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Focus – ethnicity and health in London

In this section...

- Key issues relating to ethnicity and health in London are explored, including the use of language
- Patterns of health and well-being in BME communities are described, and experience of disease outlined
- Influences on the health of BME communities are described
- Opportunities for change are identified, along with action that builds on current policy initiatives.

What part can this report play?

London is a uniquely vibrant and diverse world city. It is the most ethnically diverse city in Europe. This diversity is reflected not only in the variety of cultures and languages that exist in the city, but also in the variety of needs around public services, disease prevention, care and well-being.

Ethnicity, race and culture are important determinants of health. Certain diseases or conditions are more common in some ethnic groups compared with others. Differences in treatment outcomes and health service use also vary between different ethnic groups.

Where information was available, previous *Health in London* reports highlighted the health differentials and aspects of disadvantage experienced by London's ethnic minorities. This report considers Black and minority ethnic health in more depth, with this section providing a framework for understanding and interpreting some of the detailed findings reported in Section 3. In particular, this section explores:

- key issues relating to ethnicity and health in London, including the use of different types of language and underlying theoretical models
- patterns of health, well-being and experience of disease in Black and minority ethnic communities in London
- influences on the health of Black and minority ethnic communities in London
- opportunities for change and action that build on current policy initiatives.

Discussion relates mainly to those groups referred to in 1991 and 2001 census categories. This is because information is lacking on some of London's minority ethnic communities, especially groups of mixed race heritage which were not identified separately in previous census data. (See 'Implications for action', page 15 and Appendix 1 for census categories.)

The relationship between ethnicity and health: key issues

It is increasingly recognised that ethnicity and health interact in complex ways. Sometimes the associations are positive. Take, for example, lifestyle factors such as diet, smoking and alcohol consumption patterns. Several minority ethnic groups in London have been shown to live in a way that fits well with nationally recommended standards. Sometimes the association are negative, as where health differentials among different ethnic groupings are clearly related to inequalities of the kind discussed in Section 1 of this report.

The following issues seem key to understanding the different perspectives involved and, just as importantly, to making constructive use of the insights gained:

- collecting in a systematic way, and at different levels, accurate and up-to-date information on the changing profile of London's population
- recognising the importance of addressing diversity and reducing health inequalities through mainstream services and programmes
- acknowledging the complexity of the relationship between ethnicity and health.

Collecting accurate and up-to-date information

Latest data from the 2001 census, and comparisons with the 1991 census, show that nearly 30% of adult Londoners belong to an ethnic minority group other than White British (see Box 1 on page 24). This figure rises to 40% when we look at children (under 15yrs old). Between 1991 and 2001, the ethnic composition of the capital has changed significantly, with a decrease in the percentage of the White population and an increase in percentage of all other ethnic groups.

It is now well established that the unemployed, many ethnic minority groups, guest workers, disabled people, refugees and homeless people are at particular risk of ill health and premature death (Wilkinson and Marmot, 1998).

Health differentials have been related to health beliefs, diet, genes, behaviour and lifestyles, which have been observed to vary across ethnic groups. Country of origin, social class, religion and migration history, also have a role to play in explaining health differentials between ethnic groups. In addition, access or lack of access to appropriate health-related services directly affects health and illness, as well as influencing health behaviour and treatment choices.

Advances in research methodologies have not kept up with the changing profile of London. As illustrated by Box 1, there are constant and often rapid changes in the make-up of London's population. For example, the 2001 census was the first to record information about the proportions from mixed race groups; and it showed that substantial numbers of people from mixed race heritage are living in London. Data from the 2001 census needs to be supplemented by the systematic

gathering of information, at London-wide and local level, on emerging health needs within the different populations.

In addition, building on data emerging from the 2001 census, research needs to be carried out into how different factors, such as socio-economic standing, faith, gender, ethnicity and disability, interact to determine the health status of groups within wider communities.

At the level of service provision, planners, commissioners and providers are increasingly making use of service user profiling, including ethnic monitoring.

Ethnic monitoring – why is it important?

The categorisation and division of people on the basis of race and ethnicity often raises important questions about values. Human and political values have driven decisions to divide people in categories, often with grave consequences which still persist today (Bhopal, 2003).

However, as discussed earlier, many people from many ethnic minorities experience inequalities in access to prevention, treatment, health and social care. These inequalities can be addressed and improved, and ethnic monitoring can provide a useful tool to increase understanding of ethnicity and health.

The Race Relations (Amendment) Act 2000 (RRA) requires that public sector organisations monitor their activities for any adverse impact on race equality and demonstrate that they are making progress in race equality over a three-year period. This means that public sector bodies such as the NHS need to know the ethnic composition of their population and service users to assess whether they are providing equality of access in relation to need.

