Leading Article

Ethnicity and the use of health services

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Much of the literature linking ethnicity and health is predicated on two assumptions. Firstly, the health status of ethnic minorities is thought to be poorer than that of the indigenous population. Secondly, ethnic minorities are widely regarded as underusers of health services. Both these assumptions rely heavily on extrapolation from social class-related health inequalities. For neither assumption is there much more than anecdotal evidence. How well does the National Health Service (NHS) serve non-White Britons?

The concept of ethnicity

Ethnicity is notoriously difficult to define and record. The label 'ethnic minority' is applied to those groups which by virtue of racial, religious, national, linguistic and other cultural differences are singled out for differential treatment and may therefore regard themselves as objects of collective discrimination. The value of such a loosely defined social variable for epidemiological stratification is questionable.¹ In the 1971 census, information was included for the first time on the country of birth of individuals and their parents. Regrettably, in 1981 the collection of data on ethnicity and race was deemed politically contentious. Much literature on ethnic minorities in Britain is therefore based on *ad hoc* surveys and small-scale studies.

Social class and the use of health services

Ethnic minorities are over-represented in the manual classes. In 1981, 40% of employed West Indian and Guyanese and 36% of employed Indians, Pakistanis and Bangladeshis were in socioeconomic groups IV and V compared with 25% of employed Whites.² Post-war expansion in the British economy created gaps in the labour market

that only came to be filled with the help of immigrants from the New Commonwealth and Pakistan. These immigrants, first from the Caribbean and then from South Asia, tended to occupy jobs not wanted by native workers. Their position in the reserve army of labour left them extremely vulnerable at times of economic contraction. In the 1980s, unemployment rose faster among non-Whites.³

American research tends to support modified versions of a 'culture of poverty' approach: associated with low incomes are attitudes regarding health which make the use of health services less likely, particularly in discretionary circumstances.^{4,5} In the UK, as in the US, the clearest evidence that there are social differences in the use of health services appears in the field of preventative care.^{6,7} Gradients in mortality⁸ and numerous other health-related variables by occupational class persist.⁹ However, extrapolation from these findings is dangerous for two reasons. Firstly, a clear inverse association between social class and mortality has not been found among immigrants other than the Irish.¹⁰ In these groups social class may be a less reliable determinant of life style. Secondly, the evidence relating occupational class to the use of health services is ambiguous. The General Household Survey has repeatedly found that the lower social classes are more likely to have attended their general practitioner in the study period and that the same groups report more illness. Le Grand therefore examined the ratio of health service utilization to need and found that the top two socioeconomic groups received 40% more health care expenditure per person reporting sick than the bottom two groups.¹¹ Collins and Klein, on the other hand, examining the distribution of general practitioner services only, found little evidence of such inequity.¹² A recently published study indicates that within morbidity groups persons with lower incomes receive, on average, more NHS resources than those in higher income groups.¹³ This pro-poor distribution may be consistent with allocation according to need. This confusion emphasizes the importance of direct evidence on ethnicity and the use of health services.

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Mortality and morbidity among ethnic minorities

The needs of ethnic minorities have undergone reappraisal in recent years. Research and planning have traditionally been focused on conditions associated with particular groups such as rickets, osteomalacia, the haemoglobinopathies and tuberculosis. Though these diseases may require specialized services, they affect comparatively few people. They may deflect attention from more widespread needs assessed in the light of community surveys, morbidity and mortality data.

Lower mortality rates among first generation immigrant males (with the exception of the Irish) as compared with the indigenous population and those of their country of birth have been explained in terms of the 'healthy migrant effect'.¹⁰ Cultural adaptation and environmental exposure are likely to be contributing to more uniform mortality patterns. The marked differences between immigrant groups in causes of death are well known. There are high rates from hypertension and cerebrovascular disease and low rates from ischaemic heart disease among immigrants from the West Indies and Africa; high rates from ischaemic heart disease, infections and diabetes and low rates from cancer among those from the Indian subcontinent; and high rates from hepatic cirrhosis, accidents and tuberculosis among those from Ireland.^{10,14} Still-birth, neonatal and post-neonatal mortality rates are higher for children of mothers born in Pakistan, India, Bangladesh and the West Indies than children of UK-born mothers.¹⁵

There have been few large-scale community-based morbidity surveys. Several studies attest to the high prevalence of diabetes mellitus among populations from the Indian sub-continent.^{16,17} Insulin resistance may link the high rates of diabetes and ischaemic heart disease in these people.¹⁸ Levels of disability among the ethnic elderly appear to be similar to those among the indigenous population.^{19,20} The health concerns of younger members of ethnic minority communities appear to be more commonplace – asthma, infertility, psychosexual problems, etc – than those targeted by health education programmes.²¹

Hospitalization rates reflect the differences described. For example, Britons of Asian descent are more frequently admitted for ischaemic heart disease,²² diabetes mellitus,²³ asthma and tuberculosis.²⁴ Admission rates for cerebrovascular disease²⁵ and schizophrenia are high among Afro-Caribbeans.²⁶ The infant mortality differentials described have been attributed, in part, to reduced take-up of antenatal services among non-Whites.²⁷ Increasing levels of antenatal care delivered in a health maintenance organization in the USA have been associated with greater reductions in low birth weight among black infants than among white infants.²⁸

Studies in general practice have consistently found high consultation rates in Asian males^{29,30} though in only one study were these rates standardized for social class.³¹ With the possible exception of West Indian males, consultation rates among other ethnic minorities are lower than those of whites. Otherwise lack of base-line prevalence data renders interpretation of service utilization rates largely speculative.

