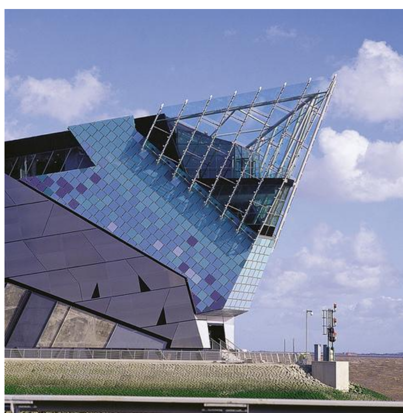
Hull City Council

NHS Hull

Black and Minority Ethnic Group communities in Hull: Health and Lifestyle Summary



Public Health Sciences
Hull Public Health
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Key points/headlines

- The 2011 Census found 26,500 of Hull's 244,000 residents (10.3%) were from a Black or Ethnic Minority group (BME – this includes all people who do not classify themselves as White British)

- While the number of Hull BME residents has tripled in the last 10 years, when compared to the UK average, Hull still has lower proportions of nearly all BME groups

- The greatest increase in BME numbers was due to increased numbers of white Europeans, mostly from Poland and other East European countries

- Other groups who have more than doubled in size in the last ten years were Chinese (mostly students), African and Middle Eastern

- Achieving a healthy diet seems to be the area where the BME groups on the whole do worse than the overall adult Hull population

- Conversely smoking and drinking rates among BME groups as a whole (apart from Gypsies & Travellers) tend to be lower than the overall adult Hull population

- The Gypsy & Traveller group tend to have poor physical health, display negative health behaviours but enjoy good mental health and high social capital

- It is likely that BME group is often not the factor that has the greatest influence on health, with the young ages of many BME respondents having more influence than their ethnicity

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Contents

Key points/headlines i
Introduction 1
Census 2011 3
Non-British White 4
Mixed ethnicity 5
Indian 6
Bangladeshi/Pakistani 7
African 8
Chinese 9
Arab 10
Gypsy and Traveller 11
Caribbean, other Black, other Asian, other not specified 12
Health literacy 13
Refugees and Asylum Seekers 14
Further Information 16

Introduction

This brief report on the health and lifestyle of some of the main Black and Minority Ethnic (BME) groups in Hull uses data collected during the 2011-12 heath and lifestyle surveys conducted in Hull, with fieldwork by a local market research company, Information by Design (IbyD). The full reports from each of the surveys may be found at www.hullpublichealth.org.

The aim of the BME survey was to examine the health status, health related behaviours and social factors within different BME groups in relation to Hull's overall population. Unlike in the main adult health and lifestyle survey, the different sampling methods mean the BME survey is not a representative sample of the whole BME population in Hull, but rather a snapshot from a number of BME individuals who were identified and questioned by researchers from IbyD.

While the main representative adult health and lifestyle survey had more than 13,500 respondents, the BME survey had 1,000 respondents, while an additional survey of the Gypsy and Traveller community had 72 respondents. The questionnaires used in each of the three surveys were identical and asked questions covering topics such as: general health; lifestyle risk factors; perceived health benefits of lifestyle changes; demographic and household information; and measures of social capital.

The age profile of each BME group was younger than for the main survey (***Table 5***). BME respondents were three times more likely to be aged 16-24 years than main survey respondents, with the largest percentage among Chinese respondents (82%). Less than 2% of the BME respondents were aged 65 years and over, compared with almost 20% from the main survey. Most BME groups surveyed were more likely to be female than in the main survey, with the largest percentage among non-British White (71%) and Gypsy and Traveller (72%) respondents, while only Africans (42%) and Arabs (50%) had fewer female respondents than in the main survey.

Table 1 Percentage of survey respondents in each BME group by age (years)

BME group	Percentage of respondents by age group (years), or by gender						Total (N)
	Age group (years)				Gender		
	16-24	25-44	45-64	65+	Men	Women	
Non-British White	28.6	62.1	7.9	1.4	29.1	70.9	293
Mixed	34.5	49.1	14.5	1.8	36.4	63.6	55
Indian	31.1	47.5	14.8	6.6	43.5	56.5	62
Bangladeshi/Pakistani	31.0	59.2	9.9	0.0	33.3	66.7	72
African	35.6	46.6	16.9	0.8	57.1	42.9	119
Chinese	81.6	16.0	1.5	1.0	39.6	60.4	207
Arab	15.4	61.5	23.1	0.0	50.0	50.0	40
Gypsy and Traveller	22.2	38.9	33.3	5.6	27.8	72.2	72
Other	45.7	41.1	11.3	2.0	46.7	53.3	152
All BME groups	**41.8**	**45.2**	**11.3**	**1.8**	**38.9**	**61.1**	**1,072**
Main survey	15.2	34.0	31.1	19.7	45.9	54.1	13,553

Across the three surveys, there were 100 nationalities represented in Hull, apart from British (broad groups shown in ***Table 2***). Again, excluding those born in the UK, respondents in the three surveys in 2011-12 were born in 112 different countries (broad groupings shown in ***Table 3***). In homes where English was not the main language spoken at home, 79 different languages were spoken at home (broad groups shown in ***Table 4***). These are all indicative of the very diverse nature of the BME communities living in Hull.

Table 2 Nationality of respondents, broad regional groups

Nationality (group)	N	%
British	12,916	90.3
Irish	20	0.1
Eastern European /former USSR	410	2.9
Other European	122	0.9
Chinese	199	1.4
Other South East Asian	128	0.9
South Asian	52	0.4
African	129	0.9
Middle East	65	0.5
Australasia	6	<0.1
The Americas	26	0.2
Other, not specified	68	0.5
Rather not say	168	1.2

Table 3 Country of birth, broad regional groups

Country of birth (group)	N	%
UK	12,566	88.9
Eire/Republic of Ireland	40	0.3
Eastern Europe / former USSR	401	2.8
Other European	172	1.2
China	208	1.5
Other South East Asia	126	0.9
South Asia	157	1.1
African	121	1.6
Middle East	99	0.7
Australasia	18	0.1
The Americas	49	0.3
Other	82	0.6
Rather not say	161	1.1

Table 4 Language spoken at home, broad regional groups

Nationality (group)	N	%
English	12,997	91.9
English + other	73	0.5
Eastern European languages / Russian	336	2.4
Other European languages	84	0.6
Chinese languages	223	1.6
Other South East Asian languages	62	0.4
South Asian languages	106	0.7
African languages	41	0.3
Arabic/Kurdish/Persian/Turkish	97	0.7
Other	62	0.4
Rather not say	69	0.5

Census 2011

At the time of publication of this summary report the ethnicity data from the 2011 census were available for each local authority, but for all ages only. The aim was for the main health and lifestyle survey to be a representative sample of Hull's population aged 16+ years. From this survey an estimate of the size of Hull's BME population could be drawn. From the main survey 6.6% of Hull's population aged 16+ years were from a BME group. This compares with 10.3% from the 2011 census. Thus it is likely that the main survey under-estimated the percentage of Hull's population from BME communities. It is likely that the 'focused enumeration' methodology was largely responsible for this discrepancy.

Despite this discrepancy between the main survey and the 2011 census in the overall percentage of Hull's population from both the main survey and the BME survey may be compared with that for the 2011 census (***Table 5***). The ethnic profile of Hull's BME communities from the main survey is largely similar to that from the 2011 census, although White Irish were over-represented in Hull, while Arabs and those of Mixed ethnicities were under-represented.

