2 Focusing on ethnicity and health in Haringey

2.1. Ethnicity in Haringey

The ethnic origin of Haringey's population now

Haringey has one of the most ethnically diverse populations in the country. There are high proportions of people from all the continents across the world living in the borough and, according to school registers, over 175 languages are spoken by local residents.

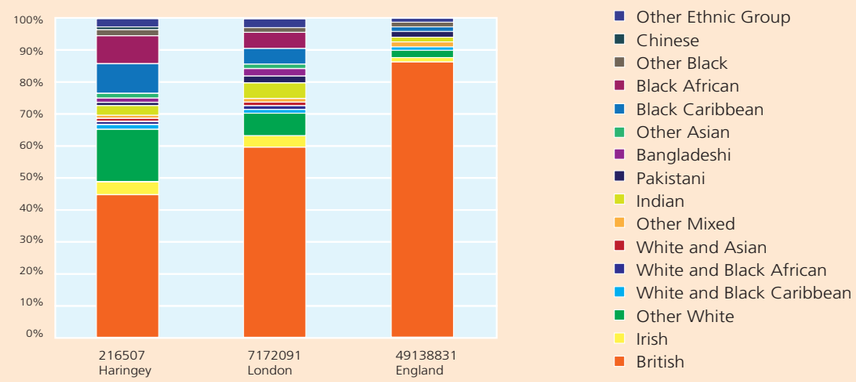
Every 10 years a census is undertaken. This is a count of all people and households and it provides invaluable information about ethnicity because people are asked to say which ethnic origin they use to describe themselves. It is the most complete source of information about the population that we have. Because the same questions are asked of everyone, it is easy to compare different parts of the country. The latest census was held in 2001.

The 2001 census shows that Haringey is more ethnically diverse than both London and England as a whole. In Haringey, approximately 45% of the population are of White British background compared to 60% for London and 85% for England (see Figure 1). Furthermore, within Haringey wards the proportion of White British varies considerably. The most ethnically diverse ward in Haringey is Northumberland Park where 28.9% of the population are of White British background. In contrast, the least ethnically diverse ward is Muswell Hill where 71.1% of the population are of White British background.

Migration

Migration is a process of social change in which an individual leaves one geographical area for prolonged stay or permanent settlement in another geographical area.[5] Migration is important in the planning of services as there is a need to know how the population has changed over time and is likely to change in the future.

Figure 1: Ethnic comparisons between Haringey, London and England



Source: Census 2001

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Key messages:

- Haringey has one of the most ethnically diverse populations in the country. In 2001, 45% of the population were of White British background compared to 60% for London and 85% for England.
- The young population of Haringey are more ethnically diverse than the older population.
- In 2001, 63% of the population in Haringey were born in the UK. Nine percent were born in Africa, 8% were born in Asia and smaller proportions were from South America and Oceania. A Further 12.6% of the population in Haringey were born in a European country other than the UK.
- The relationship between health, ethnicity and migration is complicated. Many ethnic groups are more likely to experience poorer health outcomes than the general population.
- Data collection and analysis on health, ethnicity and migration needs to be improved.

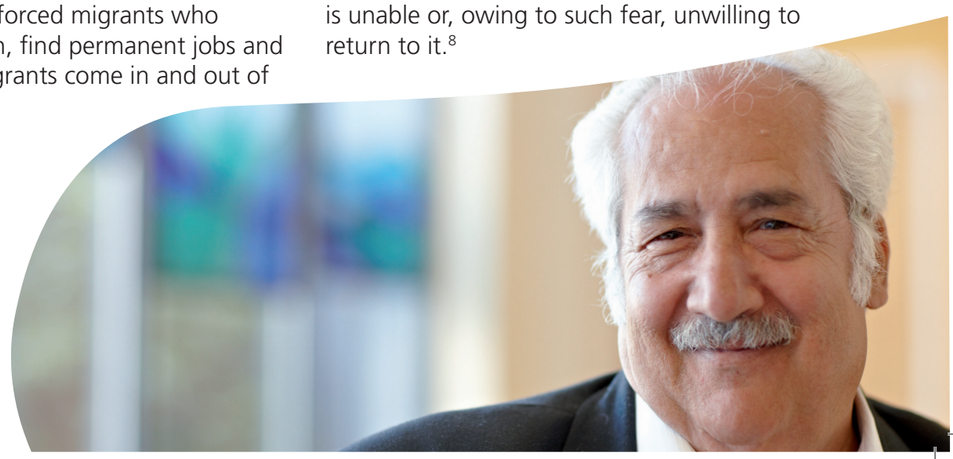
This requires an understanding of migration patterns, as well as the ethnic origin of the population.

