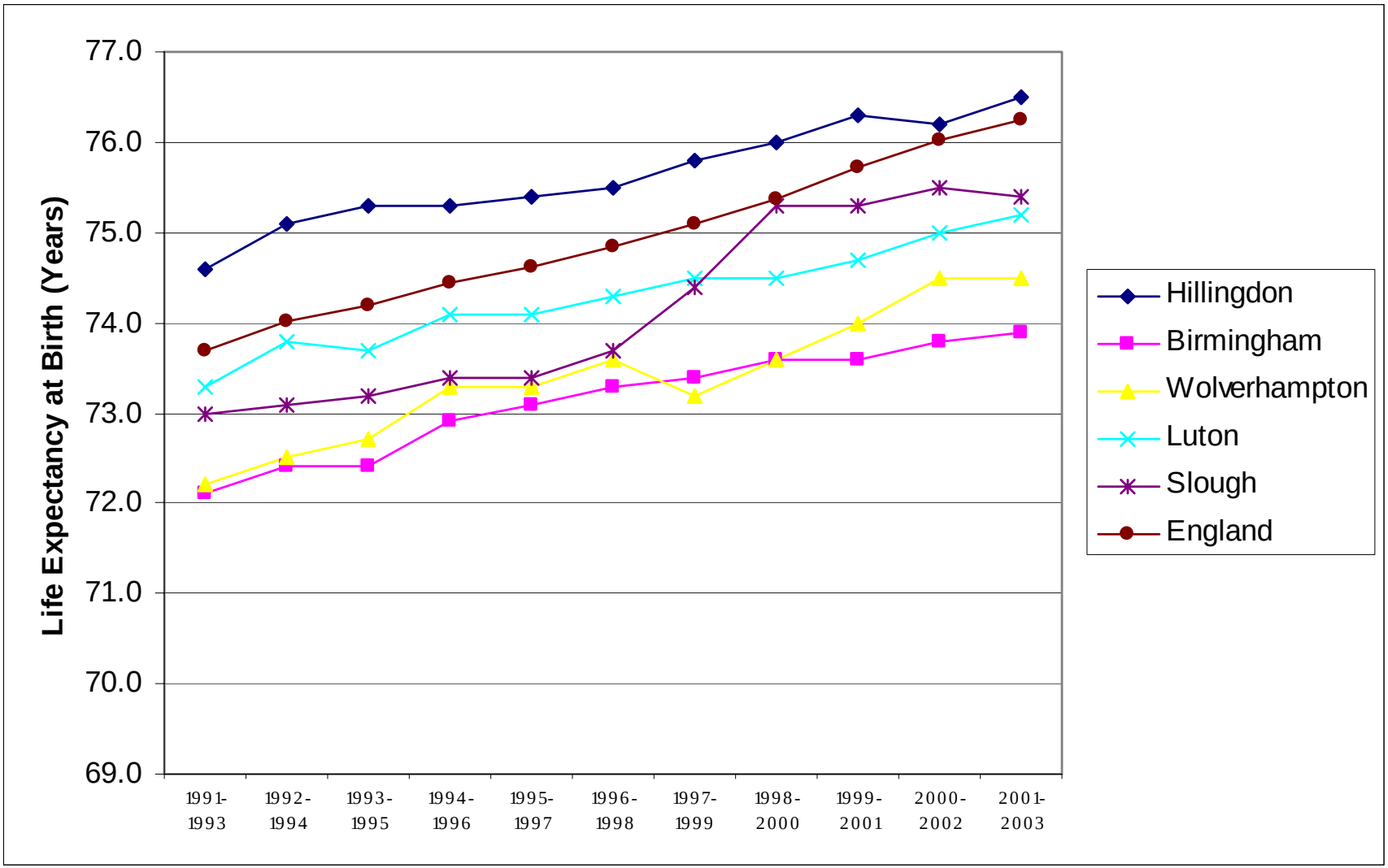
Inequalities in health

Different health experiences of different groups of people

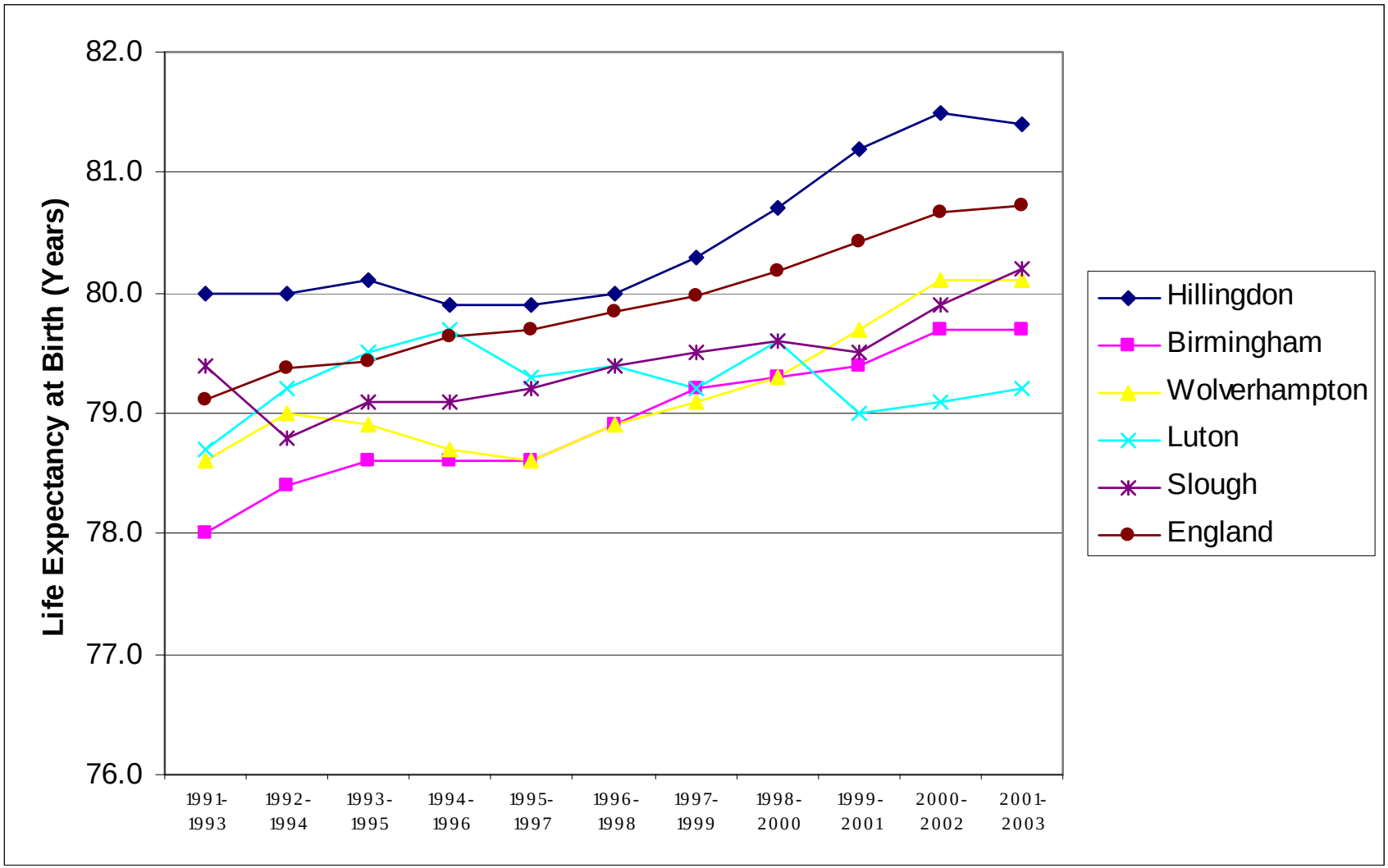
Areas where ethnicity and health inequality may be linked

- Disease Morbidity/Mortality
- Lifestyle & Health–related behaviour
- Access to and uptake of health services
- Determinants of health (e.g. Income, Education, Housing)

