Contentions
Religious identity

Aziz Sheikh
Professor of Primary Care Research & Development
The University of Edinburgh
DH Workshop, 30th March 2010

Four contentions…and a note of caution

1. Religious/faith identity matters to many people
2. Religion can impact on health and health seeking behaviour
3. Religious identity is often overlooked by UK researchers/healthcare providers
4. Considerations relating to religion need to be more centralised in the context of health services research
5. Pursuing this course could, if not handled carefully, exacerbate societal tensions

Contention 1: Religious identity matters

Religion in the 2001 Census?

“I think it is becoming clear that more people are identifying themselves in terms of their religion or culture than ever before. That is why there is need to expand on the kind of ethnic monitoring that is carried out in the Census… the basic classifications of Black, white or Asian are simply out of date”.

British Home Secretary, Rt Hon. Jack Straw MP, 1998

Religion

The 2001 Census of Population

England/Wales

10 What is your religion?

- This question is voluntary.
- ✓ one box only.

- ☐ None
- ☐ Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
- ☐ Buddhist
- ☐ Hindu
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ Any other religion *please write in*

Scotland

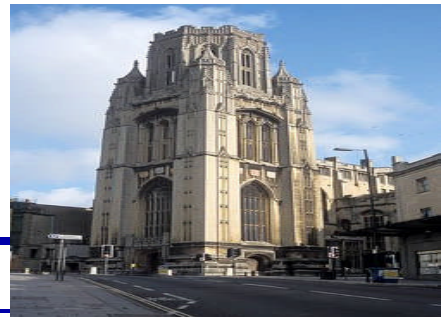
13 What religion, religious denomination or body do you belong to?

- ☐ None
- ☐ Church of Scotland
- ☐ Roman Catholic
- ☐ Other Christian, *please write in*
- ☐ Buddhist
- ☐ Hindu ☐ Jewish
- ☐ Muslim ☐ Sikh
- ☐ Another religion *please write in*

14 What religion, religious denomination or body were you brought up in?

- ☐ None
- ☐ Church of Scotland
- ☐ Roman Catholic
- ☐ Other Christian, *please write in*
- ☐ Buddhist
- ☐ Hindu ☐ Jewish
- ☐ Muslim ☐ Sikh
- ☐ Another religion *please write in*

Religious diversity in Britain



	Thousands	%
Christian	42079	71.6
Buddhist	152	0.3
Hindu	559	1.0
Jewish	267	0.5
Muslim	1591	2.7
Sikh	336	0.6
Other religion	179	0.3
All religions	*45163*	*76.8*
No religion	9104	15.5
Not stated	4289	7.3
All no religion/not stated[1]	*13626*	*23.2*
Base	*58789*	*100*

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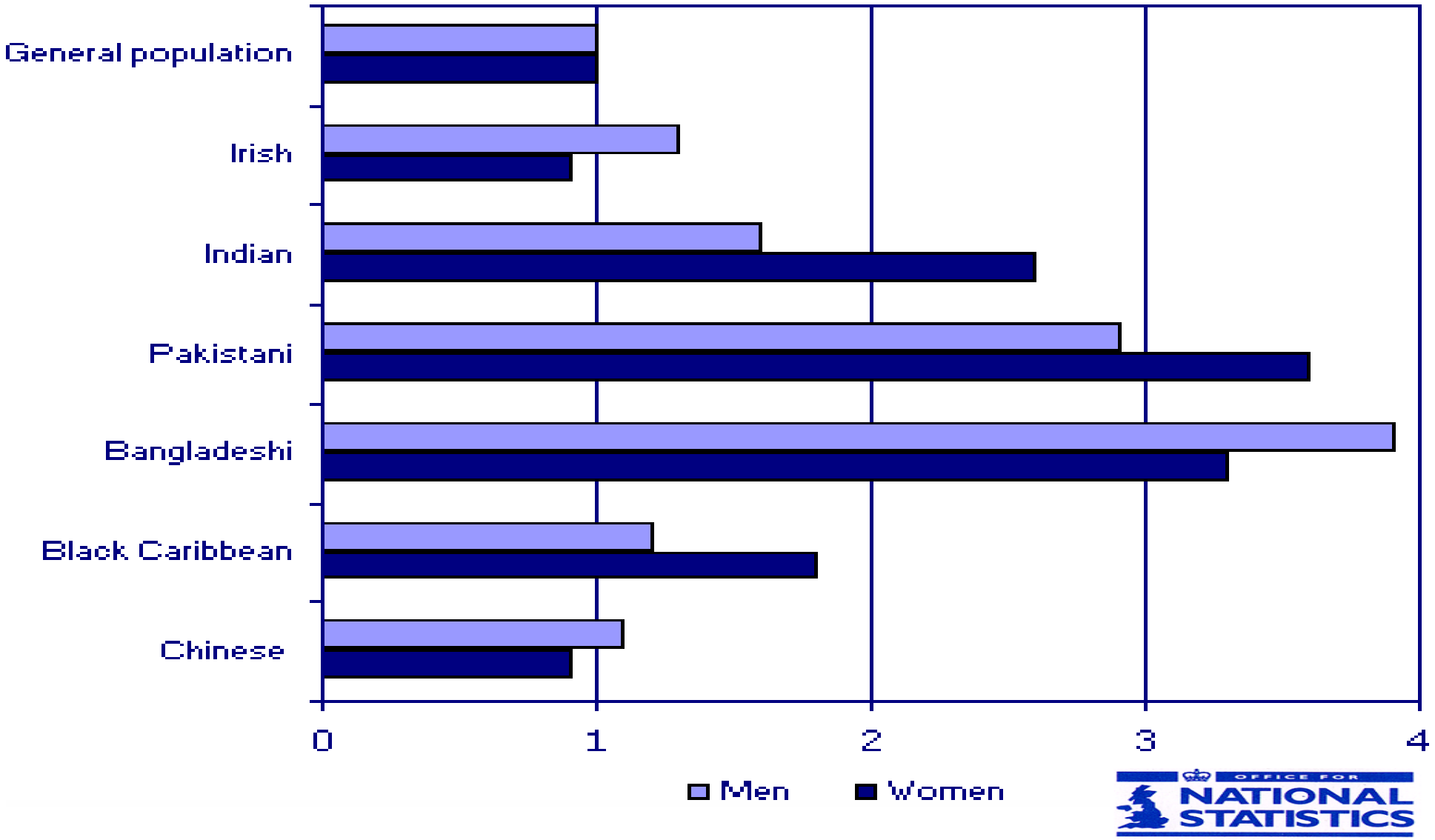
Scotland's CENSUS 29 APRIL 2001