Interactions with health workers

There are many reasons for believing that the experience of ethnic minority patients may differ from that of indigenous patients when consulting a doctor. Different cultural backgrounds shape patients' views about illness and treatment. These views may not be compatible with the scientific medical approach of middle-class white doctors. Medical anthropology has provided useful classifications of non-Western illness aetiologies³² but these are difficult to operationalize. Little research has been carried out on how illness is perceived among different ethnic minorities in the UK. How far do Ayurvedic or traditional Chinese medicine influence the health beliefs or practices of the children of migrants from South Asia? It is not clear that these systems are less congruent with western medicine than lay models revealed among the native population.^{33,34} Eastern and western explanatory models may be converging. The growing interest in holistic medicine suggests a greater appreciation of ill-health as resulting from disequilibrium between individuals and their social and physical environment.

Communication difficulties may affect doctor-patient interaction in several ways. There is some evidence that poor communication can lead to non-compliance and hence affect the outcome of treatment.^{35,36} An obvious barrier to health care is the inability to speak English which is associated with lack of awareness of available services. Surveys from Nottingham and Leicester found that 88% and 79% of Asian elders respectively could not speak English.^{21,37} These percentages must be declining but, in both studies, few elderly Asians were aware of social services such as meals-on-wheels, home helps, social workers and chiropody. Asians of all ages may make less use of social services than the native population.³⁸ These findings have obvious implications for health educators. Initiatives directed at these people must employ alternative methods such as Asian radio programmes and home videos providing information on health and welfare services.³⁹ There are staffing implications also. Interpreters and link-workers are nowadays more widely employed in the NHS but few such schemes have been formally

evaluated.⁴⁰ In the long term, it makes more sense for districts to intensify efforts to recruit staff from local ethnic minority groups.

The implicit assumptions and stereotypes in terms of which doctors relate to patients may influence the outcome of interactions. While there is evidence of racial discrimination against providers in the NHS,^{41,42} the evidence from consumers is largely anecdotal.⁴³ Black American in-patients have been found to receive fewer investigations than expected on the basis of their health characteristics.⁴⁴ In another study, Blacks were found to be two to four times more likely to have surgery performed by residents than by fully trained surgeons.⁴⁵ Have investigators here simply been more circumspect than their North American counterparts?

Thus many factors may influence patients' choice of doctor. However, Chanchal Jain *et al.* found that choice of general practitioner by Sikh, Hindu and Muslim patients appeared to be determined more by proximity of the patient's home than by ethnic considerations.⁴⁶ The importance of traditional practitioners to sections of the Asian community is well documented but the extent of use is unknown.^{47,48}

Mental health

The issues and difficulties described above are nowhere better illustrated than in trying to interpret service utilization rates in the field of mental health. Though not all studies are consistent, Asians appear to have lower rates of admission for psychiatric care.⁴⁹ Some community surveys have suggested that Asian immigrants suffer less psychological disorder than the native population⁵⁰ but such surveys present major methodological difficulties.⁵¹ Alternatively, psychological distress may be less readily recognized in Asians.⁵² Somatization may result in the misinterpretation of symptoms presented to general practitioners.^{30,53} Unsubstantiated explanations offered include greater stigmatization of insanity leading to concealment by the families of sufferers, treatment outside the NHS and better social support networks leading to less reliance on formal care.⁵⁴

Evidence suggesting higher rates of psychological disorder among Afro-Caribbeans should be viewed cautiously.⁵⁵ West Indian men are more

likely to be admitted to psychiatric hospitals with psychotic illness than white men.⁵⁶ They are more likely to be detained involuntarily and to receive phenothiazines and electroconvulsive therapy.⁵⁷ Racial differences and ethnocentrism can be difficult to distinguish from 'institutional' racism.⁵⁸ Littlewood and Lipsedge contend that overt racial discrimination is rare, perhaps because of the large numbers of mental health workers who themselves belong to ethnic minority groups.⁵⁹ On the other hand, the presence of migrant workers in lowly positions within the NHS may reinforce attitudes towards black people as second class.⁶⁰ Studies are badly needed which control for variables such as bed numbers, admission and discharge procedures, the availability of out-patient and community facilities, in addition to ethnicity and social class.

Conclusions

The fragmentary and conjectural nature of a lot of the work linking ethnicity with the use of health services is apparent. Pleas for further research provide a disingenuous conclusion. Given the complexity of concept and phenomenon, the literature is likely to remain largely atheoretical. The health status, beliefs and practices of Britain's ethnic minority population are changing. Research may serve unintentionally to foster stereotypes. This is not to argue for the abandonment of ethnicity as an explanatory variable but to recognize the need for specification of ethnic factors operating in the health field.

All such work has political overtones. The notion that 'cultural differences' determine health inequalities obscures disadvantages in employment, housing and education facing ethnic minorities. The constraints that race relations legislation may place on health planners attempting to meet 'special needs' are discussed elsewhere in this issue.⁶¹ Policies of 'multiculturalism' in health as in other spheres have been attacked for 'objectifying black culture and lifestyles and trying to divide the black community into separate and competing groups'.⁶² However, in the coming medical market place, needs assessment may take second place to political pressure groups in ensuring access to appropriate health services for Britain's ethnic minorities.

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