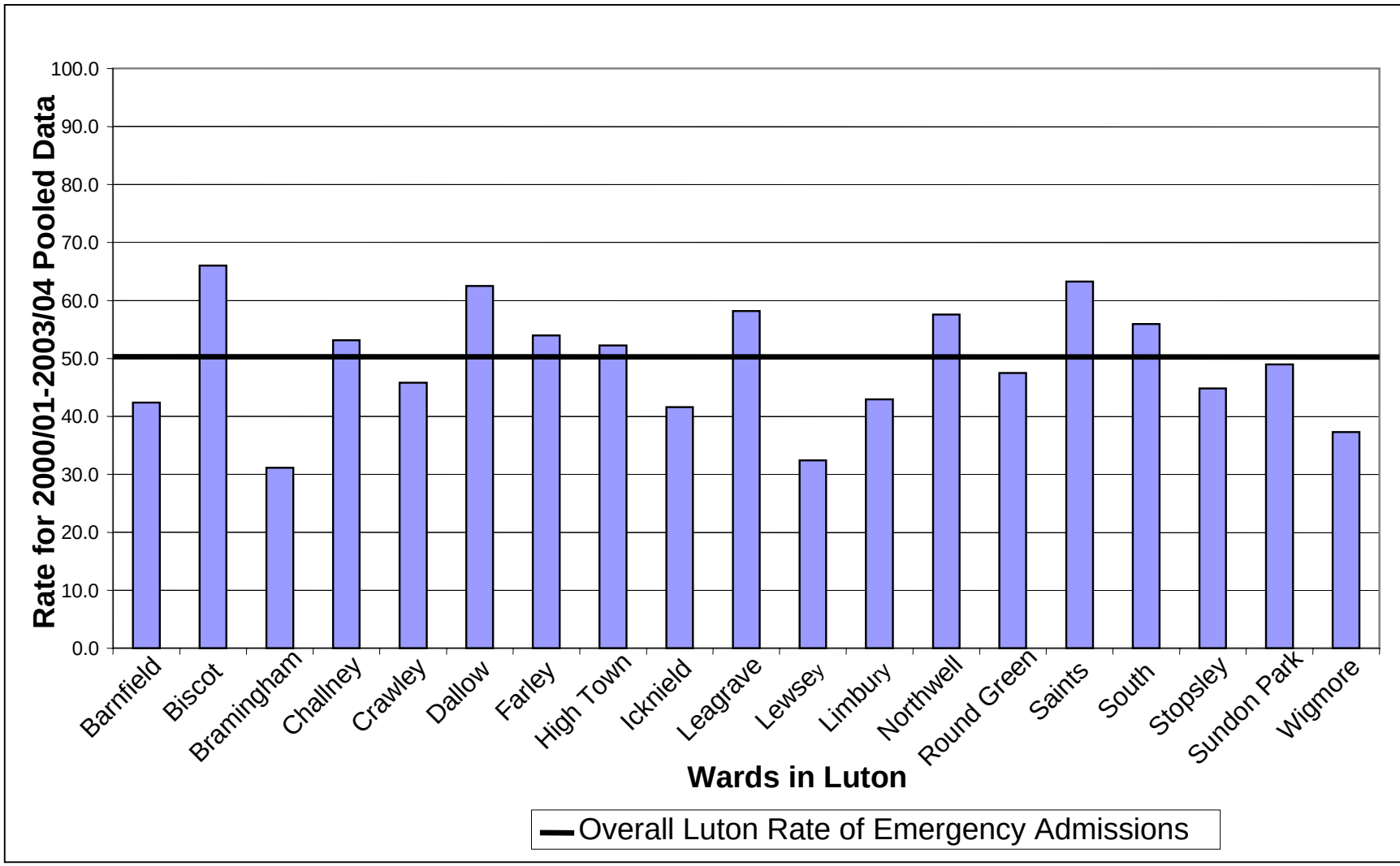
Male Life Expectancy Trends 1991 - 2003



Female Life Expectancy Trends 1991 - 2003



Emergency Admission Rates for Luton Wards 2000/01-2003/04 Pooled Data

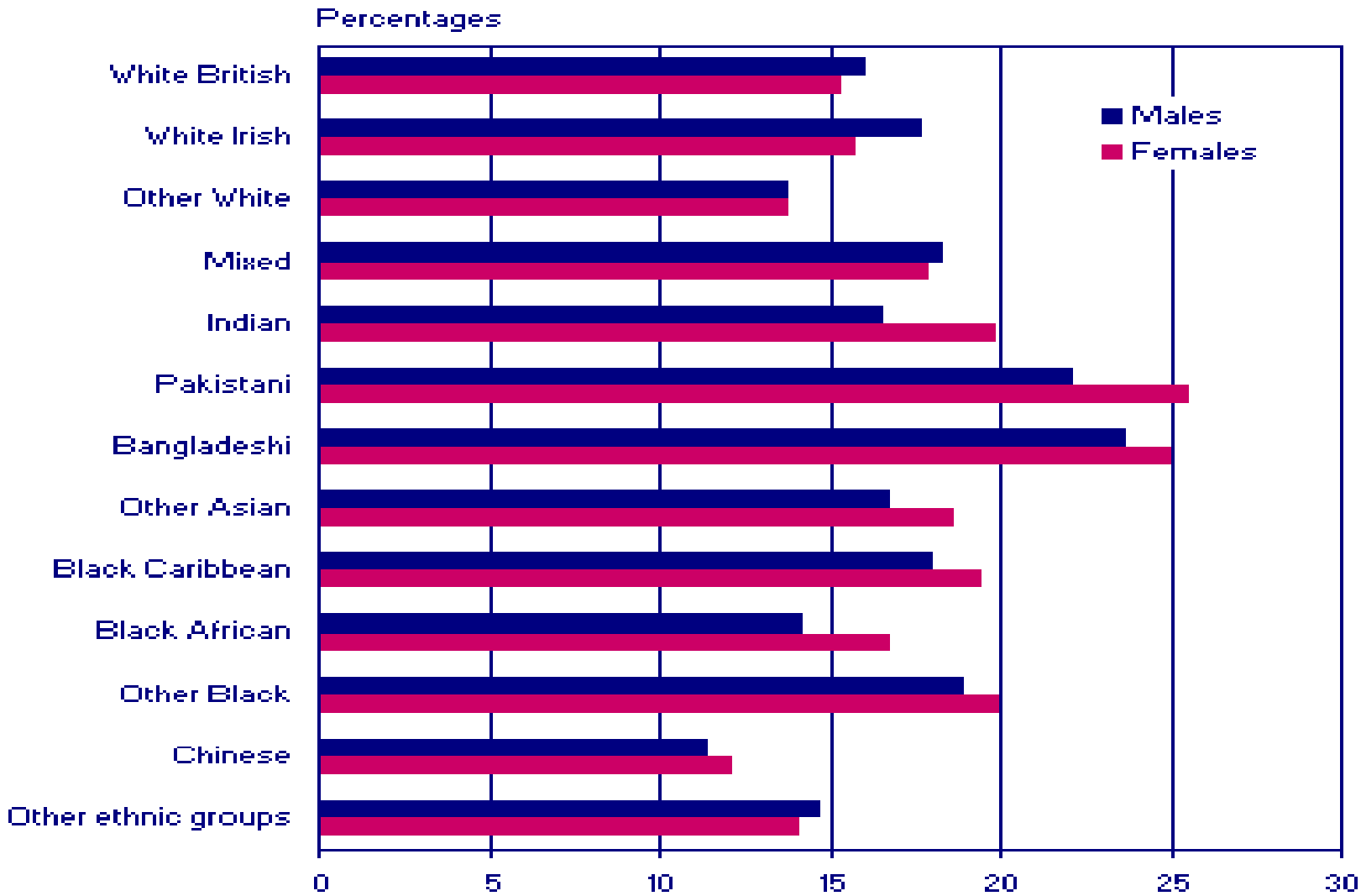


Ethnicity in Luton

Percentage of resident population in ethnic groups:	Luton	England
White	71.9	90.9
(of which White Irish)	(4.6)	(1.3)
Mixed	2.6	1.3
Asian or Asian British	18.3	4.6
Indian	4.1	2.1
Pakistani	9.2	1.4
Bangladeshi	4.1	0.6
Other Asian	0.8	0.5
Black or Black British	6.3	2.1
Caribbean	4.2	1.1
African	1.7	1.0
Other Black	0.4	0.2
Chinese or Other Ethnic Group	0.9	0.9
Total	100.0	100.0

