

From awareness to action: Tackling health inequalities through improved health literacy among ethnic minorities in England

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ABSTRACT

Health disparities persist among ethnic minority communities in England, despite the efforts of the national health service to provide equitable healthcare access. Recent statistics highlight that individuals from ethnic minorities are more likely to report poor health and face difficulties accessing healthcare compared to their white counterparts. One critical factor contributing to this inequality is health literacy, which influences individuals' ability to seek, understand, and utilize healthcare information. Factors such as language barriers, diverse health beliefs, and lower educational attainment contribute to the lower health literacy levels observed in these communities. This paper assesses the health outcomes of ethnic minority groups, with a focus on COVID-19 vaccination uptake and cervical cancer screening. By examining existing interventions aimed at reducing health disparities, this report identifies potential strategies to improve health literacy, with the goal of enhancing health outcomes among ethnic minority populations in England.

Keywords: health inequalities, health literacy, ethnic minorities

INTRODUCTION

An essential goal of the national health service (NHS) is to guarantee equitable access to healthcare services for all. Despite efforts, data indicates the ongoing presence of health inequalities in England, particularly impacting ethnic minority communities. Recent statistics reveal a significant disparity, with those from ethnic minority groups more likely to report being in poorer health and have poorer experiences using health services when compared to their white counterparts. One significant contributing factor to this disparity lies in variations in health literacy between these groups.

Health literacy, defined as the extent to which individuals possess the ability to seek, understand, and utilize information and services to make health-related decisions, plays a crucial role. Within this context, numerous factors contribute to lower levels of health literacy among ethnic minorities in England, including language barriers, diverse health beliefs, and reduced levels of educational attainment.

This paper will assess the health outcomes of ethnic minority groups in England, with a particular emphasis on examining the uptake of COVID-19 vaccination and cervical screening. It will explore existing efforts aimed at narrowing health disparities among these groups and discuss potential future interventions centered around improving health literacy to enhance overall health outcomes in these communities.

HEALTH STATUS OF ETHNIC MINORITY GROUPS IN ENGLAND—A SUMMARY

In England, individuals from ethnic minority backgrounds are more prone to self-reporting poorer health and expressing less satisfactory experiences with healthcare services compared to their white counterparts [1]. Determining the roots of these health disparities is challenging, but evidence indicates a multifaceted interplay of factors, including deprivation, environmental influences, health-related behaviors, and health literacy. Many ethnic minority groups bear a disproportionate burden of socioeconomic deprivation, a fundamental determinant of health status across all communities. According to ONS statistics from 2011-2014 and continuing into 2022, life expectancy at birth for the white and mixed ethnic groups was lower than for other ethnic groups. However, the COVID-19 pandemic altered the mortality landscape, reversing the all-cause mortality advantage observed in some ethnic minority groups due to significantly higher COVID-19 mortality rates they experienced [2]. It should be emphasized that precise life expectancy figures for each ethnic minority remain unavailable as ethnicity is not mandated on death certificates. To ascertain the ethnicity of deceased individuals, death records were connected to 2011 census data. This required adjusting for issues like missing census entries, cases where records didn't match, post-census migration, and other factors.

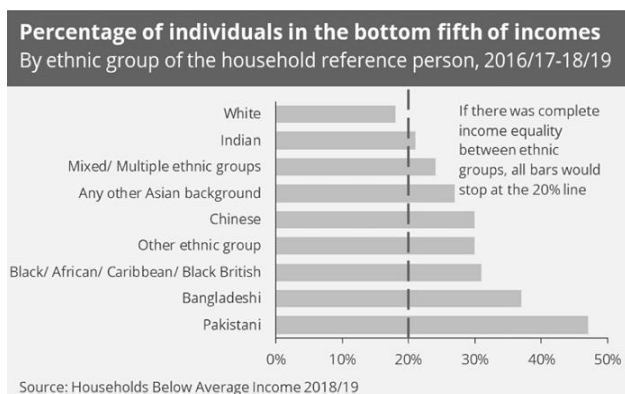


Figure 1. Percentage of individuals in the bottom fifth of income, 2018/19 [3]

