Why is healthcare inadequate for ethnic minority elders?

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Healthcare may be inadequate for black and minority ethnic (BME) elders because: (i) we have underestimated the number and distribution of BME individuals in the United Kingdom and, therefore, inadequately addressed their social needs; (ii) we do not appreciate the proportion of the BME sector affected by mental or physical disorders, or the type of problems experienced; (iii) the services provided may be underused by BME individuals. Although health inequalities have been measured since the 17th century, explicit focus on BME communities began with the 1991 Census, the 1993-1994 Fourth National Survey of Ethnic Minorities, the 1997 Acheson Independent Enquiry into Inequalities in Health and the 1999 Health Survey for England (Evandrou, 2000). The number of BME individuals aged over 65 increased from 1% in 1981 to at least 3% in 1991, at which time 5.9% of English and Welsh may have been from an ethnic minority, and is predicted to increase to about 16% by 2011. Although fewer than 10% of elderly ethnic minorities were born in the UK (Shah, 1998), over 90% have lived here for more than ten years (Lowdrell et al., 2000). Only during the last ten years have academics begun to seriously consider the circumstances of BME elders (Grewal et al., 2004), due to expectations that their families will care for them.

Migration has disproportionately come from different regions at different times: from the Caribbean during the 1950s, from India and Pakistan during the 1960s, South Asians from East Africa during the 1970s, from Bangladesh and China during the 1980s and from Africa during the 1980s and 1990s. Consequently, although 6% of BME groups are aged at least 65 this figure includes 9% of African-Caribbeans, 6% of Indians and 4% of Pakistanis (Grewal et al., 2004). Although all medical practitioners and support staff speak at least one language, English, over 300 languages are spoken in London. Many ethnic minorities have difficulty understanding English. Some cannot read or write the languages they speak, if, unlike for Sylhetti, there is a written form of communication. Although Chinese and Indian students tend to be better educated than any other group, including whites, 1/5 white, 1/4 Irish, 1/3 African-Caribbean, 1/2 Indian and 3/5 Bangaladesh and Pakistani elders are in the lowest 20% of the income distribution (Evandrou, 2000). Once figures have been equivilised to account for variations in household size 90-93% of Bangladeshis, 69-77% of Pakistanis and just over 48% of African-Caribbeans, 45% of Indians and 41-59% of Chinese are in the lowest income third. Chinese are equally represented to white people in the top-income third. BME people are less likely to have worked in industries with occupational pensions and are less likely to have self-funded state or private pensions (Grewal et al., 2004). Ethnic minorities are more likely to be unemployed by age 40-60 (Lowdrell et al., 2000). Among males aged 50-65 rates of employment were lower for all BME groups compared with a white English group, with particularly low rates for Bangladeshis (16%) and Pakistanis (31%) (Grewal et al., 2004). The 2001 Census showed that BME individuals are more likely to live in large urban English areas and that 45% of BME individuals live in the London region. 78% of Africans, 61% of African-Caribbeans and 54% of Bangladeshis live in London compared with 20% Pakistanis. The 1991 Census showed that over 50% of BME individuals live in areas with more than a 44% BME population. BME individuals tend to live in areas rated poorly on the 2000 Index of Deprivation. There are an average 4.5 Bangladeshis, 4.1 Pakistanis, 3.3 Indians and 2.0 whites or black-Caribbeans in each household, including at least one dependent child with 74% likelihood for Bangladeshis, 66% for Pakistanis, 50% for Indians and 28% for British. About 50% of African parents are lone
parents. Service providers may provide less care for people in extended households (Lindesay, 1998).

Bangladeshis and Pakistanis report the poorest health followed by African-Caribbeans and then Indians, with Chinese and white people having the best health (Nazroo, 2003). Much of this variance can be accounted for by income, housing tenure and economic activity. There are high but variable rates of diabetes and low rates of respiratory illness across all non-white groups. Africans have a higher incidence of stroke and end-stage renal failure, whereas South Asians additionally have a high risk of cardiovascular disease (Bhopal et al., 1999; Cappuccio, 1997; Lightstone et al., 1995), particularly Bangladeshis and Pakistanis. Hypertension is 3-4 times more prevalent among Africans than South Asians, while African-Caribbeans, Bangladeshis and Pakistanis are 3-6 times more likely to have type-2 diabetes than are whites. The prevalence of type-2 diabetes remains similar in Indians regardless of when they migrated (Cappuccio et al., 2003). Nevertheless, diabetes may more likely be detected in Africans due to high co-morbidity of hypertension and diabetes. There are high rates of sexually transmitted illness among African-Caribbeans. The prevalence of cancer, cardiovascular disease and diabetes increases with age.