Contention 2: Religious identity can impact on health and health seeking behaviour

Poor health by sex and ethnic group, 2001



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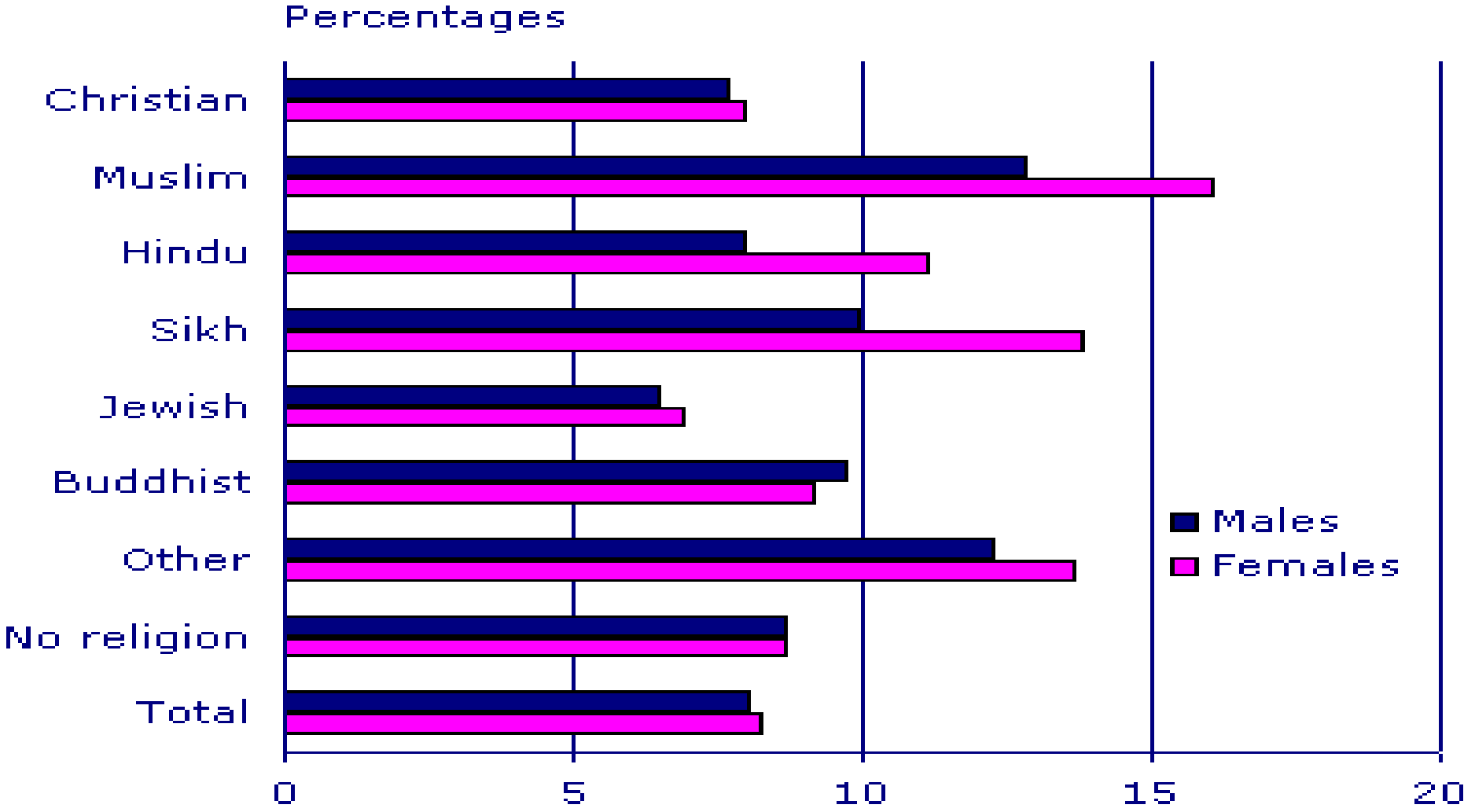
Self-reported poor health status by religious group



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From: [redacted] Sent: Tue 02/02/2010 10:55
To: Aziz.Sheikh@ed.ac.uk
Cc:
Subject: RE: gelatin in capsules

Dear Aziz

Is there an acceptable answer to this problem (see below)?

Best

[redacted]

[redacted]
Sent: 01 February 2010 15:18
[redacted]
Subject: gelatin in capsules

[redacted] points out that many capsules are pork gelatin, which begs the question as to whether we should be informing each muslim patient of this, and not prescribe capsules to muslim patients.....

Thus far I have not / do not do this...

