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Coronary Heart Disease and Diabetes among Black and Minority Ethnic Elders An overview of the Issues

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Background

The Policy Research Institute into Ageing and Ethnicity (PRIAE) was established in 1998 to bring the needs of BME elders on to the agenda of social and healthcare policymakers and to act as a conduit for the expression of the views of BME service users. As elders and as BME individuals, they all too often experience a double discrimination. This discrimination is then compounded by their lower socio-economic status, feeding into and exacerbating their health problems.

PRIAE has catalysed the mainstream providers of health and social care into developing awareness of the needs of BME elders and has begun to map those needs. Its evidence to the Royal Commission on Long Term Care informed a number of the Commission's recommendations and was published by HMSO in 1999. (See *UK Black and Minority Ethnic Elderly: perspectives for the Royal Commission on Long Term Care*.) Its ground-breaking work on the needs of BME elders with Alzheimer's (the CNEOPSA project) has involved voluntary community organisations, sufferers and health care providers in developing appropriate dementia care that will improve the quality of life for sufferers. (See *Dementia Matters: Ethnic Concerns*.) It has also completed a study for Help the Aged on the experiences of BME elders in hospital, under that organisation's 'Dignity on the Ward' initiative. (See *Dignity on the Ward*.)

It is therefore appropriate for PRIAE to identify, explore and begin to map the particular health problems of BME elders in other areas. While some primary research work has been done, for example, on conditions such as sickle-cell anaemia which only affect particular ethnic groups, less has been done on exploring the particular effect and incidence among BME groups of more common conditions that are

prevalent among the wider population. And even less has been done to single out their particular impact on BME elders. Hence PRIAE has undertaken to examine recent literature on diabetes and/or coronary heart disease, focusing particularly on South Asian and African Caribbean elders. It is worth pointing out at the outset, however, that there is a substantial imbalance in the literature, with far less apparently relating directly to the African Caribbean community than the South Asian community. This lacuna should be of direct concern to the planners of health care provision.

Population

At the time of writing, the full analysis of the 2001 Census data is not available that would give a breakdown of the BME population by age-band. However, ONS states that the proportion of minority ethnic groups in *England* has risen from '6 per cent [in 1991] to 9 per cent partly as a result of the addition of mixed ethnic groups in 2001'. It adds that there were increases in each of the Asian ethnic groups in England and in the proportion of Black Caribbean and African people. Most current assessments, based on projected estimates from the 1991 census plus other instruments such as the Labour Force Survey, give a total *UK* percentage for the BME population of around 6 per cent.¹

London – where some half of the total BME community lives – is indisputably the region with the highest BME population. This is around 25 per cent of London's total population, according to the London Health Observatory, and possibly as high as 30 per cent, according to the Commission for Racial Equality quoting the London Research Centre. There are also substantial BME populations in the west Midlands, the north-west, the Yorkshire conurbations and the east Midlands.² Basing their summary on the 2001 Census, Demirbag and Aldridge show that the Indian population accounts for approximately

one-quarter of the total BME population ... the Pakistani population has recently overtaken the black Caribbean population as the second largest ethnic minority group; each group constitutes around 15% of the total BME population ... the black African population [is] ... just under 10% of the BME population ... The Bangladeshi population makes up around 6% of the minority ethnic population.³

Working from data from the Labour Force Survey, Demirbag and Aldridge show that the proportion of each BME population that is aged over 65 is increasing rapidly. Of all groups, the black Caribbean has the oldest profile; the percentage in this age cohort has trebled since 1991, while the percentage for the Indian population has doubled. No national projections for the future growth of BME elder populations are available, but Lowdell et al have produced data for London which demonstrates that, from the 1991 base, the proportion of BME elders over 65 is expected to triple by 2011.⁴ Hence the growing urgency to examine problems that specifically affect BME elders.

Context for PRIAE'S work

According to the Minority Elderly Care Project, a PRIAE-led initiative which is building up a database on and researching the needs of minority elders in ten European countries, the issues of 'ageing' and of 'race and ethnicity' have begun to converge and come on to the agenda of policy-makers and social planners across Europe. Moreover, according to Naina Patel,

Ageing as an issue impacted particularly on the BME population because of its age structure at the time of its initial entry. In the UK, immigrants entering as adults soon established settled black communities. Thus, an age 'bulge' is working its way through the system of those who entered in the late 1950s and early to mid-1960s, settled as UK citizens and had families.⁵

It should be noted that this is in the context of the UK population ageing generally; according to Fletcher and Rake in 1998, '[p]eople over 65 years of age currently account for 18% of the UK population, and this proportion is forecast to rise to 23% by 2030 ... an increase from 11 million to 14 million people'.⁶

As Mehmet Demirbag and Mark Aldridge show in their MEC chapter on the UK, BME elders face, in addition to all the health and social problems associated with ageing, the additional burdens of racism and discrimination.⁷ This is then further compounded, for many, by a poorer socio-economic profile, in comparison with their host-society peers. Thus, the generality who immigrated to Britain for work as mature adults and found employment in low-status, low-pay occupations are now 'pension-poor', in that their working life contributions to the old-age pensions have been reduced both by their shorter working lives and the lower wages on which contributions have been levied. DSS figures for 2001, cited by Demirbag and Aldridge, show that all BME groups, regardless of age, are overrepresented in the bottom quintile of income level.⁸ Citing the report by Lowdell et al, *Health of Ethnic Minorities*, Demirbag and Aldridge further show that some '27% of white people aged 60+ are in the bottom fifth of income distribution compared to 65% of Pakistani/Bangladeshi elders, 55% of Indian elders, 43% of black Caribbean elders and 46% of Chinese elders'.⁹ The implications for health and welfare problems among a comparatively impoverished population, in a social context in which racial discrimination has by no means been eradicated, are clear.

