

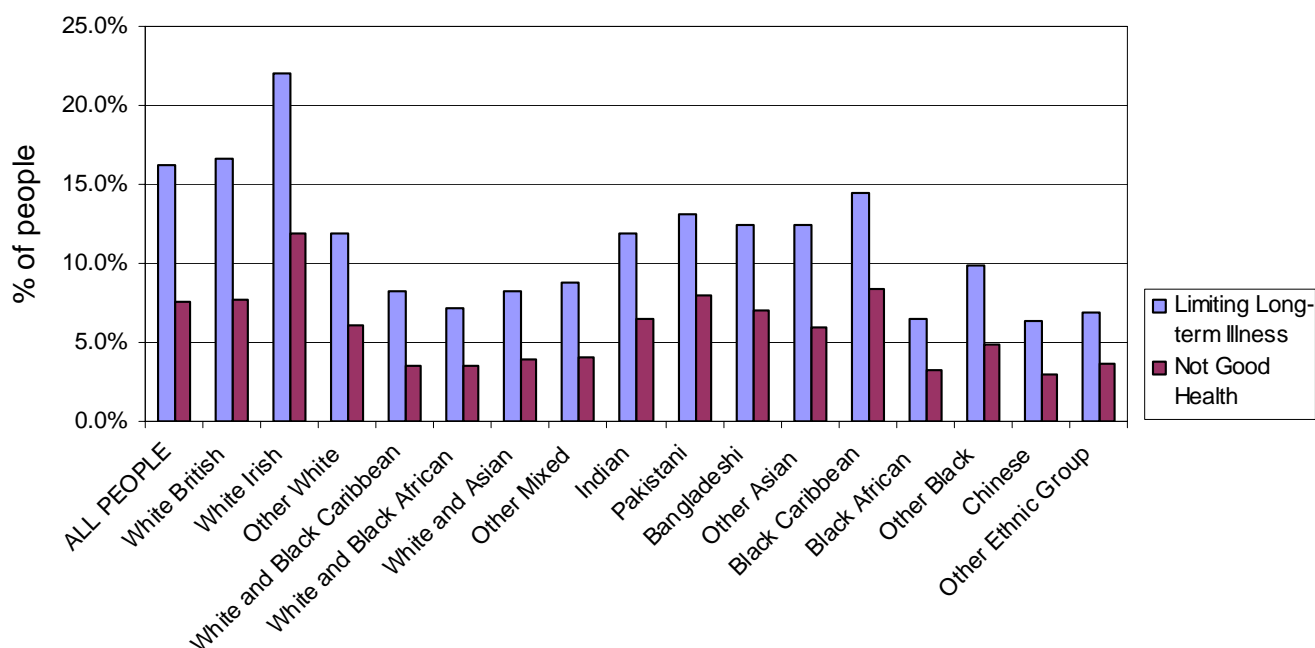
## 5.0 Health

### 5.1 “Not good” health and limiting long term illness

The Census provides information about two aspects of health – the presence of any long-term illness, health problem or disability that limits one’s ability to perform daily or work activities; and the general state of one’s health in the previous year (good, fairly good or not good). Both these items rely on self-report and it is important to remember that they therefore reflect a person’s *perception* of their health rather than an externally defined absolute. This information can be assessed by ethnic group.

**Figure 5.1.1 % of Eastern Region residents with limiting long-term illness or “not good” general health by ethnic group**

Source: Census 2001, Table S107



It can be seen from Figure 5.1.1 that the average proportion of people reporting limiting long-term illness (LLTI) in the population of the Eastern Region is 16.2%. LLTI is most commonly reported by those in the White Irish group (22.1%), followed by those in the White British category (16.6%). The ethnic groups with the lowest proportion of members reporting LLTI are the Chinese (6.4%), Black African (6.5%) and Other Ethnic Groups (6.9%).

A lower proportion of East of England residents report “not good” health (7.6%). Again those in the White Irish group are most likely to report this problem (11.9%) followed by those in the White British group (7.7%). The Chinese group are least likely to report “not good” health, with only 3.0% doing so, followed by Black Africans (3.2%). The Other Ethnic Groups and the Mixed groups also have low proportions of their members reporting “not good” health.

