

The health of people from ethnic minority groups in England

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[14 comments](#)

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This long read examines ethnic differences in health outcomes, highlighting the variation across ethnic groups and health conditions, and considers what's needed to reduce health inequalities.

Key messages

- In England, there are health inequalities between ethnic minority and white groups, and between different ethnic minority groups¹([#footnote1_b62462i](#)). The picture is complex, both between different ethnic groups and across different conditions, and understanding is limited by a lack of good quality data.
- Access to primary care health services is generally equitable for ethnic minority groups, but this is less consistently so across other health services. However, people from ethnic minority groups are more likely to report being in poorer health and to report poorer experiences of using health services than their white counterparts.
- Before the Covid-19 pandemic, life expectancy at birth was higher among ethnic minority groups than the white and Mixed groups. The headline figures conceal significant differences between ethnic groups, for example:
 - people from the Gypsy or Irish Traveller, Bangladeshi and Pakistani communities have the poorest health outcomes across a range of indicators
 - compared with the white population, disability-free life expectancy is estimated to be lower among several ethnic minority groups
 - rates of infant and maternal mortality, cardiovascular disease (CVD) and diabetes are higher among Black and South Asian groups
 - mortality from cancer, and dementia and Alzheimer's disease, is highest among white groups.
- The Covid-19 pandemic has had a disproportionate impact on ethnic minority communities, who have experienced higher infection and mortality rates than the white population. Geography, deprivation, occupation, living arrangements and health conditions such as CVD and diabetes accounted for a large proportion, but not all, of the excess mortality risk of Covid-19 in ethnic minority groups. Covid-19 has reversed the previous picture for some ethnic minority groups which now have higher overall mortality than the white population.
- Unpicking the causes of ethnic inequalities in health is difficult. Available evidence suggests a complex interplay of deprivation, environmental, physiological, health-related behaviours and the 'healthy migrant effect'²([#footnote2_zrdyc1g](#)). Ethnic minority groups are disproportionately affected by socio-economic deprivation, a key determinant of health status in all communities, but it is not clear if the relationship applies equally across all ethnic groups.
- Among ethnic minority groups structural racism can reinforce inequalities, for example, in housing, employment and the criminal justice system, which in turn can have a negative impact on health. Evidence shows that racism and discrimination can also have a negative impact on the physical and mental health of people from ethnic minority groups.
- Covid-19 has shone a light on inequalities and highlighted the urgent need to strengthen action to prevent and manage ill health in deprived and ethnic minority communities. A cross-government strategy for reducing health inequalities (and the wider socio-economic and structural inequalities that drive them) and addressing the diverse health needs of all groups at risk of poor health and high mortality has never been more urgent.
- Comprehensive, good-quality data is essential for enabling policy-makers and health care professionals to identify the specific needs of different ethnic groups, respond with tailored strategies for addressing inequalities, and track the impact of these strategies.

The references providing the evidence to support the contents of each section of this explainer are listed in drop-downs at the end of each section.

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1. (#footnote3_4f6k260) minority' or 'ethnic minority groups' refer to people belonging to ethnic groups that are in the minority in the context of the population of England.
2. (#footnote3_4f6k260) The 'healthy migrant effect' is the mortality advantage in migrants relative to the majority population in host countries that is reported in many countries. It could be due to the selective migration of healthy individuals and/or healthier lifestyles such as lower smoking and alcohol consumption.

Introduction

In the 2011 census, 15 per cent of people in England identified themselves as belonging to an ethnic minority group (see [Table 1 \(https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england#Table-One\)](https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england#Table-One),³ (#footnote3_4f6k260)). Ethnicity is a complex, multidimensional concept, defined by features such as a shared history, origins, language, and cultural traditions. Although it is a social construct often used to describe distinct populations, it is a subjective identity based on how individuals define themselves.

Health patterns differ significantly between ethnic minority groups and the white population, and between different minority groups, reflecting the diversity of demographic, socio-economic, behavioural, cultural and other characteristics between ethnic groups.

This explainer provides an overview of health outcomes and their determinants among ethnic minority groups. It focuses on selected topics where ethnic differences are significant and affect large numbers.