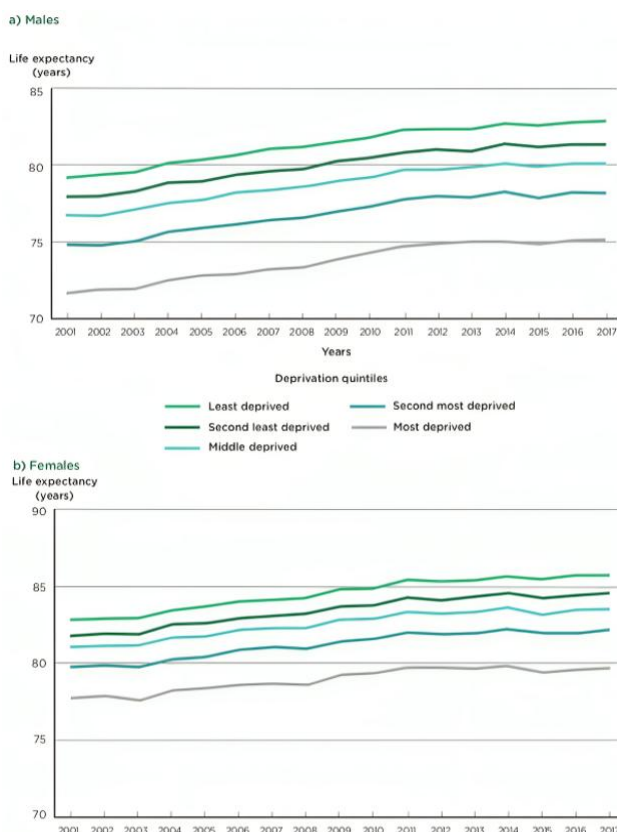


Figure 2. Life expectancy by are deprivation quintile and sex, England, 2001-2017 [4]

However, the linkage to a census a decade old introduces inaccuracies in rates and other metrics due to demographic changes over time. Given the known impact of COVID-19 on ethnic minority populations and the associated higher mortality rates, addressing these health disparities becomes a pertinent and pressing issue to explore.

Despite generally enjoying a longer life expectancy, individuals from ethnic minority groups are more prone than their white counterparts to report enduring long-term health conditions and overall poor health. This implies a reduced healthy life expectancy, indicating a shorter duration of living in good health. Rates of diagnosed ill health are notably higher among Pakistani, Bangladeshi, and Black Caribbean groups when compared to the overall population [1]. Data reveals a heightened disease burden from diabetes and cardiovascular issues in ethnic minority communities. Among individuals aged

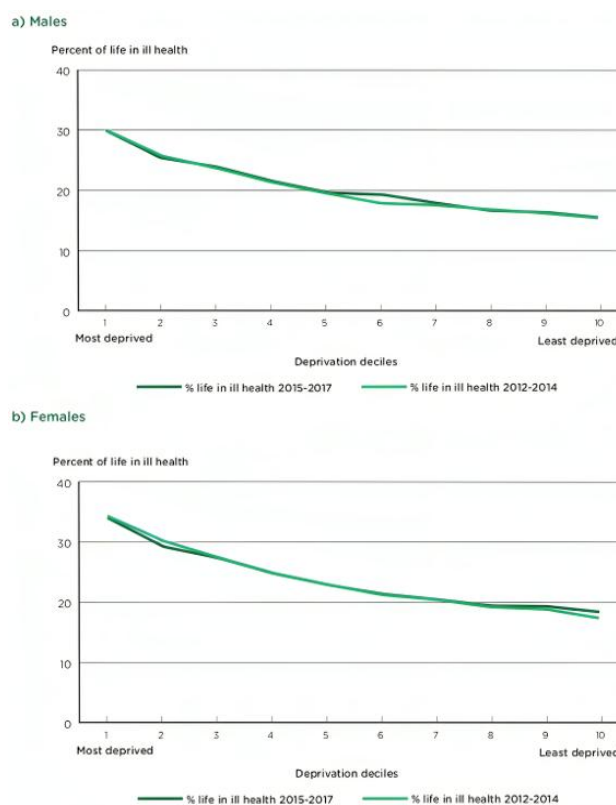


Figure 3. Life spent in ill health by deprivation decile and sex, England, 2012-2014 and 2015-2017 [4]