Box 1 Changes in London's profile between 1991 and 2001

- London's population has increased by about 4% between 1991 and 2001. During that time, the ethnic composition of the population has changed. The White population has fallen in number as a percentage of the total, while all other ethnic groups have increased in number and as a percentage of the total.
- There are now more than 2 million London residents in ethnic groups other than White, plus more than 220,000 Irish and nearly 595,000 Other White groups. This adds up to almost 2.9 million London residents who are in ethnic groups other than White British.
- Around 46% of all non-White ethnic minority groups in England & Wales live in London. Some ethnic groups are mainly based in London (for example 79% of Black Africans), some are based elsewhere (only 20% of Pakistanis live in London).
- The Black populations of England and Wales (Black Africans and Black Caribbeans) are far more concentrated in London than any of the other ethnic groups.
- Just over 6% of London's population is Indian (the largest single non-White group), the second largest group in London is the Black African, closely followed by Black Caribbean (which was the second largest group in 1991).
- Based on ethnic diversity in English and Welsh local authorities, 16 of the 20 most ethnically diverse are in London. Two London boroughs, Newham and Brent, have the highest proportion of non-White residents (60.6% and 54.7% respectively).
- In 1991, the second largest non-White group, after Indian, was the Black Caribbean group. The Black African group has more than doubled in the last ten years and now outnumbers the Black Caribbean group as second largest ethnic minority.
- The number of Bangladeshis has increased by nearly three quarters since 1991, Pakistanis by more than half, while the Indian group has only grown by just over a fifth.

Source: DMAG/GLA 2003

Without good and reliable information on ethnicity, it is difficult to identify and address ethnic inequalities in health. For example, a current government consultation to improve service delivery for BME communities in the mental health system says: 'Those responsible for planning, delivering and monitoring services both to individuals and collectively, need to ensure that good quality data on ethnicity is comprehensively collected and intelligently used.

This is considered essential if services are to be able to meet their legal obligation under the RRA to monitor the impact of services on all racial groups.' (DH, 2003b)

The needs of various communities in relation to alcohol and drugs services have also been identified and considered in London-wide work to reduce the harm individuals and communities experience in relation to substance misuse. 'The highs and the lows' (GLA and GLADA,

2003, Feb) highlighted significant differences in patterns of drug use in various minority ethnic communities. The report also highlighted the failure by policy makers, planners and commissioners to sufficiently address some diversity and equality issues associated with problem drug use and its treatment.

The key challenges related to ethnic monitoring in London are summarised on page 38.

Addressing diversity and reducing health inequalities: a mainstream concern

Many activists from civil society, along with a number of politicians, have championed the issue of inequalities and inequities experienced by London's BME communities. Considerable numbers of documents have captured the tensions that exist between the Black community, carers, patients and the mental health system (Black Health Workers and Patient Group, 1980; Keating, 2002).

Organisations, patients and carers emanating from BME communities have often been instrumental in challenging mainstream service provision and putting their specific issues on the national health policy agenda. Public policy and many health improvement initiatives have attempted to address ethnic health inequalities, but significant health inequalities persist.

Recent developments in public policy at national level present new opportunities to focus efforts on reducing ethnic health inequalities, as discussed in Section 1. In addition, ethnicity and race issues are being debated at national level in areas such as mental health and inherited disorders of the blood (haemoglobinopathies), as well as in policy areas

such as policing and education. London is also experiencing many local and regional initiatives to challenge ethnic health inequalities.

In 1998, the Acheson Inquiry noted that ethnic origin was 'not routinely recorded in the NHS' (Acheson, 1998). Recent progress in ethnic monitoring in the NHS in London is outlined in a report from the London Health Observatory (Jacobson, 2003a). However, ethnicity is still not systematically recorded at birth and death registration; and the absence of robust tools of this kind remains a major hurdle for evaluation and benchmarking of health improvement activities within BME communities.

The efforts of voluntary and community groups over many years have resulted in key issues about race and health being 'brought in from the margins to the mainstream'. That said, there will continue to be an extremely important role for voluntary and community groups in monitoring progress, advising on developments, and suggesting new initiatives.

The relationship between ethnicity and health: addressing the complexity

The pattern of health differentials across different ethnic groups cannot be described or explained adequately by reference solely to the 'medical model' of health. Models of this kind focus primarily on individual patients' experience of disease and individual users' experience of health services. Much information of great value emerges from the use of such models. However, the wider picture of social, political and cultural complexity tends to be obscured, with the result that, for example, problems associated with racism can be overlooked.

Accordingly, those working with issues of ethnicity and health need to look to other fields as well as medicine. Of particular value are models based on socio-cultural approaches, including communities' experience of health and well-being; these provide valuable additional insights.

Different theoretical models and types of discourse often reveal themselves in the choice of language. Policy makers, practitioners and members of communities may use a wide variety of different terms (and pull back from using other kinds of language). Discussed below are some of the key terms that inform discussion of the issues.