Table 5 Ethnicity distribution in BME respondents compared to 2011 Census

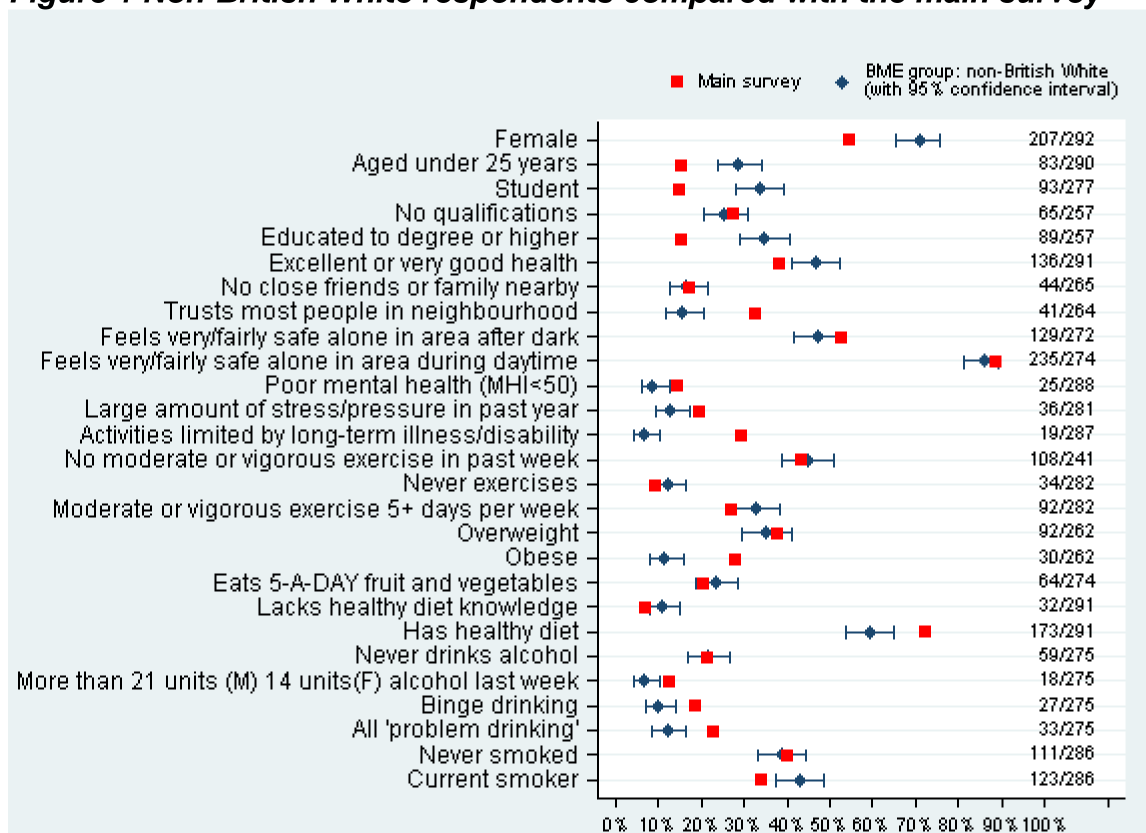
Ethnicity	Percentage of population		
	Main survey (16+ years)	BME survey* (16+ years)	Census 2011 (all ages)
White Irish	5.2	0.6	2.1
White Gypsy or Traveller	1.3	6.7	1.1
White other	39.0	26.8	39.9
All non-British White	**45.4**	**34.1**	**43.0**
Mixed White & Black Caribbean	3.2	0.8	3.3
Mixed White & Black African	2.5	1.5	3.1
Mixed White & Asian	3.4	1.6	3.6
Mixed other	2.2	1.3	3.1
All Mixed	**11.4**	**5.1**	**13**
Asian/Asian British Indian	4.0	5.8	4.1
Asian/Asian British Bangladeshi	3.6	2.9	2.9
Asian/Asian British Pakistani	2.8	3.8	3.3
Asian/Asian British Chinese	10.7	19.3	8.0
Asian/Asian British other	4.7	8.4	6.1
All Asian/Asian British	**25.7**	**40.2**	**24.4**
Black/Black British Caribbean	0.9	1.1	0.9
Black/Black British African	9.3	11.1	9.3
Black/Black British other	0.9	0.7	1.1
All Black/Black British other	**11.1**	**12.9**	**11.3**
Arab	3.2	3.7	4.3
Any other ethnic group other	3.2	4.0	3.9

Non-British White

This group was made up of 293 respondents. One third of these were students, but the majority (63%) were from the EU and working in Hull, in either short-term (8%) or long-term (55%) employment. 71% of non-British White respondents were women, and 29% were aged under 25 years. This is a well educated group, with 35% educated to degree level or higher. A summary of some of the key findings from the BME health and lifestyle survey for this group are shown in ***Figure 1*** with comparisons to the main survey.

Compared with the main survey, non-British White respondents were more likely to smoke (43%), but less likely to binge drink (10%) or exceed the recommended maximum weekly alcohol consumption (7%). They were less likely to eat a healthy diet (59%), but also far less likely to be obese (11%), more likely to get 30 minutes of moderate or vigorous exercise on at least 5 days per week (33%), less likely to have their activities limited by long-term illness or disability (7%), and more likely to report their health as excellent or very good; although these are findings are to be expected as this group are made up mostly of students and young workers, who tend to be fit and healthy. They were less likely to have poor mental health (9%) or to have experienced a large amount of stress or pressure in the past year (13%). They were less likely to feel very/fairly safe when alone in their local area, especially after dark (47%), and were far less likely to trust most of the people in their neighbourhood (16%).

