adopted (Model 3) a more opportunistic approach had to be taken to bring minority ethnic issues to key personnel within the Health Authority. Summaries of the results of consultations would be prepared and opportunities sought to get these on the agendas of various senior managers. The Model 1 approach adopted by the Wirral Health Authority was unique with community leaders having regular and direct access to the Director of Public Health, a key person with the Health Authority. This provided the opportunity for direct consultations at a senior level. It placed the responsibility on this Director to raise the issues arising out of these consultations with minority ethnic communities with senior colleagues. Each of these approaches clearly had advantages and disadvantages. Model 1 allowed direct access by communities to senior managers but would have limited the number of views which would be heard since attendees at quarterly meetings would have been restricted to selected community leaders. Model 2 provided a forum for regular discussions and the mechanism for documenting the conclusions from these discussions. However, it required that senior managers within the Authority follow the deliberations which were taking place within the Health and Race Monitoring Group from the minutes which were subsequently circulated. There was more flexibility in the Model 3 approach
and this allowed views from a number of community representatives to be heard. However, there was less structure in the way community views were then forwarded to senior personnel. Interestingly, both the Model 1 approach and the Model 3 approach suffered from an important weakness in that they were dependent to a considerable extent on single individuals within the Health Authority - in the case of the Wirral Health Authority, the Director’s of Public Health own personal commitment to minority ethnic issues and in the case of the Wigan and Bolton Health Authority the ability of the Ethnic Health co-ordinator to forge links with communities within the Health District. Although the approaches described in Box 7.12 have been attributed to one particular Health Authority this has only been for convenience of presentation. Similar strategies were adopted by other Health Authorities not referred to in the above. The Manchester Health Authority for example applied Model 3 while the North West Lancashire Health Authority applied Model 2. Further, Health Authorities did not apply only one method in their consultation strategies but, on occasion, used variations on all of these approaches, for example, the Wigan and Bolton Health Authority has renewed efforts to develop a community based Ethnic Health Forum.

The question, “with whom should Health Authorities consult?”, is not one for which there is any simple or legitimate answer. An immediate and unmeasured response though may well be that Health Authorities should consult as widely as possible. This is almost always not possible since there are no defined limits for how wide is wide enough. The pragmatic approach often taken therefore by Health Authorities in the North West was to consult with individuals who were thought to understand the issues which were being explored. This would have included community members and representatives, health and social service workers and academics.

**Box 7.13 - An approach to identifying community contacts.**

*The Bury and Rochdale Health Authority had a uniquely interesting and structured method for facilitating this approach. This Health Authority maintained a database of community contacts and their various interests, and used this database to select the appropriate individuals for consultation on specific issues.*

There was always the concern that views of individuals identified for consultations could be biased (or mis-informed), that Health Authorities would consult with individuals who put themselves forward (and who might not always be appropriate for the consultation) or that Health Authorities might only consult with individuals who were “easy to deal with” (and who might also not be appropriate for the consultation).

**7.6 The Quality assessment** - the processes through which the quality of services were judged.

The quality of the service provided by health care institutions, as perceived by the users of these services, can be related to the level of utilisation of these services by potential clients. Client based evaluations are therefore an important component of any understanding of why services
might be considered inappropriate and therefore less accessible to minority ethnic groups. Here we address how Health Authorities went about evaluating how minority ethnic communities viewed the services, both primary care and secondary care, which were being provided.

In general, Health Authorities used the same consultative mechanisms described in Section 7.5 for assessing clients views on the perceived quality of health services. In addition, the Salford and Trafford Health Authority had instituted a process of surveying minority ethnic communities on their level of satisfaction with the services offered within the Health District.

In all Health Authorities, much emphasis was reported to be placed on quality assurance criteria written into contracts with health care providers who reported on a predetermined basis on whether they had been able to fulfil these requirements. This approach although convenient for commissioners of health care services would have been limited in several respects. Firstly, health care providers were expected to evaluate themselves with respect to these quality criteria. Secondly, there was the distinct possibility that within the myriad of quality assessment criteria those relating to minority ethnic issues could easily be lost. Thirdly, the significance of these criteria to Health Authority personnel not familiar with minority ethnic issues would be limited. Fourthly, there was often no clearly defined relationship between these criteria and the quality of service eventually delivered to minority ethnic groups.

7.7 The Living environment and The Community.

The final sections of the interviews with Directors and Managers within Health Authorities sought to evaluate the availability of information on the physical environment of the neighbourhoods in which minority ethnic groups lived as well as community networks within these neighbourhoods.

In general, Directors and Managers in Health Authorities had rather broad views of the living environments of minority ethnic groups in their Health Districts and these were often based on their own experience of these neighbourhoods or on the reports of health and social care workers. In no instance did an interviewee report that the Health Authority had readily available to it, for example, details of the physical amenities available to residents of any particular neighbourhood. There was however, a general opinion that this information was available from within Local Authorities and could be obtained from these sources if required.

With regard to community networks, Health Authorities which had personnel assigned exclusively to overseeing minority ethnic issues had a better opportunity for understanding the social dynamics of minority ethnic communities. These Health Authorities, Manchester and Wigan and Bolton Health Authorities in particular, through the efforts of these designated personnel were able to develop extensive links with community organisations within their respective Health Districts.

7.8 Ethnic Monitoring.
Ethnic monitoring refers to the collection of data on the ethnicity of patients using health care services and incorporates the use of this data to assess health care utilisation and to improve the appropriateness of services for minority ethnic groups. The summary of discussions which referred to this ethnic monitoring requires special mention in this report for several reasons. Firstly, as a national requirement made compulsory by a directive from the Department of Health since April 1995, it provided a relatively well defined measure by which health care providers and in effect Health Authorities could be monitored for progress in addressing minority ethnic issues. Secondly, as a crucial step to developing quantitative elements for addressing issues related to health service usage and barriers to access to services, it provided an indication of whether Health Authorities could potentially apply quantitative variables to its planning processes.

In no Health Authority included in the interviews was there an opinion that ethnic monitoring had progressed to a level which would allow the quantification of the health needs of minority ethnic communities and the fine tuning of health care delivery for these communities. Coverage was variable among hospitals within the region. There were reports of ethnic monitoring coverage close to 100% in some hospitals and in others less than 50%. Ethnic monitoring in primary care was at an early stage of development. There was hope however that at two primary care sites within the region, one in Liverpool and the other in Wigan, that ethnic monitoring would be established before the end of 1998. This initiative, supported by the Department of Health, aims to provide a model of how ethnic monitoring can be introduced into a primary care setting and how the information obtained can be used to improve the appropriateness of health care services for Black and Ethnic Minority communities.