I rang pharmacy info at Whitt who were unable to help- they were unable or unwilling to say what % capsules this may apply to and depends on brand etc too. They say patients have to ask chemist to check with maker of whichever item is dispensed...

This could potentially cause significant increase in work load (for us counselling pts) & for community pharmacists...

What do the rest of you do? Thoughts please
Should we discuss with Prescribing Advisor ie: is there or should there be a sub-formularly specifically for muslim patients??

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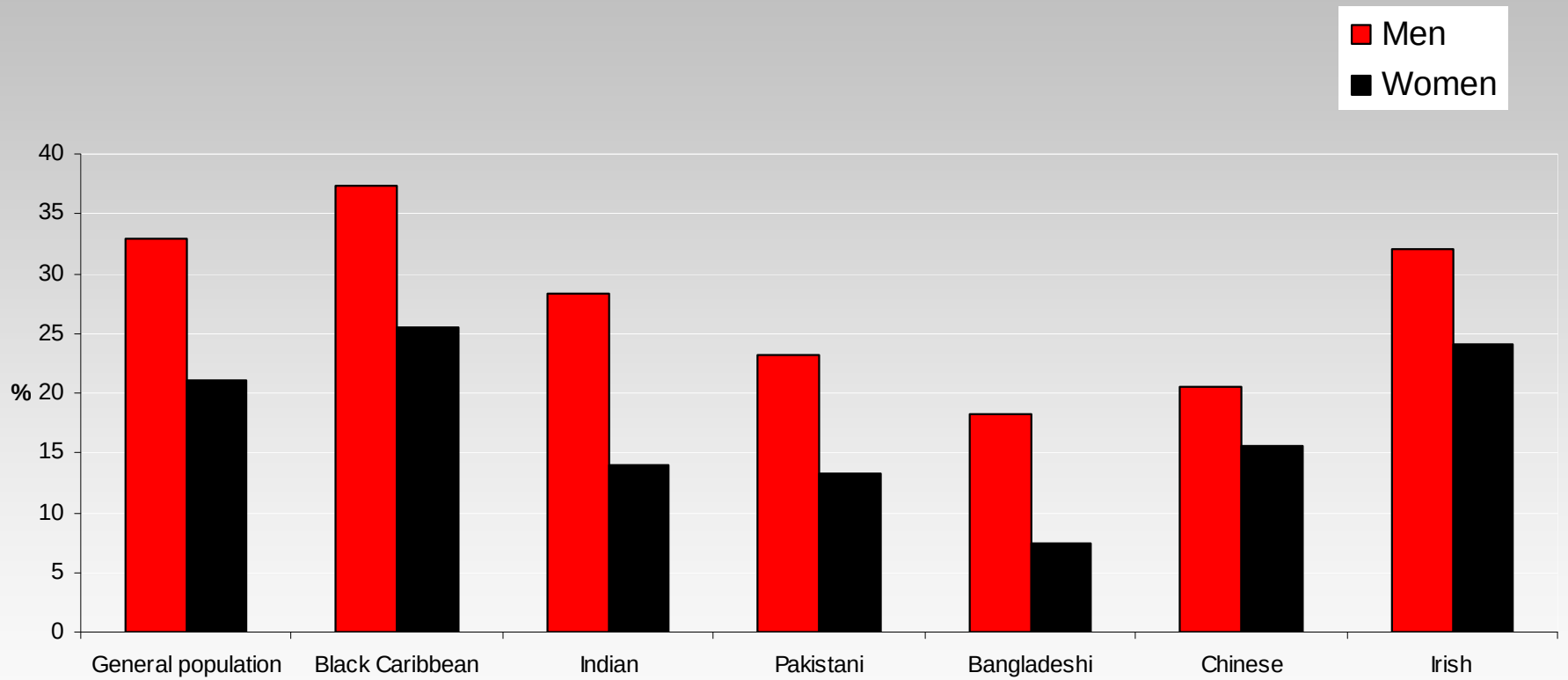
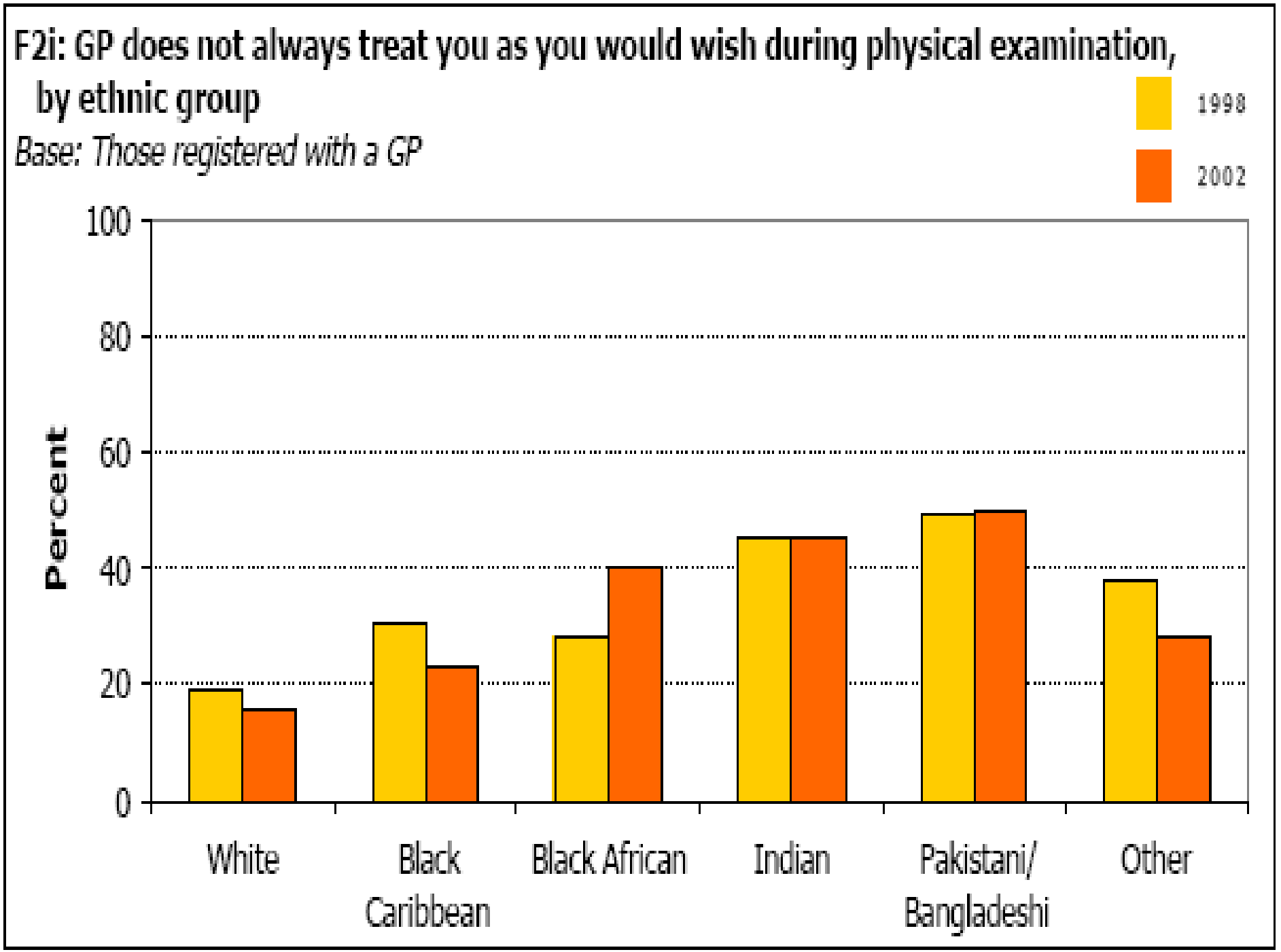
Contention 3: Religious identity is still often overlooked