Figure 1 Non-British White respondents compared with the main survey

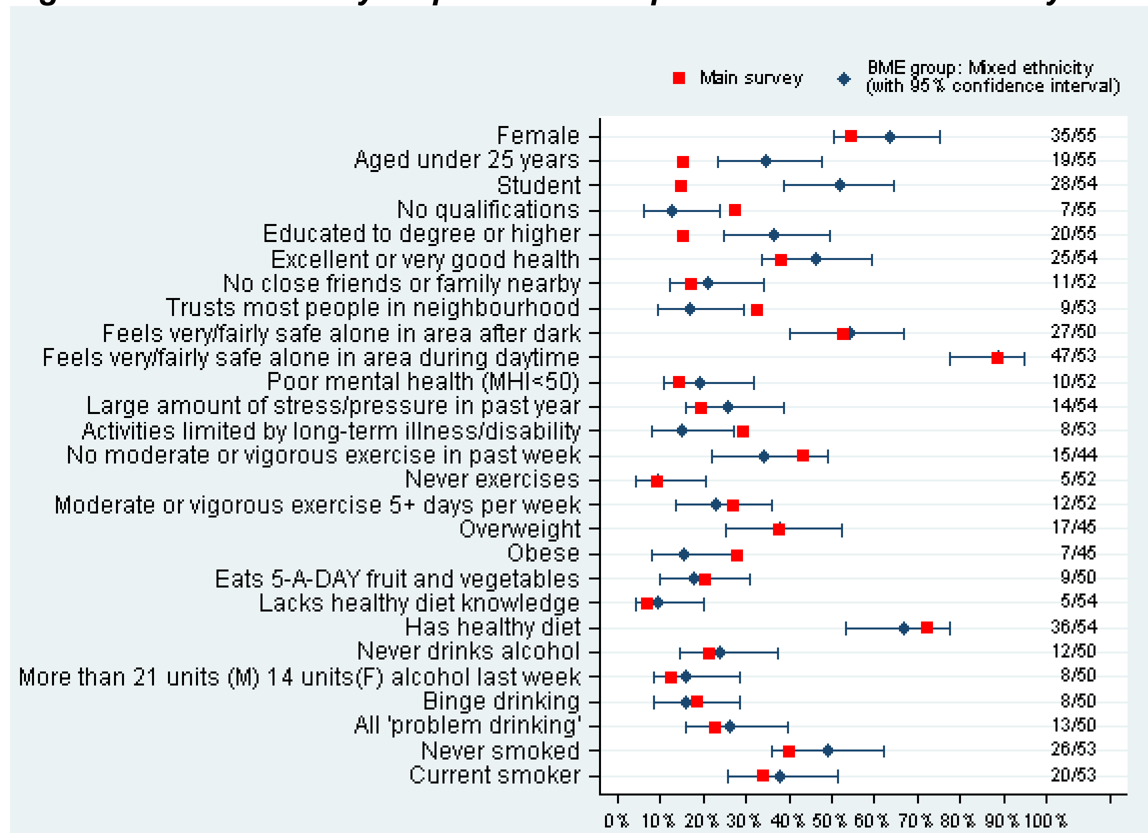


Mixed ethnicity

This group was made up of 55 respondents. More than half of these were students, one third were aged under 25 years and almost two thirds were women. This is a well educated group, with 36% educated to degree level or higher. A summary of some of the key findings from the BME health and lifestyle survey for this group are shown in ***Figure 1*** with comparisons to the main survey.

Respondents with Mixed ethnicity were similar in most respects to the main survey respondents, with no significant differences in smoking, alcohol or dietary indicators. They were, though, less likely to be obese (16%) and less likely to have their activities limited by long-term illness or disability (15%). They were also less trusting of people in their neighbourhood, with only 17% saying they trusted most of the people in their neighbourhood.

Figure 2 Mixed ethnicity respondents compared with the main survey

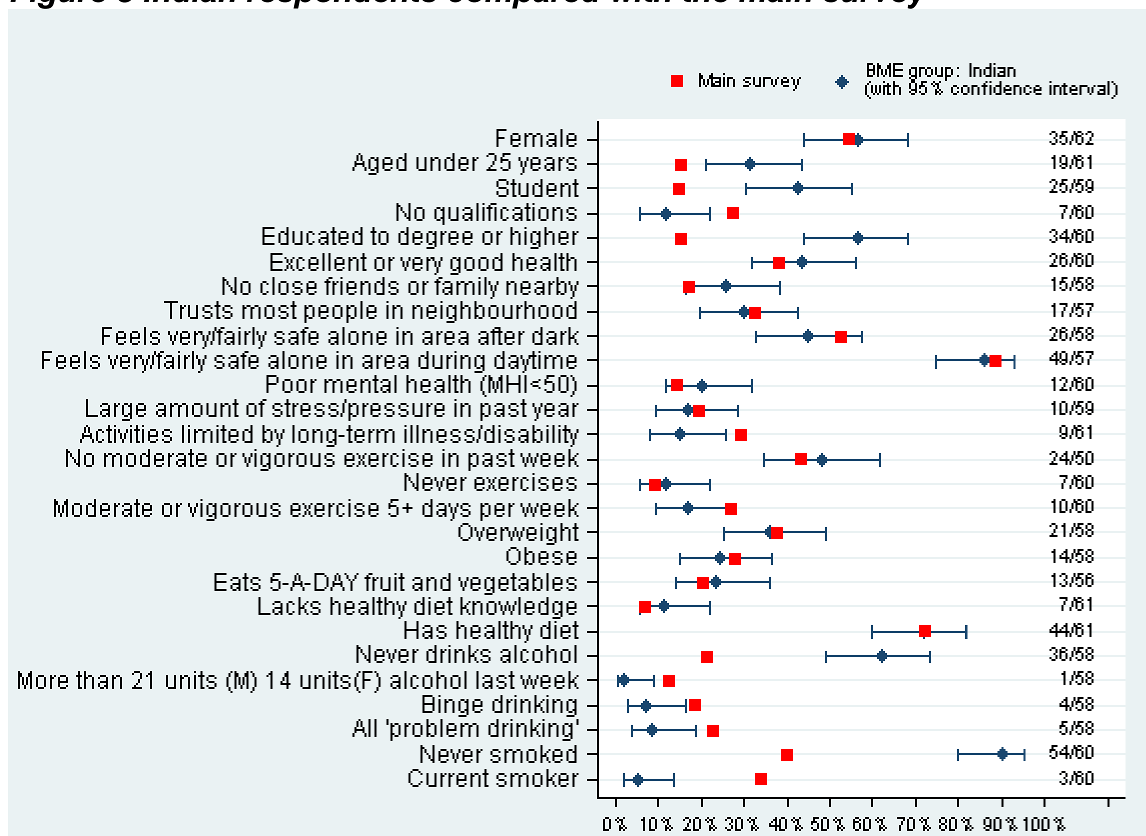


Indian

62 respondents identified their ethnicity as Asian Indian or British Asian Indian. 42% of this group were students, 31% were aged under 25 years, with more than half educated to degree level or higher. Indian respondents differed from main survey respondents in some of the key lifestyle behaviours, as shown in ***Figure 3***.

Compared with main survey respondents, Indian respondents were much less likely to smoke (5%) and much more likely to have never smoked (90%). They were also less likely to binge drink (7%) or to exceed recommended weekly maximum units of alcohol (2%), and far more likely to never drink alcohol (62%). In terms of diet and levels of overweight or obesity, there were no significant differences between Indian respondents and main survey respondents. Indian respondents were less likely than main survey respondents to take sufficient moderate or vigorous exercise (17%). They were also less likely to have their activities limited by long-term illness or disability (15%), but there were no significant differences between Indian respondents and main survey respondents in the percentages with poor mental health or reporting their health to be excellent or very good. There were also few differences between Indians and main survey respondents in feeling very safe alone in the local area or in trusting most people in their neighbourhood, although Indians were more likely to have no close friends or family living nearby (26%).