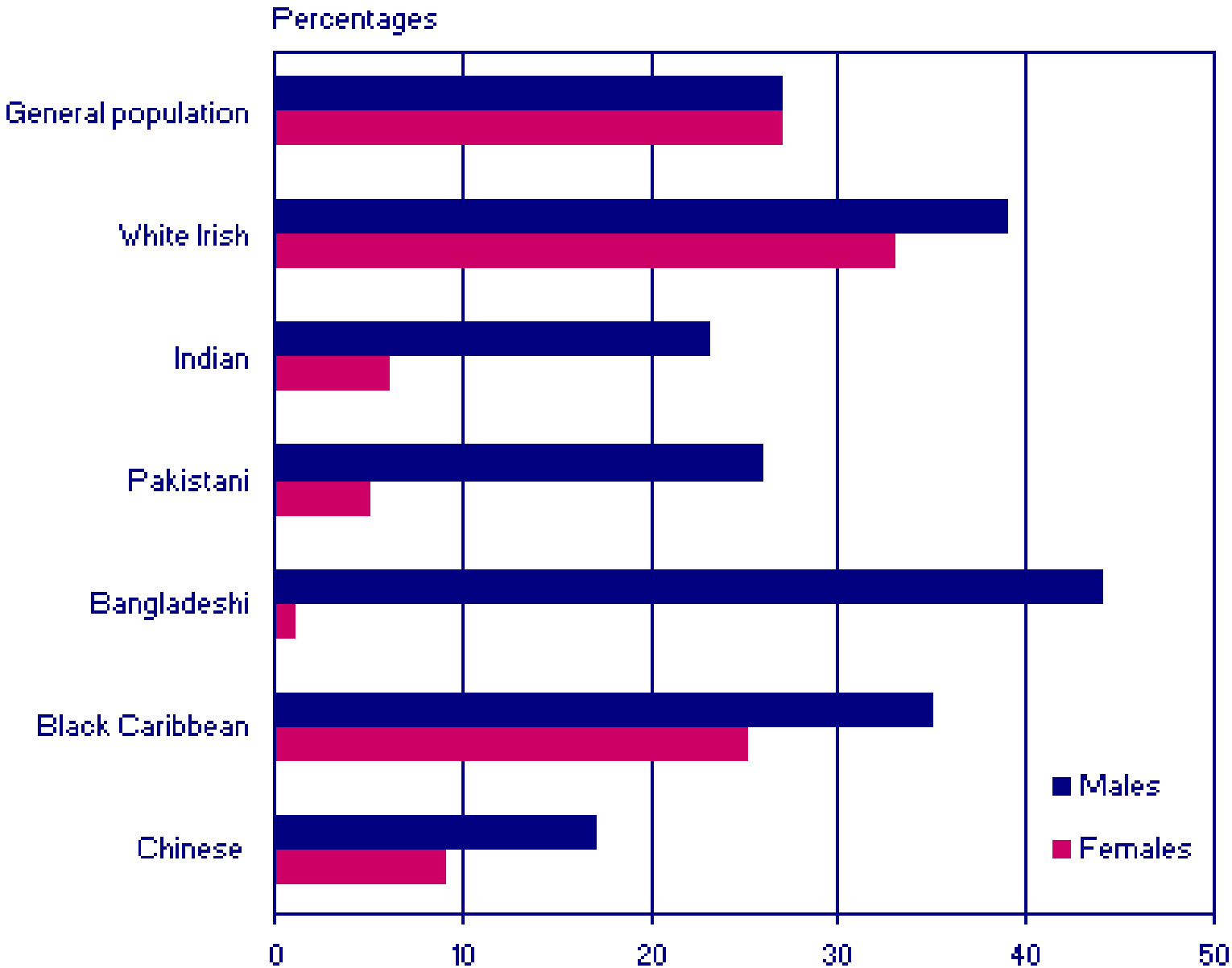
Source: ONS 2001 Census

Ethnicity in Health: Long term illness/disability rates



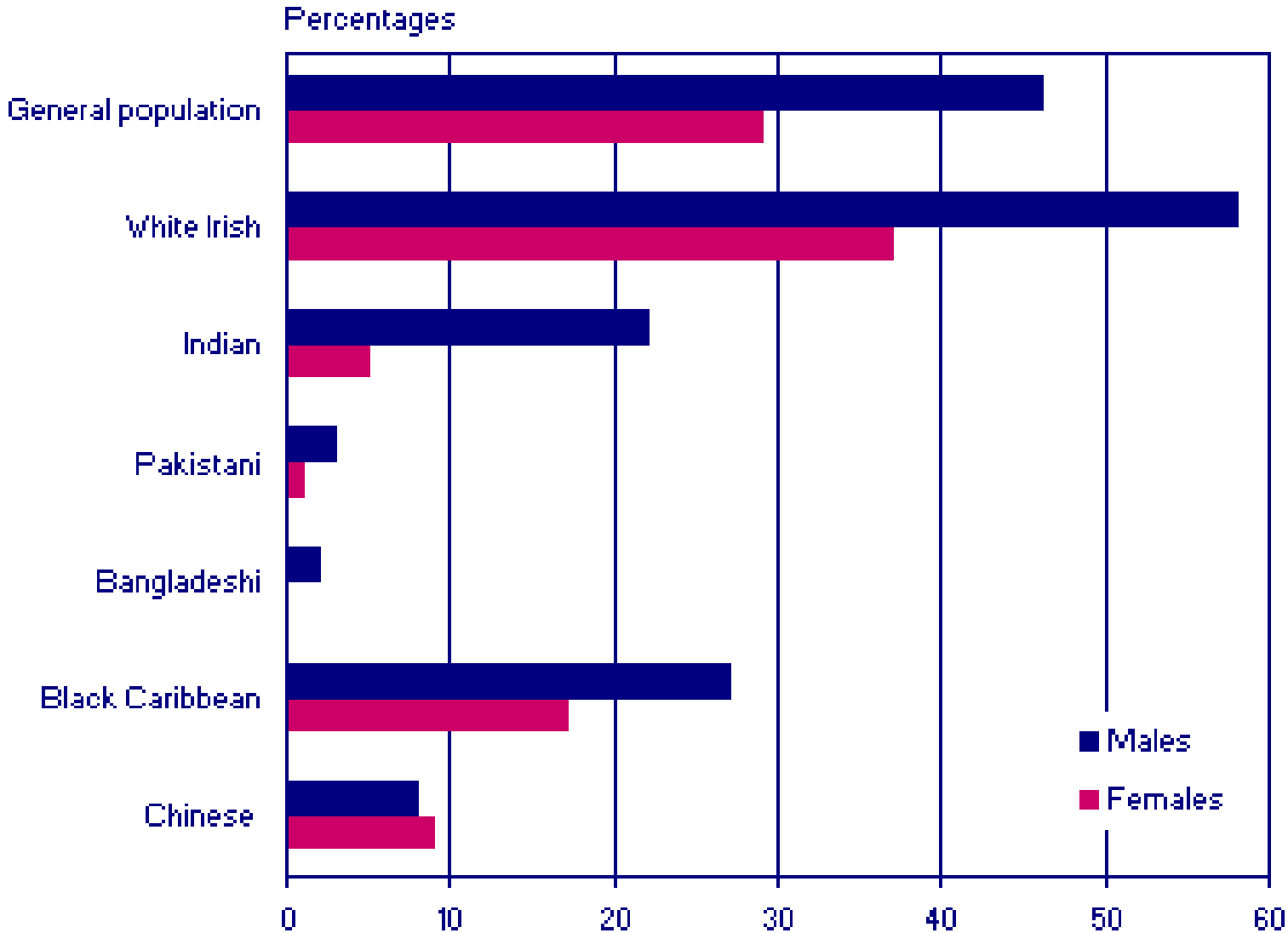
Age standardised rates of long-term illness or disability which restricts daily activities: by ethnic group and sex, April 2001, England & Wales

Smoking



Current cigarette smoking: by ethnic group and sex, 1999, England

Alcohol Consumption



Adults drinking above recommended daily alcohol guidelines:
by ethnic group and sex, 1999, England

Table 9 Breast screening rates by ethnic origin (%)

	All	16-29	30-49	50-74
UK population	21	3	16	41
African-Caribbean	14	5	12	31
Indian	7	6	5	14
Pakistani	7	3	8	18
Bangladeshi	4	1	5	14

Health enhancing activity by ethnic origin

	Any activity %	General physical activity %
UK population	62	22
Caribbeans	55	10
Indian	46	12
Pakistani	41	8
Bangladeshi	37	5

Social class or ethnicity?