Percentage of adults participating in 30 minutes or more physical activity on at least 5 days a week, by sex and ethnic group, 1999

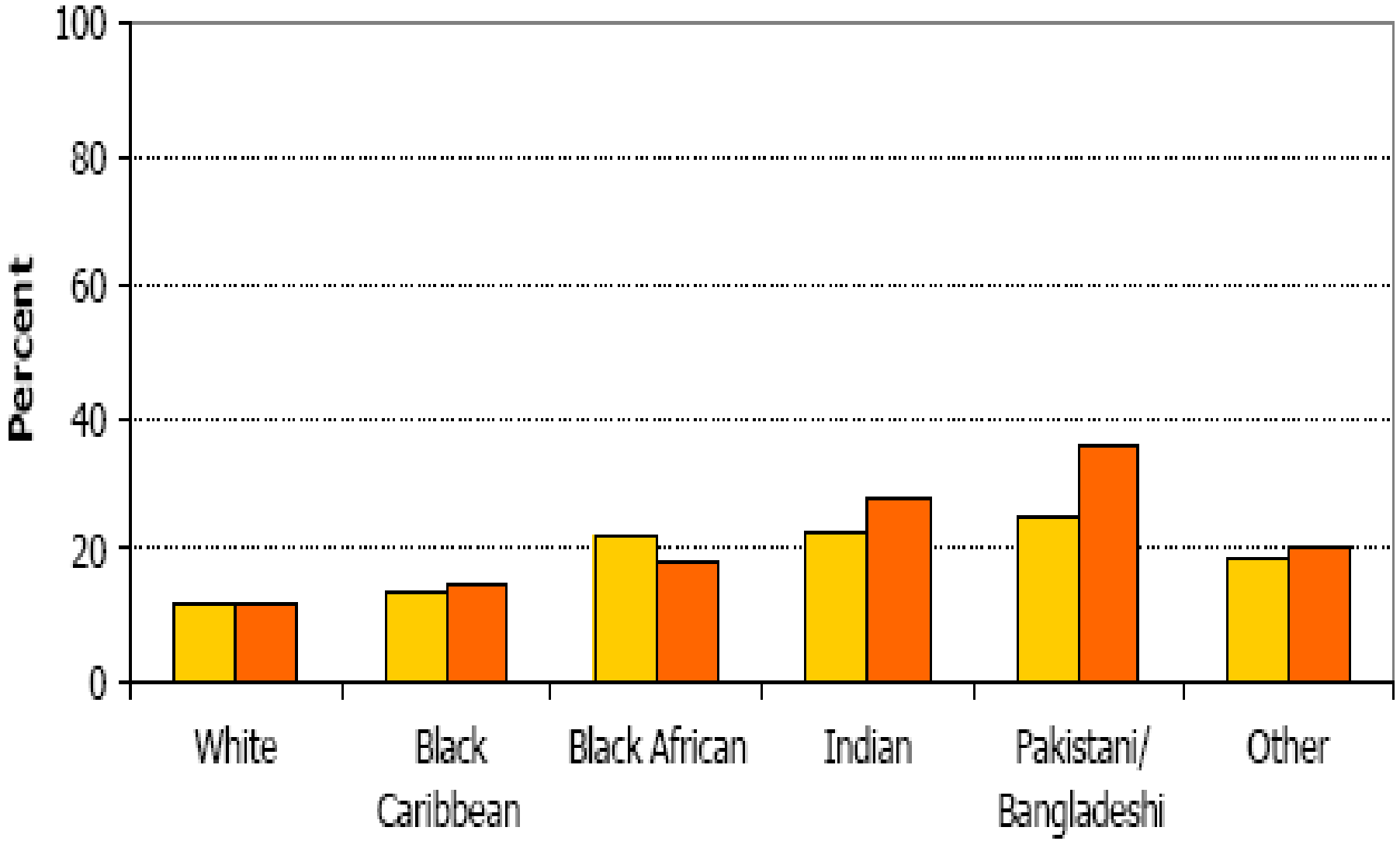


www.heartstats.org

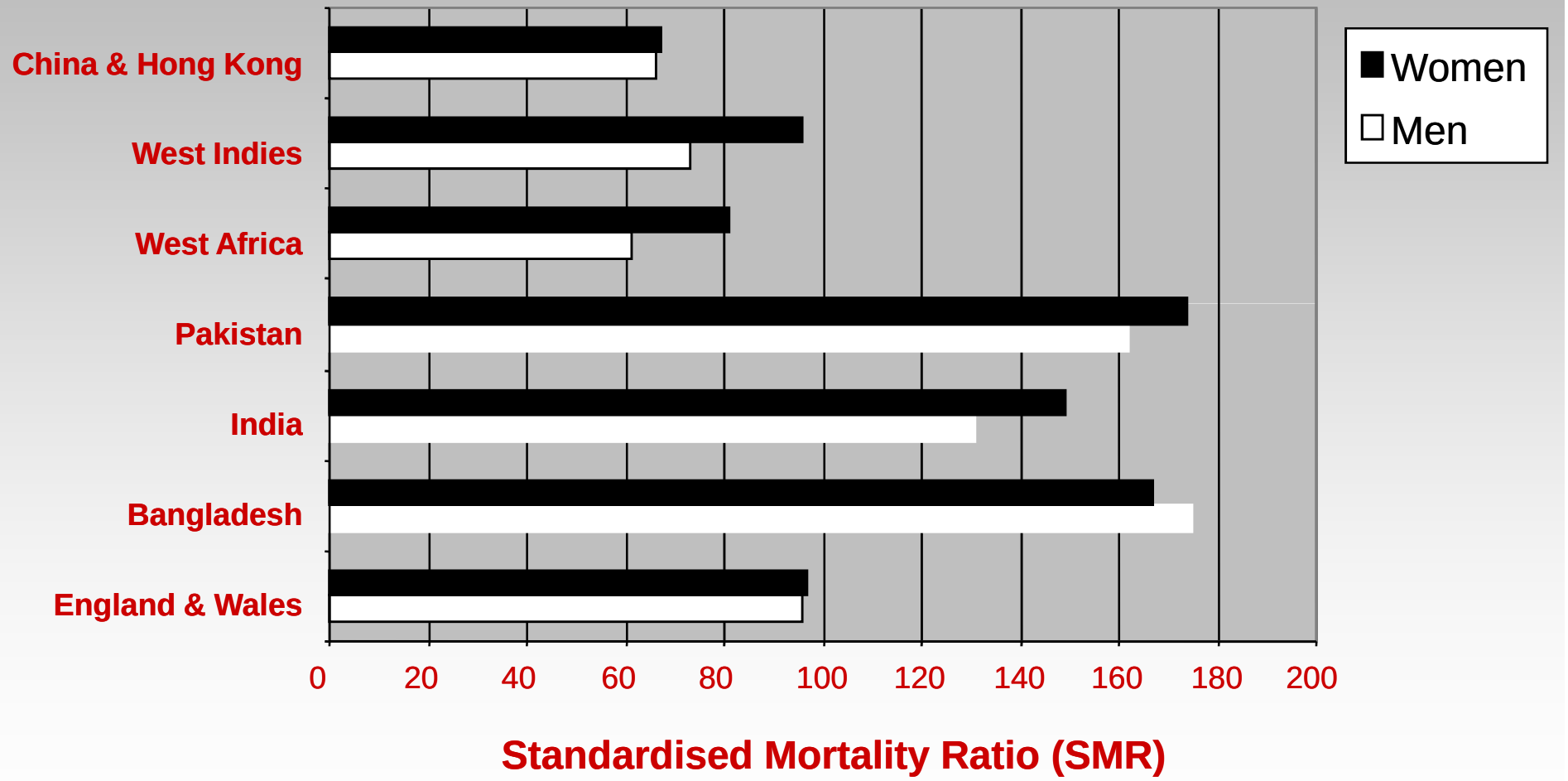

F2i: GP does not always treat you as you would wish during physical examination, by ethnic group
Base: Those registered with a GP
1998
2002
Percent
100
80
60
40
20
0
White
Black Caribbean
Black African
Indian
Pakistani/ Bangladeshi
Other

F7: Felt like making a complaint in last 12 months, by ethnic group

Base: Those registered with a GP



South Asians have beaten the world leaders in ischaemic heart disease mortality



S Wild et al, Journal of Public Health 2007

UK datasets

- 62/132 (46%) of datasets had an ethnicity variable
- 7/132 (5%) of datasets had a variable on religion/faith

RESEARCH

Most UK datasets of routinely collected health statistics fail to collect information on ethnicity and religion

Kishwar Sultana[1] • Aziz Sheikh[2]

[1] General Practitioner, Glasgow

[2] Professor of Primary Care Research and Development, Division of Community Health Sciences: GP Section, University of Edinburgh, Edinburgh EH8 9DX, UK

Correspondence to: Aziz Sheikh. E-mail: Aziz.Sheikh@ed.ac.uk

DECLARATIONS

Competing interests
None declared

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Guarantor
KS

Contributorship
AS conceived this study and oversaw protocol development, data extraction and analysis. KS undertook data extraction, analysis and drafted the paper

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Introduction

The reduction of ethnic inequalities is a long-declared UK government priority,[1] but despite the moral and increasingly legal imperative to provide equitable healthcare to all sections of the population, there is very limited evidence of progress in achieving this objective. More recently, New Labour has also committed itself to tackling the very considerable religious inequalities in health and social outcomes that have become evident from analysis of data from the 2001 Census.[2] Similar ethnic and religious inequalities in health outcomes almost certainly exist in many other pluralist societies.