Indeed, this is borne out by the health profile of BME elders drawn up by Demirbag and Aldridge. Levels of limiting longstanding illness are relatively high among South Asian men and women aged 55+, as well as black Caribbean women aged 55+. This is replicated by the London

Health Observatory, which shows that white pensioners (36.1 per cent) showed a below average proportion reporting limiting longstanding illness, compared to Bangladeshis (45.9 per cent) and Pakistanis (45.5 per cent).¹⁰ Indications are that BME communities also experience higher levels of mental health problems than the general population, evidenced by their greater frequency of consultation with GPs over anxiety, depression, mental or emotional problems.¹¹ The identification of higher levels of health problems among BME communities is not a completely new phenomenon. In 1995, Chris Smaje documented the major health problems that particularly affect BME communities, such as circulatory diseases, diabetes, sickle cell and thalassaemia.¹² In 1999, the Health Survey for England, which looked at the health of ethnic minorities, showed that certain groups suffered worse health than others.¹³ In April 2000, the ALG repeated the message,¹⁴ as did Arora, Coker and Gillan in 2001.¹⁵ In November 2002, the London Health Observatory, following Smaje, again listed conditions that particularly afflict BME communities.¹⁶ Of those conditions, two – coronary heart disease (CHD) and diabetes – are the focus of this guide.

Nature of the guide

Material has been obtained by trawling through earlier literature reviews on related subjects, in relevant databases, through standard literature and in specialist libraries for studies linking BME elders – whether classified by ethnic origin or by more general terms (black, minority, ethnic) – with the two conditions under discussion. In undertaking this, PRIAE has worked closely with the King's Fund. With the assistance of the King's Fund Research Librarian, Caron Hartley, a search was undertaken which identified a range of types of literature, from journalistic reports to systematic reviews. The literature included published and unpublished project reports and information posted on

various web sites. Since the aim was to identify the range of approaches, all these different types of information were useful as pointers to examples of practice that might usefully be followed up, though PRIAE was clearly aware of the limitations of some of the articles. In total, some 190 pieces of literature, of varying quality, were identified.

The selection of material discussed in this guide has not been determined by the application of exogenous standards – does this study/article accord with certain pre-determined criteria? – but rather by whether it includes or aligns itself with a perspective that can shed light not only on the clinical condition under discussion but on the particular conflux of problems that beset BME elders. Thus, consideration was extended beyond purely clinically-based articles to informed journalistic accounts of local health initiatives, and so on. This accords with PRIAE's inclusive approach to all its work, in which the views of practitioners, policy-makers and elders are sought and given weight. It is *not* a purely academic approach.

PRIAE's aim in undertaking this survey of the literature is to see how services can be tailored to best address the health promotion, prevention, support and care needs of BME older people. The specific aim of this review is to assist with preparation for project development work on pilot sites as outlined in the final section of this report. It aims both to indicate gaps in the literature and point to potentially beneficial approaches to the problems.

In fact, very little material has been found that connects the problems of elderhood *per se* with either of the two conditions reviewed here, though there are a number of studies that discuss the incidence of these two conditions among the communities.

Broad-based literature reviews

There are a number of relevant literature reviews that serve to map the field, though none overlap precisely with our area. In 2001, the Community Health Sciences Research Group produced *Systematic Reviews of Access to and Uptake of Health Services by Ethnic Group: cardiovascular disease: mental health*.¹⁷ Involving input from five health authorities in greater London, this major review set out to examine literature on any variations in access to and use of health care services among BME groups in the relevant fields. It was posited that such variations may arise from ‘socio-economic disadvantage and discrimination ... cultural characteristics ... which may lead to distinctive health beliefs and behaviours ... specific aspects of the experience of some members of these groups ... for some refugees, past experience of conditions of war or political persecution ... interaction with health care institutions which may include language barriers ... aspects of the organisational culture and priorities of NHS institutions which may affect minority groups in distinct ways’.¹⁸

The review evaluated a body of research literature on cardiovascular disease services in relation to ethnic minorities in the UK (under which, of course, studies of CHD would fall), and found some ‘evidence for poorer access to angiography and revascularisation for south Asians ... it is unlikely that lower use of angiography and revascularisation is a result of a lesser need, particularly when the age-corrected prevalence of coronary heart disease is higher than in south Asian than white populations in the United Kingdom.’¹⁹ Overall, the review concluded that there were too few studies, based on too small samples to reach definitive conclusions on the factors underlying such variations. It recommended much broader-based research, with the funding of cohort studies of cardiovascular service use and greater priority to be accorded to collecting ethnicity-based data, linked to NHS number, as

well as the collection and collation of data on the socio-economic status of GP patients.

The *Systematic Review of Ethnicity and Health Service Access for London* also published in 2001 concentrated on those studies it graded as 'A' standard in terms of quality and content.²⁰ It found that published research activity that was concerned with ethnicity focused on four main areas: health improvement and promotion; general access issues; primary care and mental health. 'Non-permanent populations' – such as asylum seekers, homeless, travellers, were also a fairly major focus. Although substantially less literature was found relating to elders, it argued that this will be an 'increasingly important area of research'.²¹ The literature examined was mainly concerned with identifying problems of access to care at the primary level. It called for more clinical research into the diseases of ageing and for more research into non-GP-led services in the care of BME elders. Relevant to our concerns, literature on diabetes and cardiovascular disease was also examined. It found 'a strong need for improved information on morbidity ... at present based on incomplete ethnic monitoring data for inpatient episodes ...some evidence that South Asian people may experience greater delays in accessing specialist management of heart disease [and] little literature on African Caribbeans'.²² In relation to diabetes, it argued that:

although there is less evidence of barriers to access, poor long term outcomes for ethnic minority populations may be indicative of important underlying unresolved issues. More research is needed on dietary control, compliance and the cost effectiveness of interventions to reach minority populations ... service developments need to consider African Caribbean populations as well as Asian ones.²³