Reasons for migration can be voluntary (sometimes called elective); for example, to study or for employment. They can also be forced; for example, the movement of people who are either internally or externally displaced as a result of natural or environmental disasters, slave trade, human trafficking, war and violence and ethnic cleansing.

In the UK there is no legal definition of migration. Traditionally, it has been associated with some notion of permanent settlement. Reality, however, suggests that the concept of migration refers to a general 'movement' embracing various types of mobility, with migrants often being able to transform into something else driven by the process of migration.[6] For example, refugees may come to exile as forced migrants who eventually settle down, find permanent jobs and naturalise. Labour migrants come in and out of labour markets.

Some migrants arrive as asylum seekers. The legal definition of an asylum seeker is a person who enters a country to apply for asylum on the grounds that if they are required to leave, they would have to go to a country to which they are unwilling to go owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion.[7] Individuals undergoing the asylum process have their claims assessed.

The definition of a refugee is a person who, owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of nationality and is unable, or, owing to such a fear, is unwilling to avail themselves of the protection of that country; or who, not having a nationality and being outside the country of their former habitual residence as a result of such events, is unable or, owing to such fear, unwilling to return to it.[8]



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Migration to the UK and Haringey

The UK is home to many immigrants who have come from different parts of the world. Most recently, migration has been characterised by the arrival of migrants from other European countries and South Asia.[9] In 2001, 7.53% (approximately 4.3 million) people living in the British Isles were born outside the UK.[10]

The number of migrants in the UK has increased over time. For example, the number of people arriving in the UK each year increased from approximately 300,000 in 1995 to over 500,000 in 2005.

The majority of migrants are young adults of working age. They often have extremely diverse experiences of migration, ranging from those who left their home country in a search for better living circumstances and employment opportunities, to those who were forced to migrate due to war and violence.

Most migrants who arrive in the UK tend to resettle either in London or in the south-east of the country, although their geographical distribution varies according to country of origin. In London, most migrants tend to resettle in areas with the highest proportions of non-UK born residents, which also tend to be the areas with high levels of deprivation.

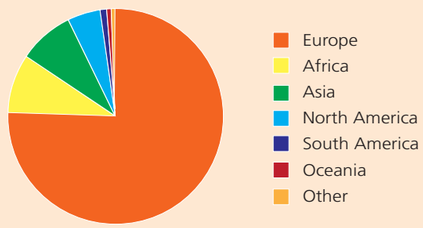
It is difficult to quantify the exact number of migrants in Haringey because of a lack of accurate data. Many services do not record information on immigration status. Ethnicity is usually used as a proxy measure for migration, but this category does not distinguish between recent immigrants and people who are descended by birth from migrants but were born in the UK.

Information on country of birth or country of origin would be a better measure of migration. However, it is not recorded systematically.

Migrants also tend to be excluded from surveys for several reasons. They are not always aware of their entitlements, they may be illegal immigrants or they may fear authority as a result of past negative experiences related to encounters with officials in their country of origin.[11] Insufficient knowledge of language, lack of professional interpreters and greater costs when conducting interviews with migrants may all lead to difficulties with engaging this population group in any systematic research on health outcomes.

