Essay: To what extent has the practice of medicine reinforced health inequalities among minority ethnicities?

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Introduction

In the event of recent years many politicians have said that Britain is on its way to becoming a multicultural country, due to the ever increasing number of ethnicities that live within the city of London and throughout the country. “Britain is a radically more diverse society than it was in the 1960’s, with about 8% of the population nationwide and nearly 30% in the cities like London coming from an ethnic minority background.” (Bloch, A & Solomos, J: 2008) many have talked about in length about how London has become one of the most ethnically diverse cities in the United Kingdom. In London alone there is an estimated of roughly 100
Different languages are spoken throughout the city such as Italian, German, Spanish, English, etc. Across the English regions and Wales in 2011, London has the highest proportion of ethnic minority groups and the lowest proportion of the white ethnic group. The largest ethnic minority in London is African 7%, Indian 6.6%, and Caribbean 4.2%. (ONS: 2011) Although there are many ethnic minority groups in Britain, Indian is still one of the biggest but the White British are still what the majority of people identify themselves as. In the Office of National Survey article in 2011, “White was the majority ethnic group at 48.2 million in 2011 (86.0 per cent). Within this ethnic group, White British was the largest group at 45.1 million (80.5 per cent)” (ONS: 2011) This research will take an objective observation at the different ethnic minorities throughout Britain and the different type of ethnic inequalities that they have to overcome but will focus on the ethnic inequalities in health. I also intend to analytical look at a number of healthcare programmes that the government has created and supported to help society such as the King’s Funds and also the Public Healthcare system and the National Health Service which were programmes to reduce the inequalities between communities and individuals. Lastly we will take time to examine whether ethnic minorities across the country have equal or ease of access to proper healthcare and the difficulties that they have to overcome to receive access to a doctor and proper medical attention.

First we must define what ethnicity is before we can define what it means in the eye of the healthcare system. Ethnicity is a group or population whose members believe that in some senses they share common descent, heritage or culture. Currently the Indian category constitutes the largest ethnic minority in the UK, Indian Migrants who migrate to Britain are mainly located in areas such as London and the Midlands. In 2011, the number of foreign born Indian national's resident in the UK was 729,000, followed by Poland, Pakistan and the Republic of Ireland. In researching inequalities about ethnicity in connection with health around Britain we have to look at the other aspects of inequalities that surround ethnicity as many theorists believe that all of the aspects of inequalities are the reasons why many people in ethnic minorities are becoming ill and in need of medical attention. Inequality can be found in Social and Economic Environment, Lifestyle and Access to services. Which Giddens states on his Sociology book "many aspects of health have worsened since the 1970’s. He also states that the Government’s White Paper, Our Health Nation (1999), emphasized that there are many diverse influences that causes ill health which are social, economic, environmental and cultural. Which work together to produce ill health." (Giddens, A: 2013)

Inequalities of Health first started with the inequalities between class during the Victorian times, with the working class needing more medical attention than the upper class. This was due to the fact that during this time the majority of death and ill was working class people, due to the reason that not many working class people were able to afford doctors while the upper class could and were immediately looked after. Nettleton says "poor experienced more diseases and illness than those who were rich.” (Nettleton, S: 2013) which connects with Payne, He states “They had no spare money to meet the extra costs of illness or pay for heating that needed to relieve symptoms.” This was because in those times they were still lacking of doctors around and they were mostly private for which the only people that could afford it was the upper class. Marxist believe that the social class inequalities are the reasons why there is inequalities between class and health and class divisions in society. “The distribution of benefits within health services is therefore explained by reference to class conflict and the dominance of the bourgeoisie.” (Ham, C: 1999)

You may think that because this was years and years ago that the health care/ medical achievements and society in the UK have vastly changed with inequalities but it has not changed very much which is why by the start of the twentieth century the government commissioned to research more on the inequalities between health.

This was called the Acheson Report 1998, this stated that although the death rates have been falling for both men and women. The upper class still had a better chance of living longer than the working class people because of their profession and also because of their income. “The mortality rate among men of working age was almost twice as high for those in class V (unskilled) as for those in class I (professional). By the early 1990s, it was almost three times higher. This increasing differential is because, although rates fell overall, they fell more among the high social classes than the low social classes.” (Acheson, D: 1998) As shown in Table 4.2 for the men and 4.3 for the women, in Payne’s Social Divisions ethnic groups are more likely to be employed in lower paid jobs/ unskilled work than the majority of white who have higher paid jobs and are professionals in
large companies for the men. Although for the women it shows that there are very little inequalities as the white have a high percentage of unskilled jobs too. Both graphs show that although ethnic minorities are mostly employed in the unskilled sector of employment, they are changing as African and Asian minorities are increasing to professionals with the white men and women.