The key issues related to ethnic monitoring which arose during interviews are summarised in Box 7.14

**Box 7.14 - Issues related to ethnic monitoring.**

- There is no doubt as to the crucial importance of ethnic monitoring in both primary and secondary care as a means to determining disease morbidity, health service utilisation and access to health services.
- Ethnic monitoring must be along nationally agreed guidelines so as to allow across region and across district comparisons to be made.
- Ethnic monitoring must at the same time be locally appropriate. It must provide information which is useful for health service planning at the local level.
- To ensure uniformity health service personnel involved in ethnic monitoring procedures must be adequately trained.
- Communities must be involved in consultations concerning the need for ethnic monitoring data as well as the methodology for collecting this data. Without the support of the community progress will be difficult, if not impossible.
• Development of the procedures and the systems for using ethnic monitoring data must be an integral part of the initiative. Personnel involved in the use of this data will require training.
• Policy makers within Health Authorities and health care Provider Units must have a commitment to bring about changes to the ways in which health services are delivered.

Part 2
Access to Health Services for
Black and Ethnic Minority communities
in the North West of England

7.9 Introduction.
The following is based on discussions which were part of the interviews with Directors and Managers in Health Authorities and which were not covered in Sections 7.1 to 7.8. It includes as well, the results of interviews with Managers of Provider Units, Community Health Council Chief Officers, link workers and community representatives. It reflects the views of interviewees on issues related to access to health services for Black and Ethnic Minority (B&EM.) communities. Often these views were not based on the findings of scientific investigations but on the experience of individuals and their understanding of the conditions within their communities, localities or districts. These views might at times conflict with past and recent research findings from elsewhere in the United Kingdom (and reported in Chapters 2 to 6) but considering the well documented difficulties in researching many of these issues, these views should not / must not be under valued. More importantly it must be recognised that these views, in the absence of appropriate local research data, often form the basis for strategic planning of the provision of health services for B&EM communities in the North West of England.

7.9.1 Methodology of the investigation.
Interviews with individuals who were not Health Authority personnel took the same format as described in Section 7.1.1. Health care Provider Units to be interviewed were identified from the National Health Service Directory - North West. Institutions which were considered by the research team to be major providers of health services for Black and Ethnic communities were chosen from this directory. The basis for the choices which were made, was the geographical distribution of Black and Ethnic Minority communities in the North West of England. The same rational was used for selecting community health councils and link workers. Interviews with community representatives were opportunistic and resulted mainly from introductions by Community Health Council Chief Officers and link workers. In total, twenty seven (27) Health Authority personnel, eleven (11) Community Health Council Chief Officers, twelve (12) Provider Unit Managers, eight (8) community representatives and six (6) link workers were interviewed. Interviews were semi-structured in format (except for those
with community representatives which were un-structured) and interviewees were allowed the flexibility of exploring different topics as they arose.

7.10 A categorisation of factors which determine access.
Here we propose a classification of the factors which determine access to health services for Black and Ethnic Minority communities (see Box 7.15).

Box 7.15 - A proposed classification of factors which determine access to health services.

- Factors inherent to the users of the service - user factors.
- Factors inherent to the service itself - service factors.
- Factors inherent to the physical and social environment in which the services are delivered or in which clients live - environmental factors.

There is a complex relationship between these groups of factors. However it is useful to attempt to dissect out individual components in this way since this process can contribute to a better understanding of the particular problems of access which may be present in any particular situation. It is this clarity which may provide opportunities for finding appropriate solutions to problems of access. When services are not being utilised as expected or desired there is sometimes a tendency on the part of health service personnel to blame potential users of the service for the low uptake. However, individuals retain the right to use or not to use health services and they make these decisions based on their knowledge and understanding of the services being offered. Fundamental to this decision making process is a personal evaluation on the part of potential users, of the benefits to be obtained from using the services weighted against the costs of doing so. In addition, this decision on whether or not to make use of particular services, will be based on whether use of these services comes into conflict with cultural, religious or other values (Ahmad 1994, Scrambler 1991).

7.10.1 Factors inherent to the users of the service.
This step in this approach to identifying factors which affect access to health services for B&EM communities is by no means a way of apportioning some of the blame for under utilisation of health services to the users of services themselves. It must be viewed as a part of the process by which services can be evaluated for appropriateness and subsequently modified to match the requirements of the individuals for which they are intended. The consequences of these user factors can be considered to be variable in most instances, ranging from a situation where there is minimal effect on access to one where a particular factor can totally exclude individuals from specific services. Most often however, the consequence of these user factors are not clearly defined and therefore the extent to which they exert their effect on access cannot easily be determined. The user factors which were proposed, during interviews in this review, to have the most effect on decreasing access to health services in the North West are listed in Box 7.16.
Box 7.16 - User factors reducing access to health services.

- English Language proficiency.
- Mother tongue literacy.
- Religious restrictions.
- Cultural restrictions.

7.10.2 Factors inherent to the service. The way services are structured and delivered has a profound effect on their accessibility to B&EM communities (Smaje 1995). The present National Health Service which developed over the past fifty years as a service aimed at providing for the needs of a majority White, English speaking, western population has, not unexpectedly, reflected western concepts of health, illness and treatment and been founded on the values and expectations of the majority White population (Ahmad 1994). The resulting service has therefore often found difficulty in coping with the different values, cultures, religions and languages of the minority non-White population.

The service related issues which were considered by interviewees to affect access to health services for B&EM communities in the North West, are listed in Box 7.17.

Box 7.17 - Service related issues affecting access to health services.

- Quality of services
- Gender of staff
- Ethnicity of staff
- Racism and racial stereotyping

7.10.3 Factors inherent to the physical and social environment.

The ways in which factors in the physical environment can affect access to health services are often quite clear and ways of dealing with these uncontroversial. In contrast, factors within the social organisation of communities which affect access to health services (and ways of dealing with these) are often not as clear. To address these factors requires an clear understanding of (and respect for) community and family relationships, cultural values and religious beliefs. Difficulties with access to health services for B&EM communities should not be considered to be as a result of the pathological customs, values and beliefs of these communities but as a result of a lack of correspondence between their customs, values and beliefs and those on which the services were founded. The environmental factors which were considered by interviewees to impact on access to health services in the North West are listed in Box 7.18.

Box 7.18 - Environmental factors affecting access to health services.

- Economic situation
- Living environment
7.11 User factors affecting access to health services.

7.11.1 Language proficiency.
Limited ability or inability to speak and read English has been recognised nationally as an important barrier to accessing health services for many individuals from B&EM communities (Smaje 1995). All interviewees identified this as a key factor associated with the under utilisation of health services, in particular preventive services. This was not unexpected since limited ability to use the English language has important effects on a number of determinants related to service utilisation.