One of the main causes of ill health – both LLTI and “not good” health – is old age because most people’s health deteriorates as they get older. As has been demonstrated in Figures 3.1 to 3.11, the different ethnic groups in the Region have very different age structures. It follows that groups with an older age structure, such

as the White British and White Irish groups, would have more members suffering from ill health and that without allowing for this statistically, a meaningful comparison could not be made between the health of members of these groups and the health of those who belong to ethnic groups with a younger age structure.

It is common in health research to use *age standardised ratios* to compensate for the different age and sex structures between groups – in essence to filter out these factors. This standardisation allows us to calculate the rate of illness we would expect in the average population and apply this to the observed rates in each ethnic group. A ratio of 100 indicates that the rate of illness in a particular population is neither lower nor higher than we would expect. Higher rates indicate a greater amount of ill health and lower rates a lesser amount of ill health. If for example we were to see a rate of 50 this would indicate that there were half as many cases of LLTI and “not good” health as we would expect to see in a population with a given age structure. If we were to see a rate of 150, this would indicate that there were 50% more cases than we would expect.

**Table 5.1.1 Indirectly age standardised limiting long-term illness and “not good” health ratios**

Source: Census 2001, Tables S16, S65, S101, S107

Ethnic Group	Limiting long-term illness		"Not good health"	
	Female	Male	Female	Male
ALL PEOPLE	100	100	100	100
White British	100	100	99	99
White Irish	103	110	115	127
Other White	91	87	96	94
White and Black Caribbean	137	123	143	132
White and Black African	104	113	117	120
White and Asian	110	103	113	116
Other Mixed	116	108	115	119
Indian	115	99	132	102
Pakistani	161	147	199	198
Bangladeshi	165	145	198	177
Other Asian or Asian British	115	101	112	97
Black Caribbean	124	104	147	120
Black African	83	70	75	79
Other Black or Black British	115	99	133	86
Chinese	68	58	63	58
Other Ethnic Group	67	80	65	88

Table 5.1.1 shows the indirectly age standardised ratios of self-reported LLTI and self-reported “not good” health for male and female members of each ethnic group. The White British group have neither greater nor lesser rates of LLTI than one would expect and a slightly lower proportion of people reporting “not good” health. It is expected that this would be the case, as they make up such a large proportion of the population against which these ratios are standardised.

Both male and female Pakistanis show particularly high levels of LLTI and “not good” health. In fact, almost double the number one would expect given the age structure of the group, report “not good” health. Bangladeshis are also particularly likely to report LLTI or “not good” health, especially the female members. This is in contrast to the Indian and Other Asian groups who, although there is a slightly

higher proportion of LLTI and “not good” health among the female group members, exhibit around the expected level of ill health.

Within the Black or Black British groups, Black Africans show lower levels of LLTI and “not good” health than would be expected within a population of that demographic structure, whereas Black Caribbeans show higher levels. Other Blacks are interesting in that the male members of the group exhibit slightly lower levels of illness than would be expected, whereas the female members exhibit higher levels.

The Chinese have the lowest proportions of LLTI and “not good” health, with males reporting more than 40% fewer incidences and females more than 30% fewer for both categories of illness. Those in Other Ethnic Groups and Black Africans also have far lower numbers of incidences than would be expected given their population’s age structures.

Females on the whole show greater proportions of both self-reported LLTI and self-reported “not good” health in nearly every ethnic group. The exceptions to this are Other Ethnic Groups (where both male and female members show less LLTI and “not good” health than would be expected); White Irish (where the higher rates found among males are perhaps due to factor of lifestyle, such as greater levels of smoking and alcohol consumption among males); and the Mixed White and Black African group. In all other groups females have higher levels of LLTI than males, although in the Mixed White and Asian group, the Other Mixed groups and the Black African group, males have higher levels of “not good” health.