65 and older, the average health-related quality of life score consistently ranks lower in the Arab, Bangladeshi, Pakistani, and White Gypsy/Traveler groups [1].

SOCIO-ECONOMIC INEQUALITIES

A profound and systematic correlation exists between health and deprivation, wherein more economically deprived communities exhibit poorer health and shorter life expectancy compared to their less deprived counterparts. Deprivation levels are notably elevated among various ethnic minority groups, and these communities are disproportionately concentrated in more deprived neighborhoods. **Figure 1** shows the percentage of individuals in the bottom fifth of income [3]. On a broader scale, Asians (15.7%) are the most likely, followed closely by Black individuals (15.2%), to reside in the most deprived 10% of neighborhoods, whereas White individuals (9%) are the least likely [1].

As illustrated in **Figure 2**, life expectancy is notably higher in the least deprived areas of England [4].

Additionally, it is established that the percentage of life spent in ill health is greater in the most deprived decile compared to the least (**Figure 3**) [4].

HEALTH LITERACY

The extensive statistics on health disparities among ethnic minorities underscore a vital factor: the considerable influence of health literacy, offering a potential explanation for these discrepancies. Research on British adults' health literacy links lower levels to social deprivation, limiting health conditions,

lack of qualifications, and affiliation with BAME communities [5]. While research on this aspect in England remains limited, the observed lower health literacy could stem from language barriers and varied health beliefs, emphasizing the urgent need for interventions aimed at educating and empowering individuals in these communities.

COVID-19 PANDEMIC AND VACCINATION UPTAKE

Throughout the COVID-19 pandemic, mortality rates were notably elevated among ethnic minority groups in comparison to their white counterparts. Notably, during the period when the Omicron variant prevailed, males within the Bangladeshi ethnic group exhibited the highest COVID-19 death rate, being 2.7 times higher than that of males in the White British ethnic group. This trend was also observed among Pakistani males (2.2 times higher) and Black Caribbean males (1.6 times higher). Similarly, females in the Pakistani ethnic group had the highest COVID-19 death rate, 2.5 times higher than females in the White British ethnic group, followed by Bangladeshi females (1.9 times higher) and females in the Mixed ethnic group (1.4 times higher) [6].

The United Kingdom (UK) took the lead in launching a national vaccination program in response to COVID-19 in December 2020. This initiative utilized a delivery strategy that included mass vaccination sites operated by NHS hospitals, primary care centers, and local pharmacies. Recent studies indicate that the mortality for unvaccinated patients was higher than when compared to vaccinated individuals (odds ratio 2.46, 95% confidence interval: 1.71-3.53) [7].

Despite the nationwide vaccine rollout, persistent gaps in coverage continued to impact specific populations, particularly ethnic minority and marginalized social groups. Evidence suggests that Black and minority ethnic communities have shown a higher tendency to decline vaccination. Data from a study revealed that, while overall vaccine hesitancy was low (17%), rates of hesitancy were significantly higher among Black (71.8%) and Pakistani/Bangladeshi (42.3%) ethnic groups [8]. This panel study invited participants aged over the age of 16 to take an online or telephone survey regarding their views about the COVID-19 vaccine. Conducted to gather quantitative data, this study demonstrated strength in its substantial participant enrolment ($n = 12,035$). However, it is crucial to acknowledge various limitations. The primary challenges stem from the web-based survey methodology, which may introduce bias due to non-participation. Despite efforts to address this concern through result weighting, the inherent limitation persists. Furthermore, the study's reliance on a limited number of participants from certain ethnic groups restricted in-depth analysis, particularly for specific ethnic groups. The absence of inquiries into various vaccine types further limits the overall comprehension. Nevertheless, the study's descriptive findings on vaccine hesitancy across demographic groups provide valuable insights for effective vaccination planning.

