

Health and health care in south Asian communities in the UK

In the 2001 census the population of the UK was estimated to be around 59 million, of which the ethnic minorities comprised just over 4.5 million (Office of National Statistics, 2001). People from India, Pakistan and Bangladesh (the south Asian communities) made up nearly 2 million or 4% of the total UK population. The health-related problems of this section of the population are in many ways different from the native Caucasian population. Moreover, this section of the population is itself heterogeneous, with different cultural and religious beliefs and varying dietary and lifestyle habits.

Health issues in the south Asian community

The south Asian population in the UK has been shown to have a four to six-fold increase in the prevalence of type 2 diabetes and a much higher morbidity and mortality from cardiovascular disease (Health Survey for England, 2004). These two factors to a large extent contribute to the increased prevalence of stroke in this community. While a greater genetic susceptibility and a tendency to abdominal obesity play a crucial part, lifestyle factors such as smoking and sedentary habits also have a significant effect. Both men and women of Indian, Pakistani and Bangladeshi origin have much higher levels of central obesity than the general population. Smoking is particularly common in south Asian men, especially of Bangladeshi origin, compared to the general population.

Type 2 diabetes is nearly six times as prevalent in south Asians than the white population, with 25% of this group being affected by the age of 25 years (Department of Health, 2004). The onset of diabetes in this group at a younger age adversely affects the cardiovascular morbidity. Diabetes is also more common in the socially deprived where its complications are greater and mortality is higher.

South Asian people tend to be more insulin-resistant and have characteristic risk factors which are more strongly associated with the metabolic syndrome than the corresponding white Caucasian population.

A recent study from Canada has suggested that inflammatory bowel disease may be on the increase in the immigrant south Asian population, although no clear contributing factors could be identified (Pinsk et al, 2007).

Mental health problems are of particular concern for the ethnic minorities, especially the black and Afro-Caribbean population in the UK, with wide inequalities in the rates of mental ill health, predominance of institutional models of care and lack of priority to individual needs and rights.

Access to and delivery of health care

Access to health care is at times difficult and inappropriate for the south Asian community living in the UK. South Asians are more likely to live in the poorest 20% of local authority areas, which puts them at a disadvantage. In addition there are several barriers to accessing health care among these people.

General poor health, lack of time, lower socioeconomic status and absence of support are some of the factors which influence people's ability and motivation to access health care and lead a healthy lifestyle. South Asians also face additional barriers and disadvantages. Difficulties in access may be compounded by care not being sensitive to the religious and cultural needs of the local population. It is important to assess the quality of care from the user's perspective and there needs to be a clear plan for consultation, involvement and partnerships with the local population (Singh et al, 2006). Issues around dignity and respect in dealing with and in the treatment of older people from these communities, which at times may be different, need to be clearly recognized. Communication needs may

be highlighted by lack of link workers and interpreting services. Non-availability of single sex exercise programmes and culturally suitable healthy lifestyle promotion materials may make this community even less receptive to the widely available resources.

The immense time constraint on the length of consultations, especially where there are communication barriers, is a key factor in the inadequate assessment of these people. There is no provision for 'interpreters' time' and often relevant past or family medical history is missed completely.

Another very important barrier to accessing appropriate health care is the people's own low literacy levels and health beliefs. Traditional values in these communities also include a lot of unsubstantiated beliefs and fatalistic attitudes towards life's challenges. This barrier can be extremely difficult to break down, resulting in inadequate and superficial use of health services.

Improving access to health care

Despite sustained progress and several initiatives in addressing health inequalities, improving health and health care within this group of the population continues to be a major challenge.

There needs to be a strong focus on health education and health promotion. Services such as smoking cessation and exercise promotion which are acceptable to the community should be provided as part of health care. Childhood obesity is an international challenge and health education and dietary advice, especially to children, is critical.

There needs to be greater research aimed at risk assessment in diabetes and cardiovascular disease in the black and minority ethnic communities and improved awareness of issues around mental and gastroenterological illnesses.

Treating people with dignity and respect is a national priority and dignity for black and minority ethnic communities may mean more than just being worthy of

respect or protection from abuse. People need to be involved in true partnerships and making them feel valued may improve their sense of self-worth and dignity.

It is important that the black and minority ethnic communities are involved in the strategy, policy, commissioning and delivery of health care at all levels. Commissioners and providers of health care need to develop partnership with local communities and these partnerships

need to be strong and meaningful. It is important that consultations are ongoing and regular rather than one off and for these to be successful it is equally important that there is a regular review and monitoring. Feedback should include how the consultations have helped to change practice or bring about improvements. This will contribute to continuing consultation and ensuring proper access to culturally sensitive health care. **BJHM**

KEY POINTS

- Morbidity and mortality from cardiovascular diseases is high in the south Asian population in the UK.
- Access to health care is at times inadequate and inappropriate.
- Involvement at all levels including strategy and delivery must be through local and national partnerships.
- Treating people with dignity and respect will help improve people's experience of health care.

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