Overall, the study argued for improvements in ethnic monitoring; longer-term research, including longitudinal and epidemiological studies; and improved dissemination of research evidence on access to services for black and minority ethnic groups.²⁴ In that it was focused on the quality of the research it examined, concentrating on peer-reviewed studies, wider questions of discrimination and disadvantage did not fall within its purview. As with other literature reviews, only those issues thrown up by the literature can be evaluated. How, then, to access the experiences of users? Of all groups, elders are in some ways the most disadvantaged. Our society as a whole places little cultural value on elderhood; age discrimination is common and a substantial percentage of elders are in poverty. All these factors are exacerbated for BME elders by the racial discrimination still prevalent in the UK. The purely academic approach may not be best suited to unearthing these issues, and it is in this respect that PRIAE's work, based on a tripartite approach involving users, practitioners and researchers is so important.

Some of these concerns are addressed by Diabetes UK, the premier UK diabetes charity and provider of a wide range of support, information and research services. Although its *Diabetes and Black and Minority Ethnic Groups: towards an organisational strategy* is not strictly a literature review per se, in its scope, extent and coverage of earlier material, it should be discussed here. The report recognised that Diabetes UK's services 'are currently inadequate to meet the needs of black and minority ethnic groups'.²⁵ The culmination of its Black and Ethnic Minorities Project, the report outlined the higher incidence of certain conditions, including diabetes, among BME groups and attempted to audit service use. Like other reviews, it pointed to the poor ethnic monitoring of patients and called for work on a common diabetes dataset that includes ethnicity.²⁶ Unlike other, more purely academic,

literature reviews, it pointed to barriers to care not necessarily thrown up by the subject literature itself but by a wider analysis of such social factors as institutional racism and social exclusion. It pointed to difficulties in accessing services for some BME individuals; widespread lack of awareness of the implications of diabetes among both sufferers and the general public; problems in communication, including language difficulties; gaps in service delivery and uptake and the particular problems of refugees and asylum seekers. The report identified a need for Diabetes UK to develop 'a multifaceted strategy for embracing diversity, tackling exclusion and being more representative' of those it serves. Central to the report was the concept of involving BME groups and individuals themselves with the activities and development of Diabetes UK, encouraging joint working projects with other agencies and working with and through community and self-help projects. In this respect, its approach bears comparison with that of PRIAE and points the way to models of good practice that are from the ground up, rather than top down, working in conjunction with statutory services. It is worth noting that the history of BME communities in the UK is characterised by the development – often small scale but nonetheless vital – of self-help projects that provided services and facilities otherwise unavailable from the mainstream, whether because of institutional racism or failure to provide culturally-specific provision. It should be noted, however, that the Diabetes UK report does not specifically deal with the problems of elders as such.

Other literature reviews whose concerns overlap with this guide include Lilley and Hunt's *Opportunities for and Barriers to Change in the Dietary Behaviour of Elderly People* and Bush and Williams's *Opportunities for and Barriers to Good Nutritional Health in Minority Ethnic Groups*, both published by the Health Education Authority.²⁷ These were followed by their 'sister publications', Fletcher and Rake's

Effectiveness of Interventions to Promote Healthy Eating in Elderly People and White et al, *Effectiveness of Interventions to Promote Healthy Eating in People from Minority Ethnic Groups*.²⁸ However, as stated before, none of these reports or reviews specifically examines the intersection of age, ethnicity and illness which is the focus here. Therefore, analysis of practice and health care interventions in our field has to be extrapolated from a number of sources, and not necessarily confined to those that are strictly academic. Moreover, both diabetes and coronary heart disease, and their attendant complications, can cut across each other, as can those types of 'self-help' and community interventions that have been locally developed to promote awareness of these conditions and a healthier lifestyle.

Coronary Heart Disease

CHD is the leading cause of death in the UK, with a prevalence of some 3.5 per cent among men and 2.1 per cent in women.²⁹ And, along with stroke, it is one of the most important causes of premature death in London, accounting for some 16,000 deaths in the capital each year – it will be remembered that London is home to around 25 per cent of the BME population.³⁰ There are many clinical studies into various aspects of the relationship between ethnicity and the incidence of CHD, as well as access to services.³¹ South Asian communities are at particularly high risk – it is generally held that the incidence of CHD is much greater in South Asian communities and a number of research studies have been done into this. McKeigue and Miller³² and Balarajan³³ are cited by Farooqi et al as demonstrating an increased risk of mortality from CHD among South Asians of up to 40 per cent.³⁴ Bhopal, in an analysis of the research on which these estimates are based, states that 'there is a virtual consensus that the excess risk in South Asians, as compared with the population of England and Wales, is about 40 per cent or more' but cautions that the 'quality of the UK

evidence in support of the belief is ... surprisingly weak'. 'Estimates of South Asians' excess risk ... are imprecise and may be too high ... or too low'. He concludes that there may be variations as between Indians, Bangladeshis and Pakistanis, but that researchers have tended to combine the groups, and calls for cohort studies to 'be designed so that data can be combined for future systematic reviews'.