While low vaccination rates may contribute to higher mortality rates in BAME communities, occupational exposure is considered a partial explanation. Many key workers during the pandemic belonged to ethnic minority backgrounds, placing them at a heightened risk of infection. Additionally, other factors, such as a higher prevalence of underlying health

conditions, particularly among Bangladeshis, Pakistanis, and Black Caribbean's, may contribute to their increased vulnerability to infection.

REASONS FOR VACCINE HESITANCY

The primary causes of vaccine hesitancy often revolve around apprehensions regarding potential side effects, long term impacts on health, and a lack of confidence in vaccines [9]. This skepticism is particularly prevalent among black respondents. Exploiting these concerns, some individuals have disseminated misinformation, further fueling the longstanding mistrust of government and public health entities within certain ethnic minority groups [10].

INTERVENTIONS TO INCREASE VACCINE UPTAKE

The health inequalities standing group of the Royal College of General Practitioners has developed materials to assist general practitioners (GPs) in the UK in enhancing vaccine acceptance within BAME communities [11]. They gathered insights from various GPs across the UK regarding strategies employed in their practices to address this challenge. These insights have been compiled and shared with the college for the benefit of other GPs seeking to learn from these experiences and to implement these interventions in their local communities. The primary approaches identified for interventions include conducting discussions at local community centers, organising online webinars, and providing multilingual educational resources [12].

The government, in collaboration with national and local partners, prioritized vaccine acceptance among ethnic minorities. Over 50 worship places became vaccination centers, supplemented by pop-up venues. Initiatives like vaccination buses and taxis brought services directly to communities. Targeted campaigns addressed lower vaccine uptake during religious festivals, backed by £7 million in government funding. Trusted figures, including faith leaders and ethnic minority celebrities, were pivotal in building trust and encouraging vaccine uptake. Social media clarified vaccine concerns, dispelling myths related to religious, fertility, and pregnancy concerns [13]. The undisclosed outcomes of these interventions hinder the validation of their effectiveness in improving health literacy and building trust in vaccines. Knowledge of these results is crucial for shaping future strategies. If known, the outcomes would serve as valuable evidence, guiding the utilization of successful interventions in upcoming vaccination campaigns. The lack of this information not only limits the assessment of current efforts but also obstructs the establishment of evidence-based practices for long-term success in vaccine acceptance and misinformation combat.

CERVICAL CANCER

Approximately 3,200 new cases of cervical cancer are reported in the UK each year, constituting 2% of all new cancer cases in females [14]. Notably, incidence rates for cervical cancer among females in England from BAME groups are lower

compared to their white counterparts. However, studies indicate that mortality rates for combined cervical and uterine cancers are generally similar or higher in females of BAME backgrounds [15]. Additional statistics reveal a 65% higher incidence of cervical cancer in the most deprived areas in England compared to the least deprived. Although not directly tied to ethnicity, it is noteworthy that those from BAME backgrounds are more likely to reside in socio-economically deprived areas [16].

Introduced in 1964, England’s cervical cancer screening has evolved. Women aged 25-64 undergo HPV primary screening every 3-5 years. High-risk HPV triggers further examination for potential cell changes. Positive findings lead to a colposcopy, allowing close examination and treatment discussion. This initiative is estimated to save 4,500 lives in the UK [17].

A case-control study published in the BMJ highlighted the effectiveness of screening, associating it with a 60% reduction in cancers in women aged 40, increasing to 80% at age 64. This underscores the critical role of screening in substantially reducing both the incidence and mortality of cervical cancer [18]. According to NHS England, during 2022-2023, 68.7% of 25 to 64-year-olds attended screening within the recommended timeframe, slightly lower than the previous year’s 69.9% [19]. Notably, uptake rates for the screening program are comparable to those of the bowel cancer screening program, standing at 70.3% [20].