This explainer describes ethnic differences in:

- [overall health \(https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england#Overall\)](https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england#Overall)
- [maternal and infant mortality, and child health \(https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england#Maternal\)](https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england#Maternal)
- [cardiovascular disease \(CVD\) \(https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england#CVD\)](https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england#CVD)
- [diabetes \(https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england#Diabetes\)](https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england#Diabetes)
- [cancer \(https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england#Cancer\)](https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england#Cancer)
- [Covid-19 \(https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england#Covid-19\)](https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england#Covid-19)
- [determinants of health. \(https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england#Determinants\)](https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england#Determinants)

This is not a comprehensive review of all aspects of ethnic minority health. In particular, it does not cover mental health because of the challenges in summarising ethnic differences across diverse forms of mental illness in a short report.

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3. (#footnote3_4f6k260) ONS estimates of population by ethnic group show the per cent non-White in England in 2018 was 16 per cent.

[Table 1 Population of England by ethnic group, 2011](#)

Ethnic group	Number	Per cent
All	53,012,456	100
White	45,281,142	85.4
White British	42,279,236	79.8
White Irish	517,001	1.0
White Gypsy/Traveller	54,895	0.1
White other	2,430,010	4.6
Asian	4,143,403	7.8
Indian	1,395,702	2.6
Pakistani	1,112,282	2.1
Bangladeshi	436,514	0.8
Chinese	379,503	0.7

Ethnic group	Number	Per cent
Other Asian	819,402	1.5
Black	1,846,614	3.5
Black African	977,741	1.8
Black Caribbean	591,016	1.1
Other Black	277,857	0.5
Mixed	1,192,879	2.3
White and Black Caribbean	415,616	0.8
White and Black African	161,550	0.3
White and Asian	332,708	0.6
Other Mixed	283,005	0.5
Other	548,418	1.0
Arab	220,985	0.4
Any other ethnic group	327,443	0.6

Source: [Office for National Statistics \(2011\)](#)

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Data on the health of ethnic minority groups

This explainer focuses on the health of ethnic minorities in England. Where articles and data sources refer to different geographies, eg, England and Wales or the UK, this is stated in the text.

The 2011 census ethnic categories are used, although sometimes data sources refer to aggregated ethnic groups when numbers are small. The categories used here are those used in the original data sources. The South Asian group refers to people from India, Pakistan, Bangladesh, Sri Lanka, Nepal, Bhutan. The Asian group generally also includes people from South East Asia. The Black group includes people of African and/or Caribbean origin.

Much of the data for examining ethnic differences in health comes from health records. However, its coverage and quality are imperfect. National data on mortality by ethnic group has not been available routinely because ethnicity is not recorded at death registration (although Scotland introduced this in 2012). Earlier analyses of mortality therefore used country of birth of migrants as a proxy for ethnicity, but this excludes second-generation migrants. More recently, analyses of mortality by the Office for National Statistics (ONS) and Public Health England have linked death records to secondary sources from which ethnicity is derived, eg, the 2011 Census and hospital records; these provide the best available national data on mortality by ethnicity but the results are subject to caveats. These data limitations present barriers to understanding health issues among ethnic minority groups.

Following the Covid-19 pandemic, NHS England is taking steps to improve ethnicity recording in health records and the government has said it will introduce ethnicity recording in death certificates. These data developments should facilitate a better

understanding of ethnic differences in health.

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Overall health

General health can be measured by self-reported outcomes, such as how people perceive their health, and observed outcomes such as mortality. There are differences in health between ethnic minority groups, and between ethnic minority groups and the white group; the patterns vary depending on the aspect of health being measured.

People from ethnic minority groups (especially Pakistani and Bangladeshi groups) are more likely than White British people to report limiting long-term illness and poor health, with those identifying as White Gypsy and Irish Traveller reporting the poorest health. Health-related quality of life scores at older ages, based on responses to the GP patient survey, are lower than average among most ethnic minority groups, especially the White Gypsy and Irish Traveller, Bangladeshi and Pakistani groups, but not among some others, including Black Caribbean, Black African and Mixed groups. Poor health co-existing with lower mortality has often been reported for migrant groups, including in the UK.

Compared with the White British group, disability-free life expectancy is estimated to be higher among the Other White, Chinese and Black African groups, lower among Black Caribbean, Other Black, Indian, Other Asian and some Mixed groups, and lowest among the Pakistani and Bangladeshi groups.