Thinking through terminology

It is important to note that the debate on terminology is constantly evolving. One important example is the term 'Black' which was originally used to refer exclusively to people of African descent, but is now sometimes used to refer to people from much wider geographic, cultural or linguistic backgrounds and from visible minority groups who may face racism. Box 2 summarises some of the key terms in the debate.

Box 2 What's meant by...?

Ethnicity

The concept of ethnicity is a complex one, and it is often confused with the concept of race (see below). Whilst the two concepts overlap, it is important to understand differences between them. Anecdotal evidence suggests that some health care professionals may feel more comfortable with the concept of ethnicity than race.

'Ethnic group' or 'ethnicity' is a short-form description, or proxy measure, for

a number of key attributes. In the context of health and healthcare, these attributes include genetic inheritance and ancestry, religion and 'culture', including diet, language, dress, and other aspects of lifestyle (Johnson, 2003).

'Ethnicity' became formally defined in UK law by a House of Lords decision (Mandla v Lee 1983) as relating to a group with 'a long shared history and a distinct culture'. The term also highlights the fact that all people belong to ethnic groups and that White people have an ethnic origin too.

The term 'minority ethnic' refers to people who belong to minority groups with a distinct cultural and historical identity. Thus people are described as belonging to majority or minority ethnic groups and this description may vary depending on the population make-up of the country or region in which communities are living.

Other characteristics that have been highlighted in defining an ethnic group include 'a common geographic origin or descent from a small number of common ancestors; a common language; a common literature; a common religion and being a minority within a larger community' (Johnson, 2003).

Self-identified ethnicity

The notion of ethnicity is strongly linked to the way people identify themselves. People may choose to belong (or not) to an ethnic group and can claim an ethnic identity based on a variety of complex factors. Additionally, like gender and sexuality, ethnic identity has become politicised and for some people has become a primary focus of their politics (Young, 1990). For these reasons

whenever possible, most specialists, as with the census, use a notion of ethnic identity based on self-identification.

Race

The modern concept of race as utilised by many scholars emphasises its social origins rather than its biological basis. In this perspective, race provides a way of defining, for social purposes, populations which look different and have different ancestral roots. Whatever the underlying concept, the term race should be used with caution because its history is one of misuse and injustice (Bhopal, 2003).

The UK Race Relations Act 1976 (Section 3) defined a 'racial group' as 'a group of persons defined by reference to colour, race, nationality or ethnic or national origins.'

Culture

There are many ways of defining culture and cultural differences between people. Various studies have tried to capture aspects of culture and cultural identity such as self-description, language, choice of schools, clothes, religion, diet, and other factors. Other studies are concerned with describing cultural practices and activities and their relevance for prevention and healthcare.

Culture is also strongly linked with identity and identification with 'Britishness' or with place of origin. Cultural identities, such as 'blackness', developed in many countries including the UK in reaction to societal racism and cultural oppression. In this context, black cultural identity takes a political dimension motivated by anti-racist struggles (Modood et al, 1997).

For a multicultural city like London, and many British urban centres, the concept of youth culture and urban culture are also important to consider.

Ethnicity and culture have been shown to have an influence on perceptions of illness, especially in mental health. A study amongst adults from different ethnic and cultural backgrounds showed that respondents' cultural backgrounds and ethnicity affected the way they perceived specific symptoms of schizophrenia. For example, Bangladeshi participants were less likely than White British participants to view hallucinatory behaviour as indicative of mental health problems (Pote, 2002).

This example illustrates some of the debates in trans-cultural medicine and the issue of misdiagnosis of mental health problems experienced by some patients from BME communities (Keating, 2003). The importance of catering for cultural difference is clear in settings concerned with providing a wide range of services in health care, social care, palliative care and so on.

Religion

Religion is a concept that cuts across races, cultures and ethnicities. Religion and religious beliefs impact on an individual's lifestyle, diet, health beliefs, coping strategies during illness, and a wide range of other areas. People with certain religions have specific rules around acceptance of medication, treatment or organ transplant or donation.

The 2001 census included a question on religion for the first time. This provides us with useful data on groups which were not referred to, or were previously hidden, such as the

significant Jewish population living in London. Christians are the largest group in London (over 58%), followed by Muslims (8,5%) and over 15% of people described themselves as having no religion. The 2001 census confirmed that religion is an important aspect of ethnicity and the way people define themselves. Table 1 provides an overview of the religious composition of London.

Religious difference (like racial difference) can be motives for prejudice and discrimination. Research has highlighted the continued existence of anti-semitism and islamophobia in Britain (CRE, 2002a).

Some surveys like the Health Survey for England 1999 have included a question on religion. The study revealed many differentials in health and lifestyle between the groups studied and the majority population.

Census categories

Many specialists have worked on various ways to define ethnic groups in London. However, ethnic groups as defined in the 1991 and 2001 censuses are increasingly used as a common ground to define people's ethnicity (and race). The census itself offers a frame of reference which can enable comparisons and analysis of

population trends over long periods of time (decades).