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The London Health Observatory, citing Balarajan, states that 'mortality rates are around 40 per cent higher for South Asians than for the white population, and early onset of the disease can be 2-3 times higher'.³⁶ The Health of Londoners Project, analysing mortality data, showed CHD mortality rates '20 – 40 per cent higher than average in people born in Pakistan and India'.³⁷ When this is linked with factors leading also to a high incidence of diabetes among these groups, it can be seen that there are significant additional burdens of ill health facing South Asian elders – who not only have higher rates of such conditions, but experience them at an earlier age. As the London Health Observatory study goes on to show, there are 'large social class inequalities in mortality from cardiovascular disease [which] can be seen in the relative mortality rates in the most and least deprived areas within London'.³⁸

The situation facing South Asians stands, in some ways, in contrast to that of African Caribbeans, whose mortality from CHD is low yet who suffer far higher rates of hypertension and diabetes.³⁹ Data presented in the MEC report, *Minority Elderly Care in Europe* show that, among those aged over 55, around 11 per cent of Indian, Bangladeshi and Pakistani men have suffered a heart attack, compared to around 2 per cent of Black Caribbean men. Yet in relation to hypertension, Indian African and Chinese respondents report lower blood pressure rates

than white respondents, while black Caribbeans are 'almost 50% more likely to report hypertension than white respondents'.⁴⁰

The Community Health Sciences Research Group review found evidence of poorer access to angiography and revascularisation among South Asians but, citing Bhopal et al, stated that this was unlikely to be the 'result of lesser need, particularly when the age-corrected prevalence of coronary heart disease is higher in South Asian than white populations in the United Kingdom'.⁴¹

Addressing the problems

It is worth pointing out that the higher incidence of CHD among South Asians was largely placed on the agenda by South Asians themselves. As in other areas of BME life, it was communities themselves that first began demanding that their specific problems be addressed. As early as 1985, the Confederation of Indian Organisations approached the Coronary Prevention Group concerning its anxiety over the high rates of CHD among Asians in Britain. The resulting report, *Coronary Heart Disease and Asians in Britain* raised many of the issues that are still being unravelled, but appears to be rarely cited.⁴²

A number of studies have attempted to discover the clinical reasons for such a high incidence, and factors such as diet, lifestyle, metabolism and genetic predisposition have all been adduced.⁴³ Much large-scale clinical research remains to be done. For example, the incidence of hypertension – a risk factor implicated in CHD, itself a risk factor of diabetes – is higher among middle-aged south Asians (around 30 per cent) and African Caribbeans (around 25–35 per cent) than among the overall population (10 to 20 per cent).⁴⁴ Yet the incidence of CHD is lower among African Caribbeans than the national average, while the incidence of stroke is higher.⁴⁵ One small scale survey, starting from

the premise that differences in rates for the main cardiovascular risk factors are not substantial enough to account for the major differences in the incidence of CHD, surmised that worse 'socio-economic circumstances (especially those associated with stress, such as that related to employment, income and housing)' among Asians may also be a factor.⁴⁶ The London Health Observatory has drawn attention to the 'interaction between [health] risks' and 'low income, unemployment, poor quality housing and low educational attainment' as 'especially important in terms of differences in health between ethnic groups', with BME groups tending to have lower average incomes and higher unemployment.⁴⁷ Bardsley et al also call for more resources to be put into 'Exploration of how differences in mortality by country of birth relate to socio-economic variables such as social class'.⁴⁸ As we have already seen, BME elders, as pensioners, are among the poorest of an already poor social group – so the link between their health status and socio-economic status is not hard to discern, though it may be awkward to quantify and isolate in a rigorously academic way.

Similarly, it is difficult rigorously to quantify or isolate the factors underlying differential access for BME individuals to specialist services. Hence, material attempting to address this issue tends to fall outside the remit of the more purely academic literature reviews. Here, the expertise of PRIAE is important, in that, through its contact with BME elders at the receiving end of services, it can uncover the factors that may hinder them from getting appropriate care. More research has been done in the mental health field, relating to ethnicity, diagnosis and treatment, and discrepancies arising from discriminatory approaches, but little has been done in relation to other conditions. According to the London Health Observatory:

The concept of equity of access to care has been recognised in national performance frameworks for the health service. In

relation to ethnic minorities the key question is whether the uptake of services for specific ethnic group is higher or lower than would be expected, given known differences and similarities in the prevalence of particular health problems... Some examples of ethnic difference that have been observed include:

- out-patient attendance rates are lower for some ethnic minority groups
- ... some evidence of inequity in specialist cardiac investigation services, especially for South Asian groups ...

Other barriers to access cited by the LHO include language, for which interpreting services are necessary; cultural differences in the perception of ill-health; failure in care settings to acknowledge religious and cultural differences relating, e.g., to accommodation, food and modes of address.⁴⁹ All these are factors which will particularly impinge on BME elders, but, apart from PRIAE's work, their experience of medical and care services has not been examined.

According to the Eastern Region Public Health Observatory, which looked at the causes of ethnic inequalities in health, 'most of this difference [between BME groups and the white population] can be accounted for by material deprivation and consequent lower living standards. In addition, ... racism seems to be an important factor ... Genetics, cultural practices and unhealthy behaviours play a minor role in deaths and illness from all causes ... BME groups experience inadequate access to quality health services.'⁵⁰

As Gupta, de Belder and O'Hughes pointed out in 1995, 'Unless something is done to reduce the risk of heart disease in the Asian population in Britain, all indicators suggest that the problem will increase. Data from Leicester indicate that, by 2008, half its Asian

population will be over 50 and, if their risk of coronary death remains 1.4 times that of the rest of the population the numbers of deaths from coronary heart disease will double.’⁵¹ This is a direct warning to health care planners of the need to factor in the specific growth in the BME elder population.

