MSc Public Health and Social Care in Practice

Healthcare disparities among ethnic minorities in the UK

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ABSTRACT

Background

Healthcare disparities among ethnic minorities in the UK represent a significant public health concern. These disparities can manifest in various ways, such as differences in access to healthcare services, the quality of care received, and health outcomes.
While these ethnic minority groups migrate to developed, high-income countries like the United Kingdom (UK), the challenges in accessing services such as GP and hospital care remain unchanged.
In the UK, ethnic minorities face disparities in access to healthcare due to a complex interplay of causes, including socioeconomic status, language barriers, cultural implications, and past experiences with healthcare (NHS England, 2023).
These disparities often manifest themselves in poorer health outcomes, delayed diagnosis and less positive experiences with healthcare services. The NHS Race and Health Observatory highlighted specific areas of concern, such as access to healthcare services and specialist testing.

This systematic review examines disparities in access to healthcare services among ethnic minorities in the United Kingdom and understands the underlying causes contributing to inequalities. Although there is a vast supply of literature available on disparities in healthcare services, there remains a significant gap in understanding the specific services suggested to ethnic minorities in the UK.

Methods

This systematic review was conducted to gather material from existing research. According to the PRISMA statement, an electronic database search was performed using ProQuest and Google Scholar from 2013 to 2025.
The search terms included “ethnic minorities,” “BAME,” “healthcare access service,” and “disparities in healthcare.” Also, the relevant studies were identified and critically analysed. The search encompassed various databases and included qualitative and quantitative methods.

Results

This systematic review demonstrated a disadvantage in accessing healthcare services because certain ethnic minority groups experience significant disparities in healthcare access, leading to worse health outcomes compared to the white British population. On the other hand, disparities in healthcare access for ethnic minorities in the UK also resulted in poorer health outcomes, including higher rates of certain diseases and increased mortality. Factors like structural racism, poverty, language barriers, and cultural differences influence these disparities.

Conclusion

The dissertation highlights the urgent need for targeted interventions and policy reforms to address disparities in accessing healthcare among ethnic minorities in the UK. By exploring the complexity of inequalities in accessing primary care, specialist services, and overall healthcare experiences, this research provides valuable insights into the challenges faced by ethnic minorities in their healthcare access. Culturally competent healthcare services, training for healthcare professionals, and community-based interventions are essential to promote health equity for all ethnic minorities, regardless of ethnicity or background.

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ABBREVIATIONS

BAME - Black Asian Minority Ethnicity

UK – United Kingdom

CVD - cardiovascular disease

SLR - Systematic Literature Review

GP - General Practitioner

Chapter 1: Introduction and Background

1.1. Introduction

Healthcare disparities among ethnic minorities are defined as "racial or ethnic differences in the quality of health care that are not due to factors related to access or clinical needs, preferences, and appropriateness of the intervention” (Egede, 2006).

However, racial and ethnic disparities in health care exist, and because they are associated with worse outcomes in many cases, they are unacceptable (Robertson et al., 2021; Egede, 2006).

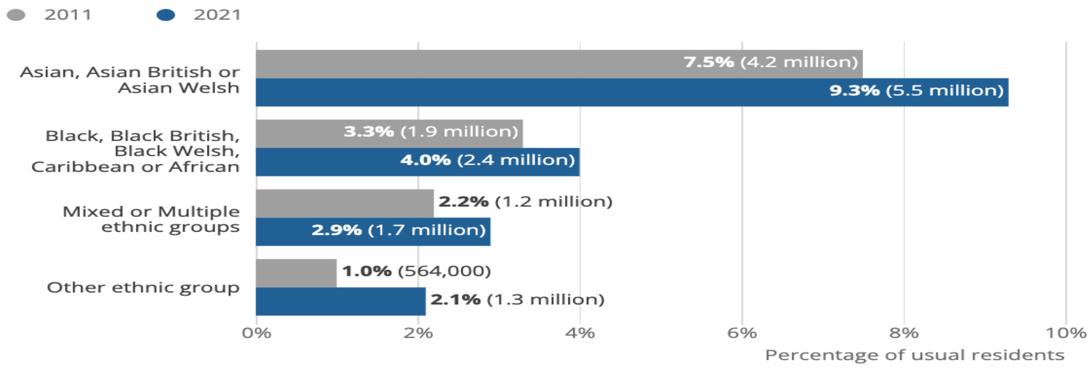
But, healthcare disparities among ethnic minorities are a major problem in the UK because, despite significant advances in the diagnosis and treatment of most chronic diseases, there is evidence ethnic minorities in the UK tend to receive lower quality healthcare than non-minorities and that ethnic minority patients suffer greater morbidity and mortality from various chronic diseases than non-minorities (Robertson et al., 2021, Egede, 2006).

