



Ethnic density, health care seeking behaviour and expected discrimination from health services among ethnic minority people in England



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ABSTRACT

The health of ethnic minority people is reported to be poorer in areas of lower ethnic density. Based on this literature, higher rates of health seeking behaviours would be expected among ethnic minorities resident in neighbourhoods of lower ethnic density. Should health seeking not increase in areas of lower ethnic density, a possible explanation might be that ethnic minority people resident in these neighbourhoods are not accessing services for fear of racial discrimination. The present study examined this hypothesis using two nationally-representative surveys from England. Health seeking behaviour did not vary by ethnic density. Lower ethnic density was associated with increased reports of expected discrimination from services, but also with increased satisfaction with services.

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1. Introduction

Studies report an ethnic density effect, whereby as the residential concentration of an ethnic minority group increases, their health complications decrease (Halpern and Nazroo, 2000). Associations between ethnic density and decreased morbidity have been reported for several outcomes, although reviews of the literature assert that ethnic density effects are generally stronger for mental, rather than physical health (Shaw et al., 2012; Bécarea et al., 2012a).

Ethnic density has been found to protect the health of ethnic minority people through several pathways, including increased social support (Das-Munshi et al., 2010), increased social cohesion (Bécarea et al., 2011), and decreased exposure to racism (Bécarea et al., 2009; Das-Munshi et al., 2010). This latter pathway proposes that ethnic minority people living in neighbourhoods of higher ethnic density are less likely to experience interpersonal discrimination, and if they do, the social networks existent in these neighbourhoods provide buffering effects against the detrimental association between experienced racism and poor health (Bécarea et al., 2009). Also relevant to this pathway of reduced exposure to racial discrimination, and more broadly to the documented existence of racism in the UK, is an extensive literature documenting that some ethnic minority groups are more likely than the white

British population to experience coercive pathways into mental health care (Bhui et al., 2003; Morgan et al. 2005a, 2005b). For example, a systematic review of the literature on ethnic variations in pathways to specialist mental health services reported that black people are less likely than White people to be referred by their general practitioner to specialist services, and that of all ethnic groups with a mental disorder, South Asians are the least likely to be referred to specialist care (Bhui et al., 2003). Over 54% of black people in inpatient mental health units are compulsorily detained under the Mental Health Act, compared with 32% of the general population (NHS Information Office, 2009). Black African and black Caribbean people are also more likely to receive medication for mental health problems as the primary form of treatment (Department of Health, 2003), and less likely to receive psychotherapy (McKenzie et al., 2001).

Although there is no evidence of ethnic inequalities in accessing primary care services, or in clinical outcomes of care for hypertension, raised cholesterol and diabetes (Nazroo et al., 2009), ethnic inequalities have been documented for access to some forms of antenatal care (Bharj and Salway, 2008), access to hospital services, and dental services (Nazroo et al., 2009). There are also suggestions that the quality of service received by ethnic minorities is poorer; analyses of a routine patient survey in inner London and across all English general practices have found ethnic minority people to rate their primary care more negatively than white people (Campbell et al., 2001; Mead and Roland, 2009), and surveys of patients in an accident and emergency department reported that ethnic minority people were less likely than white

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people to report satisfaction with access and waiting times; less positive about receiving safe, high quality care; and more likely to say that staff talked about them as if they weren't there (Department of Health & Healthcare Commission, 2008). However, area-level variation in local services has been documented, with discrepancies in reports that ethnic minority patients are less likely to maintain contact in some neighbourhoods, but not in others (Bhui et al., 2003). Nonetheless, when taken as a whole, an overall pattern of ethnic inequalities emerges from the literature in relation to access to some services, particularly in relation to mental health. The causes behind this differential care are contested, but racial discrimination has been stated to play a strong role (Bradby and Nazroo, 2010; Cochrane and Sasidharan, 1996; Chakraborty et al., 2011; McKenzie and Bhui, 2007), suggesting that ethnic minority people experience differential treatment as a consequence of institutional discrimination, and may also be less likely to present to health care services and primary care when unwell, possibly due to expected racial discrimination.

A greater understanding of the association between ethnic density and health care seeking behaviour would greatly contribute to both the literature on ethnic density effects, and to the literature on ethnic health inequalities in health care. If the literature on ethnic density effects is mirrored by rates of service contact or health seeking reported by ethnic minority people, higher rates of health seeking behaviours would be expected in neighbourhoods of low ethnic density, as prevalence and incidence of mental disorders appears to be greater in these neighbourhoods. If, on the other hand, discrepancies exist between health seeking behaviours and prevalence of mental and physical morbidity among ethnic minority people, one line of enquiry might be to assess if reduced health seeking behaviours by ethnic minority groups might be a function of greater perceived discrimination from services in neighbourhoods of lower ethnic density.