**Figure 5.1.2 Indirectly age standardised LLTI ratios in the Eastern Region**

Source: Census 2001, Tables S16, S65, S101, S107

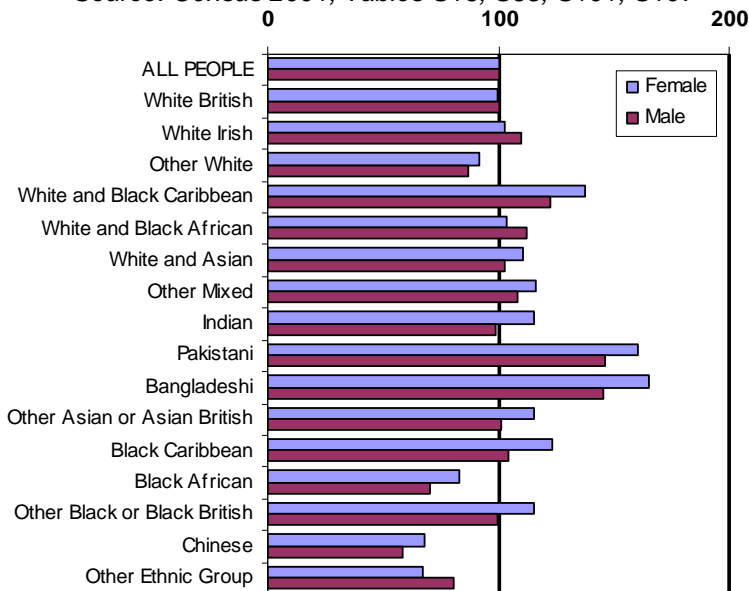


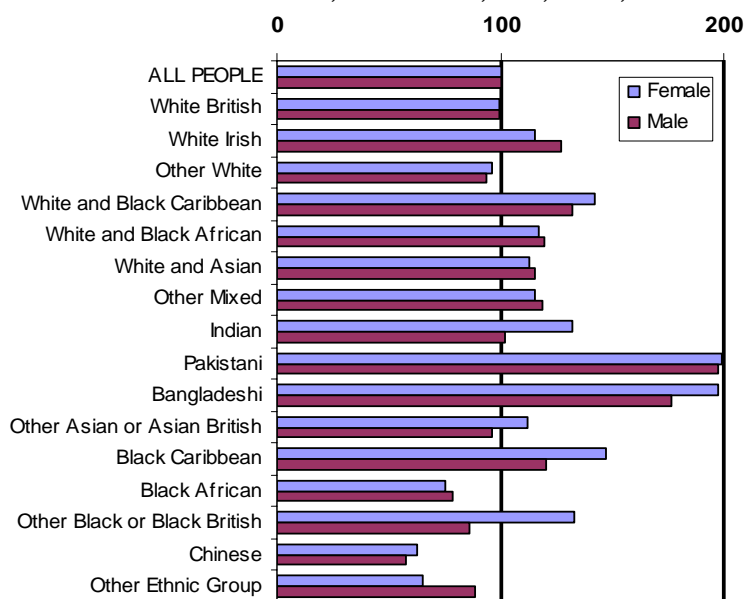
Figure 5.1.2 illustrates the figures discussed above for LLTI. Bars extending beyond the central line indicate greater incidence of LLTI than would be expected in a population with a given age structure, whereas bars which do not reach the central line indicate lower incidence of LLTI.

It can clearly be seen that Pakistanis and Bangladeshis have the highest ratios of LLTI and that the Chinese and Other Ethnic Groups have the lowest.

In nearly all cases females have greater incidence of self-reported LLTI than males

**Figure 5.1.3 Indirectly age standardised “not good” health ratios in the Eastern Region**

Source: Census 2001, Tables S16, S65, S101, S107



Once again, the greatest over occurrence of “not good” health is evident in the Pakistani and Bangladeshi populations.

The Chinese group, along with Black Africans and Other Ethnic Groups, have the lowest incidence.

In the majority of groups, there is a slight bias towards greater incidence of “not good” health in females, and this is particularly pronounced in the Other Black and Black

Caribbean populations. It is interesting to note the difference between these two groups and Black Africans, who have much better rates of health than would be predicted on the basis of their age structure. Black Africans are often successful people, who might be here as students, academics or for some other economic reason. Conversely, Black Caribbeans are more likely to be born in the UK or to have immigrated here in the mid 20<sup>th</sup> Century, and to be subject to deprivation, which is linked to ill health.