'Experimental' ONS statistics show that in 2011–14, life expectancy at birth among males and females of White and Mixed groups was lower than in all other ethnic groups (see Figures 1a and 1b below), and that the white group had higher mortality from most leading causes of death. The ONS findings are consistent with other evidence that most ethnic minority groups and foreign-born migrants in England and Scotland had lower overall mortality than white counterparts before the Covid-19 pandemic. This could be due to many factors including the 'healthy migrant effect', which may mitigate some impacts of socio-economic disadvantage. Moreover, some risk factors, eg, smoking and alcohol consumption, are lower among ethnic minority groups. Studies also show that this mortality advantage among migrants is reduced over time and in UK-born descendants – possibly because cultural assimilation over time leads to lifestyle changes, eg, in diet and smoking.

Although overall mortality declined subsequently in all ethnic groups, ethnic differences remained similar through to recent years: in 2017–19 the white group had higher overall mortality than any other ethnic group.

 A chart showing male life expectancy at birth by ethnic group, England and Wales, 2011 to 2014

 Chart showing female life expectancy at birth by ethnic group, England and Wales, 2011 to 2014

Source: ONS (2021)

(<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/articles/ethnicdifferencesinlifeexpectancyandm>

However, the Covid-19 pandemic reversed the mortality advantage in some ethnic minority groups. Between 24 January 2020 and 31 March 2021, compared with the White British group, overall mortality was higher in Bangladeshi and Pakistani males and females, and in Black Caribbean males, and lower than, or similar, in males and females in remaining ethnic minority groups.

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Maternal mortality, stillbirths and infant mortality, and child health

Maternal mortality

30 per cent of the 640,000 babies born in England and Wales in 2019 were to mothers of ethnic minority origin (see Table 2).

Compared with the white group, the rate of women dying in the UK in 2016–18 during or up to one year after pregnancy is more than four times higher in the Black group, and almost double in the Asian group (although the number of such deaths is relatively low – under 10 a year in both the Black group and the Asian group).

Stillbirths and infant mortality⁴ (#footnote4_icl6ha1)

Although stillbirth and infant mortality rates in England and Wales have fallen in all ethnic groups since 2007, they remain higher among ethnic minority groups. They are highest among babies from the Pakistani and Black groups (see Table 2).

The causes of infant mortality differ between ethnic groups. South Asian and Black mothers have higher proportions of premature and low birthweight babies than white mothers. Immaturity-related conditions, such as respiratory and cardiovascular disorders, contribute most to infant mortality in most ethnic groups; however, in the Pakistani and Bangladeshi

groups congenital anomalies cause the most infant deaths. Babies of South Asian women have a lower rate of unexplained deaths in infancy. Explanations for these ethnic variations in infant mortality are complex, involving the interplay of environmental, physiological and socio-cultural factors. Deprivation is a significant risk factor: compared with white groups, higher proportions of mothers from ethnic minority groups, especially Black groups, live in deprived areas.

Table 2 Live births, stillbirths and infant mortality by ethnic group, England and Wales

Ethnic group	Live births 2019	Per cent of live births 2019	Stillbirths per 1000 total births 2017-19	Infant deaths per 1000 live births 2017-19
White British	377,916	59.1	3.5	3.2
White other	74,332	11.6	3.8	2.7
Bangladeshi	9,505	1.5	5.2	5.0
Indian	20,627	3.2	4.9	4.5
Pakistani	27,573	4.3	6.1	6.8
Any Other Asian background	16,169	2.5	4.9	4.4
Black African	21,589	3.4	7.2	6.5
Black Caribbean	5,480	0.9	6.3	6.5
Any Other Black background	3,777	0.6	8.3	6.8
Mixed/multiple	41,918	6.5	3.6	3.7
Any Other ethnic group	15,523	2.4	4.6	3.9
Not stated	25,578	4.0	5.5	5.5
Total	639,987	100.0	4.0	3.8

Source: ONS (2021)

Child health

Health and wellbeing in the early years have a significant bearing on future health. Childhood obesity rates are higher among Black and Asian children (see Table 3). Some of these differences may be associated with higher levels of deprivation among ethnic minority groups, as children in deprived areas are twice as likely to be obese than those in less-deprived areas. Children in Asian (37 per cent) and Black (37 per cent) households are twice as likely to live in persistent low-income households than children from white households (18 per cent).

South Asian children also have lower levels of physical fitness than children in white European and Black groups, and physical activity levels are lower among children from Bangladeshi and Pakistani groups.