7.11.1.A English language literacy.
Interviewees reported that for some ethnic minority communities, particularly elderly women from the Indian subcontinent ethnic groups, not being able to read material related to health services which were being offered limited their access to these services. This view was consistent with national survey results of English language proficiency (Modood 1997, HEA 1994). They added that information on services in the local or national press or in promotional material distributed by the health services or other organisations was often in English only. This reduced the chances of individuals from these communities knowing the details of the services which were being offered or the benefits which could be expected from using them.

Box 7.19 - Comment of English literacy.
“Many of our community miss out on what is in the news about health issues. This is an important way in which people find out about what is available. They cannot read English... so they just do not know.”

District Health Visitor

The view was expressed that the front covers of brochures, pamphlets or other printed material were often designed to attract the attention of specific target populations since the first step to having these read was having them picked up. This was often done using attractive colours, patterns and words. The potential attractiveness of the English words used in this way however, was lost to non-English reading persons. As a result, the frequency at which printed material in English was likely to be picked up by persons not able to read English was less than would be desired. This reduced the opportunities for these to be translated at a later date for the individuals concerned, by a family member or a significant other. Other comments are listed in Box 7.20.

Box 7.20 - Comments on English language printed documents.
“Often people will not take up things (information brochures) they are not sure about. They are sometimes afraid that they will pick up something offensive or embarrassing to their families.”

Health Promotion Manager.

“We should people pick up paper that is of no use to them”

Health Promotion Manager.

To overcome this particular limitation related to printed material in English, many organisations reported that they had set about producing promotional and educational material in languages other than English. In the North West, most Health Districts were supplied with nationally and locally produced material of this type either produced by national organisations, various health service providers, departments within District Health Authorities and Local Authorities or voluntary organisations. There was a general agreement however, that the number of topics which these covered were limited and that there was a clear need for providing more printed material in appropriate languages. In order to address this deficiency, a number of publications were presently being considered by several organisations within the North West. These varied widely in their proposed content - from printed material detailing the services offered within health institutions and how individuals could gain access to these services to information on lifestyles and health.

However, while the arguments for the need to produce printed material to advertise services or to inform individuals about health issues had received a sympathetic hearing from some within National Health Service and within other organisations, the feeling among many, in particular those who worked most closely with communities, was that the benefits to be gained from this use of resources might be limited. This opinion was supported by the anecdotal accounts of multilanguage printed material being produced but rarely being used for the purposes for which they were intended. More convincing arguments had been provided by surveys of the language and literacy skills of Black and Ethnic Minority communities (Modood 1997, HEA 1994). These surveys reported on the limited English and mother tongue literacy abilities of some communities such as the elderly female Bangladeshi population for whom these leaflets and other written word presentations would be of limited value (see Section 7.2.3). Even for the literate, information translated from English to mother tongue languages had often been less useful than would have been desired. The reasons for this appeared to lie firstly, in the difficulty of translating some types of information and some concepts from English into languages where the equivalent words or expressions did not exist and secondly, in ensuring that these translations reflected the cultural and social structures within the communities for which they were intended. Related comments are listed in Box 7.21.

Box 7.21 - Comments related to the usefulness of printed material.
“Individuals who can read mother tongue languages are often the better off members of the community. They often speak and read English as well. The persons we really want to reach usually can’t read their language.”

Health Service Manager.

“Sometimes I wonder where people go to get things translated …some (translations) are just awful…”

Community Leader.

“There are some things that you just cannot translate easily.”

Health promotion Manager.

These controversies around the possible benefits to be gained from multi-language printed material were further complicated by the limited agreement among Hospital and Community Trusts, General Practices, Health Authorities and Social Services departments on how printed material meant to inform individuals from B&EM communities should be financed. Health Authority personnel proposed that providers of health services (Hospital and Community Trusts) should provide appropriate printed material for clients as part of the contractual arrangements which existed. Managers from Provider Units on the other hand found this difficult to accept and argued that services might have to be compromised if funding was not made available from the present budgets to fund these publications.

Although there did appear to be many difficulties associated with the use of printed material to inform Black and Ethnic Minority communities there were situations where they were appropriate and had the potential to provide significant benefits. There was therefore a need (even a responsibility) to find solutions to these difficulties and some of these potential solutions which came out of the interviews are presented in Section 7.14.

7.11.1.B Ability to speak the English language

Using any service in which there is difficulty in understanding what is being said or in expressing oneself, clearly does not facilitate obtaining the greatest benefit from that particular service. In a general sense the level of benefit obtained can be related to the level of English language ability. For individuals therefore with the least English language ability, the comparison of the benefits gained from using the service with the costs incurred in doing so may well weigh heavily on the cost side of the equation. B&EM users of health services, as would be expected, were reported to place great importance on having a good understanding of what was being said to them and on being understood when they attended health services. This was evident from the comments of link workers / interpreters who reported on the level of dissatisfaction expressed by some non-English speaking users of health services (see Box 7.22).
Further, an integral component of any service offered, in primary care or in secondary care settings, is the information and counselling which goes hand in hand with the medical treatment which is provided. Very often this is more important and of greater value to the patient than the tangible component of the treatment. For non-English speakers, this component can be completely inaccessible if adequate provisions are not made.

7.11.1.C. Interpreters / translators

A number of initiatives were reported to have been instituted (or were in the planning stages) to address issues related to difficulties some B&EM individuals face in understanding health care workers who in the main were only English speaking. These initiatives centred around providing interpreter / translator services, establishing or extending link worker services, producing multi-language audio and video tapes and making health staff with multi-language skills available whenever possible (see Section 7.14). Translator / interpreter services, in particular, were considered by interviewees, to be an essential requirement, when health services were to be provided for elderly South Asians and Chinese, and Yemenis and Somalis. However, there was some disagreement on how these services should best be provided and on whether the level of service which was available at the time of interview was adequate for the level of need. It was not uncommon for Health Authority and, Hospital and Community Trust representatives to consider the present arrangement for interpreter services to be adequate. In contrast, translators / interpreters and community representatives usually reported that these services were severely inadequate for meeting the needs of communities. When confronted with this inconsistency, Hospital and Community Trusts often referred to their own assessment of the need for interpreter services which were usually based on payments for these services or use of these services. These assessments, by their very nature, were not able to establish the true need for interpreters since they only included information on when the services were used and neglected instances when interpreter services were requested but were not available or when they should have been requested but were not (see Section 7.2.3).