Historically, migration into Haringey, as with other parts of London, was from the Caribbean and Asia. However, in more recent years migrants have arrived in the UK from many different countries. The largest numbers are now from Eastern Europe and other parts of the European Union, although there are still consistent flows from the other continents. This has been facilitated by the introduction of new member states to the European Union.

Figure 2: Country of birth of Haringey residents



Source: 2001 Census

The 2001 census asked residents of Haringey the country in which they were born (see Figure 2). This gives another indication of people who have migrated to Haringey from abroad as opposed to how people describe their ethnic origin. In 2001, 75% of the population in Haringey were born in Europe, 9% were born in Africa, 8% were born in Asia and smaller proportions were from South America and Oceania. Of the 75% of people who were born in Europe, the majority (63%) were born in the UK. Six percent of the local residents were born in Eastern Europe, 3.9% were born in other Western European countries and a further 2.7% were born in Ireland.

The NASS (National Asylum Support Service) regularly sends NHS Haringey details of people who have arrived in the borough seeking asylum. Table 1 describes the number of people who have been given asylum and were resettled in Haringey between 2003 and 2008. The number of asylum seekers has dropped by 82% between the beginning and end of the period, possibly due to the make-up of the European Union. The proportion of people migrating from different countries has changed over time and some countries from which asylum seekers arrived in the past are now part of the European Union. The highest proportion of people seeking asylum in Haringey were from Turkey (29%), mainly of Kurdish background.

Table 1: Ethnic composition of NASS notifications between 2003 and 2008

Nationality	2003	2004	2005	2006	2007	2008	2003 to 2008	%
Turkey	563	320	178	87	21	44	1,213	29.02
China	69	106	148	38	7	15	383	9.16
Somalia	143	70	52	52	17	16	350	8.37
Iran	44	48	57	32	6	25	212	5.07
Congo	46	41	28	11	5	5	136	3.25
Kosovo	34	33	15	15	0	2	99	2.37
Eritrea	19	10	23	24	7	14	97	2.32
Albania	21	23	21	18	3	5	91	2.18
Iraq	31	11	8	4	4	14	72	1.72
Ethiopia	19	18	14	3	5	4	63	1.51
Afghanistan	23	11	3	7	5	11	60	1.44
Algeria	17	14	20	5	2	1	59	1.41
Romania	47	8	0	3	0	0	58	1.39
Columbia	28	21	1	4	3	0	57	1.36
Uganda	16	10	14	2	3	8	53	1.27
Jamaica	16	4	18	5	8	1	52	1.24
Yugoslavia	23	15	3	2	2	3	48	1.15
Pakistan	8	7	14	13	4	1	47	1.12
Zimbabwe	15	4	3	2	2	10	36	0.86
Cameroon	7	6	7	4	3	5	32	0.77
Nigeria	6	5	4	8	0	8	31	0.74
Total	1,487	985	822	468	160	258	4,180	