Figure 3 Indian respondents compared with the main survey

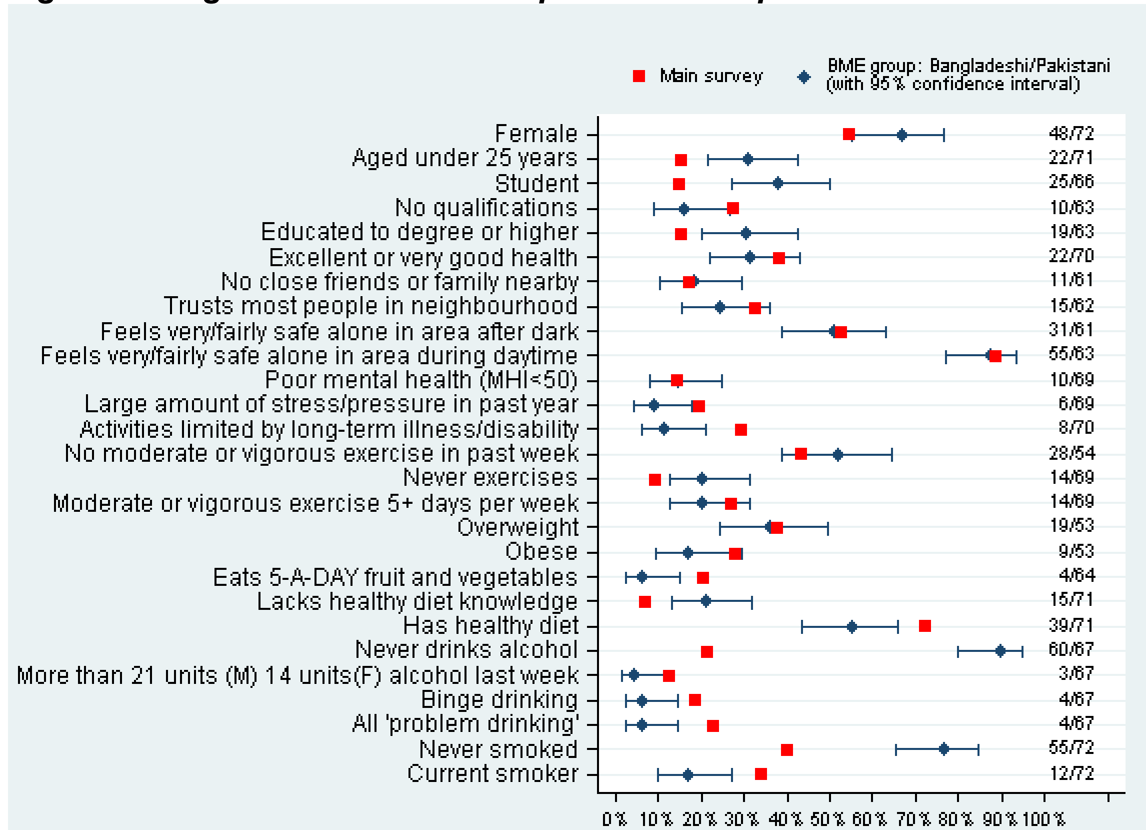


Bangladeshi/Pakistani

Of the 72 respondents whose ethnicity was recorded as Asian Pakistani, Asian Bangladeshi, Asian British Pakistani or Asian British Bangladeshi, nearly a third of were educated to degree level, two thirds were female and almost one third were aged under 25 years. They were different to main survey respondents in some of the key lifestyle behaviours, as shown in ***Figure 4***.

Compared with main survey respondents, Bangladeshi/Pakistani respondents were much less likely to smoke (17%), binge drink (6%) or exceed recommended weekly units of alcohol (4%), and much more likely to have never smoked (76%) or to never drink alcohol (90%). They were less likely to eat 5-A-DAY fruit and vegetables (6%) or to have a healthy diet (55%) and more likely to lack knowledge around healthy eating (21%), yet were less likely to be obese (17%) despite being more likely to never exercise (20%). Bangladeshi/Pakistani respondents were less likely than main survey respondents to have their activities limited by long-term illness or disability (11%) or to have experienced a large amount of stress or pressure in the past year (9%), although percentages with poor mental health or reporting excellent/very good health were similar to those from the main survey.

Figure 4 Bangladeshi/Pakistani respondents compared with the main survey

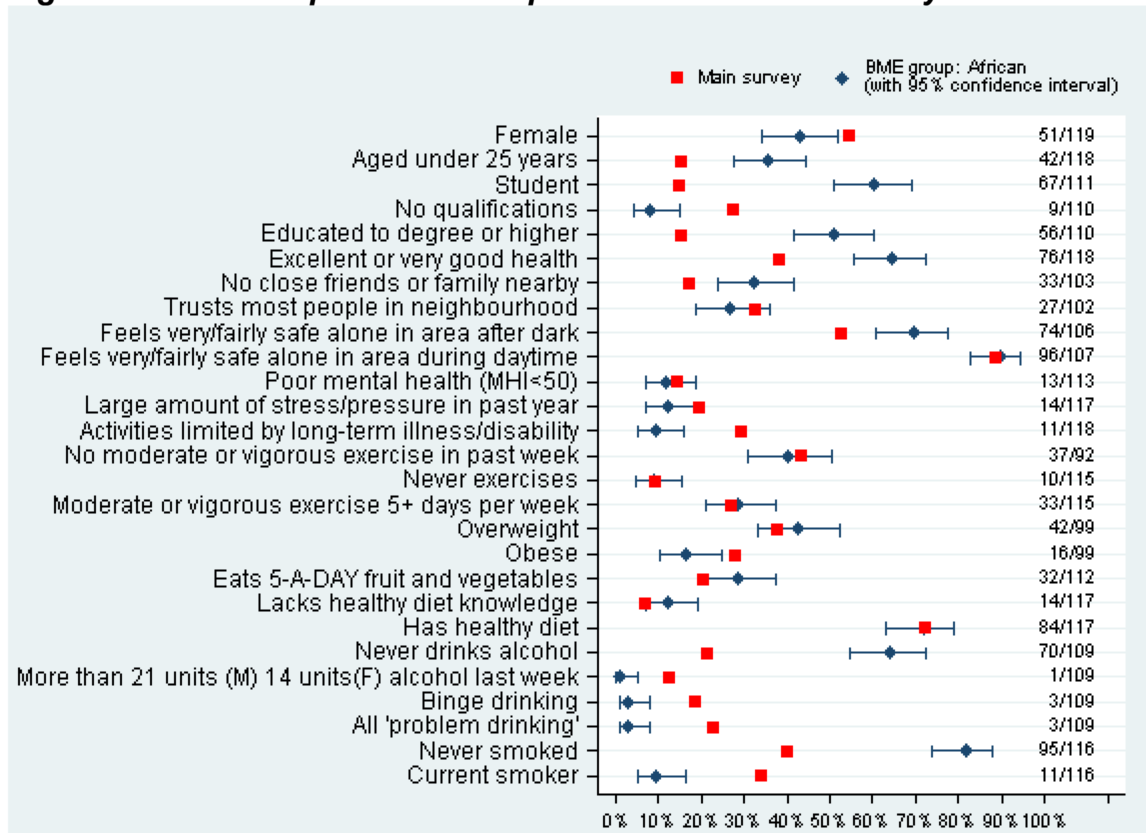


African

119 respondents identified they ethnicity as Black African or Black British African. 60% of respondents in this group were students, half were educated to degree level or higher, 36% were aged under 25 years, while this was one of only two BME groups with fewer women (43%) than in the main survey. They were different to main survey respondents in some of the key lifestyle behaviours, as shown in ***Figure 5***.

Compared with main survey respondents, Africans were much less likely to smoke (9%) and much more likely to have never smoked (82%), and were far less likely to binge drink (3%) or to exceed recommended maximum amounts of alcohol (1%) and much more likely to report never drinking alcohol (64%). African respondents were more likely than main survey respondents to eat 5-A-DAY fruit and vegetables (29%), and less likely to be obese (16%), although there were no differences in exercise levels. African respondents were also less likely than main survey respondents to have their activities limited by long-term illness or disability (9%) or to have experienced a large amount of stress or pressure in the past year (12%), although there was no difference in the percentage with poor mental health, but they were more likely to report their health as excellent or very good (64%). African respondents were much more likely than main survey respondents to feel very/fairly safe when alone in their local area after dark (70%), but more likely to have no close friends or family living close by (32%).