In the present study we examined whether ethnic density is associated with access to and satisfaction with health services, and expected racial discrimination from health care settings. We base our work on the documented association between ethnic density and health, and examine whether this association holds true in our dataset, examining the association between ethnic density and a range of health outcomes (common mental disorders, psychotic symptomatology, and suicidal ideation, limiting longstanding illness). Aims of our study were thus to examine the association between decreasing ethnic density and: (i) health, (ii) health service use, (iii) satisfaction with health services, and (iv) expected discrimination from health services.

Based on the literature reviewed, we hypothesised that a decrease in ethnic density would be associated with an increase in access to health services due to increased need; with a decrease in satisfaction with health services; and with an increase in expected racial discrimination from health care settings.

2. Methods

2.1. Data

This study used two cross-sectional nationally representative surveys from England: the Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC), and a merged dataset of the English samples from the 2005 and 2007 Citizenship Survey (CS).

The EMPIRIC is a nationally representative follow-up study of a subsample of ethnic minority people from the 1999 Health Survey for England (HSE). The 1999 HSE was comprised of a general population sample of 7798 respondents, selected from about 6500 addresses in 312 postcodes. All adults in the selected households were surveyed, as well as children older than two. If there were

more than two children in the household, two were randomly selected for inclusion (Erens et al., 2001). Among all eligible ethnic minority informants at an address, a maximum of four adults and three children were selected to be interviewed, using a random selection procedure (Erens et al., 2001). The EMPIRIC survey included all HSE 99 informants aged 16–74 years from the Black Caribbean, Indian, Pakistani, Bangladeshi and Irish ethnic groups who agreed to be recontacted (92% response rate), and collected additional information on mental health, access to health care, ethnic identity and experiences and perceptions of racism and discrimination (Sproston and Nazroo, 2002).

The CS, previously carried out by the Home Office and known as the Home Office Citizenship Survey (HOCS), is a biennial survey that started in 2001 and provides an evidence base for the work conducted by the Communities and Local Government Department. It consists of two separate components: a core representative sample of the general adult population of England and Wales, and an ethnic minority boost sample. The core sample was obtained from residential addresses selected from the Royal Mail's postcode address file (PAF). A two-stage sampling approach was used to select the addresses. At the first stage, a random sample of Census Area Statistics (CAS) wards was selected. At the second stage, addresses were sampled within the selected wards. The ethnic minority boost sample was chosen from wards selected for the core sample as well as from an additional boost sample of 150 wards, using screening and focused enumeration (Michaelson et al., 2006). In 2005, a total of 9691 respondents aged 16 and older were surveyed for the core sample (9336 in 2007) and 4390 for the ethnic boost sample (4759 in 2007). (For further information on CS methodology please see Michaelson et al. (2006) and Agur et al. (2009).

2.2. Individual-level measures

Four measures were selected to examine the association between ethnic density and health: limiting longstanding illness, common mental disorders, psychotic symptomatology, and suicidal ideation. Both the CS and EMPIRIC included limiting long-term illness (LLTI) as a measure of physical health. LLTI is one of the most common measures of chronic ill health, which is frequently used as a morbidity index in national health surveys (Power et al., 2000a, 2000b) including the census, and as a predictor of mortality and health service utilization (Charlon et al., 1994; Cohen et al., 1995). Both surveys used the same wording to capture LLTI, which was analysed using a derived variable based on two questions: 'do you have any long-standing illness, disability or infirmity? By long-standing I mean anything that has troubled you over a period of time or that is likely to affect you over a period of time?' Those participants who responded affirmatively were then asked, 'does this illness or disability limit your activities in any way?'

Mental health was assessed in EMPIRIC. Common mental disorders (anxiety and depression) were measured using the clinical interview schedule-revised (CIS-R), a structured validated diagnostic tool (Lewis et al., 1992). Initial filter questions focus on symptoms experienced in the previous month, with more detailed questions asking about the previous week. We considered common mental disorder to be present if the CIS-R total score was higher than 11 (Lewis et al., 1992).

To assess psychotic symptomatology we used the Psychosis Screening Questionnaire (PSQ; Bebbington and Nayani, 1995), a 12-item interviewer-administered structured instrument which asks about psychotic experiences within the previous year. The PSQ focuses on five symptom domains: auditory hallucinations, persecutory delusions, hypomania, a feeling that 'something strange' is going on which others might find hard to believe, and thought interference. Each section begins with an introductory

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