Table 3 Prevalence of obesity by ethnic group, England, 2019/20

Ethnic group	Ages 4-5 years per cent	Ages 10-11 years per cent
White British	9.7	19.0
White Other	9.1	22.5
Bangladeshi	12.6	30.1
Indian	7.2	21.6
Pakistani	10.8	26.2
Any Other Asian background	9.4	24.7
Black African	15.9	30.5

Ethnic group	Ages 4-5 years per cent	Ages 10-11 years per cent
Black Caribbean	13.1	30.3
Any Other Black background	13.9	27.4
Mixed	10.3	23.4
Any Other ethnic group	10.7	25.4
Not stated	9.4	20.8
TOTAL	9.9	21.0

Source: NHS Digital (2020)

4. (#foa) Stillbirth is a baby born with no signs of life at or after 28 weeks' gestation. An infant death is the death of a child under one year.

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Cardiovascular disease

Cardiovascular disease⁵ (#footnote5_abyf2qp). (CVD) is a leading cause of death nationally and in ethnic minority groups, causing 24 per cent of all deaths in England and Wales in 2019. It is a significant contributor to inequalities in life expectancy and a risk factor for poor outcomes from Covid-19. Up to 80 per cent of premature deaths from CVD are preventable through better public health. Diabetes increases the risk of CVD almost two-fold.

Prevalence of and mortality from CVD

Studies in the UK and across the Indian diaspora (eg, Europe, Fiji, Singapore, South Africa, the US and Canada) consistently show a higher incidence, prevalence and mortality from CVD in South Asian groups compared with the white group or national average. South Asian groups have the highest mortality from heart disease and also develop heart disease at a younger age. As with heart disease, stroke incidence and mortality are also higher in the South Asian population. CVD mortality is high and rising in South Asia, in contrast to the declining trend elsewhere.

These patterns are associated with a higher clustering in South Asians of risk factors⁶ (#footnote6_raztz0l) that increase the risk of heart disease, stroke and diabetes. Although body mass index (BMI) levels are lower among South Asian groups compared with normal ranges, rates of excess abdominal fat and insulin resistance are higher. Hence National Institute for Health and Care Excellence (NICE) guidelines specify lower BMI thresholds for use by health care professionals for introducing preventive interventions in these groups. In terms of other risk factors, although smoking prevalence is lower among South Asian groups, they have low physical activity rates, especially among women. The causes of increased CVD risk among South Asian groups are multifactorial and include physiological susceptibility, environmental determinants such as deprivation, and adverse changes to lifestyle and diet following migration.

In contrast to South Asian groups, Black groups in the UK have a significantly lower risk of heart disease compared to the majority of the population, despite having a high prevalence of hypertension and diabetes (risk factors for heart disease and stroke). Lower cholesterol levels among people of African Caribbean heritage than white Europeans may protect them against heart disease. Heart disease rates are low in sub-Saharan Africa and the Caribbean.

However, Black groups have higher-than-average incidence of and mortality from hypertension and stroke, and they have strokes at a younger age. The prevalence of hypertension, a risk factor for stroke, is high in Africa and the West Indies. Obesity levels are also higher in Black groups, with NICE guidelines specifying lower BMI thresholds for them.

Care for CVD

Recent evidence suggests that greater awareness among health care providers of the CVD risk in South Asian populations, earlier diagnosis and improved management of diabetes and CVD, together with second-generation adopting healthier lifestyles than first-generation migrants, have reduced CVD mortality risks relative to white Europeans. Research also indicates that South Asian groups have equitable access to care for heart disease and better survival rates from it.

In contrast, Black groups have lower than expected rates of access to and use of cardiovascular care.

⁵ (#footnote5_abyf2qp) Cardiovascular disease (CVD) is the collective term for diseases affecting the circulatory system, ie, heart, arteries, blood vessels. The main forms of CVD are heart disease and stroke.

⁶ (#footnote6_raztz0l) This clustering of risk factors is called the metabolic syndrome and includes abdominal obesity, high blood pressure, high blood sugar levels, high triglyceride (fat in the blood) levels and low HDL (the 'good' cholesterol) levels. It is associated with obesity, physical inactivity and insulin resistance (inability to control blood sugar levels because the body doesn't respond properly to insulin).

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Diabetes

Diabetes⁷ (see references) is a long-term condition that can cause serious secondary complications and premature death if it is not well managed. This explainer considers type-2 diabetes. Being overweight, abdominal obesity and physical inactivity are risk factors for diabetes. The prevalence of diabetes is higher among South Asian and Black groups than in the white population and people in these groups develop the condition at a younger age.