## 5.2 Specific Medical Disorders

It can be seen from the Census data that certain ethnic groups report being in worse health than others. Firstly, it is important to state that the levels of limiting long-term illness and “not good” health are self-reported. They are not gleaned from examination of medical records or hospital reports and it is possible that they represent culturally different ways of describing health and interpretations of ill health in addition to ‘concrete’ illness. However, if we accept that at least in part this data represents real health differences between ethnic groups, it is interesting to consider whether this is related to specific types of illnesses or medical problems.

Large-scale investigation into this matter has often been curtailed by impoverished data due to poor and inconsistent monitoring of ethnicity by services. Additionally, mortality data is not collected by ethnic group. Two recent reports (Aspinall & Jackson, 2004 and Fitzpatrick *et al*, 2005) address this issue for certain types of disease nationally and regionally respectively and this section will consider these two reports in tandem. It is important to remember that impoverished data particularly comes into play when considering the regional picture. The East of England has the second most incomplete data on the measures used in Fitzpatrick’s *et al* (2005) report – only the data for the South East is less complete. For example, the ethnicity monitoring data on Hospital admissions (HES) is 42.0% incomplete in this region.

Once again it should be noted that this means that any conclusions drawn on the basis of this evidence are tentative.

All the following information can be found in the two reports above and was drawn from a variety of sources:

- Hospital Admissions 2002/03 – Hospital Episode Statistics (HES)
- AIDS/HIV 2003 (SOPHID)
- TB surveillance 2000-02 (ETS)

Information is presented on coronary heart disease (CHD), diabetes, cancers, sexually transmitted diseases and tuberculosis. Data is also presented on mental health, but this will be covered in more detail in section 5.3.

### *Coronary Heart Disease (CHD)*

For all ethnic groups, the East of England has a higher proportional hospital admission rate (or PR - the proportion of all hospital admissions for a condition in each ethnic group compared to the average for all ethnic groups) for this disorder. It is known nationally that those in the Asian group, particularly Pakistanis and Bangladeshis show higher rates of prevalence of this disease, although if socio-economic factors are accounted for, this disparity is somewhat reduced. Other factors that may influence the high incidence of CHD in the Asian groups are lifestyle factors such as smoking and the presence of other high-risk medical factors such as high blood pressure and insulin resistance. The regional picture bears this out, with all Asian groups having increased proportional admission rates (PRs) for CHD, particularly the Indian and Pakistani populations. The White British population also has a very high PR, while the Other White groups have rather low PRs. No other ethnic groups differ significantly from the average incidence for this disease.

Aspinall & Jackson (2004) suggested that nationally, the Asian groups were less likely to receive coronary revascularisation (for example, heart bypass surgery or coronary angioplasty) than other groups, however, the regional data suggests that in the East of England provision of this treatment is according to need in the Asian groups and this inequity is not present.

### *Diabetes*

For all ethnic groups combined, the East of England has significantly high PR rates for diabetes. A common finding in studies is a very high prevalence of non-insulin dependent diabetes in Asian groups and a raised rate in Black Caribbeans, which cannot be explained by socio-economic factors. Aspinall & Jackson (2004) point out that the disease also presents at a significantly earlier age in sufferers in the Asian population, and that its effect in this group is often confounded by poor compliance of the patients due to their lack of knowledge of the disease. They suggest this is due to inappropriate health information. Up to 40% of Asian sufferers remain undiagnosed.

In the East of England, as expected, all the Asian groups and the Black Caribbean group have elevated PRs for diabetes, as do the White British and the Other White

groups. The rates for Black Africans, the Mixed White and Asian group, the Chinese group and the Other Ethnic Groups are also high.

### *Cancer*

Information on cancer incidence is not reported regionally, and indeed, nationally the evidence is sparse. Among Asian groups, there is a lower rate of all cancers than for non-Asian groups, although research studies show significantly higher rates of oral cancers. Generally, lower rates of breast cancer are found in all migrant groups, although this is still one of the most significant causes of death. Very little other data is available in the UK.