Source: NASS

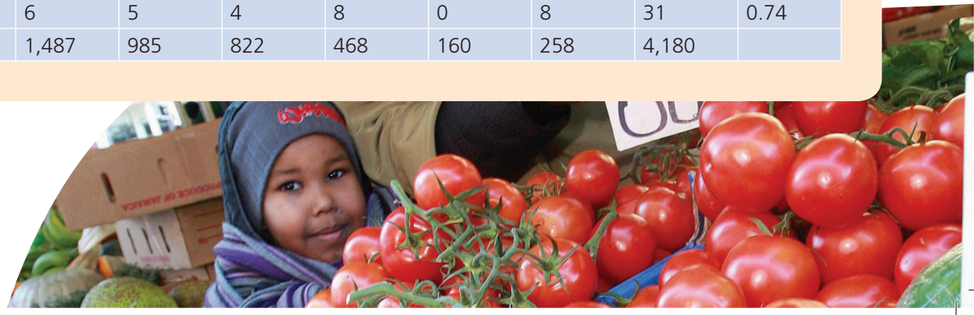


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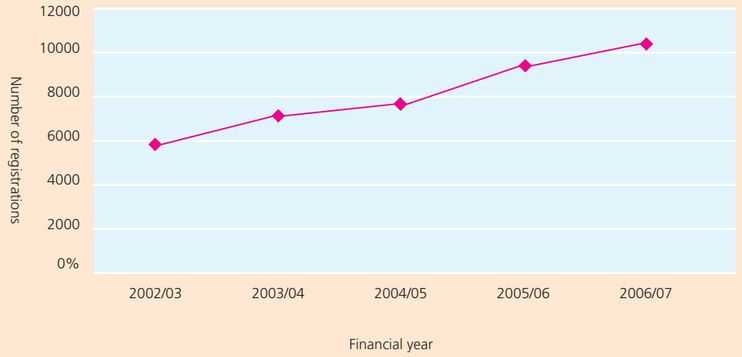
Figure 3: National insurance number registrations in respect of non-UK nationals, by local authority and country of origin, 2002/03 to 2006/07



Source: National Insurance Recording System (NIRS)

One of the other sources of data on migration to Haringey is national insurance registrations. Once someone arrives in the country and is seeking work they are required to register for a national insurance number so that they can legally work and pay national insurance contributions. However, this data underestimates the actual number of migrants in employment, because a proportion of people do not register for a national insurance number.

Between 2002/03 and 2006/07, the number of people registering for national insurance contributions rose steeply from 5,890 to 10,970, a shown in Figure 3.

The highest number of registrations between 2002/03 and 2006/07 were by people from Poland (8,770), accounting for approximately 24%. This was followed by registrations from Turkey, Italy, France and Australia, as shown in Figure 4.

How the ethnicity of Haringey's population is expected to change in the future

The London Health Observatory completed a study of birth trends in London in 2008. The analysis concentrated on the country of birth of the mother, grouping them into those born in the UK, those from A8 countries (European Union accession countries) and those from other parts of the world.

In London, 82% of additional births were from England and Wales and from the rest of the world, and only 14% were from the A8 countries. Births from A8 countries accounted for only 2% of all of the births in London. However, the pattern varied across London boroughs (see figure 5). The analysis showed that 50% of all additional births from A8 countries were from only nine boroughs (Ealing, Newham, Waltham Forest, Haringey, Brent, Barnet, Hounslow, Enfield and City and Hackney). The average proportion of additional live births across London was 2.3%, with the highest proportion in Ealing (5.6%) and Haringey (4.5%).