For practical purposes, in most areas of social policy, the groups identified by the Office for National Statistics in the decennial UK census have become adopted as the most significant groups (see Table A1, Appendix 1).

The 2001 census definitions of ethnicity are much more flexible than previously. There are 87 ethnic categories, grouped under 16 sub-categories. However, discussions about categories continue to take place, and it is possible that additional categories or sub-categories will be included in future data collections.

A substantial number of ethnic minorities were classified as 'White' in the 1991 census. This has led to situations where certain minority ethnic groups, such as Eastern Europeans and Gypsies or Roma were excluded from race equality strategies or ethnic monitoring exercises. The 2001 census provided much more flexibility and possibilities for respondents to choose and describe their ethnicities.

Two additional categories; 'White Irish' and 'White other' offered the first opportunity to monitor all ethnic groups, rather than just 'visible' minority ethnic groups.

Table 1 Largest religious groups in London

Group	% of London population	% of population of England and Wales living in London
Christian	58.2 %	11.2 %
Buddhist	0.8 %	37.6 %
Hindu	4.1 %	52.9 %
Jewish	2.1 %	57.6 %
Muslim	8.5 %	39.3 %

The 'Mixed' category also provides new opportunities to recognise and monitor issues in groups such as White and Black Caribbean, White and Black African or White and Asian.

Patterns of health, well-being and experience of disease in London's BME communities

Scientists have been studying the distribution of disease among different ethnic groups for a very long time. As far back as 1845, Frederick Engels observed that Irish people living in England had a poor health and a high mortality record (Modood et al, 1997). He also made the link between these poor health outcomes and the 'miserable' living conditions that Irish people were experiencing at the time. Much more recently, an important opportunity to study health differentials between various ethnic groups and the majority population was offered by the Fourth National Survey of Ethnic Minorities in Britain (Nazroo, 1997). In 1999, the Health Survey for England provided additional opportunities to compare health differentials between some of the largest minority ethnic groups in England and the majority population. Since that time, a range of specialists have attempted to improve research methodologies and data collection systems.

A large amount of data relating to the health of minority ethnic populations is reported by an epidemiological approach. This approach describes rates/occurrence of disease, disability/impairment and death within and between populations.

Annual Public Health reports in many London primary care trusts regularly

feature analysis of ethnicity and health inequalities in their respective catchment areas and are an important source of current local data. Many of them also describe specific health improvement measures to reduce ethnic health inequalities.

Migration and immigration

According to the last census, over 60% of Londoners from ethnic minorities (other than White British) were born outside the United Kingdom. Migration and fertility rates contribute to current changes in the ethnic composition of London (GLA, 2003, Dec).

Migration is an important determinant of both identity and health outcomes, but this relationship is difficult to assess. On one hand, people who migrate in and out of the country are likely to be relatively young, 'fit' and healthy. This creates the 'healthy migrant effect' (Nazroo, 1997). On the other hand, some people with poorer health might be motivated to move to London in order to access better livelihood, employment opportunities or healthcare. There is, however, little evidence to support this possible explanation of the poor health of migrant groups.

The relation between migration and health is further complicated when time (since arrival) and generational factors (between migrants and their offspring) are analysed. Many studies have shown that migration can itself have negative health consequences on people's health. For example, Irish-born men are the only migrant group whose mortality is higher in Britain than in their country of origin (Davey Smith, 1990).

Migration in itself involves pressures on individuals, such as the disruption of social support systems and stress. Social

networks, which get broken down by the migration process, may take time to be recreated in London (Nazroo, 1997; see also the sub-section on social capital on page 34.)

After migration has occurred, great changes may occur in people's socio-economic circumstances. Professional qualifications or experience acquired in many countries are not recognised in the UK, and many migrants are often forced to reside in unfamiliar or hostile environments, resulting in high levels of stress.

Some studies have also shown that the offspring of migrants often had higher levels of mental health problems, compared with their parents and the general population (Nazroo, 2001).

Migration within London is a major cause of vulnerability, especially for groups experiencing high levels of homelessness such as asylum seekers (GLA, 2004, Feb).

Refugees and asylum seekers

Refugees have been part of London's history for many centuries. Recent focus on asylum seekers and refugees has been motivated by perceived public opinion, and a strong debate in the political arena.

Refugees and asylum seekers are not a homogenous group; they have very diverse social backgrounds, cultures and histories.

In 1999, an attempt was made to capture some of the main public health issues in relation to asylum seekers and refugees (Aldous et al, 1999). The report highlighted the difficulty in assessing the needs of refugees and asylum seekers. Some of these difficulties arose from the rapid change over time of the needs of

refugees and from the wide variation in the health care needs of asylum seekers and refugees.