Diabetes

In many ways, the story is similar to that relating to CHD – the condition is perhaps more complex although the two are linked through risk factors. Type 2 or late onset diabetes (non-insulin dependent) is the focus here, since it is this that usually develops in older people and that disproportionately affects BME communities. According to Hawthorne, it is ‘up to four times commoner in people of South Asian origin in Britain than in the indigenous white community’.⁵² Moreover, they develop it at a younger age and are at higher risk of renal failure, as well – as we have seen – of CHD. Hawthorne also points to the fact that ‘South Asians share a common experience of socio-economic deprivation, unemployment (35 per cent in British Asians versus 10 per cent in whites in 1994) and difficulties in access to health care’, in order to stress that health problems are as likely to have an economic/political basis as a biological/cultural one.⁵³ Diabetes UK shows that South Asians and African Caribbeans are 4 to 6 times more likely to be diagnosed as having diabetes. that the onset is earlier and that ‘health outcomes are generally worse with a 3-6 fold higher rate of mortality.’⁵⁴ Complications arising from diabetes result in a ‘2-3 fold excess of mortality from coronary heart disease’ for South Asians and a ‘3-fold excess of stroke mortality’ for African Caribbeans.⁵⁵ Bardsley et al state that the ‘proportion of deaths from diabetes was over 4 times higher than average amongst people born in Bangladesh, the Caribbean and West Indies and Pakistan’.⁵⁶ Forecasts suggest that the number of people in the UK with diabetes will double by 2010.⁵⁷

Again, there is a link with poverty and class – with ‘particularly poor outcomes in those of a lower socio-economic status’. While one in four Asian men over 60 will have diabetes, African Caribbean women over 40 are ‘nearly 6 times more likely to have diabetes than Caucasian women’.⁵⁸

In the light of all this, the Diabetes Development Fund was set up by Diabetes UK North West as a three-year project to raise awareness and understanding of diabetes among BME communities.⁵⁹ Despite the serious consequences of diabetes for both Asian and African Caribbean communities, it is striking that the literature focuses far more on South Asians than on African Caribbeans.⁶⁰ Diabetes has huge implications in terms of quality of life, while the complexity of the condition means that a wide range of service provision has to be brought to bear upon it. Given the already low socio-economic status of BME elders, the fact that their numbers are rapidly increasing *and* that the incidence of a condition which demands careful management is also increasing, it is imperative that future demands on health and social care are thought through and planned for. For example, the need for renal replacement therapy is proportionately much greater among Asians and African Caribbeans – with greater difficulties in tissue matching in cross-racial transplants, a need which, as Raleigh shows, will increase with the growth in the elder population.⁶¹ Hence the importance of early control and intervention measures.

Health initiatives

A number of mostly locally-based initiatives have attempted to encourage action aimed at reducing risk factors for CHD and awareness of and control strategies for diabetes. These will be considered together here, since many of the ‘healthy living’ messages

underlying both are similar. Given the link between diabetes and CHD and diabetes and stroke, measures aimed at reducing the risk factors for one will help reduce risk factors for the other. Those discussed below are only a random sample; there are numbers of local nurse or health visitor-led clinics aimed at health education and management of diabetes/CHD, which achieve some measure of success but are of course vulnerable to changes in personnel, loss of funding , etc. There are weight clinics (Manningham); Gardening for Health (Bradford); community food schemes (Sandwell).⁶²

An analysis of diabetes health promotion to BME communities was conducted by Ian Leedham for the British Diabetic Association, Wales (BDA was the former title of Diabetes UK). Unlike many other projects, this focused mainly on eliciting the views and attitudes of BME people with diabetes through interviews and focus groups. It revealed widespread variations in understanding of the condition, widespread variability in the quality of service – and level of explanation about diabetes – received. Participants emphasised the importance of relatives or friends (in the absence of professional linkworkers) to help them through the system. Leedham endorsed the approach of Greenhalgh et al in building on already held beliefs – about diet and the value of physical labour for example – to promote healthy eating and exercise messages tailored to particular communities.⁶³

Major initiatives include the Bradford Health Authority's diabetes project. Bradford has an incidence of diabetes six to eight times the national average; Originally government funded under the Health Action Zone initiative, Bradford's diabetes services now include three full-time district nurses; special clinics attached to GP surgeries; information and support material in different languages; screening sessions at mosques and community centres; fitness classes; advice

tailored to recipients on diet and exercise. People are now being diagnosed earlier, and management and control is better. The proactive nature and personalised service given by the Bradford project would appear to make such a strategy adaptable to the needs of elders elsewhere. The Bradford strategy is currently being evaluated under a three-year research project for Diabetes UK.⁶⁴

Coronary heart disease has been targeted in Sheffield, under its 'City-wide initiative for reducing cardiovascular disease'. This again was initially funded under the Health Action Zone scheme. And it too foregrounds the work of nurse specialists, with one nurse specialist focusing on BME communities. A development officer also works with BME community projects to form support groups and encourage patients to visit their GPs. Dieticians, physiotherapists and psychologists are also involved. Sheffield is a highly polarised city, containing some of the most affluent areas in England, alongside extremely deprived wards. These inequalities are reflected in mortality statistics, with, in relation to 'cardiac and cardiovascular deaths a 2.7 times variation in the Standard Mortality Ratio between the most and least deprived areas'. Only around 30 per cent of those with a heart problem had been getting the preventive treatment and advice they needed. But premature deaths from heart disease have now been cut by some 15 per cent. Like the Bradford project, the Sheffield initiative benefits and can be used by the whole community – but, in targeting the most deprived, brings BME communities substantial benefits without divisiveness or alienation. And its holistic approach means that it is able to make provision for culturally-sensitive services.⁶⁵