Given the difficulties in reducing health inequalities for certain disorders, the very considerable gaps remaining in our knowledge in relation to minority communities for many other conditions, and the known under-representation of minority groups in research (both in the UK and US),[3,4] it is important that every effort is made to make use of existing data sources to describe and understand the nature of ethnic- and faith-based variations in health outcomes, and assess progress in tackling these inequalities.

The UK enjoys some of the foremost datasets of routinely collected health statistics, and greater exploitation of these is potentially of considerable importance to shaping policy, prioritizing research and identifying foci for service delivery improvements. In order to investigate the fitness for purpose of these datasets, we sought to interrogate them for evidence of inclusion of ethnicity and faith variables and, where recorded, to assess whether there was a consistent approach to recording that would allow comparisons between datasets.

Methods

We interrogated the Directory of Clinical Databases (DoCDat), which is a comprehensive, freely available UK compilation of 162 local and national health datasets. These datasets contain records of demographic and clinical data from individuals presenting to different health-care providers or participating in academic studies. Such clinical and/or research encounters provide an important opportunity to obtain data that could be used to assess disease profiles, health services' use and clinical outcomes across and between ethnic and faith groupings.

Launched in 1999, DoCDat was developed and has since been maintained by the London School of Hygiene and Tropical Medicine.[5] A structured questionnaire is used by those compiling and maintaining DoCDat to determine general details about individual datasets relating to, for example, when the dataset was established and what fields it contains. The quality of datasets is also assessed by scrutinizing the validity and reliability of data held against pre-defined criteria.[5]

DoCDat was accessed between May and August 2006 and a table detailing information on all datasets available online was compiled. Each dataset within the Directory was interrogated online by means of detailed searches of questionnaires and webpage information against pre-defined criteria using a standardized approach to ascertain whether or not ethnicity- and faith-related data were collected and, if so, which specific questions were used. If answers were unavailable through online searches, the custodian of the individual datasets was contacted by email in an attempt to obtain this information.

Data were abstracted onto a customized data extraction sheet and descriptive statistics were employed to summarize results.

Results

Online information was available for 95 of 162 datasets. Custodians of the remaining 67 datasets

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About you

Age (35-74): 41

Sex: (•) Male ( ) Female

Ethnicity: White or not stated

Leave blank if unknown

Postcode: EH17 8UD

Clinical information -- check those that apply

- Do you smoke at all? ☐
- Do you have Type 2 diabetes? ☐
- Are you on regular steroid tablets? ☐
- Do you have high blood pressure requiring treatment? ☐
- Have you had a heart attack, angina, stroke or TIA (a mini-stroke with full recovery within 24hrs)? ☐
- Has anyone in your immediate family* had angina or a heart attack whilst under 60? ☑
- Do immediate family* have diabetes? ☑
- Have you been diagnosed with rheumatoid arthritis? ☐
- Have you been diagnosed with chronic kidney disease? ☐
- Have you been diagnosed with atrial fibrillation or irregular heartbeat? ☐

*mother, father, brothers or sisters

Leave blank if unknown

Cholesterol/HDL ratio: 4

Systolic blood pressure (mmHg): 110

Body mass index

Weight (kg): 70

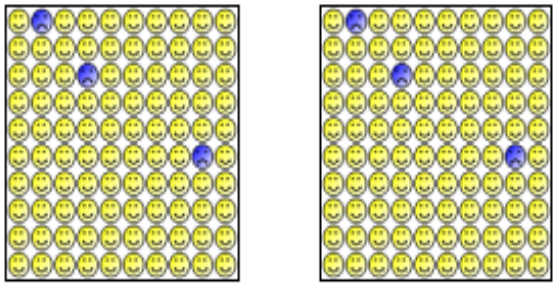
Height (cm): 173

Calculate

Your results

Your 10-year QRISK®2 score and QDScore® are: **3%** and **3%** respectively.

In other words, in a crowd of 100 people like you, 3 will develop heart disease or have a stroke/TIA in the n
years. Similarly, 3 will develop diabetes in the next 10 years. This is represented by the smileys below.



QRISK2
Cardiovascular disease

QDScore
Type 2 diabetes

Your score has been calculated using the data you entered. Your body mass index was calculated as 23.4 k

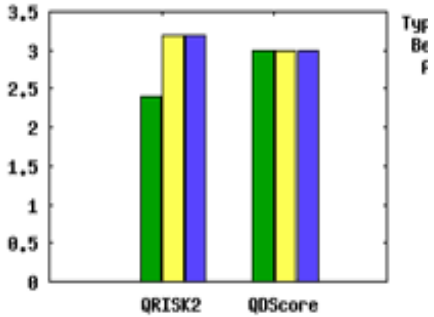
A typical person with the same age, sex and ethnicity would have a 2% risk of getting cardiovascular diseas
risk of getting diabetes in the next 10 years.

Your QRISKage*, (i.e. the age at which a typical person of your sex and ethnicity has your 10-year QRISK®
44.