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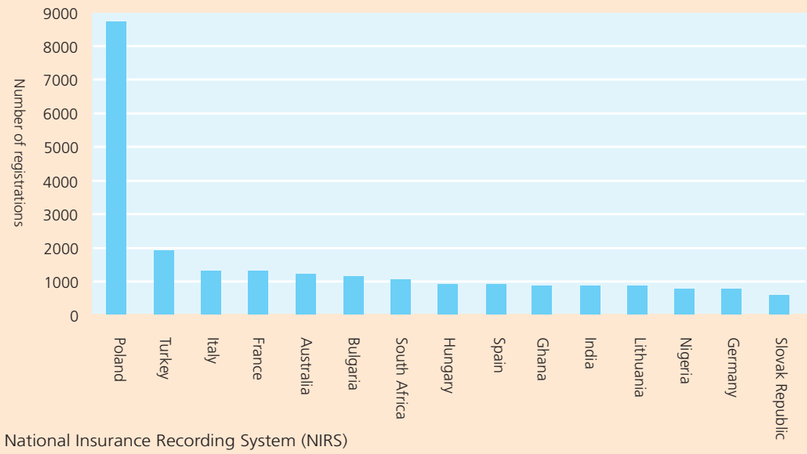
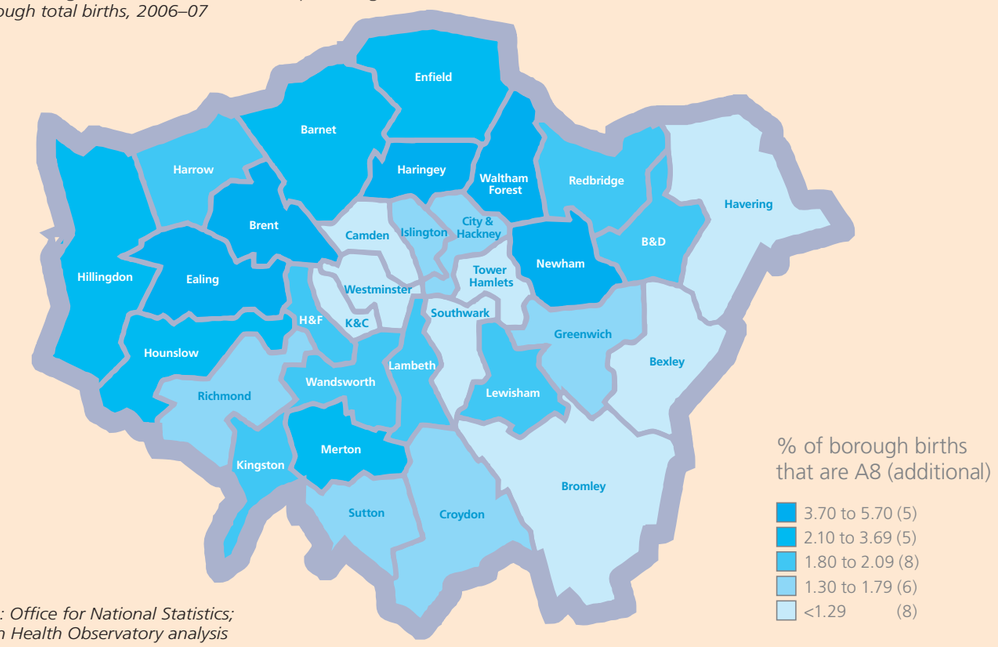
Figure 4: Number of national insurance registrations by country of origin, 2002/03 to 2006/07



Source: National Insurance Recording System (NIRS)

The Greater London Authority (GLA) has also completed a study of ethnicity of new birth registrations and has predicted how the patterns are likely to change across London. In 2001–02, 48% of births to Haringey women were from those of White ethnic origin (which includes White British, White Irish and White Other) and this is estimated to increase to 51% by 2025–26. Births among Black Caribbeans and Black Africans are expected to make up lower proportions

Figure 5: Borough A8 'additional' births as a percentage of borough total births, 2006–07



Source: Office for National Statistics; London Health Observatory analysis

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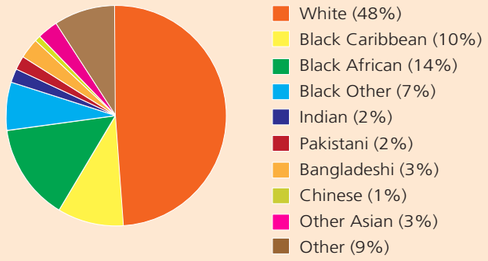
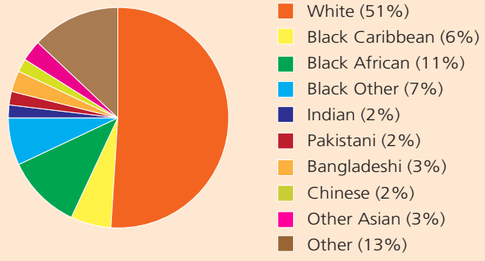
Figure 6: Ethnicity of births in Haringey, 2001–02, as a percentage of all births