Figure 5 African respondents compared with the main survey

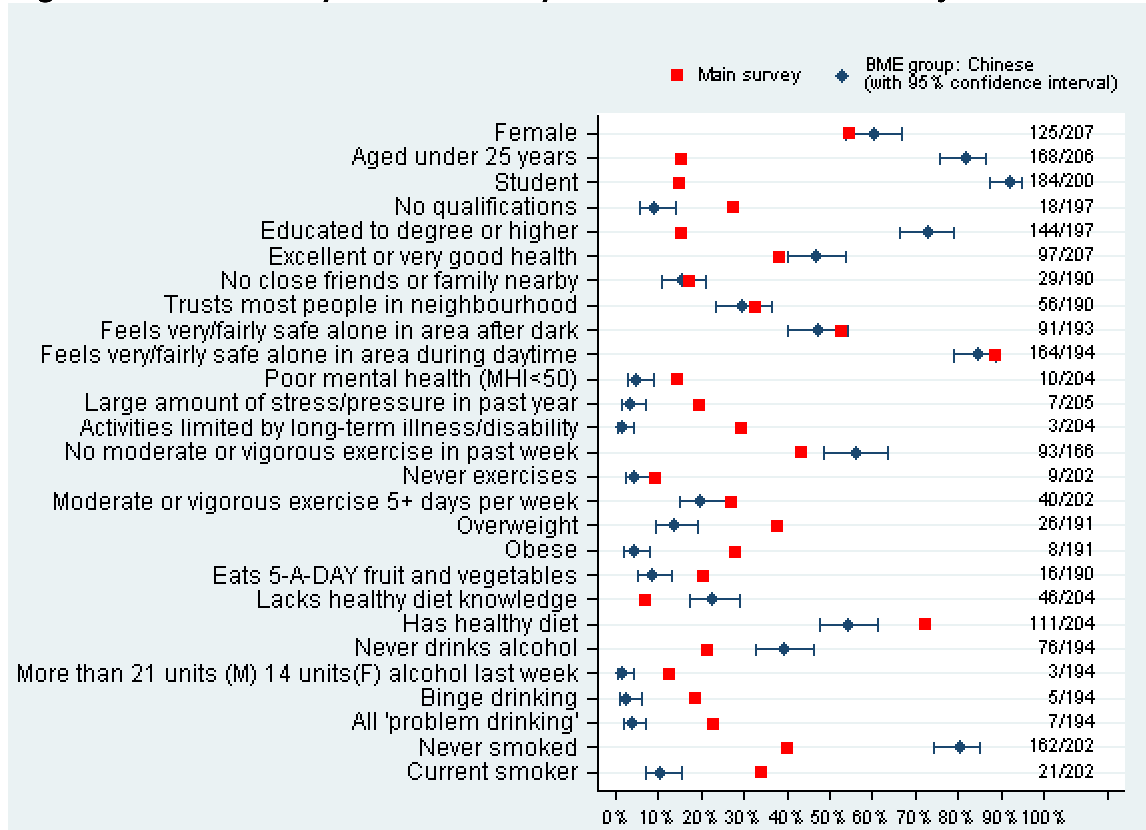


Chinese

There were 207 respondents that identified themselves as Chinese or British Chinese. More than 90% of respondents from this group were students, with more than 80% aged under 25 years and 60% were female. Almost three-quarters were educated to degree level or higher. This group were very different to the main survey respondents in most of the areas shown in ***Figure 6***, which is to be expected, given the very young age profile of this group.

Compared to main survey respondents, Chinese respondents were much less likely to smoke (10%), much more likely to have never smoked (80%), and much less likely to binge drink (3%) or exceed recommended maximum amounts of alcohol (2%). They were much less likely to eat healthily (54%), eat 5-A-DAY (8%) and more likely to lack knowledge about healthy eating (23%), as well as less likely to get sufficient moderate or vigorous exercise (20%) and more likely to have not exercised in the past week (56%). Despite this they were much less likely to be overweight (14%) or obese (4%). Chinese respondents were much less likely than main survey respondents to have their activities limited by long-term illness or disability (1%),to have experienced a large amount of stress or pressure over the past year (3%) or to have poor mental health (5%), as well as more likely to report having excellent or very good health (47%).

Figure 6 Chinese respondents compared with the main survey

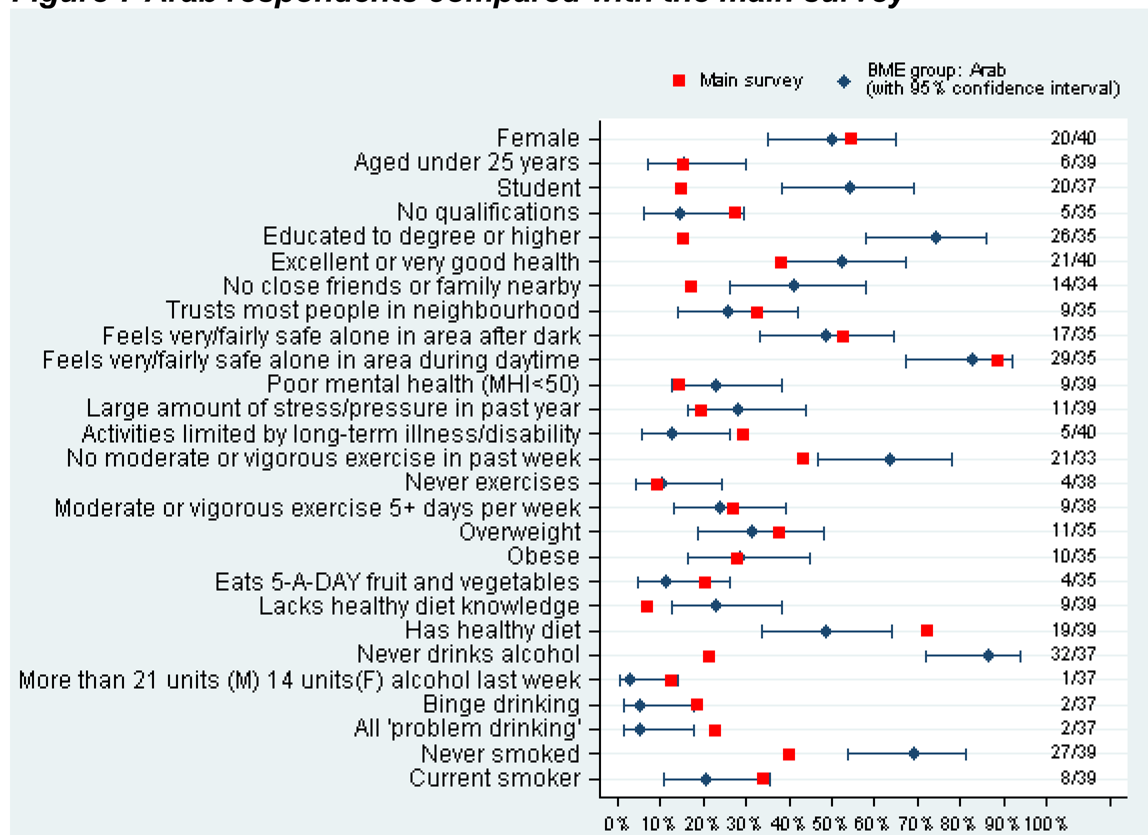


Arab

40 respondents identified their ethnicity as Arab. Nearly one third were Refugees or Asylum Seekers, just over half were students and nearly three quarters were educated to degree level. With 50% women, this was the only BME group with fewer female respondents than in the main survey, and the only group with the same number of respondents aged under 25 years (15%). Arab respondents differed from main survey respondents in some key lifestyle behaviours, as shown in ***Figure 7***.