For example, in the UK, rates of infant and maternal mortality, cardiovascular disease (CVD) and diabetes are higher among black and South Asian groups than among white groups (Raleigh, 2023).

Ethnic minorities in the UK refer to all ethnic groups except the White British group (Office for National Statistics, 2022).

Figure 1: The percentage of the population in all high-level ethnic groups, excluding “White”, has increased since 2011

Ethnic group distribution (high-level categories), 2011 and 2021, England and Wales



Source: Office for National Statistics – Census 2021

(Office for National Statistics, 2022)

Health inequalities are unfair and avoidable differences in health across the population and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the healthcare services that are available to them (NHS England, 2023).

Typically, individuals residing in regions of significant deprivation, members of Black, Asian, and minority ethnic communities, as well as those from inclusion health groups, such as people experiencing homelessness, are at the highest risk of facing these disparities (NHS England, 2023).

This systematic review examines disparities in access to healthcare services among ethnic minorities in the UK. Although there is a wealth of literature available on healthcare services inequalities, there remains a significant gap in understanding the specific healthcare challenges faced by ethnic minority groups in the UK.

This systematic review aims to fill these disparities (gaps) and contribute to developing specific interventions and policies.

The choice to select the subject of healthcare disparities among ethnic minorities in the UK is significant because inequalities have resulted in worse health outcomes, higher morbidity and mortality rates, and increased healthcare services costs for these communities. Addressing these issues can enhance public health and reduce the economic burden on the healthcare system.

Healthcare Services refer to services provided by health professionals and institutions to maintain or improve individuals' and communities’ health. (World Health Organisation, 2009).

These services encompass preventive care, diagnosis, disease treatment, rehabilitation, and palliative care. Healthcare services can be offered in various settings, including GP offices, hospitals, clinics, community health centres, and home care (World Health Organisation, 2009).

Healthcare disparities refer to differences in health outcomes and access to health services experienced by different populations (National Library of Medicine, 2021).

In the UK, ethnic minorities face significant barriers to accessing healthcare, leading to poorer health outcomes. Various factors contribute to this public health problem: **financial constraints, Quality of care, Health literacy, and cultural beliefs** (National Library of Medicine, 2021).

1.2. Background and Current Context

There has been considerable concern over disparities in healthcare for ethnic minorities in the UK, which has drawn significant attention to this matter.
Additionally, socioeconomic status can impact the quality and accessibility of healthcare services, leading to differences in healthcare outcomes across populations. However, inequality in treatment and health outcomes is a common issue for ethnic minorities in the UK, as they are often treated differently from the general population. Fatefully, in numerous regions of the UK, disparities in accessing healthcare among ethnic minorities are inequities, considering their complex and varied characteristics. This happens because ethnic minorities from lower socioeconomic status are not consistently experiencing the same access to healthcare as other ethnic groups, such as White British (Fenney and Buck 2021).
It is equally important to acknowledge that the NHS cannot tackle ethnic healthcare services disparities independently but can collaborate with broader partners, such as the voluntary and community sector, which possesses their links and insight into local communities and their significant part in aiding communities to voice their concerns and convey their experiences, in addition to local governments, which have strong connexions to local communities and their impact on numerous wider health determinants. (Fenney and Buck 2021).

There is interest and increasing exploration around underrepresentation in health research. This was accelerated during the COVID-19 pandemic when it was highlighted that there was disproportionately low representation in research trials from some population groups (Ekezie et al., 2021).
A focus was placed on black, Asian, and minority ethnic (BAME) groups (Witham et al, 2020a). However, it became evident that this extended to other underserved

populations, all known to carry a greater burden of incidence and effects of the disease (Ekezie et al., 2021).

A significant proportion of the UK's population is ethnic minorities. Health disparities are frequently assumed by individuals of this category, who comprise roughly 14% of the population. Research has shown a higher prevalence of chronic conditions, particularly those related to ethnic minority backgrounds, such as diabetes and hypertension. Also, they often face difficulties accessing healthcare services (The Centre for Social Justice, 2020).

The prevalence of CVD is a significant concern, with 24% of all deaths in England and Wales due to this disease occurring in 2019 and affecting many people, particularly those who are ethnically black or from other races.
This is a significant contributor to differences in life expectancy and is one of the reasons for adverse outcomes from COVID-19. However, 80% of premature deaths due to CVD can be prevented by improving public health initiatives and managing risk factors such as obesity, diabetes, and insufficient physical activity (Raleigh, 2023).