### *HIV and sexually transmitted diseases*

HIV and other sexually transmitted diseases are much more prevalent among Black and Minority Ethnic groups than the White population. In the East of England, the Black African group accounts for the largest proportion of patients seen for care for HIV – more than half of all HIV patients in the region are from this group. Asian groups have low incidence of HIV, but Aspinall & Jackson (2004) caution that newly diagnosed cases of HIV in England and Wales are now commonly contracted in Asia.

Other sexually transmitted diseases are found disproportionately in Black Caribbeans and those belonging to the Other Black ethnic group. In the case of gonorrhoea, 50% of cases nationally are found in the White groups and 30% in the Black Caribbean group. In the East of England the proportions are slightly higher for those in the White group and slightly lower for those in the Black Caribbean group.

### *Tuberculosis*

The number of cases of TB in England has risen by 25% over the last ten years. Since the risk of infection is higher for those who have lived in parts of the world where the disease is more common, migrants are disproportionately affected. Black Africans have the highest rates of TB, followed by those in the Asian groups. Black Caribbeans and Chinese have lower than average rates. However, these rates are inconsistent across the country. Nearly 40% of cases in the East of England are found among the White group, with the Black African and Indian groups each accounting for around 10% of cases. Slightly more than 10% of the cases are in the Pakistani group, with smaller numbers in all other groups and particularly low incidence in the Black Caribbean, Other Black and Chinese groups.<sup>4</sup>

## **5.3 Mental health issues**

The most current and complete information about the national rates of mental health of BME groups is found in the Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC) reports (2002). Both a quantitative study and qualitative study were conducted, with the quantitative study making use of clinical instruments

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<sup>4</sup> Enhanced TB Surveillance (ETS) in England, Health Protection Agency, 2000/2002

and interviews (for full list of the instruments used see the EMPIRIC report<sup>5</sup>) to reveal general trends in measures of mental health. The qualitative report was designed to expose any cultural difference in the experience and expression of symptoms of mental ill health that may have affected the results of the quantitative study.

The sample for the report was drawn from a pre-existing sample from the Health Survey for England (HSE) 1999 and included members aged 16-74 of the Black Caribbean, Indian, Pakistani, Bangladeshi and White Irish ethnic groups, along with a general population sample from the White group. Full details of sampling issues are available in the report. It is important to note that the samples from the different ethnic groups were heterogeneous along measures that are known to affect mental health, such as age, socio-economic status and marital status.

A full review of this extensive topic is out-with the scope of this review, however, the key findings from the EMPIRIC reports are as follows:

#### *Common Mental Disorders (CMD) such as anxiety and depression*

Common Mental Disorders (CMD) affect around 15% of people in the community (Singleton, *et al*, 2001) resulting in a range of physical and mental impairments. Before adjusting for age, similar levels of CMD (also known as neurotic disorders) were found among men in all the ethnic groups sampled, with the exception of White Irish men who had a statistically higher rate of CMD than found in the White group. After correcting for age (as we have shown different ethnic groups have very different age structures – see section 3 – which is a major predictor of illness), this trend was no longer significant. For women, Whites, Irish and Black Caribbeans had similar rates of CMD, however there were elevated rates in Indian and Pakistani women and much lower rates in Bangladeshi women. After adjusting for age, only the low rates in Bangladeshi women remained statistically significant, although the authors suggest that the non-significant results for the other female groups may be due to small sample sizes.

Anxiety disorders in the male groups were most common in the Irish group and least common in the Indian group. In the female group anxiety disorders were most common in members of the Indian and Pakistani groups. For the male groups, depressive episodes were least common among Irish men and for the female group depressive episodes were most common among Indian and Pakistani women. Bangladeshi women had the lowest prevalence of any CMD. The Indian group was the only one with significant gender differences.

Initial adjustment for socio-economic and age related factors made little difference to the findings and the authors point out that this is interesting in light of the high socio-economic deprivation in their Bangladeshi sample.