Mason states "There is a growing evidence that ill health and unemployment are positively correlated and there is also a well-established link between ill health and poverty." (Mason, D: 2000) Studies have also found that ethnic minority origins have the higher risk of unemployment than the white majority. Which Payne states "The healthy get better jobs, the unhealthy descends into unemployment or low paid jobs." (Payne, G: 2006) This statement was very accurate as we can see from the table presented by Labour Force Survey in Payne’s Social Divisions Section 2 Ethnicity, it shows that Bangladeshi’s men had the highest male unemployment rate in the UK at 20%, while the Indian men was only 7%. Similarly, with the women it was also quite high, it showed that Bangladeshi women's unemployment rate was 24% which is 6 times greater than the white British while the Indian women were only 7% too which is similar to the men’s. Nettleton states "Twenty-first century is no different: poor people die younger than people who are rich; they are more likely to suffer from most of the major ‘killer’ diseases; and they are more likely to suffer from chronic long-standing illnesses.” (Nettleton, A: 2013) I believe that this is true for instance even though society is changing and the inequalities are getting smaller to have a better life and to be equal for everyone, Income, Housing, Occupation and Education need to be good too for instance with better education gets better occupation and great occupation develops decent income which then able them to have a better home.

In the UK it has been said that 67% of people from black minority ethnic communities live in deprived districts in England compared to 37% of white population. This could be because of income as I have stated above many ethnic minorities have low paid and unskilled jobs. This could also be because of Racism, Castles and Miller say that where racism is involved people tend to move to other places where less racism is. “Where racism and social exclusion is strong, spatial clustering persists or even increases as migrants are often kept out of certain areas.” (Castles & Miller: 2009) Which could be why many ethnic minorities around the UK such as Indians tend to live in places where other ethnicities of Indians are. While some of the other ethnicities sometimes just tolerate their living conditions.

In accordance with Engels and Booth they state that inequalities between poverty and health are in connection with each other. In the 1980s the most famous report that was recorded was The Black Report. The Black Report, showed that there was evidence of inequalities between classes, gender and ethnicities. The Black Report first looked at the health gap between people at opposite ends of the social strata that are widely increasing in the UK such as the upper class and the working class. Which was updated by Townsend and Davidson in 1982 they argued that inequalities in health are found at birth, in childhood, in adolescence and throughout adulthood. They also argued that health inequalities were widening. Although; According to Macionis and Plummer patients who are working class are treated differently to upper class. “Those who is in need is less may get more resources, while those in greatest need get less” (Macionis) Meaning that While the upper class don’t really need it they get more the attention that the working class people who really need it most, the people to blame for this is doctors I believe.

In Britain it is said the ethnic minorities have poorer health in all aspects than the white British group. It is said that they have the poorest health out of everyone in Britain due to climate change, lifestyle, behaviour and also other aspects that they are quite different from their own country. It is also said that older women in ethnic minorities have bad health than the men. In terms of long term illness, it is said that women have the worse health than the men and also than the White British groups. Although some ethnic groups are not as bad or is quite similar to White British. As Shown in Figure 7.1 graph of long term illness in Barry & Yuill’s Understanding the Sociology of Health, Bangladeshi’s and Pakistani’s are the most affected with long term illness, but it shows that the women in those ethnicities are more affected than the men. In the graph it also shows that the least affected by long term illness are the ethnic minority of Chinese. They are even lower than the White British groups.