What if..? (Scroll down to see the full results)

- I were to go on statins? ☐
- I lose enough weight to bring my body mass index down to 25? ☐
- I stop smoking? ☐
- I get my systolic blood pressure down to 140 mmHg? ☐

Calculate the "What if"s



With these interventions, you would have a 3% risk of getting cardiovascular disease and a 3% risk of getti
in the next 10 years.

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About you

Age (35-74): 41

Sex: (•) Male ( ) Female

Ethnicity: Pakistani

Leave blank if unknown

Postcode: EH17 8UD

Clinical information -- check those that apply

- Do you smoke at all? ☐
- Do you have Type 2 diabetes? ☐
- Are you on regular steroid tablets? ☐
- Do you have high blood pressure requiring treatment? ☐
- Have you had a heart attack, angina, stroke or TIA (a mini-stroke with full recovery within 24hrs)? ☐
- Has anyone in your immediate family* had angina or a heart attack whilst under 60? ☑
- Do immediate family* have diabetes? ☑
- Have you been diagnosed with rheumatoid arthritis? ☐
- Have you been diagnosed with chronic kidney disease? ☐
- Have you been diagnosed with atrial fibrillation or irregular heartbeat? ☐

*mother, father, brothers or sisters

Leave blank if unknown

Cholesterol/HDL ratio: 4

Systolic blood pressure (mmHg): 110

Body mass index

Weight (kg): 70

Height (cm): 173

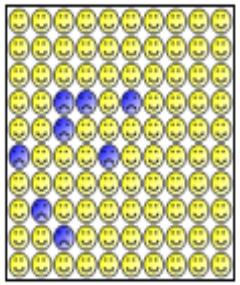
Calculate

Your results

Your 10-year QRISK®2 score and QDScore® are: **6%** and **8%** respectively.

In other words, in a crowd of 100 people like you, 6 will develop heart disease or have a stroke/TIA in the ne
years. Similarly, 8 will develop diabetes in the next 10 years. This is represented by the smileys below.

QRISK2
Cardiovascular disease



QDScore
Type 2 diabetes

Your score has been calculated using the data you entered. Your body mass index was calculated as 23.4 kg

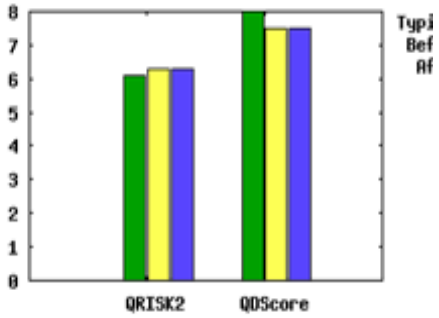
A typical person with the same age, sex and ethnicity would have a 6% risk of getting cardiovascular diseas
risk of getting diabetes in the next 10 years.

Your QRISKage™, (i.e. the age at which a typical person of your sex and ethnicity has your 10-year QRISK®2
42.

What if..? (Scroll down to see the full results)

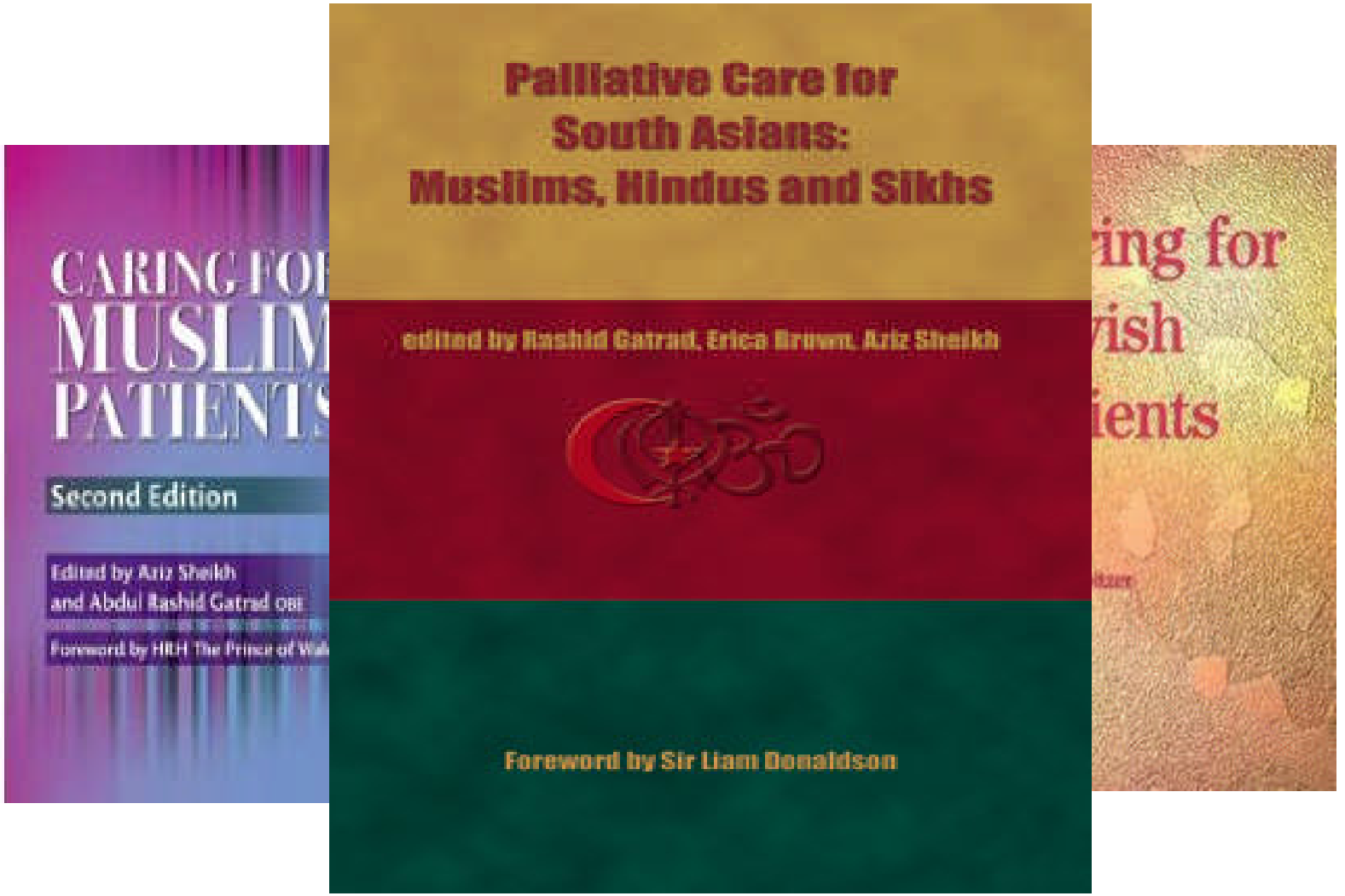
- I were to go on statins? ☐
- I lose enough weight to bring my body mass index down to 25? ☐
- I stop smoking? ☐
- I get my systolic blood pressure down to 140 mmHg? ☐