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<sup>5</sup>The full text of the EMPIRIC reports is published by the Department of Health and can be accessed at <http://www.doh.gov.uk/public/surveys.htm>

## *Psychotic Disorders including schizophrenia and other delusional/hallucinatory disorders*

These disorders are relatively rare in the community, with only around 1 in 200 people affected each year (Singleton, *et al*, 2001). However, in those they do affect they have very serious debilitating consequences. Studies over the last 30 years conducted on patient populations have shown consistently higher prevalence rates of certain psychotic disorders (schizophrenia particularly) in the Black Caribbean population (e.g. Bagley, 1971; Van Os, *et al*, 1996). However, these findings have been challenged by studies that do not rely on treatment data. In the South Asian (Pakistani, Indian and Bangladeshi) population there are even more conflicting results with some studies suggesting that prevalence rates of psychotic disorders are in line with those in the White population (Bhugra, *et al*, 1997) and others suggesting that they are similar to those found in the Black Caribbean population (King, *et al*, 1994). These conflicting results from treatment data are addressed by the community-based EMPIRIC study, but the question of how and why treatment is sought by certain groups is left open.

Once again, for full information about the instruments used for assessment, please refer to the EMPIRIC study.

Unlike the studies mentioned above, which indicate that prevalence rates of psychotic symptoms are three to five times higher in the Black Caribbean community compared to the White community, the EMPIRIC survey found double the rate in Black Caribbeans. This only reached statistical significance among the female group and was not significant for Black Caribbean men, or for the ethnic group as a whole.

The Irish group had similar rates of psychotic symptoms as the White group, and though the rates were higher in the Indian and Pakistani groups, this did not reach statistical significance. Once again, the Bangladeshi group showed lower prevalence than the White group, but this also was not a statistically significant difference. Factors that affected the rates for these groups were age on migration, with 'migrants' showing lower prevalence than 'non migrants'.

Socio-economic deprivation appeared to increase risk for the White, Irish and Black Caribbean groups, but not for the South Asian groups.

### *Qualitative data*

A concurrent qualitative study was carried out with a sub-set of the groups sampled for the quantitative report. A full review of the rich qualitative data is not possible here, but issues affecting the apparent prevalence of mental health disorders such as reluctance to report mental health difficulties to one's doctor, different experience and interpretation of symptoms of mental ill health and experiencing physical symptoms in response to mental distress (somatisation) are discussed. Possible causes of mental distress that could differentially affect certain cultures (although of course each group will have different experiences), such as the experience of racism, family situation, arranged marriage and domestic abuse are also considered.

Regional figures on mental health by ethnicity are not available at the present time, however figures from the Psychiatric Morbidity Among Adults Living in Private Households, 2000 report (Singleton, *et al*, 2001) suggest that prevalence rates of mental disorders in the East of England do not significantly differ from those in the UK as a whole. It is likely that the national data presented in the EMPIRIC report is therefore applicable to the East of England.

### 5.3.1 The patient population

#### *The patient population in England*

Table 5.3.1.1 compares the general population in England to the psychiatric care population. As mentioned above, in the patient population a higher incidence of psychotic disorders is found among Black Caribbeans than among the White group, with possible higher incidence among other ethnic groups. It can be seen that the psychiatric population in England does indeed have a higher proportion of Black Caribbeans than found in the population as a whole. A slightly higher proportion of White Irish are also in psychiatric care than one would expect from their general population profile and a very slightly higher proportion of Black Africans and those with a White and Black Caribbean ethnic background. All other groups have lesser or equal proportions of their members in psychiatric care, compared to their general population profile.

**Table 5.3.1.1 % of people in England in the general versus the psychiatric care population by ethnic group**

Source: Census 2001, Tables S101 & S125

	All people		Males		Females	
	% general population	% psychiatric care population	% general population	% psychiatric care population	% general population	% psychiatric care population
ALL PEOPLE	100.0%	100.0%	48.7%	57.3%	51.3%	42.7%
White: British	87.0%	77.5%	42.4%	43.7%	44.6%	33.8%
White: Irish	1.3%	2.0%	0.6%	1.1%	0.7%	0.9%
Other White	2.7%	2.7%	1.2%	1.6%	1.4%	1.1%
White and Black Caribbean	0.5%	0.7%	0.2%	0.6%	0.2%	0.2%
White and Black African	0.2%	0.2%	0.1%	0.2%	0.1%	0.0%
White and Asian	0.4%	0.3%	0.2%	0.2%	0.2%	0.1%
Other Mixed	0.3%	0.3%	0.1%	0.2%	0.2%	0.1%
Indian	2.1%	1.0%	1.0%	0.7%	1.1%	0.3%
Pakistani	1.4%	0.5%	0.7%	0.4%	0.7%	0.1%
Bangladeshi	0.6%	0.1%	0.3%	0.1%	0.3%	0.0%
Other Asian	0.5%	0.4%	0.3%	0.3%	0.2%	0.1%
Black Caribbean	1.1%	3.4%	0.5%	2.6%	0.6%	0.8%
Black African	1.0%	1.2%	0.5%	0.9%	0.5%	0.3%
Other Black	0.2%	0.7%	0.1%	0.6%	0.1%	0.1%
Chinese	0.4%	0.1%	0.2%	0.1%	0.2%	0.1%
Other Ethnic Group	0.4%	0.3%	0.2%	0.2%	0.2%	0.1%