According to Gupta et al ethnicities such as Bangladeshi and Pakistani have long term illness due to class and the effects of lower paid jobs. But I believe that it is not just about class and because of lower paid jobs, I believe this is because of their diet other aspect, for example both genders in Chinese have a lower percentage of long term illness because their lifestyle is more on exercise and they also eat better quality of
foods such as noodles, vegetables and not too much meat as their diet. However, the graph that was presented in Barry and Yuill’s was during 2001, in the 2011 census conducted by The University of Manchester in The Dynamic of Diversity it shows that the men that was affected most with long term illness are the White Gypsy or Irish Travellers and Black Caribbean groups and surprisingly the lowest in the men’s group are the Bangladesh and Pakistani’s. Similarly, with the 2001 census women in both Bangladesh and Pakistani are still at a quite high percentage of 70% with long term illness than White British, and the Chinese are still having the lowest percentage. Even though we do know the reasons of their ill health because the graph does not tell us in the Census. Davey Smith et al, in Nettleton’s The Sociology of Health and Illness, He tells us that Indian subcontinent have higher than average rates of heart disease, diabetes and tuberculosis. He also tells us that African and Caribbean countries have higher rates of strokes, high blood pressure and diabetes. Chahal and other researchers says that the Black minorities are the most talked about and most researched minorities within health. They are also known for being the most problematic minorities with negative health care services. Which is true in the cases of Mental Health. Black and African Caribbean people are mostly affected with Mental Health, this can be shown in Figure 5.3 in Barry and Yuill’s Understanding of Health. The kind of Mental Health that they mostly face are schizophrenia. Black minorities are mostly affected by schizophrenia for the reason that they accommodate in rural areas that are quite deprived places, where there is lots of pollution. For the reason that of their living conditions are quite bad it makes their illness worst. “Diagnosis of Schizophrenia is around five times more likely for African-Caribbean males. Similar differentials can be found among women” (Mason, D: 2000) In addition they are known for living in these type of living conditions due to having the highest unemployment rates among any other ethnicities. On the other hand, it is said that the Asian minorities have the high percentage of Suicides. Emile Durkheim stated in her research between countries and between religions, patterns of Suicide were high among Catholic countries than Protestant countries, while the Jewish societies had the lowest suicide rates between countries. This could be quite surprising as Catholics are supposed to believe that they do not take their own life or anyone else’s. Although I can believe that Asian minorities have a high percentage of suicides because of their culture, they have more pressure on them to succeed.

“Health inequalities are differences between people or groups due to social, geographical, biological or other factors. These differences have a huge impact, because they result in people who are worse [sic] off experiencing poorer health and shorter lives. Some differences, such as ethnicity, may be fixed. Others are caused by social or geographical factors (also known as ‘health inequities’) and can be avoided or mitigated” (National Institute for Health and care Excellence: NICE: 2012)

Nowadays, medicine practices are well subsidizing by our local and international governments in reaching out the medical needs of our fellowmen especially the indigent individuals and for those people who live in remote areas. In Health care sector, there were a lot of health care programs allocated to reinforced health care inequalities among minority ethnicities such as the National Health Service, Community Care and many aspects of The Public Health too. Overall people think that Britain has the best health care due to the National Health Service while other countries such as US and Europe still have to pay. “Industrialized countries have achieved universal or near universal health care coverage, generally funded through mandatory taxation or social insurance.” (Mossialos and LeGrand: 1999)

During the Enlightenment, The Hippocratic Oath was made, this was pledge for doctors and nurses and other physicians. This was a promise that they had to make when working in this profession. This stated that the task of doctors and nurses are to help patients no matter what the situation is. “I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm” (Tyson, P: 2001)
the government’s plans for health care which stated:
“Government’s vision of the NHS that puts patients and the public first- where patients, service users, carers and families have far more influence and choice in the system, and the NHS is more responsive to their needs and wishes.” (Department of Health, 2010) (Nettleton, S: 2013)
The NHS was then finalised during 1948, the main role of the NHS was to reduce health inequalities throughout Britain, so that everyone could be treated the same way, whatever their finance stability, job status and location. UK population have the right to equitable access to NHS services regardless of income, socio-demographic background and health status. (Barry & Yuill: 2012) They believed that this programme should have reduced inequalities throughout Britain. It was created by Aneurin Bevan and Edwin Chadwick but it was successful until the Prime Minister at the time who was Margaret Thatcher accepted the Bill through Parliament. The NHS included the Public Health Acts such as maternal and child welfare, availability for beds in hospitals and General Doctors in local areas. The NHS also included things such as Vaccinations and Immunisations and social work skills such as home helps and also residential care. Griffiths has outlined that the Faculty of Public health is trying to help the country become a healthier nation with improving housing, informing us about healthy lifestyles such as cutting down on sugars and they are also trying to help the health care system, with the services such as immunization and screening especially for women.