CERVICAL CANCER SCREENING UPTAKE AMONGST ETHNIC MINORITY GROUPS

The annual statistics from the NHS screening program provide insights into the age and location of women who decline screening invitations, yet they do not offer a breakdown based on ethnic origin. To address this gap, research has delved into the barriers faced by BAME women, examining cervical cancer screening uptake and knowledge within these communities and comparing findings with responses from white British women. A study commissioned by Jo’s Cervical Cancer Trust and conducted by YouGov revealed that a third more BAME women of screening age (12%) than white women (8%) reported never attending a cervical screening appointment [21]. However, this study’s limitations are notable, characterized by a very small and non-representative sample. Conducted online, it employed qualitative methods, with figures primarily sourced from YouGov Plc. The survey included 1,179 white women and 1,177 BAME women aged 25-65, lacking a specific ethnic breakdown. While the results were categorized into two groups, the equal representation of white and BAME women, coupled with the overall small sample size, diminishes the study’s representativeness. Caution is warranted in generalizing findings, given these limitations in sample composition and methodology. Another study identified ethnicity as an independent predictor influencing women’s attendance, indicating a 32% lower likelihood of Asian women participating in cervical screening compared to white women [22]. When exploring health beliefs and knowledge related to cervical cancer, it was evident that a smaller percentage of Asian women were familiar with cervical cancer screening, and fewer BAME women considered screening a necessary health test compared to their white counterparts [23]. This data underscores the pressing need for increased education within

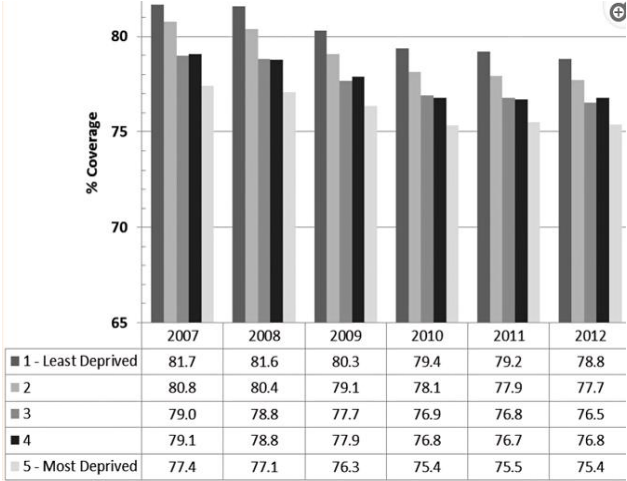


Figure 4. Cervical screening uptake by deprivation, England, 2007-12 [24]

the BAME community regarding the significance of cervical cancer screening. Furthermore, it emphasizes the substantial opportunity for enhancing health literacy among the ethnic minority population in England, aiming to reduce health inequalities. Another study focusing on cervical cancer screening uptake identified that women residing in the most deprived areas of England were less likely to attend screening compared to those in the least deprived areas (Figure 4) [24].

The limitation of this study lies in its reliance on deprivation measures tied to geographical areas, which may not adequately capture the nuanced individual variations. This could potentially introduce a constraint in understanding the association between deprivation and cervical cancer screening behavior. Data reveals significant differences in cervical cancer screening rates and beliefs, particularly among ethnic minorities. A study indicates that twice as many BAME women than white women would attend with better knowledge about the test [21]. Enhancing education on cervical health is crucial for improving uptake in these communities. While the screening program has effectively reduced overall cancer incidence and mortality, disparities persist, especially among ethnic minorities. Lower incidence rates may seem positive, but higher mortality rates suggest worse outcomes post-diagnosis. The data also underscores intersectional barriers, with women in deprived areas less likely to attend screening, highlighting a gap in understanding challenges faced by ethnic minorities.