In terms of gender, males are over-represented in the psychiatric care population, while females are less commonly seen for psychiatric care than would be expected from the population structure. Both Black Caribbean males and females are more often seen for treatment, but males to a much greater extent. Amongst men, all the Black groups have a higher proportion in the psychiatric care population than the general population, as do certain Mixed groups and Other White groups, although to

a lesser degree. In the female group, with the exception of Black Caribbean females, only White Irish females have a larger proportional presence in the psychiatric care population than the general population.

As was stated in the EMPIRIC report, it should be remembered that these rates are representative only of the patient population and may not be directly comparable with the population as a whole.

*The patient population in the East of England*

Figure 5.3.2.1, below, shows the comparable rates for the Eastern Region. Within this region, the Other Black group has a particularly high psychiatric care population compared to its general population. This is especially evident in the male members of the group. In line with the picture for England as a whole, the Black Caribbean population has around three times the proportion of members in psychiatric care than one would expect from their representation in the general population, but unlike the national picture, in the East of England this affects both male and female Black Caribbeans to a similar extent.

**Table 5.3.1.2 % of people in the East of England in the general versus the psychiatric care population by ethnic group**

Source: Census 2001, Tables S101 & S125

	All people		Males		Females	
	% general population	% psychiatric care population	% general population	% psychiatric care population	% general population	% psychiatric care population
ALL PEOPLE	100.0%	100.0%	49.0%	59.8%	51.0%	40.2%
White: British	91.4%	86.3%	44.8%	51.0%	46.7%	35.3%
White: Irish	1.1%	1.9%	0.5%	0.9%	0.6%	0.9%
Other White	2.5%	1.8%	1.2%	1.2%	1.3%	0.6%
White and Black Caribbean	0.4%	0.9%	0.2%	0.6%	0.2%	0.3%
White and Black African	0.1%	0.0%	0.1%	0.0%	0.1%	0.0%
White and Asian	0.3%	0.0%	0.2%	0.0%	0.2%	0.0%
Other Mixed	0.3%	0.0%	0.1%	0.0%	0.1%	0.0%
Indian	0.9%	0.5%	0.5%	0.3%	0.5%	0.2%
Pakistani	0.7%	0.3%	0.4%	0.3%	0.4%	0.0%
Bangladeshi	0.3%	0.2%	0.2%	0.2%	0.2%	0.0%
Other Asian	0.2%	0.5%	0.1%	0.2%	0.1%	0.3%
Black Caribbean	0.5%	1.8%	0.2%	1.0%	0.2%	0.8%
Black African	0.3%	0.2%	0.2%	0.2%	0.2%	0.0%
Other Black	0.1%	2.6%	0.1%	2.5%	0.0%	0.2%
Chinese	0.4%	0.2%	0.2%	0.2%	0.2%	0.0%
Other Ethnic Group	0.3%	0.3%	0.1%	0.3%	0.2%	0.0%

Again, as was found nationally, a higher than expected proportion of White Irish people are found in the psychiatric population but for this group also, unlike the national data, this appears to affect males and females to a similar extent. White and Black Caribbeans of both sexes also have elevated proportional rates of psychiatric care. Higher proportions of the Other Asian groups are also found within the psychiatric care population and interestingly, this appears to disproportionately affect female members of the group.

No other groups in the East of England were found disproportionately within the psychiatric care population.