Compared with main survey respondents, Arab respondents were less likely to smoke (21%), and much more likely to have never smoked (69%). They were much less likely to be 'problem drinkers' (5%) and four times as likely to never drink alcohol (86%). Arab respondents were less likely to report eating a healthy diet (49%) and more than three times as likely to lack knowledge about healthy eating (23%), as well as more likely to have taken no moderate or vigorous exercise in the past week. Arab respondents were less likely than main survey respondents to have their activities limited by long-term illness or disability (13%) and more likely to report having excellent or very good health (53%). Arab respondents were more likely to have experienced a large amount of stress in the past year (28%, the highest of all BME groups), or to have poor mental health (23%) as well as more than twice as likely as main survey respondents to have no close friends or relatives living nearby (41%).

Figure 7 Arab respondents compared with the main survey

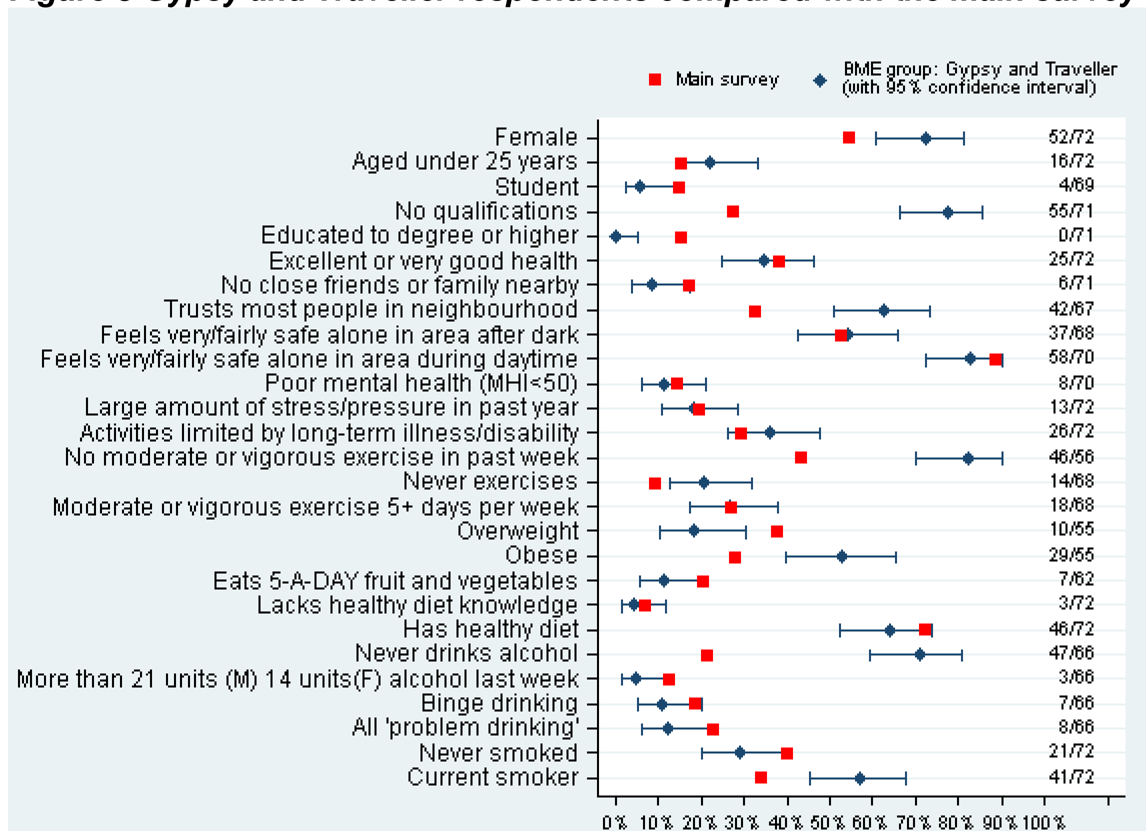


Gypsy and Traveller

The 72 respondents from the Gypsy & Traveller survey were largely female (72%), with 22% aged under 25 years. None were educated to degree level, more than three-quarters had no qualifications, and only 6% were students. Gypsy and Travellers had the highest percentage of respondents not working due to long-term sickness or disability (23%) compared to 8% in the main survey. Results from the Gypsy and Traveller survey were different to the main survey in several respects, as shown in ***Figure 8***.

Compared with the main survey, Gypsy and Travellers respondents were much more likely to smoke (57%), but less likely to be 'problem drinkers' (12%), and more than three times more likely to never drink alcohol (71%). They were less likely to eat 5-A-DAY fruit and vegetables (11%), and twice as likely to never exercise (21%), and almost twice as likely to have taken no moderate or vigorous exercise in the past week (82%). They were almost twice as likely to be obese (53%), but half as likely to be overweight (18%), than main survey respondents. Gypsy and Travellers were more likely than main survey respondents to have their activities limited by long-term illness or disability (36%). Gypsy and Traveller respondents had high levels of social capital; compared with main survey respondents, they were more likely to feel very or fairly safe alone in their local area during the daytime (83%), almost twice as likely to trust most of the people in their neighbourhood and were less likely to have no close friends or relatives living nearby (8%)