All interviewees from Hospital and Community Trusts admitted that family members (and in some institutions members of staff from minority ethnic groups) provided an important alternative to established translator / interpreter services. There was however little indication that this could prove inappropriate at times. In contrast, when community representatives were interviewed strong concerns were expressed about the use of family members to provide translations, in particular the frequency with which, children were doing interpretations for parents in quite delicate situations. Some of the comments which were made are listed in Box 7.23.

Box 7.23 - Comments on the use of family members as interpreters.

“Much too often children are translating for their parents. This is just not right.”

Link Worker.
“Does the doctor leave out really personal questions he should ask .... about sex for example......when children are translating for their parents.”

Link Worker.

“Children have to translate very personal things for their mothers at times. This is not right”

Community Leader.

When interviewees from NHS institutions did report that they considered their translator / interpreter services inadequate they often added that this was due to the limitations of the organisations, usually Local Authority translator / interpreter services, which provided the institutions with this service. A common concern was the difficulty in obtaining interpreters in times of an emergency or after normal working hours.

There was the view among all interviewees, including translators themselves, that translators / interpreters do have special training needs. It was recognised that some understanding of common medical terminology and the working of the National Health Service was essential. Further, it was considered necessary for these individuals to receive training in methods for interviewing patients, for working with communities and for working alongside health care personnel.

Box 7.24 - A training initiative in the West Pennines.

The Connect-4-Health project, a collaborative venture between the West Pennine Health Authority, the NHS Trusts and Tameside Council, provides training for local Asian people in various aspects of health and related areas of work. Training modules have included; communication and research skills, the structure of the health service and the Local Authority and opportunities in health service employment.

7.11.1.D Link workers.

There was a general consensus among interviewees that the role of link workers should go beyond providing translation services. There was the view that an important element of their responsibilities should lie, as their title implied, in providing links between the health service and communities. Further, that they should be expected to play a key role in informing communities about the services which were available, about healthy lifestyle choices and about diseases and their treatments. Finally, they should provide a mechanism through which communities could express their views about the services they were receiving and about the services they desired. This concept of the role of link workers was also held by link workers themselves but they complained that their time was so taken up by the requirement for translating and interpreting that they had very little time for providing other services. Interviewees from Health Authorities and Hospital and Community Trusts agreed that link workers played an important role in improving
the health of B&EM communities. They however reported that limited resources were available and to extend these services might require cutting back on other already established services.

7.12 Service factors affecting access to health services.

7.12.1 Staffing in the NHS - Gender.
There was a general consensus that although some White women preferred to be seen by female health personnel this requirement was significantly more critical for women from B&EM communities. This view has been strongly supported by recent evidence from the Fourth National Survey of Ethnic Minorities carried out by the Policy Studies Institute (Nazroo 1997) which showed that as many as seventy five percent (75%) of Pakistani women and eighty three percent (83%) of Bangladeshi women preferred to be seen by a female doctor as compared to nineteen percent (19%) of White women. This preference for female doctors by B&EM women, in particular Moslem women, was reported to be not adequately satisfied within the North West. Further, it was suggested that this deficiency might be reducing access to specific services for these women, cervical screening services in particular.

7.12.2 Staffing in the NHS - Ethnicity.
A major concern among health care commissioners and providers and community representatives were the difficulties and limitations which often arose out of less than desirable communications between B&EM clients and health care workers. Clearly language proficiency; health care workers able to adequately speak and understand the primary language of their clients or clients able to adequately speak and understand the primary language of health care workers, is of considerable importance. However, a good appreciation of the social structure and cultures of B&EM communities and of the health beliefs and values of these communities is also crucial. Having health care workers belonging to the same ethnic group as their clients would appear to be a desirable situation as it might fulfil both of these requirements. There was little expectation among interviewees that this situation could be achieved. Interviews with health care commissioners and providers in Health Districts in Lancashire however suggested that to some extent, this correspondence between the ethnicity of health care workers and that of their clients, at least in primary care had already been achieved. Communities of South Asian ethnic origin were reported to being seen by South Asian General Practitioners to a large extent. However, there had been very little deliberate attempts on the part of Health Authorities to encourage B&EM general practitioners to work in areas where their clients would be from similar ethnic groups and this situation had to a considerable extent developed on its own. This facility which the South Asian community in Lancashire was reported by interviewees to enjoy reflected the experience of the South Asian community nationally and in the Health and Lifestyles Survey (B&EM) it was reported that four out of five South Asians attend a general practice with a South Asian doctor (Rudat 1994).
Box 7.25 - Comment on the ethnicity of General Practitioners

“Most Asians are already being seen by an Asian GP. Whether they are using a language other than English to communicate we don’t know.”

Ethnic Health Advisor.

There was no evidence from interviews that this correspondence of ethnicity extended to other ethnic minority groups and to other members of the primary health care team. Reasons for this deficiency were attributed to the scarcity of general practitioners from other ethnic groups and to the limited number of individuals from minority ethnic groups in the nursing and other professions allied to medicine. One view expressed by an Ethnic Health Advisor in Lancashire was that the present situation was about to worsen. This was based on the understanding that the present generation of health professionals (General Practitioners) from minority ethnic groups were closely approaching retirement age and that few individuals from minority ethnic groups (other than from the Indian and Chinese communities with respect to medical doctors) were entering training programmes to replace these health professionals. Concern was also expressed that the new generation of medical doctors would not have as good an understanding of the values and cultures of minority ethnic communities as their predecessors since the vast majority of them would have been born and educated in middle class England.

7.12.3 Quality of service.

National surveys including the Health and Lifestyles Survey (B&EM) and the Fourth National Survey of Ethnic Minorities have suggested that B&EM communities primarily as a result of their concentration in deprived inner city housing areas were restricted to using primary care services which were limited in capacity (GP practices were often single handed practices) and in the variety of services which they offered. The view that this generalisation applied equally well in the North West was held by a number of interviewees. Further, it was reported to be an important barrier to access to specific services both in the primary and in the secondary care sector. In the primary care sector, primarily because they were just not available. In the secondary sector, because general practitioners remained the most important gate-keepers and channels for services in the secondary sector. Improving the capacity of primary care services was therefore considered by these interviewees to be an important step to improving access to services in general for B&EM communities.

7.12.4 Health needs assessment.

In order to obtain the greatest possible health gain from the provision of medical services it is necessary to develop services which can efficiently and effectively satisfy the health needs of communities for which these services are intended. As a starting point however, to determining which services should be offered and how these services should be structured, an assessment of the health needs and an understanding of the demographic, cultural and social characteristics of these communities are required. Determining the demographic characteristics of the communities
for which services are intended is therefore a crucial step in assessing health needs and designing appropriate services. However, the demographic data which were most readily available to commissioners and providers of health service were significantly limited in its reliability and in its level of detail (see Sections 7.2.2 and 7.2.4). This was particularly relevant when the data related to smaller communities. This deficiency imposed severe limitations on the strategic planning process and all interviewees commented on the difficulties faced in finding appropriate sources of demographic and socio-economic data which were applicable to smaller population groups (see Section 7.2.4).