However, certain health problems are more widespread amongst this group than in the population at large (Aldous et al, 1999). Many health problems associated with refugee populations are linked to poverty and social exclusion, and there is overlap with problems experienced by other Black and minority ethnic groups. Asylum seekers and refugees may be at relatively high risk from communicable diseases, either from their country of origin, or from their living conditions in the UK.

Although the majority of refugees have satisfactory physical health on arrival, a significant number suffer from problems arising from their earlier experiences, and health may deteriorate in the years after arrival. This vulnerability is compounded by the fact that asylum seekers and refugees may be poorly accommodated, and are quite likely to face racial and xenophobic harassment.

In addition, asylum seekers are not permitted to work, and refugees have higher unemployment rates than the population at large – a situation that is likely to impact over time on the health of these groups.

The most distinctive problems faced by asylum seekers and refugees are psychological and may be linked to trauma, or isolation from friends and community in the UK. Most common are problems of adjustment; whilst a small number experience post traumatic health problems.

The Health of Londoners study suggests that one in six refugees (17 per cent) has a physical health problem severe enough to affect their life, and two-thirds suffer

significant anxiety or depression. In addition, many experience barriers in accessing the right type of health care service, such as primary care (GLA, April 2003). 'Destitute by Design' a recent GLA report, highlights the potential harmful impact of aspects of the new asylum legislation such as Section 55 (GLA, 2004b, Feb).

Experience of disease and morbidity

The Fourth National Survey of Ethnic Minorities provided a major opportunity to uncover many differentials in health and disease amongst various groups (Nazroo, 1997).

Subsequent studies such as the Chinese Health and Lifestyle Survey (HEA, 1999), the Health and Lifestyle Surveys for Black and Ethnic Minority Groups (HEA) and the 4th Policy Studies Institute Study have all contributed to increasing our knowledge on ethnic health differentials.

However, all these efforts suffer from the lack of systematic collection of ethnicity information within the National Health Service. The new 'GP contract' does not mention ethnicity collection as mandatory. Ethnicity recording in cancer registries is weak, and even in areas where ethnicity collection is mandatory, the London Health Observatory has noted that completeness of ethnicity recording was only around 63 per cent.

From the existing evidence we know that ethnic minorities experience a higher burden for certain diseases. This burden has been mainly described for the following areas: coronary heart disease, haemoglobinopathies, cancers, diabetes, mental health, tuberculosis and sexual health (Cynthia and Kleinman, 2003).

Many of these conditions are currently considered in the Department of Health's Modernisation Agenda for the National Health Service, and targets to address them are identified through National Service Frameworks (NSFs). NSFs identify ethnicity in a variety of ways. Some highlight different levels of incidence of disease – for example, the Diabetes NSF which demonstrates that Type 2 diabetes is up to six times more common in people of South Asian descent and up to three times more common amongst those of African and African-Caribbean origin. Some, such as the NSFs for Older People and Mental Health, highlight the limited (and variable) accessibility and appropriateness of services for BME communities.

In addition, the Cancer Plan provides information about both incidence and lifestyle factors in a range of communities.

The successful implementation of NSFs is seen by many as key to improving health outcomes for these conditions. More information about them can be found at www.doh.gov.uk

Mortality

Registrations of deaths in the UK currently do not record ethnicity. Current data comes from various sources, all of which have limitations. A major limitation is the fact that current mortality data from death certification uses country of birth as a proxy for ethnicity (and we know from the census data that 60% of individuals from non-White BME groups were born outside the UK).

Studies have shown that poor physical health amongst minority ethnic groups is also reflected in relatively higher mortality among migrants (Marmot,

1984). Among Irish people, for example, increased mortality persists into second and subsequent generations.

Various reports highlight the different death rates within communities. For example, deaths due to ischaemic heart disease were particularly high for men and women born in the Indian sub-continent (Health Survey for England, 1999). In contrast, people born in the Caribbean and West Africa have significantly lower mortality from coronary heart disease.

There is evidence that suicide rates are twice as high for young Asian women when compared with young White women (Raleigh, 1996). A forthcoming briefing by the London Health Observatory and the Commission for Racial Equality will assess current mortality rates in relation to specific diseases (in preparation).

Health, well-being and lifestyle

The focus on mortality and disease prevalence does not provide a full picture of ethnicity and health issues. Attention needs to be paid to communities' own lived experiences of health and the health service, lifestyle and steps they take to promote or improve their own health. Dimensions of health such as mental and emotional well-being at individual or community levels are also worth considering.

The Health Survey for England (1999) measured some lifestyle indicators such as physical activity, smoking, nutrition, alcohol consumption and physical activity.

The survey found that the number of days of moderate or vigorous activity were about the same for Black Caribbean and Irish men as for men in

the general population, but lower for Indian, Pakistani and Chinese men and lower still for Bangladeshi men.