Accessing Health Care
Access to any health care system is fairly simple and easy, because of our National Health Services. Many places now have local doctors and nurses and there is often walk in centres, even in secluded areas, which we did not have before in the Victorian times, people had to travel to get some type of health care. Ethnic medical encounters are very different to the majority of White British groups; many ethnicities are afraid to come forward if they have problems with any aspects of Health. As said by HealthCare profession Alexander in Gidden’s Sociology,
“Ethnicity groups may experience unequal or problematic access to health services. Language barriers can present difficulties if information cannot be relayed effectively. The National Service has been criticized for not requiring more awareness of cultural and religious beliefs among its staff and for paying less attention to diseases that occur predominantly in the non-white population.” (Giddens, A: 2013)
Other theorist such as by Nazroo states that ethnic minority people are the most to use primary health care than the whites. Even though many of the ethnic minorities use primary health care and many of them get seen, they are often discriminated and many of them are very disappointed with the quality of the service due to language barriers and waiting times. Theorist such as Titmus states that even though ethnic minorities from the lower classes get seen the upper class still have better treatment and get seen faster.
“The higher income groups know how to make better use of the services; they tend to receive more specialist attention; occupy more of the beds in better equipped and staffed hospital; receive more elective surgery, have better maternity care; and are more likely to get psychiatric help and psychotherapy then low income groups particularly the unskilled.” (Titmus, 1968)
Healthcare system to ethnic minorities are quite accessible and are available to everyone around the country even in such secluded areas, as many secluded areas now have local doctors and nurses. Although ethnic minorities have access to Health Care’s such as GP’s and Hospitals, it does not mean that they get equal care to the White British groups. Pilgrim and Rogers have noted “Black People have different perceptions of services from white users, whether one of mistrust or of cynicism about the quality of treatment they might receive” (Barry,A.M and Yuill, C: 2012) Afro- Caribbean group tend to not see GP’s or other healthcare professions, men tend to just let things health and women tend to use home remedies. In Donovan’s research with Black People’s Health, Men say they do not go to GP’s because they do not like doctors and because of the waiting times. Carlton “I don’t like waitin when I’m sick, I’d rather just go home, sleep it off” (Donovan, J: 1986) Black minorities having a high percentage in mental illnesses, Black people are both over represented in admissions to psychiatric hospitals (Bhui et al. 2003), more likely to be admitted compulsorily and placed in secure units, and more likely to have been in conflict with the police (Barry, A.M and Yuill, C: 2012) Because they are seen as threatening and aggressive. As a result, ethnic minorities not just Black Minorities make less use of psychiatric services than white people. (Donovan, J: 1986)
Common myths were that Asian people would be looked after by their own and that services were not
wanted. (Radia: 1996) Though Donovan states that Asian women tend to rely on their GP’s. Throughout the years this could have changed, as Donovan’s research was conducted during the 1986 and Raid’s research was conducted many years after. To this day I believe that Asians are the least to visit GP’s as they are the least to get sick in long term illness and other illnesses, as we have seen in the census and graphs in Barry and Yuill’s, which I have talked about above.

Conclusion
In the end in a country like the United Kingdom where there is a National Health Service, I can’t help but believe that the Practice of Medicine does in any way reinforce health inequalities or ethnicities. If these findings were to prove anything, it proves that it removes many inequalities that has plagued the system in the past. Perhaps not every form inequality has been dissolved nor will they vanish overnight removed but it has given many of those who make up our society opportunities leading the country out of the shadow of inequalities of the past. Both local and national government allocate funds to subsidize the indigent and for those who cannot afford medical care. The government has a great responsibility playing a vital role to promote healthy medical practices especially among its citizens of minority ethnicities. The National Health Service today still suffers from problems with inequalities among other issues such as their staff and finance problems that occur. Even this research has shown problems vary based on region such as the fact health inequalities are clearly more severe in London than anywhere in England or Wales. In the fullness of time each and hopefully every last issue must be addressed and remedy for the wellness of our nation. Inequalities is a problem that occurs not just within the borders of Britain but in most countries throughout the world and possibly may always be an occurring problem unless we make every effort to balance the scales and equal for everyone regardless of social standing or class. For me I believe that to make inequalities of health better in the United Kingdom staff in any aspects of Health such as doctors, dentist, need to be more informed about ethnicities culture and their backgrounds so that they can give them better treatment. Doctors and nurses and other professions need to consider that they cannot just assume things about patients, which is why I would consider employing other minorities into the health sector because it would make ethnic minorities more confident in seeing doctors and nurses, as they would not have any more language barriers.

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