INTERVENTIONS TO INCREASE CERVICAL CANCER SCREENING UPTAKE

In 2022, the Department of Health and Social Care, in collaboration with the NHS, initiated a new nationwide campaign with the objective of boosting cervical screening participation in England. Named “Help us help you–Cervical screening saves lives,” the campaign emphasized the importance of not overlooking screening invitations. Women and those eligible were encouraged to promptly book appointments with their GP or sexual health clinic, especially if they had missed their last screening. The overarching goal was to enhance screening uptake across all demographic groups in England [25].

To specifically target ethnic minority communities, the campaign featured paid editorial activities comprising films featuring discussions between black and South Asian women and medical experts on cervical screening. This content was broadcasted on ethnic TV and radio stations, as well as social media. The campaign also utilized public relations strategies, incorporating case studies, healthcare professionals, and well-known figures from black and South Asian communities [26].

Trafford Council devised the One Minute campaign to enhance awareness of cervical screening, targeting groups with historically low attendance, such as women from BAME backgrounds and those in deprived areas. The branded campaign utilized posters and leaflets distributed across various community settings. In March, additional cervical screening clinics were commissioned, and collaboration with local organizations resulted in outreach support and a multilingual leaflet. The initiative yielded positive outcomes, with a 1.9% increase in cervical screening uptake from June 2014 to March 2015, reaching 79.9%. Notably, practices with the lowest uptake and higher BAME populations witnessed improvements, with percentage increases of 4.0%, 5.6%, and 8.6%. Beyond the initial 12-month program, the campaign continued, achieving a cervical screening uptake rate of 80.3% in June 2016 [27]. However, limitations include the short-term focus of reported outcomes (June 2014 to June 2016), which restricts understanding of the campaign's prolonged effectiveness. Furthermore, a more comprehensive evaluation could encompass additional metrics beyond uptake rates, such as follow-up screenings and patient satisfaction. The absence of a control group or comparative analysis also hinders the ability to attribute observed improvements solely to the campaign, as external factors may have influenced screening uptake during the same period. Despite these considerations, the campaign's success in Trafford, where 14.5% of residents belong to a BAME group [28] similar to the national percentage, suggests potential for broader replication if accompanied by thorough evaluation and adaptation to local contexts.

Although the mentioned initiatives showcase commendable endeavors to address cervical screening disparities, there is a need for more comprehensive statistics specifically focusing on ethnic minority uptake, factors influencing participation and to evaluate the impact of education initiatives on improving uptake. Furthermore, there is a gap in follow-up studies assessing the long-term effectiveness of these interventions. While short-term successes are evident, the lack of data on sustained impacts and ongoing improvements raises questions about the enduring efficacy of these campaigns. Subsequent efforts should involve rigorous evaluations to gauge the persistence of increased screening rates and identify evolving challenges, necessitating targeted interventions for sustained success in reducing health disparities.

CONCLUSIONS

In summary, tackling health inequalities in England's ethnic minority communities demands a focused strategy. This paper explored diverse factors influencing disparities, encompassing socio-economic gaps, COVID-19's impact on mortality, and variations in cervical cancer screening rates. The data underscores the urgent need for targeted interventions,

emphasizing health literacy, dispelling myths, and raising awareness within these communities. The discussed initiatives show promise but warrant comprehensive evaluation for effectiveness. Long-term assessments should gauge their impact on health outcomes and understand educational interventions' role in informed decision-making among ethnic minorities. Collaborative efforts among researchers, healthcare providers, and community groups are vital, ensuring sustained education, dispelling misinformation, and fostering proactive health engagement. Achieving health equity necessitates ongoing commitment, research-driven insights, and collaborative actions to ensure equal access to healthcare for all, irrespective of ethnicity.

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Declaration of interest: No conflict of interest is declared by the author.

Data sharing statement: Data supporting the findings and conclusions are available upon request from the author.

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