The use of tobacco products other than cigarettes varied between groups, and the extent to which overall tobacco use prevalence exceeded cigarette smoking prevalence also varied between different ethnic groups.

Among men, the difference was greatest in the case of Bangladeshis, of whom 44% smoked cigarettes but a total of 53% used a tobacco product. Bangladeshi women had a quite different pattern of use from women from other ethnic groups, with almost all their reported tobacco use being chewing tobacco.

A recent LHO report (Jacobson, 2003a) highlighted aspects of lifestyle such as physical activity which might be determinants of health or illness. Some studies have highlighted higher levels of healthy or health promoting practices and behaviours among ethnic minorities (including very vulnerable groups such as asylum seekers). A study of recently arrived migrants and refugees in East London has demonstrated that pre-school children often had satisfactory nutritional status, and breastfeeding practice was higher than the national average (Sellen, 2002).

The London Household Survey commissioned by the GLA found that among Londoners: 'nearly a third (30%) never drink alcohol. Bangladeshis are the most likely ethnic group never to drink (97.3%), followed by Pakistanis (94.1%) and Indians (54%). Almost half of Black people in London never drink alcohol (48.9%). In contrast less than a quarter of White Londoners never drink alcohol' (GLA, in preparation).

The ExES Study which looked at sexual attitudes and lifestyles among Asians, Africans and Jamaicans suggests that religion, gender and age affect attitudes towards sex and sexuality. The study also describes how acculturation – the extent to which individuals from migrant groups adopt cultural values from the host country – greatly affects sexual attitudes and lifestyles (Elam, 1999).

Self-assessed health and other measures of health and well-being

By using a social model of health, some researchers have looked at notions such as self-assessed (or self-reported) health and social capital.

In the 2001 census, people were asked whether over the previous 12 months their health had on the whole been 'good', 'fairly good' or 'not good'. People were also asked if they had any long-term illness, a health or disability problem. The Health Survey for England in 1999 asked participants (or their parents, for those aged 12 or less) to rate their general health on a five point scale, from 'very good' to 'very bad'. The London Health Observatory has analysed the latest census and some of the health indicators, and Section 3 of this report considers information on self-assessed health in more detail.

What influences the health of London's BME communities?

Figure 1 in Section 1 outlines wider determinants of health, including issues such as culture, social and hereditary factors. Specific issues need to be borne in mind when considering influences on the health of migrant groups. Many individuals from BME groups may have been born and may have lived in countries with very different economic

and environmental factors from those of London, the UK and Western Europe. This means the health of people living in London now may be affected by earlier exposure to environmental factors different from those existing in the UK.

The following factors may also exert a considerable influence on the health of London's BME communities:

- economic disadvantage and poverty
- racism and discrimination
- lack of social support and 'social capital'
- age, gender, disability
- access to quality public services.

Economic disadvantage and poverty

Economic disadvantage has been shown to impact adversely on health over people's entire life course. A substantial amount of research from London and around the UK has shown that people from minority ethnic communities are over-represented in economically and environmentally poor areas.

Many people from BME communities tend to be more likely to be in low paid and less desirable jobs or will experience longer periods of unemployment compared to their counterparts from the majority population (Nazroo, 1997).

The recent *London Divided* report (GLA, 2002, Nov) showed that child poverty in London remains at one of the highest levels in Europe, and the ethnic dimension of child poverty is much more marked in London than in the rest of England. For example:

- 41% of children in London are from Black and ethnic minority background;
- 41% of children from Black and minority ethnic communities in London live in workless households and this rises to 50% in inner London. This compares to 27% of White children.

Racism and discrimination

The link between racism and health inequalities has been poorly studied in the UK and Europe. Some evidence from the USA and New Zealand has made a link between a health outcome such as high blood pressure, stress and living in racist environments (Karlsen, 2002).

Recent analysis from the Health Survey for England has shown a link between self-assessed poor and fair health and experiences of racism (Karlsen, 2002). The study explains possible effects on two levels: interpersonal racism (such as being racially harassed), and the impact of institutional discrimination.

People who perceived themselves as victims of racism in wider society were more likely to report their health being poor or fairly good, compared to the majority population. This is a cross-sectional study which tries to show an association between racism and poor health.

On institutional racism in the UK psychiatric system Fernando (1991) argues that since European psychiatry developed when racist doctrines were rife in Western culture, the ideology of racism became incorporated into it as a discipline. He also argues that the emphasis on an individualised pathology, with insufficient attention paid to social pressures such as race and culture, renders psychiatry a racist institution.

Nazroo, on the other hand, argues that mental health research uses Western models assessment of mental illness. This may fail to adequately identify those from non-Western cultures who are ill. This could be due to translation difficulties, or culturally determined differences in the experience and expression of disease (Nazroo, 1997).

There have been no longitudinal studies that adequately demonstrate a causal link between perceived racial discrimination and mental ill health (Chakraborty, 2002).