Project Dil, funded by the Leicester Primary Care Trust, has also pioneered innovative services to tackle the high incidence of heart disease among Leicester's Asian communities. Outreach and the

involvement of trained lay people from within the community are essential to its success in targeting and reaching – and helping to change the unhealthy behaviours of – those most at risk. Again nurse led, it includes a CHD training and awareness programme for health care professionals; the provision and active dissemination of educational materials; organisational change to ensure an effective secondary prevention programme for general practice. An evaluation by Farooqi and Bhavsar shows it to have been highly effective, with plans for ‘the principles and lessons of Project Dil to be applied to other health areas, e.g., diabetes care and improving access to health care services for ethnic minorities’.⁶⁶

What these projects have in common is not only an apparently effective and imaginative use of existing resources and the creation of new ones, but also the ability to enlist the support, involvement and commitment of the communities they serve. In this, they hold out important lessons for the development of better provision for BME elders generally. Obviously, many elders are already users of these services in the areas under discussion. But it is clear that the talents and abilities of elders themselves are a social resource that can aid provision and help in the development of community networks. Many elders, as PRIAE’s work shows, make this kind of commitment to their communities. In providing first-rate services for all our citizens, we should not overlook the contributions that they have, and are, making.

examination of the literature on BME elders with diabetes and coronary heart disease.

REFERENCES

- ¹ See 'Census 2001 – ethnicity and religion in England and Wales' <www.statistics.gov.uk/census2001/profiles/commentaries/ethnicity.asp>; Commission for Racial Equality, 'Ethnic minorities in Britain', CRE Factsheet, 1999; Mehmet Demirbag and Mark Aldridge, 'United Kingdom', in *Minority Elderly Care in Europe: country profiles* (Leeds, PRIAE, 2003), p. 9.
- ² See London Health Observatory, 'Black and minority ethnic populations' <www.lho.org.uk/hil/bme/htm>; Demirbag and Aldridge, 'United Kingdom', op. cit., pp. 13-15.
- ³ Demirbag and Aldridge, 'United Kingdom', op. cit., p. 9.
- ⁴ Ibid., p. 11; C. Lowdell, M. Evandrou, M. Bardsley, D. Morgan and M. Soljak, *Health of Ethnic Minorities in London: respecting diversity* (London, Department of Health, 2000).
- ⁵ Introduction, in Naina Patel (ed.), *Minority Elderly Care in Europe*, op. cit., p. 3.
- ⁶ Astrid Fletcher and Christine Rake, *Effectiveness of Interventions to Promote Healthy Eating in Elderly People Living in the Community: a review* (NHS Health Development Agency, 2001).
- ⁷ Demirbag and Aldridge, 'United Kingdom', op. cit., pp. 5-31.
- ⁸ Department of Social Services, *Households Below Average Income* (London, DSS, 2001), cited by Demirbag and Aldridge, 'United Kingdom', op. cit., pp. 16-17.
- ⁹ Demirbag and Aldridge, 'United Kingdom', op. cit., p. 17, citing C. Lowdell, M. Evandrou, M. Bardsley, D. Morgan and M. Soljak, *Health of Ethnic Minorities in London: respecting diversity*, op. cit.
- ¹⁰ London Health Observatory, 'Health in London – Black and Minority ethnic populations', <www.lho.org.uk/hil/bme.htm>, p. 4.
- ¹¹ Demirbag and Aldridge, 'United Kingdom', op. cit., pp. 21, 23.
- ¹² Chris Smaje, *Health, 'Race' and Ethnicity: making sense of the evidence* (London, King's Fund Institute, 1995), chapter 3.
- ¹³ Cited in S. Field, 'Black people: pushing back the boundaries' (London, Greater London Authority, June 2002).
- ¹⁴ ALG, 'Sick of being excluded – improving the health and care of London's black and minority ethnic communities' (London, ALG, 2000).
- ¹⁵ Shona Arora, Naaz Coker and Stephen Gillam, 'Racial discrimination and health services', in Naaz Coker (ed.), *Racism in Medicine: an agenda for change* (London, King's Fund, 2001).

¹⁶ London Health Observatory, 'Black and minority ethnic populations' <www.lho.org.uk/hil/bme/htm>, pp. 3-4.

¹⁷ Community Health Sciences Research Group, *Systematic Reviews of Access to and Uptake of Health Services by Ethnic Groups: cardiovascular disease: mental health: final report to NHS Executive London Research and Development* (London, Barts and Queen Mary's School of Medicine and Dentistry, 2001).

¹⁸ Ibid., p. 6.

¹⁹ Ibid., p. 46.

²⁰ M. Clark, M. Atkinson, A. Szczepura, et al. *Systematic Review of Ethnicity and Health Service Access for London* (Coventry, Centre for Health Services Studies, University of Warwick, 2001).

²¹ Ibid., 'Executive Summary', p. IX.

²² Ibid., p. XII.

²³ Ibid., p. XI.

²⁴ Ibid., p. XV.

²⁵ Diabetes UK, *Diabetes and Black and Minority Ethnic Groups; towards an organisational strategy* (Unpublished, Diabetes UK, 2001), p. 3.

²⁶ Ibid., p. 11.

²⁷ Jeannette Lilley and Paula Hunt, *Opportunities for and Barriers to Change in the Dietary Behaviour of Elderly People* (Nottingham, Queen's Medical School, for Health Education Authority, 1997); and Helen Bush, Rory Williams, Sungita Sharma and Kennedy Cruickshank, *Opportunities for and Barriers to Good Nutritional Health in Minority Ethnic Groups* (Manchester, University of Manchester and Glasgow, Medical Research Council Medical Sociology Unit, for Health Education Authority, 1997).

