Health and ethnic inequalities: Time to shift the focus

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Modern medicine has come a long way in the past century and has been fundamental in improving the morbidity and mortality rates of the population. Although there has been much progress made, the health inequalities gap has widened (Department of Health, 1998).

Health and ethnic inequalities

Health inequalities can be described as the:

> *"[...]differences in health status or in the distribution of health determinants between different population groups" (World Health Organization, 2012).*

The term "health inequities" can be used interchangeably with health inequalities, and this refers to "avoidable inequalities that are unfair or unjust" (Leon et al, 2001).

Health inequalities among the black and minority ethnic population are referred to as ethnic inequalities. The German socialist and philosopher Frederick Engels (1845) first noted ethnic inequalities in England among the Irish population, who appeared to have a worse mortality than the indigenous population.

Bhopal (2009) describes the factors that contribute to ethnic inequalities, such as:

- Culture and lifestyle factors.
- Social factors.
- Education and economic status.
- Migration factors.
- Genetic factors.
- Access to and concordance with healthcare.

In addition to these factors, racism has been identified as a major cause of ethnic inequalities (Nazroo, 2003); however, addressing racism and its role in ethnic inequalities is a provocative area of discussion. Thus all these contributing factors limit the quest to find a definitive solution for ethnic inequalities.

There is a lack of accurate ethnic minority data that reflect the heterogeneity of the population, such as different sub-groups within an ethnic category. For example, there has been at least two generations of South Asian people (of Pakistani, Indian, Bangladeshi and Sri Lankan origin) in the UK since the 1950s (Khunti and Kumar, 2009). The 1999 and 2004 National Health Surveys in England provided data on self-reported health among six ethnic minority groups, which enabled intergenerational health status between the first and second generation to be reviewed (Erens et al, 2001; Sproston and Mindell, 2006). It was found that intergenerational mobility improved, with an improvement in the socioeconomic status between the first and second generation; however, this did not result in an improvement in health status outcomes in the second generation. This was attributed to the second generation requiring a higher degree of socioeconomic gain to lead to an improvement in health, rather than to acculturation changes.

Similarly, socioeconomic data are also inaccurate, depicting a snapshot of socioeconomic status as opposed to circumstances throughout a person's life. Thus, if possible, data should be collected at different time points of an individual's life to obtain a more accurate picture of his or her socioeconomic position (Nazroo, 2003).

The 1967 Whitehall study (Marmot et al, 1991) identified the inverse relationship that existed between social class and mortality by studying a group of British civil servants. The connotations around health inequalities are individuals who are from two extremes of social class. However, in *The Marmot Review* Professor Marmot (2010) recognised that health inequalities are not just confined to those who are rich or poor. Marmot used the term "social gradient" to describe the higher degree of input required according to the degree of disadvantage in each social class group; thus tackling health inequalities should be across the board and not confined to those in higher

deprivation categories. In Scotland, the health inequalities Government report *Equally Well* (The Scottish Government, 2008) mapped out the degree of health inequalities that exist, with an alarming acknowledgment of the Scottish mortality rates being on par with those in Eastern Europe.

Diabetes and obesity

Patterns of health and ethnic inequalities exist within the areas of diabetes and obesity. The Southall Diabetes Survey (Mather and Keen, 1985) was the first pivotal UK study that showed the higher prevalence of diabetes among South Asian people compared with the indigenous population.

The pattern of higher diabetes prevalence or ethnic inequality among the South Asian population has continued. Recent research (Gholap et al, 2011) has emerged showing current prevalence rates of diabetes in the UK; by comparing the South Asian population with the indigenous population, it was found that there is up to a fivefold excess rate of diabetes in the South Asian community. Further, South Asian people are at higher risk of diabetes complications compared with the indigenous population (Pardhan et al, 2004; Dreyer et al, 2009).

Diabetes and obesity are both strongly associated with deprivation. Childhood obesity is linked to those with a lower socioeconomic status, and is more prevalent within Asian children (Saxena et al, 2004; Law et al, 2007). The pattern of obesity in adults from ethnic minorities is mixed; for men the prevalence of obesity is lower than that for the general population, except for Black Caribbean and Irish men, and for women the prevalence is higher among Black African, Black Caribbean and Pakistani women (Law et al, 2007). Lower obesity cut-off points have been recommended for the South Asian population in view of their excess risk (Gray et al, 2011).

Causation

The epidemic of diabesity is rising, and the inequalities gap is widening; what is causing these inequalities? The role of socioeconomic inequalities should not be underestimated in contributing to the disease burden, and there has been a transition whereby such inequalities are more apparent today; indeed, 50 years ago socioeconomic inequalities were not present among children (Power et al, 2003). Policy makers should start targeting those at an earlier age as there is a positive link between inequalities and obesity from childhood to adulthood (Law et al, 2007). Thus interventions for obesity should include wider societal determinants (Friel et al, 2007).

Healthcare professionals have an affinity towards practicing a biomedical model of care. However, is the role of evidence-based medicine overrated? There may be a role for healthcare providers to veer away from the traditional model of care as life expectancy is associated with living conditions and not healthcare services (Szreter and Woolcock, 2004).

Poverty is one of the strongest indicators of poor health (World Health Organization, 2010). Healthcare professionals should take heed from the epidemiologist Geoffrey Rose (1992), who described the root cause associated with disease:

> *"The primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social."*

Health inequalities can be tackled by targeting those most disadvantaged, reducing the gap between those worse and best off or reducing the entire gradient (Graham and Kelly, 2004).

Discussion

As health inequalities are avoidable, addressing them is a social justice issue. Tackling the underlying social determinants of health will help ameliorate the disease burden. The widening inequalities gap may suggest that one model of care may not be suitable for all. Healthcare professionals have to be less parochial and look beyond the biomedical model of care. Strategies of prevention should start at an earlier age, and medical education curriculums should place emphasis on the role of the social determinants of health.

Arguably, healthcare professionals working in primary care are pressured with targets and achieving points, which can be a limiting factor to addressing the wider determinants of health;

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policies need to be implemented at a "macro" level in order to be disseminated down to a "micro" level for delivery.

Migration patterns indicate that ethnic diversity will increase. This will inevitably increase the burden of ethnic inequalities, specifically for diabetes and obesity. Researchers and policy makers need to bravely address contentious causative factors, such as racism, which should be explored in terms of their role within ethnic inequalities.

In the 21st century healthcare professionals have a lot to be proud of. However, some of the alarming inequalities that exist indicate that the current models of care may not be suitable. More research is required as to the role of cultural barriers in the determinants of health and contribution to health and ethnic inequalities. Healthcare professionals have to think outside the box, address the wider determinants of health and challenge the "one shoe fits all" model. Until then the inequalities gap will continue to widen. ■

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