Lack of social support and 'social capital'

Social capital is defined by the Organisation for Economic Co-operation and Development as the 'pattern and intensity of networks among people and the shared values which arise from those networks'.

Social capital is increasingly recognised as a determinant of health and well-being. Typically, studies which try to assess individual or community social capital measure indicators such as participation in social activities, sense of attachment to a neighbourhood, having close friends, fear of crime in the neighbourhood, and so on.

In 1999, The Health for England Survey asked one question on perceived social support. Participants were asked about the amount of support and encouragement they received from family and friends. Among the general population, men (16%) were more likely than women (11%) to be classified as having a severe lack of social support. This difference between the sexes was seen in all ethnic minority groups except for men and women of Indian origin.

Men and women of South Asian, Chinese and Black Caribbean origin were more likely than men and women in the general population to be classified as having a severe lack of social support.

It has been noted that the incidence of psychotic disorders rises among members of minority ethnic groups living in areas with lower proportions of such groups – known as the ‘ethnic density’ effect.

The reason for this, it has been suggested, is that social capital within a given minority group diminishes as it becomes a smaller proportion of the population (McKenzie et al, 2002, cited in Cameron et al, 2003).

Age, gender and disability

Age

BME communities in London tend to have a younger average age, compared with the White majority. However, generations of migrants from some countries came to Britain in the 1950s and 1960s, and many of them have reached retirement age.

A Health of Londoners report (Lowdell C et al, 2000) noted that:

- The population of elderly people from ethnic minorities will triple by 2011.
- Most older people from minority ethnic groups were born outside the UK.
- More Black Caribbean and African older men live alone than do men from other minority ethnic groups.
- Elders from minority ethnic groups in London report higher levels of limiting long-term illness. Such differences

appear to exist even within income groups.

- Bangladeshi and Black Caribbean elders are less likely to be owner-occupiers, and more likely to be living in social housing than White or Indian groups. Levels of overcrowding are especially high for older people from South Asian ethnic groups.
- In the Health Survey for England (Nazroo) and the 2001 census, elderly people from minority ethnic groups were more likely to report their health as ‘not good’, compared to all ‘White’ groups.
- The National Service Framework For Older People recognises the health inequalities experienced by older people and recommends specific measures for elderly people from ethnic minorities.

Gender

At policy level, BME women appear to be marginalised in current debates. A recent report from the King’s Fund points out that women from ethnic minorities are often viewed in stereotypic terms; for example, Asian women are viewed as having problems rooted in conflict and practice within the family (Keating et al, 2003). As a result, the problems they may be facing as women are overlooked.

Disability

As highlighted in last year’s *Health in London* report, there is limited information about disabled people’s access to, and experience of, the determinants of health. This lack of information is even more marked for disabled people from minority ethnic groups.

The London Area Transport Survey (LATS) 2001 is the fifth in a series of large-scale surveys of transport and travel in London. The LATS 2001 survey also collected information by ethnic group and showed that White residents are disproportionately represented among the disabled population. However, this is not altogether surprising since the White group has a considerably older age structure than most other ethnic groups.

The Labour Force Survey (LFS), a continuous household survey carried out by the Office for National Statistics (ONS), found that people from Black and minority ethnic groups (BMEs) are more likely to be disabled than people from White groups. After standardising for differences in age structure, the disability rate for BME groups is 20 per cent compared with 16 per cent for White groups.

An interim report produced by the Greater London Authority for Disability Capital 2003 (a recent conference for disabled Londoners) drew on findings from the GLA London Household Survey 2002 and other sources. This will be supplemented by information provided by disabled Londoners through surveys and feedback to the GLA during 2003. More information on this work can be found on the GLA website (www.london.gov.uk)

Access to quality services

As discussed in Section 3 of this report, a number of factors influence individuals' access to services that affect health, such as housing, employment and education. A key factor is the discrimination and disadvantage faced by many ethnic minority communities.

Racism at both individual and organisational levels can have a significant

impact on the accessibility of good quality services to ethnic minority communities. For example, the MacPherson Inquiry into the death of Stephen Lawrence defined institutional racism as, 'The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin'.

Several studies, supported by feedback and anecdotal evidence from minority communities, highlight a further important obstacle to access to good quality services. This is the absence of appropriate language support, advocacy, advice, information about entitlements and so on. Both academic and service-driven studies have identified the lack of language support available to Black and minority ethnic communities (Fenner and Kennedy, 2002).

Other reports highlight a range of issues which impact on access to services, including the Association of London Government's *Sick of Being Excluded* report (ALG, 2000).

Health services

In relation to improving access to health services for ethnic minorities, the report of the Acheson Inquiry (Acheson, 1998) noted, 'Gaining access to services does not mean the ability to make full sense of them or that health care needs will be met appropriately'.

For example, a scrutiny by the London Assembly and the Mayor of London highlighted that the primary care system is failing some members of vulnerable groups (GLA, 2003, Apr).