7.12.5 Racism and racial stereotypes.
There is still a substantial amount of feelings of racial prejudice by members of the White community towards ethnic minorities and this has been brought out in a number of surveys including the Fourth National Survey. In this survey more than one in every four White interviewees admitted to being prejudiced against Asians and one in five against Caribbean people (Modood 1997). Feelings of prejudice are sometimes exhibited in the form of outright harassment, verbal abuse or physical violence but much more often expressions of prejudice take the form of subtle infringements of the rights of ethnic minorities (Essed 1991).

It is optimistic to think that the health service would be spared a characteristic (racial prejudice) which appears to be so widely prevalent in the general society. However, Health Authorities, Hospital Trusts and Community Health Council personnel (except for one Chief Officer) did not seem to think that racial prejudice was any longer a major barrier to services for B&EM communities. In contrast, were the opinions of some community representatives. One community leader expressed the view that the perpetrators of racial prejudice existed at all levels within the health service; that the very limited expenditure on established services and new initiatives to improve access for B&EM communities was evidence of this prejudice; that the lesser referral of B&EM individuals for specialist services was to some extent the result of negative stereotypes of B&EM communities held by health care workers; that the words and actions of some health personnel gave the impression that they viewed B&EM communities to be over using services.

7.13 Environmental factors which affect access to health services.

7.13.1 Economic situation.
The economic situation in which individuals live affect their health in a number of ways including their access to health services and this effect on access is mediated through factors related to each of the three categories (user, service and environmental factors) identified in Section 7.10.

Interviewees agreed that on a practical level, economic circumstance determined to a considerable extent the capacity to physically get to locations where health services were
delivered. It determined whether resources were available to use the family car or whether there was a family car, whether resources were available to use public transport, or to pay for child minding services or whether time could be taken off from work. There was the view that as elsewhere in the United Kingdom, B&EM communities represented some of the least well off population groups and therefore for these groups the difficulties of getting to health services remained a significant problem. There was also the view that for many B&EM communities public transport services was the major means of transportation and where these services were limited or non-existent, individuals might as a result be less inclined to attend health facilities particularly for preventive health care. Community representatives reported on the difficulties in “having to change buses in the city centre to get to health facilities”, “having to wait for transport for a long time at bus stops” outside peak times and the “high cost of using the public service”. These difficulties were reported to become much more severe for families with young children who must be carried along to clinic appointments because of the limited availability of child minding services.

7.13.2 Religion and culture.
Interviewees agreed that in some communities religious and cultural practices were limiting the access members of these communities had to some health services. It was however added by one interviewee that this limitation of access should not be viewed as a negative consequence of these cultural or religious practices but as a failure of health services to adapt to the differences of minority ethnic communities. Managers in Health Authorities and Provider Units often expressed their frustrations about the difficulties in persuading individuals from some communities to respond to, for example, invitations for breast and cervical screening, family planning clinics or dietary counselling. There was an understanding however that the difficulties encountered were to some extent inevitable. Conflicts existed between what the social and religious structures in the community required or expected and what potential users of the services needed to do to access these services. Moslem women for example, were hampered from accessing services which were not staffed by female personnel.

7.13.3 Crime and personal violence.
The 1992 British Crime Survey indicated that persons who live in poor communities are more likely to be victims of crime than those who live in better off communities (Mayhew 1993). If this statement applied equally well to communities in the North West, it would be expected that B&EM communities would be exposed to significantly greater levels of crime than the general population since, as nationally, these communities represent some of the poorest within the region. What was suggested by one interviewee was that for a significant number of individuals from minority ethnic groups a considerable amount of insecurity and fear had developed. It was his view that this fear and insecurity arose as a result of the crime and racial harassment which individuals might have personally experienced or their families and friends encountered. Further, it was proposed that this insecurity and fear limited the freedom of some members of these
communities to go and come as they pleased. It forced individuals to develop strategies to ensure their safety such as not going out without their partner or in the dark and it therefore had a negative impact on access to health services.

7.14 Strategies for improving access to health services.

7.14.1 Written word - Topics and audiences.
The under-utilisation of printed material and the limited benefits realised from the expenditure on them might well be related to the limited understanding of the specific needs, interests and characteristics of the populations for which these publications were intended. Health service commissioners and providers were greatly handicapped in their planning by the limitations in the information which is available to them on the demographic and social characteristics of the Black and Ethnic Minority populations which they served. It should not be unexpected therefore that the situation described above would often arise. The solution would appear to lie in knowing as much as possible about the target communities and this has been discussed in Section 7.2 and is considered further in more detail subsequently.

7.14.2 Written word - Funding.
The issue of funding the production of printed material could be addressed to some extent through collaboration among health service commissioners and providers across the North West Region. In this way the production costs for publications which are common to Health Districts could be shared thereby reducing the eventual costs to the individual organisations. For publications specific to particular organisations as much of the general information as possible could be printed centrally and the more exclusive parts added by the respective organisations. Finally, the co-ordination required could be provided by the Regional Office of the NHS (North West).

7.14.3 Written word - Appropriateness and clarity.
Issues related to the limited appropriateness and clarity of the content of some publications were not uncommon criticisms of interviewees. Health service organisations were in the process of developing or introducing ways of producing publications free from these effects. The most commonly reported strategy was to utilise the resources which existed within communities to provide translation and consultancy. Community members, often local link workers, community based organisations or community leaders, were asked to provide advice and information. Using the communities for whom publications were intended, in this way, provided a number of important benefits. Key informants within communities provided information on both issues which were considered important to the respective communities as well as ways in which publications could be structured to make them more acceptable and comprehensible. Further, their involvement gave significantly more ownership of the process to the target communities. This had the additional effect of enhancing the acceptability of the productions. In some instances
Community members were paid for the services which they provided and although there was still some disagreement about whether community members used in this way should be paid or not, the benefits of bringing additional resources into a community could not be denied.

**Box 7.26 - An initiative aimed at using resources within communities.**

*The Bury and Rochdale Health District* provided a good example of the way in which communities could be utilised to provide appropriate written material for its residents. *The Women’s Health handbook* commissioned by the Health Authority and produced by the Rochdale Health Promotion Unit utilised minority ethnic communities to decide on the topics to be included in the handbook as well as women in the community to compose and translate sections of the text. Its success has led to proposals to produce a audio tape version of the handbook.

