Chapter 6
Health Literacy and Ethnic Minority Populations

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ABSTRACT

This chapter will show how optimizing health literacy can benefit the delivery of healthcare to the population in a way that materially addresses the inequalities in the National Health Service (NHS). These inequalities adversely impact different population groups in different ways, for various reasons. However, ethnic minority populations are especially vulnerable to inequalities having an adverse effect on the delivery of healthcare to the population, thereby adversely affecting their access, engagement, and healthcare benefits and consequently their general health, wellbeing, and life expectancy. Optimizing health literacy in these populations will enable increased engagement and participation, thereby delivering healthcare more effectively to the population by tailoring it to their needs and addressing current inequalities.

INTRODUCTION

The delivery of healthcare to the UK population since 1948, has been achieved through a universal system of healthcare, the National Health Service (NHS). In post-war Britain, it was the aim of the government of the day to provide the entire population with a service which was universal and free at the point of need. The service remains free, although patients who are able, in certain circumstances contribute through paying for prescriptions, dental, and optical services. The service has remained the same in principle for almost 70 years, and has resisted attempts to introduce direct contributions despite a rapidly changing and aging population, and advances in medical science that drive up the cost of healthcare and the expectations of patients. The NHS is still the largest single pay system in the world, employing some 1.4 million people.

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It could be argued, however, that the comprehensive nature of the delivery to the entire population produced a weakness which was not accounted for from the its inception (Asaria, 2017). Thus, inequalities developed, which according to Asaria (2017), have resisted various attempts over the years to mitigate.

The UK being a diverse[1] country made up of four nation, England, Wales, Scotland, and Northern Ireland, needed a service which would cater to the unique needs of the population. Early on, the system was unable to meet those needs, and inequalities appeared which can affect different populations in various ways.

It is well established that inequalities can arise from ethnicity (Szczepura, 2005), geographical location (Hacking et al., 2011), age (Raine et al., 2009), gender (Rein et al., 2010), type of illness (Emerson & Baines, 2011), and other aspects of disadvantage or vulnerability (Parry et al., 2007; Dixon-Woods et al., 2006) (as cited by Cookson, Propper, Asaria & Raine, 2016 p.1). As well as the aforementioned inequalities, there is also ample evidence that there are socio-economic inequalities in the NHS. Cookson et al (2016) concluded that despite "poorer individuals receiving a greater quantity of publicly funded NHS healthcare in terms of overall expenditure… richer patients tend to achieve better outcomes" (p.19).

Ethnic minority populations often bear the brunt of some of these inequalities as ethnicity has an impact on health inequalities (Matthews, 2015). It was established by Karlson & Nazroo (2000) that ethnicity has an impact on the health of the population and has been recognised as a crucial factor since the 1970s. (as cited by Matthews, 2015 p.18). Socio-economic inequalities affect ethnic minority populations disproportionately, as a greater proportion of them are in a lower socio-economic group and experience social deprivation in the form of unemployment, poverty, and poor housing more acutely than the rest of the population. This adversely affects their engagement with healthcare delivery, which invariably results in poorer health outcomes. Bécares (2013) has found that generally, people from black and minority ethnic backgrounds in Britain have poorer health than the rest of the population. (as cited by Matthews, 2015 p.19).

Further, Bécares (2013) found that geographical inequalities also affect ethnic minority populations more adversely, with London residents experiencing greater inequality than the rest of the population in Britain (as cited by Matthews, 2015 p.19). So, an individual of ethnic minority origin, who lives in London, can be up to three times more likely to have a long-term illness than their white counterpart. It is possible that the picture is much more complex, and indeed, Williams (2015) argues as much, but repeated research has found that these inequalities persist, despite many attempts through research and government policy to address them. (Asaria, 2017).

It has been argued that the inequalities persist due to a lack of consensus among academics and policy makers alike, as to their cause and origin. The concept of biological differences among the races has historically been used to interpret different epidemiology of the diseases of different races. However, Williams (2015) argues against this and contends that there is no evidence that biological differences exist between ethnicities as "different population groups have more biological commonalities than differences; variations that do exist are no greater than those in a single population group (White, 2013)". (Williams, 2015 p.18).

Therefore, it is logical to conclude that the inequalities persist due to the social and economic structures that contribute to the inequalities in our society, which is a conclusion Williams (2015) comes to, after he analyses the impact racism has on inequalities. Institutional racism is no doubt a factor in the way the NHS operates and relates to the ethnic minority population. A British social attitudes survey conducted in 2013 showed that, though consistently dropping since 1983, 30% of the British population still described themselves as racially prejudiced. (National Centre of Social Research, 2014). There is,