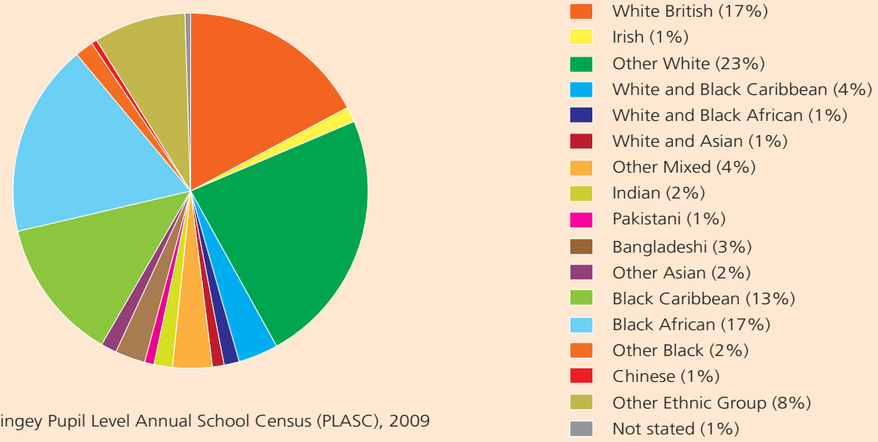
Source: Greater London Authority

Figure 7: Ethnicity of births in Haringey, 2025–26, as a percentage of all births



Source: Greater London Authority

Figure 8: Ethnic composition of children attending Haringey schools, July 2009



Source: Haringey Pupil Level Annual School Census (PLASC), 2009

in 2025–26 than they currently do and it is estimated that those from other ethnic groups are likely to increase from 9% of the total births to 13% (see Figures 6 and 7).

An additional way of looking at how the ethnicity of the population may change in the future is to look at the ethnicity of children at school. The school census, which takes place annually, describes the ethnic composition of younger people in Haringey.

The school census shows that the young population of Haringey is more ethnically diverse than the older population compared to the national census. According to the 2001 national census, 45% of the local population were of White British origin compared to data from the school census where only 17% of the local children were from this ethnic group (see Figure 8). Children from Black and Minority Ethnic groups make up by far the largest proportion of local children, and this is likely to result in a more ethnically diverse population as these young people progress into adulthood. Those groups in which the proportion of children is over-represented, when compared to the census, include those of Black African and Black Caribbean origin and those from the White Other and the Other ethnic group categories. Table 2 describes the difference between the ethnic composition of children attending Haringey schools and the ethnic composition according to the census.

2.2. How ethnicity affects health and health inequalities

A complex link

The interaction between ethnicity and health is complex. The prevalence and death rates of many diseases and disorders are known to vary by ethnic group. Compared to their White British counterparts, many Black and Minority Ethnic groups have poorer health outcomes. There is also well-documented evidence of inequities in access to prevention, treatment and social care based on ethnic groups. The difference in the quality of services received, access to treatments and outcomes related to varying access to healthcare by different ethnic groups is also well reported.

Some of the links are direct because some ethnic groups are more at risk than others of suffering from certain diseases. For example, thalassaemia and sickle-cell disease are more prevalent in people of Mediterranean, Black African and Black Caribbean origin than in the UK indigenous population. Lifestyle and health-related behaviour are shown to be linked with specific conditions. Smoking prevalence and use of alcohol tend to be higher in minority groups[12] when compared to the UK indigenous population. Dietary factors in South Asians have been linked to increased mortality from coronary heart disease and diabetes.[13] Furthermore, delayed access to services may also be a contributing factor to increased mortality in specific minority ethnic groups. Additionally, some minority ethnic groups may be less likely to access health services because of language difficulties or cultural barriers.

Table 2: Comparison of ethnicity between school census 2009 and national census 2001

Ethnicity	PLASC %	Census %
White British	17.13	45.26
Irish	1.45	4.29
White Other	23.44	16.05
White and Black Caribbean	3.62	1.48
White and Black African	1.26	0.73
White and Asian	1.04	1.07
Other mixed	3.68	1.29
Indian	1.74	2.85
Pakistani	0.90	0.95
Bangladeshi	2.70	1.37
Other Asian	1.51	1.55
Black Caribbean	13.06	9.49
Black African	17.47	9.18
Other Black	1.57	1.36
Chinese	0.57	1.13
Other ethnic group	8.35	1.95
Not stated	0.52	