The report noted that language and translation needs of patients are not

always met and this is a major barrier for London's increasingly diverse population. The report also highlighted that services such as walk-in centres and NHS Direct are underused by members of ethnic groups.

The Commission for Health Improvement (2004) carried out a survey to assess patient experiences. In A&E, outpatients and PCTs, the survey found marked differences between ethnic groups. White British and Irish respondents generally reported more positively than Other Ethnic (including Other White and Mixed groups). South Asian (Indian, Pakistani, and particularly Bangladeshi) respondents reported the poorest experience in all the surveys, followed by those of Chinese origin, Mixed origin, and White origin other than British or Irish.

These differences by ethnic group were similar in London to elsewhere, but the survey showed that all patients in all ethnic groups in London were consistently less satisfied with their care than elsewhere.

Focus on drugs services

Among reports of people presenting to specialist drug agencies, about 75% were White and less than 10% were from Black ethnic groups. In contrast, among reports of people assessed in police stations, less than 60% were White and 24% were from Black ethnic groups. The recently formed London Drug Indicators Project showed that a substantially higher proportion of crack-cocaine users arrested were from Black ethnic groups compared with crack users in treatment.

A forthcoming briefing by the London Health Observatory and the Commission for Racial Equality will review the

evidence on access and equity issues within specific service areas in the NHS.

Opportunities for change and action: building on current policy initiatives

Broad policy imperatives on health inequalities were outlined in Section 1. There are also a number of specific policy drivers encouraging, and in some cases requiring, public bodies to invest in diversity and race quality.

The impetus to invest in diversity and race equality has increased following the introduction of the Race Relations (Amendment) Act 2000, and recommendations from the MacPherson report. Crucially, the RRA places additional duties on public organisations to work to eliminate unlawful racial discrimination, and to promote equal opportunities and good race relations.

The statutory *Code of Practice on the Duty to Promote Race Equality* (CRE, 2002b) provides guidance for organisations on how to monitor their performance in meeting these duties.

The following pieces of legislation also place duties on public bodies, especially in relation to employment:

- Section 11 of the Health and Social Care Act (places a duty on statutory bodies to consult and involve patients and the public in their work)
- The Human Rights Act (2002)
- Sex Discrimination Act (1975)
- The Disability Discrimination Act (1995)
- New employment equality legislation on sexual orientation (2003)

- New employment equality (Religion or Belief) Regulations (2003).

The Commission for Racial Equality (CRE) recognises that people from some ethnic minority backgrounds are disproportionately disadvantaged by social and economic deprivation and suffer worse health as a result.

In response to this, the CRE has written a *Health and social care strategy* (2003) which seeks to achieve the elimination of differences between ethnic groups in premature death and experience of ill health.

The CRE has also published a resource for health organisations called *Performance guidelines for health organisations* (2002c). Amongst potential benefits of meeting the additional Race Relations (Amendment) Act duties, the CRE envisages that:

- Local residents and users of the organisation's services from all ethnic groups will be equally satisfied with the organisation as a whole, and individual services.
- The organisation will reach ethnic groups who have rarely used its services before.
- The general level of complaints will be low and there will be no significant differences in complaints between different ethnic groups.

The aim of the general duty is to make race equality central to the way health organisations work. It is also expected that organisations which meet the duty will experience increased staff satisfaction and equal opportunities.

Ethnic monitoring – How is London doing?

The importance of establishing effective procedures for monitoring ethnicity was discussed near the beginning of this section. Even in London, however, where health inequalities are so marked across different ethnic groups, there is a long way to go in ensuring an adequate flow of data.

Whilst ethnicity data has established that many ethnic groups experience high burdens of certain diseases, public health specialists are still unable to monitor these differences over time. This is partly because ethnicity is not systematically or appropriately collected at two key points in people's lives: birth and death.

The NHS has made ethnic data collection mandatory for hospital episode statistics (HES). However, a recent London Health Observatory report showed that the completeness and quality of the information collected has not improved.

About 38% of hospital episodes in London still recorded ethnicity as 'unknown' between 1997/8 and 2000 (Jacobson, 2003b). Ideally, data on ethnic health is needed across all hospitals, general practice, cancer registration and disease registers.

In 2002, the CRE reviewed the implementation of the RRA in public services (CRE 2002a). The review found that the majority of public bodies who made efforts to implement the new duty found positive benefits, but progress across the public sector was patchy.

The Department of Health has issued guidance and training material on *Collecting Ethnic Category Data* to assist implementation of the new 2001 census ethnic categories (2001b).

The five London Strategic Health Authorities are currently working on monitoring progress in the NHS implementing the Race Relations Amendment Act.

Several London-wide organisations, including the London Health Commission and the London Health Observatory, have campaigned in 2003 for the recording of ethnicity at birth and death registrations.