Figure 8 Gypsy and Traveller respondents compared with the main survey

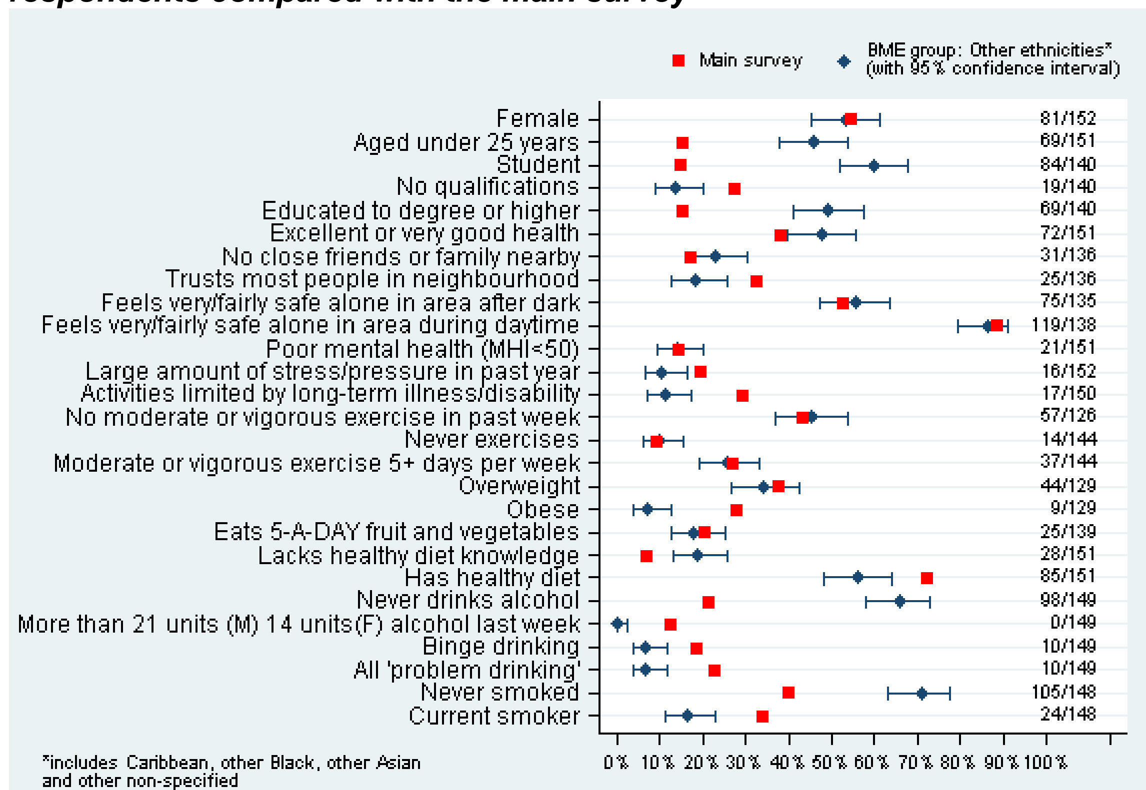


Caribbean, other Black, other Asian, other not specified

There were 152 respondents in the BME survey that did not fit into the other categories presented here. This group includes 12 Caribbean respondents, 7 other Black respondents, 90 other Asian respondents and 43 stating 'other' ethnicity. This is a diverse group, and is presented here for only for completeness, and will be referred to as other ethnicity. As with most of the BME groups presented in this report, this group are mostly young (46% aged under 25 years of age), mostly students (60%) and highly qualified (49% educated to degree or higher), although it is one of only three BME groups with fewer women (53%) than in the main survey. Although a diverse group, there were some key differences from the main survey with regard to some key lifestyle behaviours, as shown in ***Figure 9***.

Compared with main survey respondents, those in the other ethnicity group were much less likely to smoke (16%) or to be 'problem drinkers', with only 7% reporting binge drinking and none exceeding the weekly maximum recommended units of alcohol, while much more likely to have never smoked (71%) or to never drink alcohol (66%). This group were less likely to eat a healthy diet (56%) and more likely to report lacking knowledge about healthy diets (19%), but the percentage eating 5-A-DAY was similar to the main survey (18%). At 7%, obesity levels among the other ethnicity group were 75% lower than in the main survey, although percentages overweight were similar, as were exercise levels. They were also healthier than main survey respondents, although fewer trusted most people in their neighbourhood (18%) and more had no close family or friends living nearby (23%).

Figure 9 Caribbean, other Black, other Asian and other not specified respondents compared with the main survey

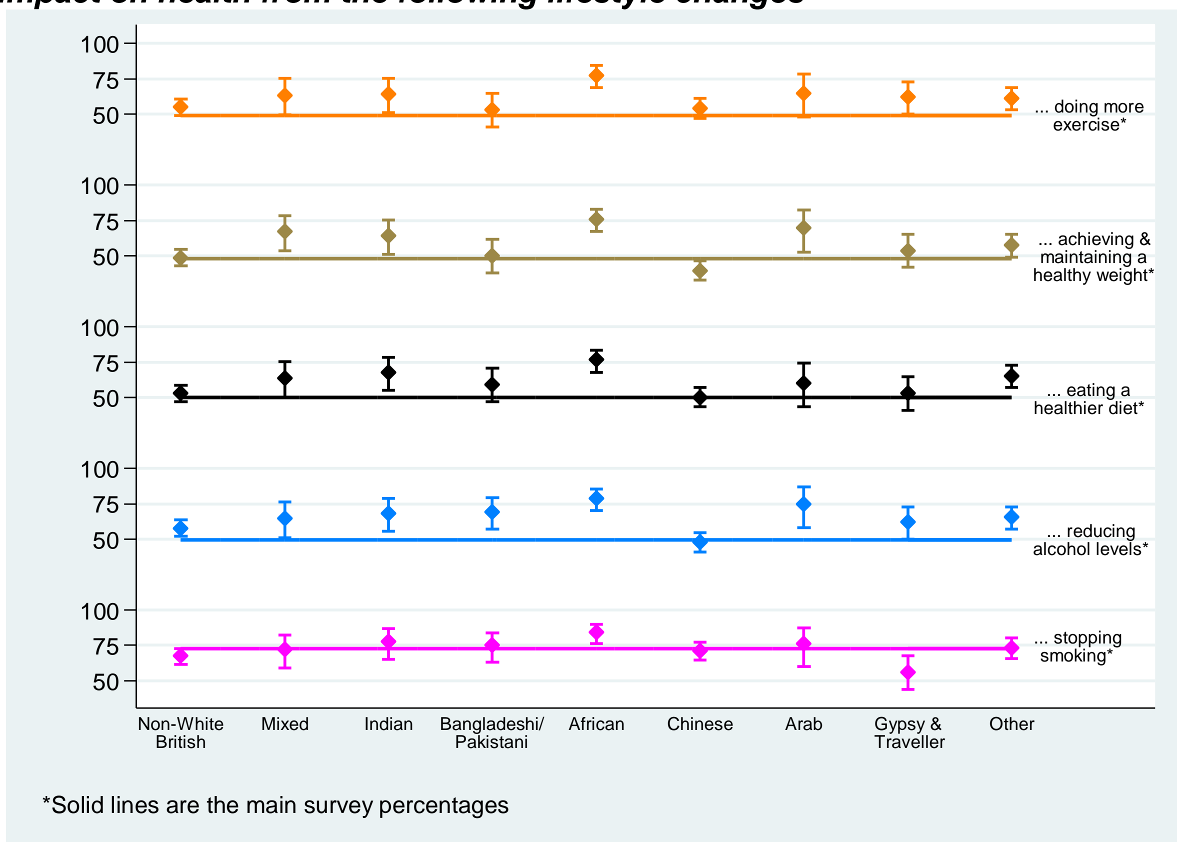


Health literacy

One measure of health literacy might be how much impact on health a person anticipates would arise from reducing unhealthy lifestyle behaviours. Respondents in the 2011-12 health and lifestyle surveys were asked to rate the health impact of stopping smoking, reducing alcohol levels, eating a healthier diet, achieving or maintaining a healthy weight or doing more exercise. The percentages saying there would be a very big impact on health from doing these are shown in ***Figure 10*** by BME group, with the main survey percentages shown as a solid line.

On this measure, Africans showed the highest levels of health literacy, with percentages expecting a very big impact from each of these lifestyle changes significantly higher than for the main survey. More respondents from each BME group, except Chinese, thought there would be a very big impact on health from reducing alcohol levels than from the main survey. The non-White British and Gypsy and Traveller groups both had lower percentages expecting a very big impact on health from stopping smoking than in the main survey, with Gypsy and Travellers also more likely than main survey respondents to expect a very big health impact from doing more exercise. Compared with the main survey, Indians were more likely to expect a very big impact from eating a healthier diet, achieving and maintaining a healthy weight and doing more exercise, while Arabs were more likely to expect a very big impact from achieving and maintaining a healthy weight.

Figure 10 Percentages of respondents that felt there would be a very big impact on health from the following lifestyle changes



Refugees and Asylum Seekers

While not a BME group, Refugees and Asylum Seekers may have different health issues to other adults. Therefore, all Refugees and Asylum Seekers from both the BME and main surveys have been examined together, with comparisons made between this group and British respondents, again from both the BME and main surveys combined.