### 7.14.4 Demographic characteristics.

Data obtained from the 1991 census was the most readily available data on the size and characteristics of B&EM populations. However, besides being now quite out of date and limited for the reasons expressed in Sections 1.5 and 1.6 they are of diminishing validity and reliability as the size of the population to which they refer decreases. At the *locality* level therefore there was a great deficiency of demographic data and the ability of Health Authorities and Hospital and Community Trusts to plan services for B&EM communities was significantly hampered by this (see Section 7.2). To address this short coming, in some Health Districts attempts had been made to supplement what information was available from the census with community based or ethnic group based surveys commissioned by the Health Authorities themselves or in collaboration with Social Services departments, with surveys carried out by Local Authorities or with data obtained from other sources including the Labour Force Survey. The Oldham Local Authority had carried out a particularly detailed population survey which included information on several socio-economic characteristics and population projections and this was being used by the West Pennine Health Authority. Other attempts used post code based population characteristics (together with a local knowledge of the geographical distribution of B&EM communities) as proxy measures for the size and characteristics of local B&EM communities.

**Box 7.27 - Efforts at matching client and health professional ethnicity.**

It was generally recognised that B&EM communities have within the communities themselves health professionals, trained in both western and alternative medicine. They have not been allowed however, the opportunity to use their skills in the formal setting to address the health needs of their respective communities. *The North Mersey Community Health Care Trust* attempted to identify these health professionals and to find ways in which they could be incorporated into the established health teams. Unfortunately, the success of these initiatives to date, with respect to professionals trained in western medicine was reported to be limited. The comment was made that there were difficulties in having the qualifications of medically trained professionals recognised by the official professional bodies in the United Kingdom and further,
that there were no established programmes or resources for the retraining of these professionals. However, there have been some successes in using medically trained professionals in other capacities such as link workers and health educators as was the case in the Bury and Rochdale Health District. Professionals skilled in alternative medicine have continued to practice their profession outside of the established health service but there were only vague comments on efforts to collaborate with them in providing care to communities.

When health professionals from minority ethnic groups were available in the secondary care setting there were special efforts in some provider units to ensure that the clients’ ethnicity matched those of health care workers. Reports of this practice were relatively common among providers of maternity services and health visitor services with Chinese, Caribbean and South Asian nurses and health visitors being assigned to patients from respective communities. The Liverpool Women’s Hospital for example, used this approach when ever it was appropriate.

A number of interviewees expressed the view that Health Authorities and Trusts had some responsibility for ensuring that the ethnic composition of health staff reflected that of the communities which they served. Some Trusts, the Central Manchester Healthcare NHS Trust for example, were actively canvassing communities in their catchment areas for new workers when vacancies arose. It was admitted however that these vacancies were limited to non-clinical posts. The Central Manchester Healthcare NHS Trust was also actively involved in encouraging young people from B&EM communities to consider professions in the health services - nursing, physiotherapy, chiropody and other professions, by having their present staff participate in career guidance counselling for young people in neighbouring communities.

7.14.5 Matching ethnicity.

In the primary care setting, for South Asians in Lancashire in particular, there was considerable correspondence between the ethnicity of clients and that of their general practitioner. However, as stated in Section 7.3.4 this correspondence often did not extend to other minority ethnic groups or to other professions within the health service. This situation was thought to be related to the unavailability of appropriate staff. In interviews, various approaches to this perceived problem of unavailability of appropriate staff were mentioned. Some of these were already part of the strategy to enhance the ethnic constitution of primary care teams while others were possibilities for the future. There were no reports of deliberate efforts on the part of Health Authorities to encourage doctors of minority ethnic origin to work in minority ethnic communities. Any efforts along these lines were limited to the GP practices them selves.

7.14.6 Matching gender.

Having female members of staff, medical doctors as well as other professionals, to provide health care for B&EM women, particular Moslem women, was considered to be an important step to improving access to health services for these women. Examples of clinics with all female staff were provided by the Liverpool and Wirral Health Districts. In these clinics all services, clinical as well as non-clinical, were provided by female staff members. It was reported that these clinics
were particularly attractive to Moslem women and to have been successful in improving access to services such as family planning and cervical screening.

**Box 7.28 - An initiative to provide a clinic for women staffed by female health care workers.**

_The Muslim and Multicultural Well Women’s Project in Liverpool provides weekly clinics for women. These clinic sessions are staffed by female personnel and are supported by four part-time bi-lingual Health Linkworkers._

### 7.14.7 Cultural awareness.

Cultural awareness programmes for staff were reported by all interviewees as potentially useful in bringing about a better appreciation of the various cultural and religious attributes of B&EM clients. Many programmes had already been carried out some as one off exercises and others on an on going basis. In the Royal Liverpool University Hospital NHS Trust and in the Central Manchester NHS Trust cultural awareness programmes were reported to be an on going process in view of the relative frequent turn over of staff. Some of these programmes had been developed and run by members of the health service organisations themselves while others had been developed in collaboration with non-health sector organisations involved with B&EM issues. The Mancunian Community Health NHS Trust and the Central Manchester NHS Trust for example, developed programmes in collaboration with the Manchester Action for the Health of Ethnic Minorities (MACHEM) a community based resource centre on Black and Ethnic Minority issues. It was generally agreed that programmes of this nature would be best developed in collaboration with local communities and with the assistance of organisations with special expertise in developing such programmes.

### 7.14.8 Translators / Interpreters / Link workers.

There was agreement that translators / interpreters services were essential when providing health services to non-English speaking individuals and there were several initiatives reported during interviews, which were aimed at improving the quality and availability of these services.

### 7.14.9 Audio material.

In the Bury and Rochdale Health Authority progress was reported to have been made in using audio tapes as a mechanism for informing non-English speaking communities about health issues. The view held in this Authority was that for some B&EM communities audio tapes had become established as one means by which individuals not able to write in their own language were able to keep in contact with their families abroad. For many telephone contact was considered expensive and mailing audio tapes to family members was considered a useful alternative. This
strategy therefore relied on this familiarity with and acceptability of audio messages and the relative availability of tape recorders in the community.

7.14.10 Video material.
There was agreement that there was great value in using video material as a means of providing health information. However, reports were that the high cost involved in their production limited their use. Two proposals which will involve video technology were mentioned during interviews. One being developed by the Health Promotion Unit at Rochdale will provide video taped information for South Asian diabetics and the other by the North Mersey Community Health care Trust will document on video elements of a project to improve access to mental health services for B&EM communities.

7.14.11 Local radio.
Health Authorities, Hospital and Community Trusts have used local radio stations to promote health issues either by providing information for broadcast or by having members of their staff participate in live or pre-recorded interviews. Staff at the Liverpool Women’s Hospital for example have been involved in the local radio station health related presentations.