Calculate the "What if"s



With these interventions, you would have a 6% risk of getting cardiovascular disease and a 8% risk of gettin
in the next 10 years.

Contention 4: Religious dimension of ethnicity needs to be more centralised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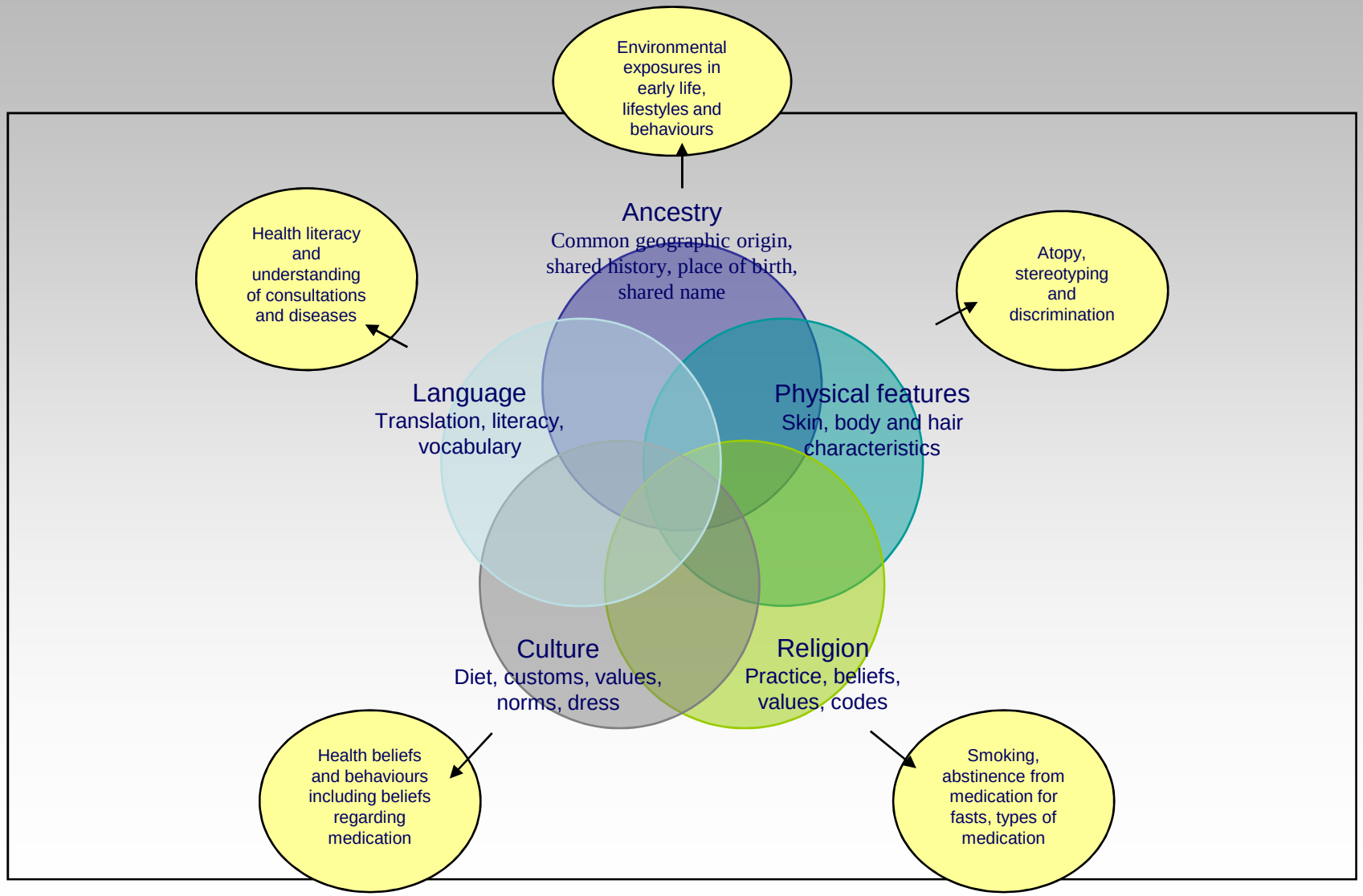
Dimensions contributing to ethnicity



Finally: A note of caution!

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