- Social class – Pakistani and Bangladeshi communities have lowest proportion in managerial and professional occupations ('Other white' group has the highest)
- Poverty/ Free school meals – highest proportions in Black Africans & Bangladeshis (lowest in Chinese, Indian and White British)
- Educational achievement – lowest in Black Caribbean and Black Other groups, highest in Chinese.

Social class or ethnicity

- Classically “social class” in the UK means occupational class
- Carries with it the inference of cultural, social as well as economic and occupation differences

Self reported Ill health ratios in the UK – “the north-south divide”

	Men	Women
England	2.68	2.23
Scotland	2.88	2.81
Wales	2.46	2.12

Self reported Ill health ratios in the UK – “the north-south divide”

	Men	Women
North east	2.51	2.14
North West	2.65	2.21
York & Humber	2.43	2.07
West midland	2.53	2.11
South East	2.69	2.12
London	2.91	2.44
East	2.51	2.83

UK – “the north-south divide”

- Clear difference between England & Scotland
- No definite north-south gradient within England

Age-standardised morbidity in men by deprivation status 1-5 (per 1000 patients)

	CHD	Depression	NIDDM
Deprivation index 1	31.3	22.2	8.6
3	35.6	23.3	9.5
5	40.9	28.3	11.7
Total	35.8	24.9	9.9

Access to and uptake of health services

Key Question: Is the uptake of services for specific ethnic groups is higher or lower than would be expected, given known differences in the prevalence of particular health problems?

Issues:
- Language barriers
- Cultural differences in the perception of ill-health
- Lack of knowledge about the availability and range of health services

All these issues can inhibit or delay access to care and lead to more severe problems