NORTH WEST HEALTH REGION
HEALTH DISTRICTS

Key
Chapter 8

Comments and Recommendations

8.1 Key posts Vs. Key individuals
There are many barriers to accessing health services for B&EM communities in the North West of England and to remove these barriers will require a considerable level of commitment by those concerned with B&EM issues. There were many individuals (White and non-White), from various organisations, from within and from outside the health service, who demonstrated a deep commitment to removing these barriers. They knew that they faced an uphill struggle but were
determined to make a difference. Much of the progress which has been made in the past must be attributed to the work they pioneered and carried through. The concern however is that too much depends on too few. If a very committed Director of Public Health, Locality Commissioning Manager, General Practitioner, Community Health Council Chief Officer or Hospital Quality Manager is replaced or moves on, does this mean that the momentum will be lost? The answer to this question seems to be - “Yes”. However, solutions to this dilemma may lie in ensuring that there are enough committed persons in the positions which matter the most, in ensuring that there are key posts within organisations, in embedding whatever progress has been made into mainstream provision and funding and in establishing mechanisms for keeping B&EM issues on the agendas of policy makers.

8.2 Measuring progress.
From the point of view of the Regional Office of the NHS, Health Authorities and, Hospital and Community Trusts, much progress has been made towards improving access to health services for B&EM communities. There has been, numerous meetings held, working groups set up and initiatives instituted. B&EM concerns are now addressed in policy documents and in service contracts and representatives from B&EM communities sit on Health Authority and Trust Boards and Committees. From the point of view of some B&EM communities however, little has changed over the years. It does not seem logical that both statements can be true at the same time and yet they are. The explanation lies in the fact that different “yard sticks” are being used to measure progress. The Health Services are using the many changes which are occurring in their management structures and processes as their measure of progress while communities are using the length of time they have to wait to be seen by their GP or whether some one will be available to help with translations when they speak with the doctor or nurse. It would appear that not enough of the progress that the Health Service has made, has filtered through as real benefits for B&EM consumers of health care.

Box 8.1 - Ensuring that there are key positions and key posts.
Health Authorities and Trusts

- must address the under-representation of Black and Ethnic Minority individuals among senior personnel within their organisations.
- must ensure that there are individuals who understand and are interested in Black and Ethnic Minority issues, in key decision making positions within their organisations.
- should ensure that there are representatives of Black and Ethnic minority communities sitting, at least as non-executive members, on Health Authority and Trust Boards and that these individuals are actively pursuing the interests of these communities.
- should have posts, supported with appropriate resources, within their organisational structure, where the post holders’ primary responsibilities focus on the needs of Black and Ethnic Minority communities.
must begin the main stream funding of projects which, from local, regional and national experience, are known to be fundamental to improving access to health services for Black and Ethnic Minority communities. There is no need, for example, for further research on the utility of “women only clinics” (see Section 7.12.1) before these services are offered as routine.

must ensure there are mechanisms through which community opinions influence health service planning and provision.

Box 8.2 - Guidelines for measuring progress
Health Authorities and Trusts

must ensure that measures which reflect consumer views on the appropriateness of services are being used to make conclusions about these services. This will require close and continued collaboration with Black and Ethnic Minority communities. The advantages and disadvantages of the models described in Box 7.12 should be considered.

must determine whether (and to what extent) changes in managerial structures and processes are influencing access to health services.

8.3 Demographic data.

It is unlikely that commissioners of health care, whether they be Health Authorities, GP fund holders or the recently proposed GP consortiums, will be able to determine or to effectively (and efficiently) satisfy the health needs of B&EM communities without the appropriate understanding of the demographic characteristics of these communities. At the Regional and District level, the demographic data available from the 1991 census can be a useful starting point for exploring the demographic characteristics of the population. However, at the level of smaller population groups where assessments of health need must be carried out limited help can be expected from this data source. More so, for ethnic groups which are not covered by the census classification, information from this source is completely absent. Other national surveys, such as the Labour Force Surveys, Health and Lifestyles Surveys and the National Surveys of Ethnic Minorities also provide very important social and demographic information but again these data often cannot be reduced to its regional or district components. The challenge therefore is to find alternative sources of information and to use what is available in the most innovative ways. Only a minority of health related organisations in the North West are pursuing alternative information strategies and often, almost complete reliance is placed on the now out of date and limited OPCS 1991 census data. For many of these organisations using the census as their only source of demographic data must hamper their ability to plan services strategically.

Box 8.3 - Improving demographic data
Health Authorities and Trusts
should use alternative sources of information on the demographic characteristics of its Black and Ethnic Minority communities to supplement what is available from the census (see section 7.2.1).

should collaborate with and support community based organisations, academic institutions, Social Services departments and Local Authorities in initiatives to determine the demographic characteristics of local minority ethnic populations.

must consider the changes which are taking place in minority ethnic population demographics in planning health services.

8.4 Community Health Councils.
The present impact of Community Health Councils in improving access to health services for B&EM communities appears to be quite limited. However, can more be realistically expected from organisations which appear to be often grossly under resourced for what is expected of them? These organisations, in general, are infrequently visited by members of B&EM communities and are not adequately aware of the issues related to B&EM health in their localities. The proposed initiative to improve the capabilities of Community Health Councils in the North West of England to address issues related to B&EM health should make an important difference to the effectiveness of these organisations in their dealing with B&EM issues and deserves support from the Regional Office of the NHS and Health Authorities within the region.

Box 8.4 - Improving the capabilities of Community Health Councils

The Regional Office of the NHS

should support the initiative proposed by the North West Regional Association of Community Health Councils which aims to enhance the capabilities of Community Health Councils in the North West of England to better represent the interests of Black and Ethnic Minority communities.

8.5 Resources.
The lack of extra resources was often the proffered explanation for the limited number of changes which have been made to health service provision in order that health care could be more accessible to B&EM communities. Statements of this nature can be viewed very negatively. Millions of pounds continue to be spent every year on providing health care in the North West and there is an understanding that these resources should be used to provide health care which realises the greatest health gains for the population. Does saying that there are no extra resources for bringing about the required changes in health care provision to improve access for B&EM communities imply that relatively little health gain is expected if these investments in B&EM health are made?

Box 8.5 - Targeting resources

Health Authorities
must identify the health care needs of communities within its Health District.

must target resources where health care need and potential to benefit from services are greatest.