²⁸ Fletcher and Rake, op. cit.; Martin White, Leslie Carlin, Judith Rankin and Ashley Adamson, *Effectiveness of Interventions to Promote Healthy Eating in People from Minority Ethnic Groups* (University of Newcastle-upon-Tyne for Health Education Authority, 2001).

²⁹ Office for National Statistics, *Key Health Statistics for General Practice* (London, ONS, 1996), cited by A. Farooqi, D. Nagra, T. Edgar and K. Khunti, 'Attitudes to lifestyle risk factors for coronary heart disease amongst South Asians in Leicester: a focus group study', *Family Practice* (Vol. 17, no. 4, 2000), p. 293.

³⁰ London Health Observatory, 'Health in London – cardiovascular disease', <www.lho.org.uk/hil/cv_dis.htm>.

³¹ These include R. Balarajan, 'Ethnicity and variations in mortality for coronary heart disease', *Health Trends* (No. 28, 1996), pp. 45-52; F. P. Cappuccio, D. G. Cook, R. W. Atkinson and P. Strazullo, 'Prevalence, detection and management of cardio-vascular risk factors in different ethnic groups, South London', *Heart* (No. 78), pp. 555-63; J.B.C. Dhawan, 'Angiographic comparison of coronary artery disease between Asians and Caucasians', *Postgraduate Medical Journal* (No. 70, 1994), pp. 625-30; P. McKeigue and N. Chaturvedi, 'Epidemiology and control of cardiovascular disease in South Asians and Afro Caribbeans', in NHS Centre for Reviews and Dissemination, *Ethnicity and Health* (York, University of York, 1996). This is only a selection: further citations will be found in particular in Community Health Sciences Research Group, *Systematic reviews of access ... op. cit.*

³² PM McKeigue and G.J Miller, 'Mortality from coronary heart disease in Asian communities in London, *British Medical Journal* (No. 297, 1988).

³³ R. Balarajan, 'Ethnic differences in mortality from ischaemic heart disease and cerebrovascular disease in England and Wales', *British Medical Journal* (No. 302, 1991), pp. 560-4.

³⁴ Azhar Farooqi, Davinder Nagra, Tony Edgar and Kamlesh Khunti, 'Attitudes to lifestyle risk factors for coronary heart disease amongst South Asians in Leicester: a focus group study', *op. cit.*, p. 293.

³⁵ Raj Bhopal, 'What is the risk of coronary heart disease in South Asians? A review of UK research', *Journal of Public Health Medicine* (Vol. 22, no. 3, 2000), pp. 375-85.

³⁶ London Health Observatory (LHO), 'Health in London – cardiovascular disease', <www.lho.org.uk/hil/cv_dis.htm>, p. 2; R. Balarajan, 'Ethnicity and variations in the nation's health', *Health Trends* (No. 27, 1995), pp. 114-19.

³⁷ Martin Bardsley, John Hamm, Caroline Lowdell, David Morgan and Marian Storkey, 'Developing health assessment for black and minority ethnic groups: analysing routine health information: summary' (London, NHS Executive, The Health of Londoners Project, 2000), p.5.

³⁸ LHO, 'Health in London, *op. cit.*, p. 3.

³⁹ *Ibid.*, p. 2.

⁴⁰ Demirbag and Aldridge, 'United Kingdom', *op. cit.*, pp. 22-3.

⁴¹ Community Health Sciences Research Group, *Systematic Reviews of Access...*, *op. cit.*, p. 46, citing R. Bhopal, N. Unwin, M. White et al, 'Heterogeneity of coronary heart disease risk factors in Indian, Pakistani, Bangladeshi and European origin populations: cross sectional study', *British Medical Journal* (No. 319, 1999), pp. 215-20.

⁴² Coronary Prevention Group, *Coronary Heart Disease and Asians in Britain: a report prepared ... for the Confederation of Indian Organisations* (London, CIO, 1986).

⁴³ See, e.g., T. Knight, Z. Smith, J. A. Lockton, P. Sahota, A. Bedford, M. Toop, E. Kernohan and M.R. Baker, 'Ethnic differences in risk markers for heart disease in Bradford and implications for preventive strategies', *Journal of Epidemiology and Community Health* (Vol. 47, 1993), pp. 89-95; Nada Lemic-Stojcevic, Ruth Dundas, Stephen Jenkins, Anthony Rudd and Charles Wolfe, 'Preventable risk factors for coronary heart disease in stroke amongst ethnic groups in London', *Ethnicity and Health* (Vol. 6, no. 2, 2001), pp. 87-94.

⁴⁴ V. Soni Raleigh, 'Diabetes and hypertension in Britain's ethnic minorities: implications for the future of renal services', *British Medical Journal* (Vol. 314, no 7075, 1997, pp. 209-13, cited in Mohammed Memon and Farha Abbas, 'Reducing health risks in ethnic communities' *Nursing Times* (Vol. 95, no. 27, 1999). pp. 49-51.

⁴⁵ LHO, 'Black and minority ethnic populations', op. cit., p.3; White, Carlin, Rankin and Adamson, op. cit.;

⁴⁶ G. Y. H. Lip, C. Luscombe, M. McCarry, I, Malik and G. Beevers, 'Ethnic differences in public health awareness, health perceptions and physical exercise: implications for heart disease prevention', *Ethnicity and Health* (Vol. 1, no. 1, 1996), pp. 47-53, citing R. Williams, R. Bhopal, and K. Hunt, 'Coronary risk factors in a British Punjabi population: comparative profile of non-biochemical factors', *International Journal of Epidemiology* (Vol. 23, 1994), pp. 28-37.

⁴⁷ LHO, 'Health in London – black and minority ethnic populations', op. cit., p. 2.

⁴⁸ Bardsley, Hamm, Lowdell, Morgan and Storkey, op. cit., p.11.