However, the study found that for most of their lives, people in the poorest areas of England, on average, have more illnesses diagnosed 10 years earlier than those in the wealthiest areas (Singleton, 2022).
For example, a woman living in the poorest areas has a life expectancy of five years shorter than those in the wealthiest areas. Then, she will spend more than half (44 years) of her shorter life in ill health compared to 46% (41 years) for a woman in the wealthiest areas (Singleton, 2022).

Regarding men, inequality in men's life expectancy is such that, despite spending a greater part of their lives with diagnosed diseases (46% compared to 44%), men in the most disadvantaged areas spend less time living with diagnosed illnesses (36 years compared to 38 years in the least disadvantaged areas) (Singleton, 2022).

Regarding ethnicity, the analysis also finds significant ethnic disparities in diagnosed illnesses, for example, people from Pakistani, Bangladeshi and black Caribbean backgrounds were found to have higher levels of long-term disease than the white population once the data had been standardised for age.
Also, people from Pakistani and Bangladeshi backgrounds have the highest age-standardised rates of diagnosed chronic pain, diabetes and cardiovascular disease (Singleton, 2022).

1.3. Rationale for Research or Problem Statement

Healthcare disparities among ethnic minorities in the UK are a significant public health concern. Therefore, several studies have highlighted that individuals from ethnic minorities often experience worse health outcomes compared to their white counterparts.
However, socioeconomic factors, including income, environment, home, education, and unemployment, play a fundamental role in defining healthcare access and quality. This proposal explores how these socioeconomic factors contribute to disparities in accessing healthcare and identifies actionable knowledge that can inform policy and intervention strategies to reduce inequalities.

On the other hand, this approach allows for the statistical analysis of socioeconomic factors while capturing the existing experiences and perceptions of ethnic minorities about access to healthcare.
Evidence from the Fourth National Ethnic Minority Survey suggests that ethnic inequalities in healthcare among minority ethnic groups increase relatively small differences at younger ages and larger differences emerge from the middle (Nazroo, 2003). Interpreting the contrasting pattern of inequalities in healthcare among minority ethnic groups in the UK across ages is not straightforward, but these data point to the need for sophisticated approaches to the explanation of ethnic inequality that place ethnic health inequalities within a broad social context (Nazroo, 2003).
For example, growing disparities in accessing healthcare among ethnic groups in the UK may reflect some co-existing explanations, including the accumulation of risks over the life course and the long-term consequences of exposure to hazards early in life.
In the UK context, the cross-sectional pattern of increasing differences in risk across age may also reflect differences between first- and second-generation migrants, as

older people are first-generation migrants, and younger people are second-generation migrants. This last point is a reminder of the need to be aware of a range of potential migration-related effects (Nazroo, 2003).

Disparities in accessing healthcare among ethnic minorities occur within a broader context of disparities in healthcare, cultural beliefs and inequalities, income and unemployment. Furthermore, ethnic minority groups in the UK face a higher risk of mortality and suffer from a range of long-term illnesses compared to their white counterparts.

According to the latest MBRRACE-UK report was published in December 2023 (using 2019-2021 data) and found that black women were 3.7 times more likely to die than white women and Asian women were 1.8 times more likely to die than white women and 1 in 9 women who died during or within a year of pregnancy in the UK were severely and multiple disadvantaged.

This is due to linguistic, cultural and access barriers to healthcare services (Aquino et al., 2015). South Asian women, and some others

Black and other ethnic minority women face barriers to accessing sexual health services in the UK.

Although ethnic minorities in the UK migrate to higher-income developed countries such as the UK, barriers and problems remain the same, unique challenges intersecting with exacerbated healthcare disparities, cultural factors and systemic inequalities, which raise a broad spectrum of concerns related to well-being and health care, including screening and health services.

1.4. Research Question

The research question would be “Healthcare disparities among ethnic minorities in the UK?”

1.5. Research Aims

The aim is to examine disparities in access to healthcare services among ethnic minorities in the United Kingdom.

1.6. Research Aims and Objectives

- Identify and classify the barriers that ethnic minorities face in accessing healthcare services

1.7. Chapter Summary

Healthcare disparities among ethnic minorities in the UK relate to challenges like socio-economic status, poor health and long-term conditions, which lead to inequalities in accessing healthcare services. Also, the culture, languages and income increasingly exacerbate the challenges.

The next chapter will provide a comprehensive review of the existing literature on the topic to understand the healthcare disparities faced by ethnic minorities in the UK in accessing healthcare services.

CHAPTER 2: Literature Review

2.1. Introduction to Literature Review Chapter

This chapter will provide a systematic understanding of the existing literature examining disparities in healthcare services among ethnic minorities in the UK. It will explore various barriers, including accessing healthcare services, cultural stigma, socioeconomic status, poor health, and language, that contribute to disparities in access to healthcare.