Prevalence of and mortality from diabetes

The risk of developing diabetes is up to six times higher in South Asian groups than in white groups and South Asian groups have higher mortality from diabetes. About 400,000 people of South Asian ethnicity in the UK have diabetes, one-fifth of the UK diabetes population. High diabetes prevalence is seen also in their countries of origin and across the South Asian diaspora worldwide, eg, in Europe, the US, Canada, the Caribbean, South Africa, Fiji. South Asians with diabetes have a higher risk of developing secondary complications of cardiovascular and end-stage renal disease. However, recent studies show that excess CVD mortality in South Asians with diabetes has reduced and overall mortality is lower than in the white group.

Explanations for the high prevalence of diabetes among South Asian groups include a mix of biological, lifestyle and socio-economic factors. As with CVD, these patterns are associated with a clustering in South Asians of risk factors (see footnote 3) that increase the risk of diabetes, exacerbated by socio-economic disadvantage and changing lifestyles after migration. Even though South Asians typically have a low BMI, excess abdominal fat increases the risk of diabetes and CVD. Accordingly, NICE, the World Health Organization and several national diabetes associations recommend lower BMI thresholds for introducing preventive measures in South Asians with diabetes.

Diabetes prevalence in Black groups is up to three times higher than in the white population and they have higher mortality from diabetes; they also have a higher risk of hypertension and stroke but, unlike South Asians, are less prone to heart disease. The physiological pathways and impacts of diabetes therefore differ between ethnic minority groups. Diabetes-related co-morbidities in Black groups are similar to or lower than in white groups, except for higher rates of end-stage renal disease. Like South Asians, excess mortality associated with diabetes is lower in Blacks groups than in the white population.

Care for diabetes

A recent study found improved diabetes outcomes in South Asians are attributable, in part, to earlier diagnosis and risk factor management, indicating increased awareness among health care providers, equity of access and standardisation of care for long-term conditions incentivised in the Quality and Outcomes Framework for GPs. It also found little evidence of inequalities in the management of diabetes among Black patients at initial diagnosis, indicative of a wider trend of shrinking inequalities in diabetes care.

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Notes:

7. Diabetes is a lifelong condition that causes a person's blood sugar level to become too high. It can lead to serious secondary complications. There are two types of diabetes: type-1 diabetes when the body makes no insulin at all, and type-2 diabetes when the body doesn't produce enough insulin or when it doesn't react to the insulin. Some women can develop [gestational diabetes](#) during pregnancy. About 90 per cent of people with diabetes have type-2 diabetes, which is potentially preventable.

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Cancer

Cancer incidence

The incidence of cancer overall is generally lower among ethnic minority groups in England than in white groups. Asian, Chinese and Mixed groups have a significantly lower risk (of 20–60 per cent) of getting cancer than the white group; smoking rates are generally lower in these groups. Cancer incidence is also lower among Black women compared with white women but similar in Black and white men.

In terms of specific cancers, Asian groups have a higher incidence than the white group of cancer of the liver and mouth (females only), and a lower risk of the four major cancers (breast, prostate, lung, colorectal) and several less common cancers.

Black groups have a significantly lower incidence of three major cancers (breast, lung and colorectal) and several less-common cancers. However, the incidence of and mortality from prostate cancer is significantly higher among Black males than white males. Black men in Africa, the Caribbean and the US are also at greater risk of prostate cancer for reasons that are unclear.

Although lower breast cancer incidence in Asian and Black women is associated with a lower risk profile (such as lower alcohol consumption, breastfeeding, childbearing), cultural assimilation over time can lead to changes in health behaviours. Some evidence suggests cancer rates in South Asian groups are converging towards those in the white population.

Cancer screening

Screening is an important part of efforts to reduce cancer mortality. Screening rates for breast and cervical cancer are lower among women from ethnic minority groups, particularly South Asians. South Asians also have lower rates of bowel cancer screening.

Poorer awareness of risk factors for cancer and symptoms, and socio-cultural and practical barriers such as language, contribute to lower cancer screening rates among ethnic minority groups.

Stage at diagnosis

The stage at which cancer is diagnosed can have an impact on treatment outcomes and mortality. It may be related to a patient's route to diagnosis, including through screening. Although data for 2012–13 showed the Black Caribbean group was more likely than White British to be diagnosed late for some cancers, 2017 data shows the proportion of early-stage cancer diagnoses among Asian and Black groups (55 per cent) was similar to the white group (52 per cent). Research has also found weak evidence of ethnic inequalities in times to cancer diagnosis and staging.