Inverse care law in the consultation
length of consultation & psycholog distress

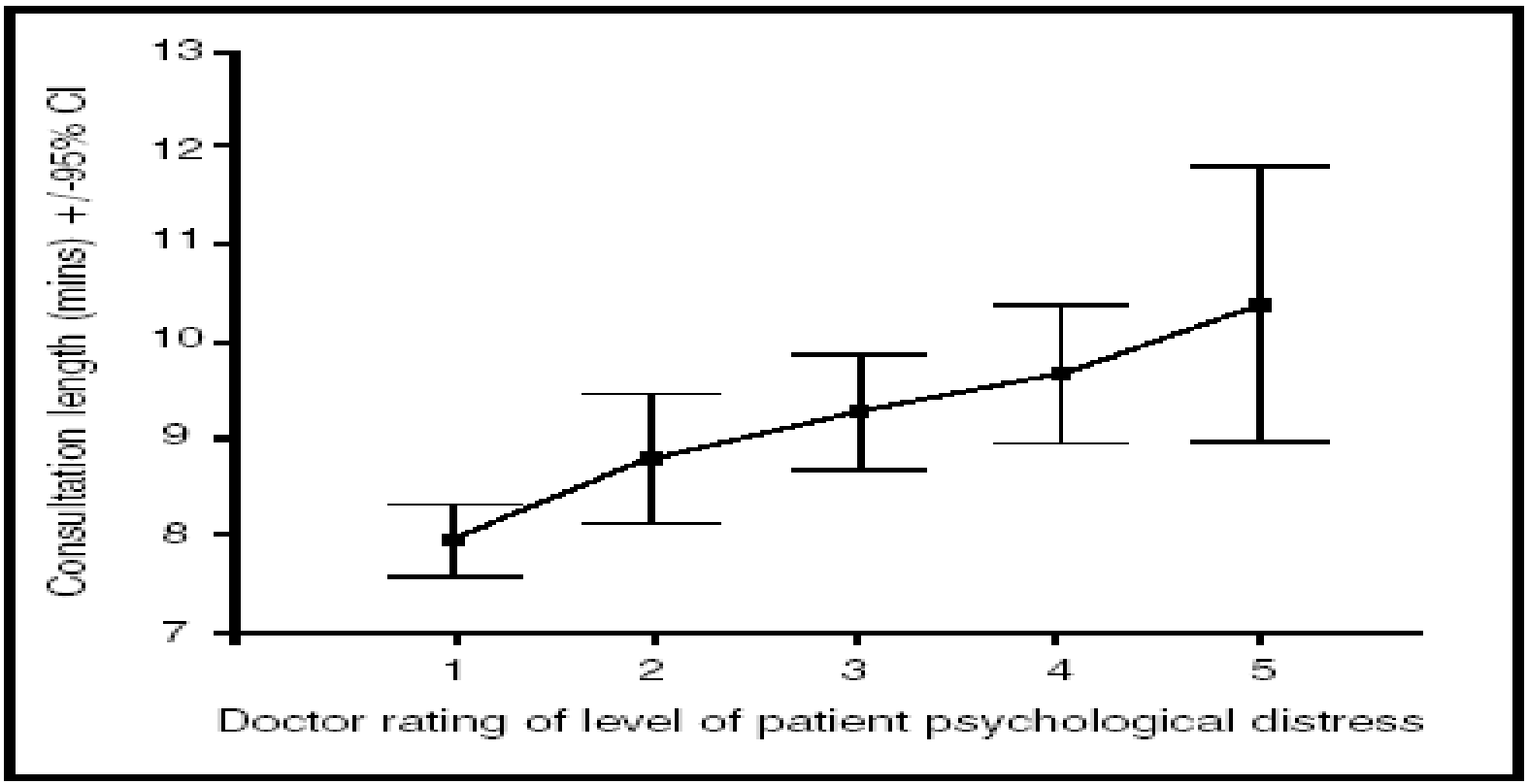


Figure 1. Mean consultation length (with 95% confidence intervals) against doctor rating of patient psychological distress.

Inverse care law in the consultation

length of consultation & psycholog distress

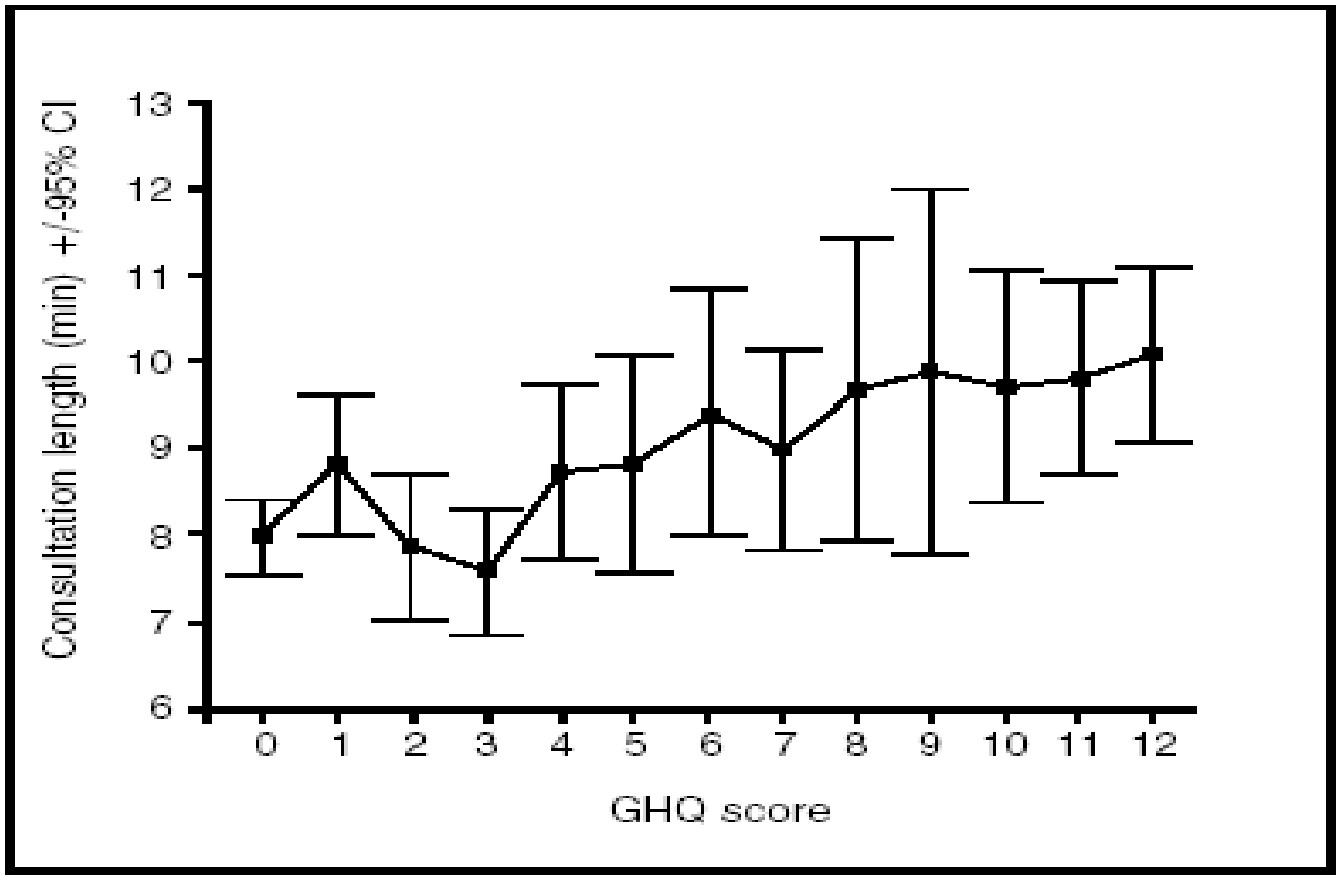


Figure 2. Mean consultation length (with 95% confidence intervals) against GHQ score.