This group of 68 respondents comprised people from several BME communities. Respondents included 34 refugees granted asylum in the last 10 years and 10 refugees granted asylum more than 10 years ago. Additionally there were 20 asylum seekers and 4 failed asylum seekers. The majority, 85%, of Refugees and Asylum Seekers were aged under 45 years. Refugees and Asylum Seekers had the largest percentage of respondents living in the most deprived fifth of areas of Hull (49%). The three BME groups with the largest representation in the Refugees and Asylum Seeker group were African (n=20), Arab (n=11) and Mixed (n=8).

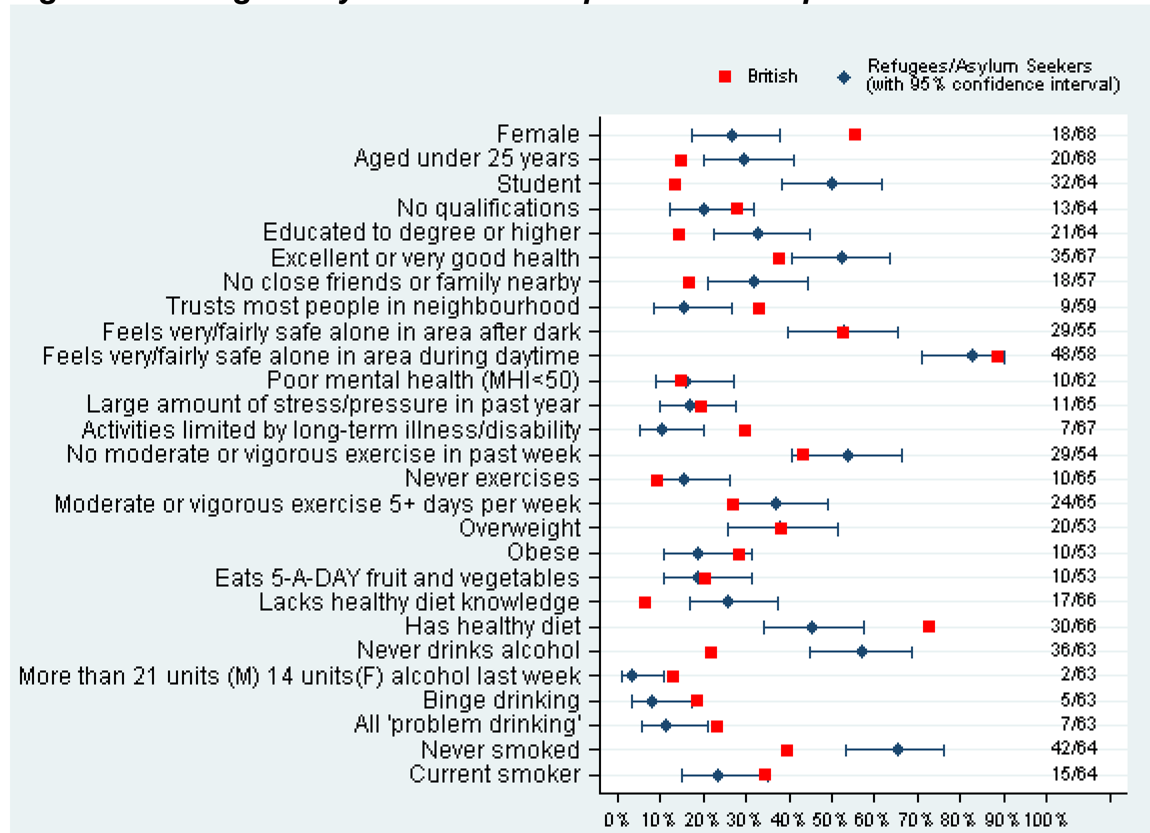
Fluency in spoken English was low among Refugees and Asylum Seekers (44%), although half were students. Refugees and Asylum Seekers taking part in the survey were predominantly male (only 26% were female), with the proportion aged under 25 years (29%) higher than for British respondents. Household incomes for Refugees and Asylum Seekers were low, with 45% of those answering the income question reporting household income of less than £5,000 per year (although 51% of Refugee and Asylum Seeker respondents would not, or could not, answer the income question.

Refugees and Asylum Seeker surveyed differed from British respondents in some key aspects of lifestyle behaviours, as show in ***Figure 11***. Compared with British respondents, Refugees and Asylum Seekers were generally a more healthy group, being less likely to smoke (23%) or to be 'problem drinkers' (11%), and much more likely to have never smoked (66%) or to never drink alcohol (57%). Refugees and Asylum Seekers were less likely than British respondents to report eating a healthy diet (45%), and more likely to lack knowledge about healthy eating (26%), but a similar percentage ate 5-A-DAY fruit and vegetables (19%), and fewer were obese (19%). Refugees and Asylum Seekers were more likely than British respondents to get sufficient moderate or vigorous exercise (37%), as well as more likely to report never exercising (15%). Refugees and Asylum Seekers were more likely than British respondents to report their health as excellent or very good (52%), and less likely to have their activities limited by long-term illness or disability (10%). Refugees and Asylum Seekers appeared to have fewer roots in their local neighbourhoods than British respondents, being much less likely to trust most people in their neighbourhood (15%) as well as being more likely to have no close friends or family living nearby (32%).

The mental health of Refugees and Asylum Seekers, as measured by the SF36 Mental Health Index, was similar to that of British respondents. This is a major change since 2007, when mental health was a particular issue among this group. This is probably related to the different composition of this group. In 2007 40% of Refugees and Asylum Seekers were failed asylum seekers, amongst whom one third

were classified as being ‘so unhappy that life was not worthwhile’. In 2011, by contrast, only 6% of Refugees and Asylum Seekers were failed asylum seekers.

Figure 11 Refugee/Asylum Seeker respondents compared with British



Further Information

For contact details and further information on this survey and other surveys, and more information about Hull and health inequalities, as well as other publications and documents produced by the Public Health Sciences team, formerly part of NHS Hull, please visit our website: http://www.hullpublichealth.org

Hull City Council

NHS Hull

Public Health Sciences

The Public Health Sciences team are now located in the old nursery at Brunswick House, Strand Close, Beverley Road, Hull.

What we can do for you:

Epidemiologists

- Help understand the health and wellbeing needs of Hull's population in terms of the following:
    - Population
    - Age / gender
    - Deprivation (IMD)
    - Ethnicity
    - General physical and mental health status of population
    - Prevalence of risk factors (smoking, alcohol, obesity, diet, exercise, etc)
    - Prevalence of diseases
    - Hospital admission rates
    - Mortality and life expectancy
- Questionnaire design and survey design and advice
- Evaluation of services/interventions
- Health needs assessments
- Explanation of and help in using statistical terms like confidence intervals, standardisation, etc
- Explanation of data including data presented in tables or plots/charts, etc
- Predictive modelling / predicting future trends or needs or towards targets
- Mapping, analyses and presentation of a wide range of segmentation tools (including ACORN, Healthy Foundations and IMD), social marketing and behavioural insight, inequality, etc to assist psychographic and socio-economic differentiation
- Provide a critical friend to all those collecting and using health-related data and information

Clinical Policy Support

- What NICE guidance is published or in progress
- Critical appraisals and evidence overviews – evidence of cost/clinical effectiveness of drugs and treatments

www.hullpublichealth.org

www.jsnaonline.org