Source: PLASC and 2001 Census

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Table 3: Proportional Admission Ratios for CHD by ethnic group (2005/06)

Ethnic group	Observed	Expected	PAR	Lower CI	Upper CI
White British	17,737	17,154	103	102	105
White Irish	1,140	842	135	128	144
Other White	2,969	3,446	86	83	89
White & Black Caribbean	69	167	41	32	52
White & Black African	46	99	46	34	62
White & Asian	85	94	91	73	112
Other Mixed	227	366	62	54	71
Indian	3,112	1,651	188	182	195
Pakistani	1,158	683	169	160	180
Bangladeshi	1,005	729	138	130	147
Other Asian	1,149	989	116	110	123
Black Caribbean	902	1,528	59	55	63
Black African	420	1,828	23	21	25
Other Black	271	1,121	24	21	27
Chinese	107	193	55	45	67
Other	1,475	1,694	87	83	92
Not known	1,994	1,585	126	120	131
Not stated	5,164	4,862	106	103	109
All Ethnicities	39,030	39,030	100	99	101

Source: Hospital Episode Statistics / analysed by the London Health Observatory

Other links are indirect. Some ethnic groups are more likely than others to have lower incomes and to live in deprived areas. The link between income and health is very well proven, so those groups who tend to have lower incomes are more likely to suffer from ill health. There is also a strong causal link between deprivation and poor health. As some ethnic groups are more likely to live in deprived areas, they show higher rates of poor health. Deprived areas also tend to have worse access to health services and poorer quality services, which exacerbates the negative health impacts of living in deprivation.

This means that it is very difficult to attribute health inequalities among different ethnic groups to ethnic origin itself, as opposed to the compounding effects of poverty, deprivation and stress.

Many of these inequalities are amenable to change and can be addressed using a range of evidence-based interventions to improve health and reduce ethnic inequalities in health and healthcare.[14] Reducing health inequalities is paramount to improvement in the overall health of the UK population and has been a focus of government policy. The NHS Plan, published in 2000, included actions and service development to tackle health inequalities, and there are national targets to reduce health inequalities.[15]

Health service utilisation among ethnic groups

Analysis of hospital admissions and outpatient and accident and emergency attendances suggests that some ethnic groups have varying levels of need compared to others. Some of this variation in need can be explained by different ethnic groups' predisposition to certain diseases, but it is likely that much of it is explained by the cumulative effect of inherited disease, attitudes to health and access to primary care.

Analysis of inpatient activity for selected diagnoses by the London Health Observatory suggests that certain ethnic groups have significantly more than expected attendances for certain diseases; this in turn suggests that ethnicity is a factor in determining admission rates within the London population. Table 3 describes the differences in the hospital admission rates for chronic heart disease (CHD) across London. Activity levels for the White British population are quite close to what would be expected compared to the distribution of this group among the total London population.

However, admission rates are much higher than expected among the White Irish and Asian communities.

Table 4 describes the activity by ethnic group that has the highest over-representations on selected diagnoses. This analysis clearly suggests that tuberculosis (TB) admission rates are very high for Black African and Asian groups and that schizophrenia admission rates are significantly higher than expected for Black communities (including Black Caribbean, Black African and Mixed Black groups). Irish groups also have a disproportional number of admissions for substance misuse and pancreatic and lung cancers.