Cancer mortality

Cancer mortality rates measure cancer deaths in relation to population size, and reflect both cancer incidence (ie, the numbers who develop cancer) and the deaths from it. Overall cancer mortality rates are lower among ethnic minority groups compared with white groups. However, lung cancer mortality is higher among Bangladeshi males and prostate cancer mortality is higher among Black males.

Cancer survival measures the proportion of people with cancer who survive, and reflects many factors including deprivation, stage at diagnosis and quality of care. Cancer survival in ethnic minority groups is reported to be similar to the white population.

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Covid-19

The Covid-19 pandemic has had a disproportionate effect on ethnic minority groups, with Black, Asian and most other ethnic minority groups more likely to be diagnosed with Covid-19, get severely ill and die compared to the white population. Several factors contribute to these patterns.

Outcomes of Covid-19

Exposure to infection is higher among ethnic minority groups because, for example, they are more likely to work in public-facing jobs such as transport and health and social care, use public transport, and live in high-density housing, multi-generation households and urban areas where transmission is higher.

People from South Asian and Black groups also have a higher prevalence of obesity and long-term conditions such as CVD, hypertension and diabetes, which increase the risk of adverse outcomes and death from Covid-19.

In the first Covid-19 wave, [8.1% \(#footnote8_3gt858w\)](#), almost all ethnic minority groups had higher Covid-19 mortality rates than the White British group; ethnic differences were reduced significantly after adjustment for location, socio-economic, household and health-related factors. In the second wave, differences in Covid-19 mortality compared with the White British population increased for Bangladeshi and Pakistani groups and decreased for Black groups. The attenuation of mortality risks for most ethnic minority groups in the second wave points to the mitigating effects of public health and lockdown measures.

Higher mortality is reported also for NHS and social care staff from Black, Asian and other ethnic minority groups.

Covid-19 and inequalities

Several studies have examined the impact of Covid-19 on ethnic minority groups and the contributory factors, including the role of structural inequalities, noting how Covid-19 has amplified health and socio-economic inequalities in UK and elsewhere. Demographic, geographical, socio-economic and household characteristics, and co-morbidities contribute significantly to ethnic differences in Covid-19 outcomes, but they do not explain all the variation. The reasons for ethnic differences in Covid-19 outcomes are not yet fully understood, and the government has funded research on this.

[8.1% \(#footnote8_3gt858w\)](#) The first wave is defined as the period from 24 January 2020 to 11 September 2020, and the second wave is defined as the period from 12 September to 31 March 2021.

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Determinants of health

Here we examine ethnic differences in some key determinants of health, namely behavioural risk factors, access to health care services, and socio-economic factors.

Selected behavioural risk factors

Smoking, high alcohol consumption, physical inactivity and a poor diet are principal behavioural risks to health; the latter two also cause obesity. Their prevalence varies across the population, although they tend to cluster in more deprived communities.

Smoking

Smoking prevalence is lower in most ethnic minority groups than in the white group, and highest in the Mixed group (see Figure 2).

 Chart showing the per cent of people aged 18 years and over who smoke, England, 2019

Alcohol consumption

Adults in ethnic minority groups are less likely to drink alcohol at a hazardous, harmful or dependent level compared to white groups (see Figure 3).

 Chart showing the per cent of people aged 16 years and over who drink at hazardous, harmful or dependent levels: England, 2014

Physical activity

Physical activity levels differ between ethnic groups and genders. People from Asian and Black groups, and women in particular, are most likely to report being physically inactive and least likely to report being active (see Figures 4a and b).

 Chart showing the per cent of people aged 16 years and over who were physically active: England, 2018/19

 Chart showing the per cent of people aged 16 years and over who were physically inactive, England, 2017-18

Healthy eating

The proportion of people eating recommended portions of fruit or vegetables per day is lower in ethnic minority groups than in white groups (see Figure 5).

 Chart showing the per cent of people aged 16 years and over who were physically inactive: England, 2017/18

Obesity

Compared with the White British group, obesity prevalence is higher in Black adults and lower among other minority groups (see Figure 6).