Inverse care law in the consultation

length of consultation & psycholog distress

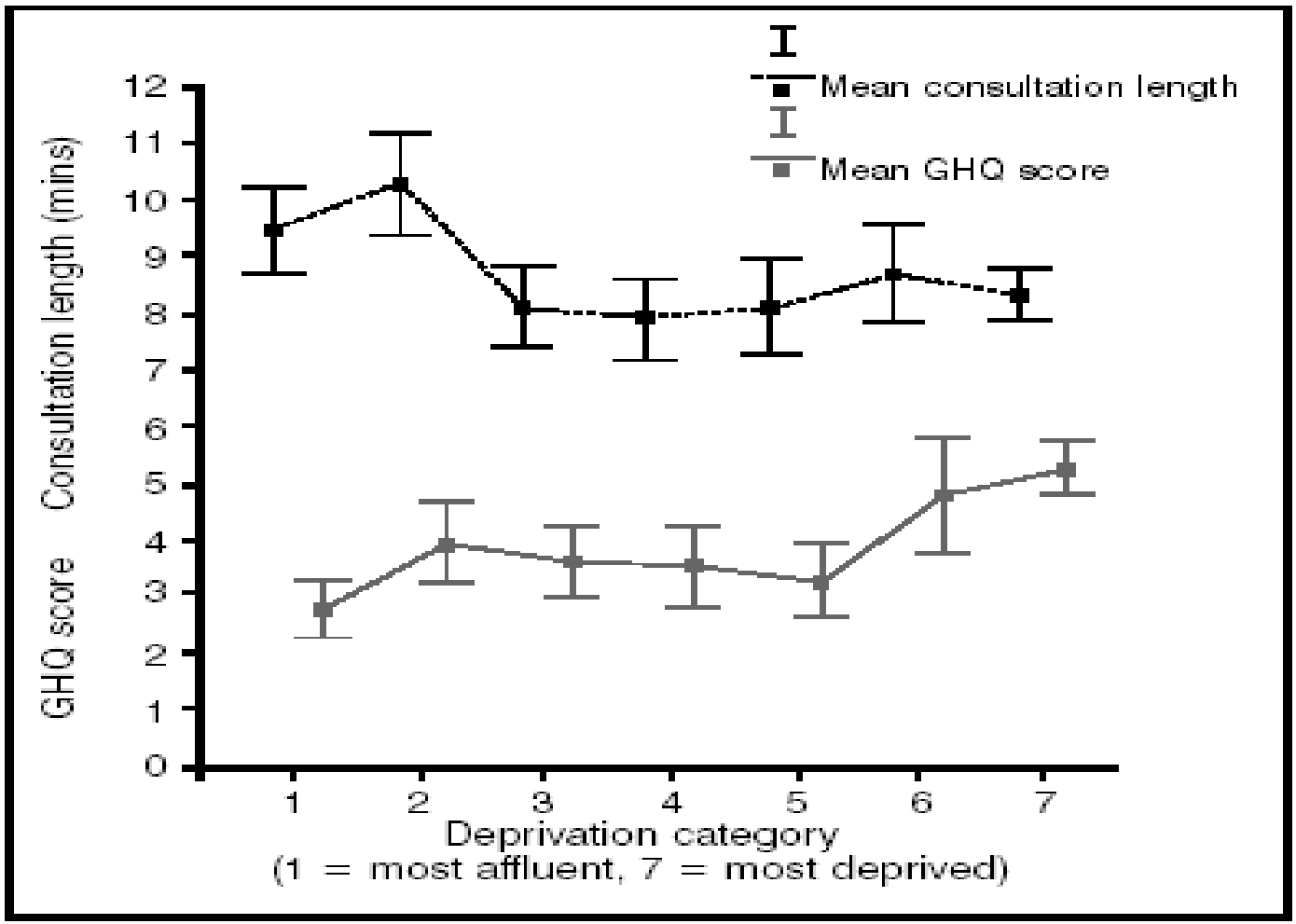


Figure 3. Consultation length and GHQ score against deprivation category.

Does consultation length matter?

Longer consultations result in :

- Less prescribing
- Inclusion of life-style advice
- Preventive activities in the consultation
- More problems being dealt with
- More information exchange between doctor and patient

What can we all do easily?

- Make NHS more accessible to the more deprived
  - Language
  - Appointment systems
  - Consultation lengths
- Invest by need rather than pressure group
- Target specific groups (e.g. the homeless, the housebound)