Table 4: Proportional admission ratios 2005-06 (PAR) – top 20 by ethnicity and diagnosis

Diagnosis or cause	Ethnic group	Observed	Expected	PAR	Lower CI	Upper CI
Cervical cancer	Chinese	26	6	463	302	678
Tuberculosis	Black African	299	75	397	353	444
Tuberculosis	Pakistani	104	28	369	302	447
Cancer of the head and neck	Chinese	60	16	366	279	470
Tuberculosis	Indian	245	68	360	316	408
Schizophrenia	Black Caribbean	588	167	352	324	382
Schizophrenia	White & Black African	35	11	323	225	449
Tuberculosis	Other Asian	122	41	299	248	357
Acute hypertensive disease	Black Caribbean	416	140	297	269	327
Schizophrenia	Other Black	341	122	278	250	310
Substance use	White Irish	430	156	275	250	303
Pancreatic cancer	White Irish	112	41	272	224	328
Schizophrenia	White & Black Caribbean	49	18	268	199	355
Tuberculosis	Chinese	21	8	264	163	403
Schizophrenia	White & Asian	27	10	264	174	384
Non-Hodgkins cancer	Chinese	102	39	263	214	319
Leukaemia	Chinese	154	59	263	223	308
Lung cancer	White Irish	505	194	260	238	284
Renal failure	Pakistani	299	115	259	231	291
Tuberculosis	Bangladeshi	77	30	256	202	320

Source: Hospital Episode Statistics / analysed by the London Health Observatory

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2.3. How migration can affect health

The health risks experienced by many immigrants

Although modern literature depicts the migration process as mainly beneficial, especially in relation to improving educational, political and socio-economic circumstances, the process itself can quite often be strenuous and traumatic. Migrants may be exposed to health risks before the migration process, during migration or after arrival in the resettlement country.

Conditions to which migrants may be exposed before migration may include natural disasters, experience of war, torture and violence, imprisonment, loss of relatives and loved ones, unfavourable socio-economic circumstances, infectious diseases, among others. Conditions during the journey may also be unfavourable and undesirable, resulting in further stress and health impairment. The process of displacement can be particularly damaging for vulnerable groups such as children and older people.

Some of the risks experienced after arriving in the resettlement country include imprisonment, long-lasting asylum seeking process and uncertainty, discrimination and marginalisation, all leading to stress and resulting in negative impacts on overall physical and psychological well-being. The process of resettlement in the new country and multifaceted integration process pose significant demand on coping mechanisms.

The migration process also influences risk behaviours and risk perception in many ways. Those affected by losses such, as loss of identity, family and possessions, may hold on to the past and turn their focus of attention on their past life in their country of origin rather than focusing on the future. Therefore, this group may be more likely to neglect health and to engage more readily in health-damaging behaviour.[16] Preoccupation with survival and socio-economic welfare is usually a much higher priority for migrants, especially refugees, than is their health and risk perception. All of this may have a negative effect on migrants' health.

Rates of infectious diseases, such as tuberculosis, HIV/AIDS and sexually transmitted infections, have been found to be more prevalent in migrants, especially asylum seekers and refugees who tend to migrate from deprived countries.[17]

However, the migrant population is an extremely heterogeneous group and the health effects of migration depend heavily on the socio-economic and cultural background of migrants, their previous health history, the nature and quality of healthcare services they previously had in their countries of origin, their genetic make-up, their ways of migration and their living circumstances in the recipient country. Consequently, it is not possible to draw universally applicable conclusions about the impacts of migration on health.

There is a need for integrated policy and long-term public health promotion and education strategies to ensure that migrants have adequate access to appropriate health and social care services. Only those who are physically and psychologically healthy can participate in community life to their full potential.

Data limitations

The data on ethnicity, migration and health is often inadequate. Knowledge about the health status of migrants is very limited due to a lack of data. Ethnicity is usually used as a proxy measure for migration, but this category does not distinguish between recent immigrants and their descendants born in the UK.

The existing evidence does allow us to draw some conclusions about the relationship between health, ethnicity and migration. Most of the presented evidence suggests that morbidity among migrants and minority ethnic groups is greater when compared to the general population. However, there are exceptions and, as always, generalisations hide complexity. What is clear is that improved data collection and analysis would allow us to deepen our understanding of the important and complicated relationship between health, ethnicity and migration. In the following chapters, this report draws attention to these data deficiencies and makes recommendations to improve these. This will allow policy makers and service providers to respond more effectively to the health needs of Black and Minority Ethnic communities and migrants.