⁴⁹ LHO, 'Health in London: black and minority ethnic populations', op. cit., p. 5, citing P. McKeigue and N. Chaturvedi, 'Epidemiology and control of cardiovascular disease in South Asians and Afro-Caribbeans', op. cit.

⁵⁰ C. Pickin, S. Karlsen, C. Mclean and G. Randhawa, 'Ethnicity and health inequalities', Eastern Region Public Health Observatory, *Inpho* (No. 2, September 2002), p. [2].

⁵¹ Sandeep Gupta, Adam de Belder and Liam O'Hughes, 'Avoiding premature coronary deaths in Asians in Britain', *British Medical Journal* (Vol. 311, 21 October 1995), p. 1035.

⁵² K. Hawthorne, 'Diabetes health education for British South Asians: a review of aims, difficulties and achievements', *Health Education Journal* (No. 53, 1994). pp. 309-321.

⁵³ Ibid., p. 309.

⁵⁴ Diabetes UK, *Diabetes and Black and Minority Ethnic Groups*, op. cit., p. 11, citing Linda Marks, 'Counting the Cost' (London, King's Fund, 1996).

⁵⁵ Ibid., citing R. Balarajan, 'Trends in mortality from diabetes in England and Wales among those born in the Indian subcontinent and the Caribbean Commonwealth', *Ethnicity and Health* (Vol. 3, nos. 1-2, 1998); H. M. Mather, N. Chaturvedi and J. H. Fuller, 'Mortality and morbidity from diabetes in South Asians and Europeans: 11 year follow-up of the Southall Diabetes Survey', London, *Diabetic Medicine* (Vol. 15, 1998), pp. 53-9; N. Chaturvedi, and J. H. Fuller, 'Ethnic differences in mortality from cardiovascular disease in the UK; do they persist in people with diabetes?', *Journal of Epidemiology and Community Health* (No. 50, 1996), pp. 50-139.

⁵⁶ Bardsley et al, op. cit., p. 5.

⁵⁷ British Diabetic Association, 'Scope of the diabetes National Service Framework: proposals from the British Diabetic Association' (London, BDA, 1999), p.6,

⁵⁸ Ibid.

⁵⁹ Liz Patroe, 'An executive summary of the Diabetes Development Fund for black and minority ethnic communities in the North West of England' (Warrington, Diabetes UK North West, 2001).

⁶⁰ Some general examples of the literature not already cited are J. Dhawan et al, 'Insulin resistance, high prevalence of diabetes and cardiovascular risk in immigrant Asians: genetic or environmental effects', *British Heart Journal* (Vol. 72m 1994), pp. 413-21; M. Harris, 'Racial and ethnic differences in health care access and health outcomes for adults with type 2 diabetes', *Diabetes Care* (Vol. 24, no. 3, March 2001); David Kelleher and Sharif Islam, 'The problem of integration: Asian people and diabetes', *Journal of the Royal Society of Medicine* (Vol. 87, July 1994), pp. 414-17; T. Greenhalgh, C. Helman and A. Mu'min Chowdhury, 'Health beliefs and folk models of diabetes in British Bangladeshis: a qualitative study', *British Medical Journal* (Vol. 316, 28 March 1998), pp. 978-83; N. Chaturvedi, J. Jarett, N. Morrish, H. Keen and J. H. Fuller, 'Differences in mortality and morbidity in African Caribbean and European people with non-insulin dependent diabetes mellitus: result of a 20 year follow up of a London cohort of a multinational study', *British Medical Journal* (Vol. 313, 5 October 1996), pp. 848-52..

⁶¹ Raleigh, 'Diabetes and hypertension in Britain's ethnic minorities', op. cit.

⁶² See, e.g., Seroj Shah, 'Preventing coronary heart disease among people of Asian origin', *Health Visitor* (Vol. 70, no. 2, 1997), pp. 77-9; C. Alderman, 'Sweet smell of success', *Nursing Standard* (Vol. 14, no. 46, 2 August 2000), pp. 16-7; M. Matthias and A. While, 'Diabetes and ethnicity: a research project focusing on care and management of diabetes in the African, Asian and Caribbean communities' (London, Lambeth Healthcare NHS Trust, 1997); Jatinderpal Kaur, 'Asian women and diabetes: an evaluation report of a community based initiative' (Wolverhampton, Wolverhampton Asian Women and Diabetes Forum, 1995); 'Gardening for health', <<http://194.83.94.80/servlet/DisplayProject?PARAM1=101>>; Manningham Weight Control Clinic, <<http://innovate.had-online.org.uk/hvsn-database/Innovations/Project/Detail.asp?ID=154>>; 'Beacons blaze a trail on nutrition', <www.hadonline.org.uk/html/hdt0301/localaction.htm>.

⁶³ Ian Leedham, 'Diabetes health promotion in ethnic minority communities: report to the British Diabetic Association (Wales)', (BDA, January 2000); Greenhalgh et al, op. cit.

⁶⁴ Mary Hampshire, 'Dealing with diabetes', *Nursing Standard* (Vol. 16, no 2, 26 September 2001); <www.diabetes.org.uk>.

⁶⁵ Seamus Ward, 'A heartfelt boost', *Health Development Today* (April/May 2002).

⁶⁶ Azhar Farooqi and Mina Bhavsar, 'Project Dil: a co-ordinated primary care and community health promotion programme for reducing risk factors of coronary heart disease amongst the South Asian community of Leicester – experiences and evaluation of the project', *Ethnicity and Health* (Vol. 6, nos. 3-4, 2001), pp. 265-70; D. Carlisle-Pesic, 'The heart of the community', *Nursing Times* (Vol. 97, no. 38, 20 September 2001).