8.6 Ethnic monitoring
The collection of information on ethnicity in both the primary and the secondary care sector is a crucial step to determining the morbidity and health service utilisation profiles of B&EM populations. This represents a progressive step but one not without difficulties. The protocol for the collection of this information must be standardised nationally so that information can be pooled and comparisons made across regions. Health service staff must be re-trained in collecting these data and clients informed as to the benefits which they will gain from providing this information. Most of all, the mechanism for using these data to inform decisions about health care provision must be established.

Box 8.6 - Making ethnic monitoring useful.

Health Authorities

must ensure that providers of secondary care are fulfilling the requirements for ethnic monitoring.

should encourage and support initiatives for the introduction of ethnic monitoring in the primary care settings and should provide incentives for these settings.

Health Authorities and Trust

must inform communities and clients as to the purposes behind ethnic monitoring and the advantages which can be realistically expected from this initiative.

must use data obtained from ethnic monitoring to inform decisions on service provision and development.

Community organisations and Community leaders

must work with Health Authorities and Trusts to inform communities as to the purposes behind ethnic monitoring and the advantages which can be realistically expected from this initiative.

must encourage communities to request / insist that their ethnicity data be collected when they use health services.

8.7 Racial prejudice
Regardless of acknowledgement, racial prejudice in the NHS still exists. The 4th National Survey of Ethnic Minorities reported that 26% of White respondents admitted that they were prejudiced against South Asians, 25% admitted that they were prejudiced against Muslims and 20% admitted that they were prejudiced against Caribbeans. It is statistically unlikely that these White
individuals with prejudiced sentiments are not also represented within the National Health Service. Racial prejudice however does not only lie within individuals but also in the systems and procedures which have developed in the NHS and in the society in general. This institutionalised racism has a multitude of effects ranging from the relative exclusion of “Black” professionals from key posts to the inappropriateness of some health care services and the resistance to improve them.

**Box 8.7 - Dealing with racial prejudice.**

**Health Authorities and Trusts**

- must ensure that their employment and recruitment practices do not limit the opportunities for individuals from Black and Ethnic Minority communities. Further, they must ensure that these practices address the under-representation of individuals from Black and Ethnic Minority communities in senior positions within these organisations.
- must actively seek out and change practices and procedures, within the organisational structure of Health Authorities and Trusts, which adversely discriminate against clients from minority ethnic communities.
- must provide efficient and effective mechanisms through which reports of racial prejudice can be heard, evaluated and dealt with.

**.8 Link workers and interpreters.**
The utilisation of link workers as the main providers of translation and interpretation services limits the benefits which may be achieved from this resource. They should have a wider role to play in promoting health and in acting as a link between communities and health service providers and commissioners. However, it must be understood that to move link-workers from their present role of providing translations without replacing them with interpreters will have disastrous effects on the provision of health care for non-English speaking patients.

**.8.9 Contracting process.**
Health Authorities and Trusts often referred to the inclusion of clauses in health service contracts which were meant to address issues related to improving the health of B&EM communities. This is an important step forward in reducing the variations in health which exist among ethnic groups. However in some instances, this step was the last and only step taken. The further step of ensuring that contractual agreements were met or that the provisions catered for in the contracting process had real benefits for B&EM communities was often neglected.

**.8.10 Regional collaboration**
More collaboration among health care workers across the region is required. There is a wealth of expertise and experience in the North West as well as a profound willingness to share this expertise and experience. What is required however is an effective mechanism for accomplishing this sharing. The electronic database of initiatives and organisations related to B&EM health which was put together as part of this review is one step towards providing this mechanism.
Box 8.8 - Improving link worker and translator / interpreter services.

**Health Authorities and Trusts**
- should review the needs of communities and clients for translator / interpreter services.
- must embed already established translator / interpreter services into routine service provision and make these part of mainstream funding.
- should endeavour to provide a more comprehensive translator / interpreter service. Appropriate arrangements for weekends, outside of normal working hours and emergencies should be established.
- must work with community organisations and community leaders to inform communities of the availability of interpreter / translator services and the ways in which these services can be accessed.
- should separate the roles of link workers and translators / interpreters. Link workers should play a greater role in health promotion and health education.

**Community organisations and community leaders.**
- must work with Health Authorities and Trusts and on their own to inform communities of the availability of interpreter / translator services and the ways in which these services can be accessed.
- must advise communities of their rights to translator / interpreter services and encourage these communities to request these services if they require them.

Box 8.9 - Making the contracting process effective.

**Health Authorities**
- must ensure that contractual arrangements with Trusts which are aimed at improving services for minority ethnic communities are being met and that these arrangements are providing real improvements in services for these communities.
- must work with communities to determine which elements of the services provided by Trusts these contractual arrangements should cover.

Box 8.10 - Improving regional collaboration

**The Regional Office of the NHS**
- should encourage collaboration on minority ethnic issues and the sharing of experience, knowledge and skills, among Health Authorities. It should provide a focus for minority ethnic issues within its organisational structure.
- should support the proposal to continually update the database of initiatives and organisations related to Black and Ethnic Minority health which has been completed as part of this review.

Some of the factors which impact most on the health of Black and Ethnic Minority communities; education, employment, housing, nutrition and racial prejudice for example, seem at first sight to be beyond the influence of the Department of Health and the National Health Service. This is however not so and there is an important role to be played by the health services, even in its present structure.

Public health practitioners within the National Health Service must continue to work towards ensuring that issues which affect the health of Black and Ethnic Minority communities remain on the agendas of policy makers in Central Government, Local Government and in private enterprise. They must continue to demonstrate the ways in which social and economic policies impact, both negatively and positively, on the health of these communities. Further, they must continue to advance the science required to inform these policy decisions.

The National Health Service remains the largest employer in the United Kingdom and its employment policies must set the correct standards for other employers. There must be equal employment and promotion opportunities for individuals from all ethnic groups within the National Health Service. Further, efforts must be made to redress the inequalities which presently exist at senior levels within this organisation.

The efforts of the West Pennine Health Authority (Connect-4-Health project) to provide training for Minority Ethnic communities with the aim to improve employment potential provides a good example of another way in which National Health Service organisations can influence employment opportunities for Minority Ethnic communities.

**Box 8.11 - Influencing the wider Public Health.**

**Health Authorities**
- must encourage and support research into ways of improving the health of Black and Ethnic Minority communities carried out by their own public health departments and those within academic institutions.

**Public Health departments in Health Authorities and Academic institutions**
- must continue to demonstrate the ways in which social and economic policies impact, both negatively and positively, on the health of Black and Ethnic Minority communities.

**Health Authorities and Trusts**
- should use their position as the largest group of employers in the region to address the higher unemployment rates experienced by some minority ethnic groups within their localities.
should work with community organisations to provide career counselling and training opportunities for individuals from minority ethnic communities within their localities.

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