There are high rates of admission to psychiatric hospitals with a diagnosis of psychotic illness among young African-Caribbean males. Depression is more likely to be experienced by ethnic minorities with 77% likelihood for Bengalis, 25% for Somalis or East London whites, 5% for North London whites and 2% for Gujaratis (Silveira & Ebrahim, 1998). For Bengalis, Somalis and East London whites depression tends to be associated with chronic health problems. Africans and South Asians may similarly have about 20% likelihood to experience depression (Rait & Burns, 1998). In contrast with white, Hong Kong and Japanese communities, where there is no special status for the elderly, suicide rates reduce with age for Arabs, Indians and Indian immigrants (Shah, 1998). The UK Fourth National Survey of Ethnic Minorities suggested widespread experiences of racial harassment and discrimination among BME individuals (Nazroo, 2003). Perceived racism might be related to poorer health (Karlsen & Nazroo, 2002). The genetic risk for mental health disorders, such as Alzheimer’s disease, may vary among ethnic minorities, possibly being explained as spiritual problems requiring religious guidance rather than medical assistance (Lindesay, 1998). Screening instruments may give false positives for cognitive impairment (Rait & Burns, 1998). Where tests are translated it is important to provide suitable culturally-specific cut-off points, while culture-free tests are also available and may be less intimidating (Parker & Philp, 2004). Dementia is frequently misdiagnosed due to language, education and cultural differences but may be experienced with 4% likelihood for South Asians and 2-8% for English-speaking Africans, higher for non-English speakers (Rait & Burns, 1998). Africans may be more likely to experience dementia regardless of language and education, possibly due to vascular risk factors (Livingston et al., 2001). Although various versions of the Mini-Mental State Examination are available including in Chinese, Gujarati and Hindi (Shah, 1998), 6% of non-impaired whites may be misdiagnosed and 42% of blacks (Parker & Philp, 2004).

Despite these variables, the poor quality care received by BME individuals is partially due to inadequate information. There are no formal data on the use of health, social and voluntary services by ethnic minority elders, although data
collected on a small scale by Age Concern and the Confederation of Indian Organisations show ethnic minority elders are less aware of secondary care services (Shah, 1998). BME individuals are not less likely to access primary care services and, in some cases, are more likely to use those services (Nazroo et al., 2009). The difference was reduced after adjustment for self-perceived need. There is no evidence of ethnic inequalities in the case of hypertension and raised cholesterol. There was some evidence of poorer outcomes for Pakistani and Irish diabetics but outcomes for hypertension were at least as good for BME individuals as they were for white individuals. For raised cholesterol Bangladeshis, Indians and Pakistanis tended to experience a better quality of care than white people. There were inequalities in access to hospital services and marked inequalities in access to dental services. Analysis of the Fourth National Survey of Ethnic Minorities (FNS) and the 1999 Health Survey for England (HSE) suggest that ethnic inequalities in health increase markedly with age (Grewal et al., 2004). Without sensitivity to the religious requirements of ethnic minorities, psychiatric difficulties are likely to be under-recognised by elders (Lindesay, 1998). The over 25,000 ethnic adults in English and Welsh care homes marks an under-representation of ethnic elders in nursing and residential care homes (Shah, 1998). There is unlikely to be substantial improvement while the care home sector struggles to meet the demands of the Care Standards Act. Ethnic elders may be unaware of organisations such as Age Concern, the Citizen’s Advice Bureaux, Dial-a-Ride and Help the Aged (Shah, 1998).

Overall, all three explanations may partially explain the inadequacy of health care for BME communities in the United Kingdom. The accuracy of information on the number and distribution of BME individuals is improving perhaps even for refugees whose activity is more difficult to monitor. More can be done to reduce inequalities in education, employment and housing. Information on mental and physical disorders needs to be communicated to BME communities and healthcare providers in ways they can understand. Similarly, more can be done to increase awareness of and access to service provision.
References