 Chart showing the per cent of people aged 18 years and over who were overweight or obese, England, 2019-20

Access to services and patient experience

Free, universal access to health care and standardised treatment protocols have resulted in greater equality of access and outcomes across ethnic groups, especially in primary care, but less consistently across other health services. However, patients from ethnic minority groups report a poorer experience than the White British group of using a range of health care services.

As we have shown, there are different patterns of health across different ethnic groups. Moreover, ethnic minority communities experience a higher burden of some conditions that are potentially preventable. For example, much of the excess morbidity and mortality from CVD and diabetes among some ethnic minority groups is associated with modifiable risk factors. Prevention should therefore be a priority for public health and health care services. Low health literacy, potentially exacerbated by language barriers, can lead to unhealthy behaviours and poorer uptake of preventive services. Modes of disease presentation and therapeutic needs may also differ by ethnicity.

Health care services therefore need to be aware of the specific health care needs, risk factors and treatment requirements in different communities and ensure services are culturally tailored to promote adherence. For example, the incidence of diabetes among ethnic minority groups can be moderated through dietary and physical activity modifications, and culturally tailored diabetes programmes are effective at improving outcomes. Research shows that culturally adapted interventions can improve participation in cancer screening.

Socio-economic inequalities

There is a strong, systemic relationship between health and deprivation, with more deprived communities experiencing worse health and a shorter life-expectancy than more affluent groups. Deprivation levels are higher among ethnic minority groups and they are over-represented in deprived communities. People from minority ethnic groups make up 15 per cent of the total population, but account for 22 per cent of the population in the most deprived areas (see Figure 7). Although ethnic minority groups experience greater deprivation on average than the white population, it is not clear whether the relationship applies equally across all ethnic groups.

If you are on a mobile device, please rotate your screen to landscape in order to view the full detail of this chart.

 Chart showing the per cent of ethnic group populations living in the ten per cent of the most deprived neighbourhoods, England, 2019

Socio-economic inequalities experienced by ethnic minority groups also include the following examples.

- Income: Asian (22 per cent), Mixed (22 per cent) and Black (25 per cent) groups are more than twice as likely to live in households with persistent low income (after housing costs) than the white group (12 per cent).
- Housing: rates of overcrowding are higher in ethnic minority households than White British households (2 per cent), and highest in Bangladeshi (24 per cent), Pakistani (18 per cent), Black African (16 per cent) and Arab (15 per cent) households.
- Unemployment: unemployment rates in Black, Pakistani and Bangladeshi communities are approximately double the national average of 4 per cent.

However, on children's education the white group compares unfavourably.

- Most ethnic minority groups had higher attainment scores at Key Stage 4 (GCSE level) in 2019/20 than the White British group, with the exception of Gypsy/Roma and Black Caribbean pupils. White pupils on free school meals had the lowest score.

Structural racism and marginalisation

The wider social context contributes to ethnic and other social inequalities. Evidence documents the prevalence of racism and discrimination in the UK, and the negative effects these can have on the physical and mental health of people from ethnic minority groups. They can also create barriers to accessing health information and health care services. Structural racism can also have an impact on health outcomes, operating via exclusionary frameworks that marginalise minority groups in, for example, the housing, employment and criminal justice systems.

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Conclusion

This explainer describes some ethnic inequalities in health, such as higher mortality among infants and from Covid-19 and a greater disease burden from diabetes and CVD among ethnic minority groups, and higher cancer mortality in the white group. Strategies for improving the health of England's deprived and ethnic minority communities need to address the multiple factors that have an impact on their health.

- **The role of public health and NHS services:** the Covid-19 pandemic has highlighted the urgent need to strengthen action to prevent and manage ill health in deprived and ethnic minority communities, with their active engagement to ensure that the planning and delivery of services takes account of their needs, experiences and expectations.
- **Addressing the wider determinants of health:** the disproportionate impact of Covid-19 on deprived and ethnic minority groups has highlighted the urgent need for a cross-government strategy to address health inequalities and the wider socio-economic and structural inequalities that drive them, and which addresses the diverse health needs of all groups at risk of poor health and high mortality. The government, NHS organisations and local authorities have a key role to play in implementing this agenda.
- **Tackling structural racism:** this requires action across national, local and societal levels. The NHS has a significant role to play in ensuring that health service provision is equitable and meets the needs of all communities, including ethnic minority communities.
- **Data:** comprehensive, good-quality data is essential for enabling policy-makers and health care professionals to identify the specific needs of different ethnic minority communities, respond with tailored strategies for addressing inequalities, and track their impact.

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