Furthermore, this chapter will examine the literature on health problems and long-term conditions affecting ethnic minorities from adulthood to old age among low-income ethnic groups.

By incorporating findings from current research, it aims to provide valuable information about healthcare disparities among ethnic minorities and inform future research, interventions, and healthcare promotion.

2.2. Literature review

A literature review is an academic part of writing that demonstrates knowledge and comprehension of the scholarly literature regarding a particular subject situated within a context. (University of Edinburgh, 2024).

A literature review additionally features a critical assessment of the content; this is the reason it is termed a literature review instead of a literature report. It represents both a procedure of examining the literature and a style of writing (University of Edinburgh, 2024).

There are two main reasons for conducting some form of literature review. The main reason is the desire to synthesise a body of evidence on a topic to reach robust and broad conclusions and implications (Baumeister 2013).

Each study involves a researcher or team collecting a sample using methods and measures. As individual studies can never be definitive, pooling the results of many different individual studies, synthesising and evaluating them, and discovering consistency greatly extend what any single study can achieve (Baumeister & Leary

1997, Cumming 2014). Thus, by their nature, review articles have a power and value that no single study can match (Baumeister & Leary 1997, Cumming 2014).

The investigations into examining disparities in access to healthcare services among ethnic minorities in the UK have been a significant emphasis, especially considering the increasing recognition of social factors influencing health; however, many notable gaps and limitations exist (The Health Foundation, 2023). An extensive search of electronic databases, including ProQuest Central and Google Scholar, was performed to identify relevant studies.

The systematic review included qualitative and quantitative studies that examined disparities in access to healthcare services among ethnic minorities in the UK. Here is a summary of the research conducted, principal findings, an evaluation of sources, and an identification of gaps in the current literature.

Research has been carried out in numerous formats, which include quantitative studies, where a significant number of studies utilise statistical evaluation of variations in accessing healthcare services and results among ethnic minorities in the UK.

This encompasses national health surveys and NHS registry information. The qualitative research has used articles focused on interviews and focus groups to understand the experiences of ethnic minorities in accessing healthcare services.

However, the primary findings or outcomes concern access to healthcare; ethnic minorities, specifically South Asian and Black communities, encounter obstacles to obtaining healthcare, such as language challenges, cultural misunderstandings, and discrimination.

Based on healthcare outcomes, disparities in accessing healthcare services are prevalent. For example, some studies have shown higher rates of certain diseases (e.g. cardiovascular disease, hypertension) and poorer mental health outcomes among ethnic minorities (Ekezie et al., 2023).

Additionally, some research suggests that ethnic minorities often receive lower quality care, influenced by biases in clinical decision-making and a lack of culturally sensitive services (Ekezie et al., 2023).

Critical Source Appraisal indicates Strengths in quantitative studies that frequently utilise extensive data sets, delivering statistically significant examinations of disparities. Qualitative research provides essential perspectives on the lived experiences of ethnic minorities and uncovers nuanced issues that quantitative data might miss.

Regarding weaknesses, certain quantitative studies might have constraints in generalizability if they do not sufficiently represent smaller minority populations. Although ample in detail, qualitative results may be restricted by limited sample sizes and personal interpretations, as research can occasionally concentrate on diseases instead of a comprehensive perspective on health disparities.

Concerning the gaps and shortcomings in current research, it was observed that certain ethnic minority groups, especially younger immigrant demographics, are frequently insufficiently studied, resulting in knowledge voids.

Conversely, there exists a necessity for additional research that examines how ethnicity interacts with other social factors, including socioeconomic status, gender, and geography. It was also highlighted that numerous studies are cross-sectional, offering a brief overview instead of insights into temporal changes and the long-term effects of disparities. A significant amount of research often centres on urban populations, possibly overlooking rural ethnic minority communities where disparities may also be present.

In conclusion, diversity research ought to be supported to foster investigations encompassing a wider variety of ethnic groups and consider intersectional factors, such as gathering longitudinal data that emphasises long-term studies to monitor disparities in health and outcomes over time.

Ultimately, more thorough evaluations of health policies are necessary to comprehend their effectiveness in tackling ethnicity-based health disparities. By addressing these shortcomings, upcoming research can help enhance the understanding of health disparities and guide more effective interventions to advance health equity in the UK.

2.3 Chapter Summary

The literature review explores disparities in access to healthcare services among ethnic minorities in the UK. It highlights some barriers and differences in access to healthcare and the results of inadequate geographic density, location, and access to primary care. Although some people from ethnic minorities born in the UK have access to healthcare, they still face institutional racism in healthcare services.

The next chapter will describe the research design, data collection methods and analytical framework used to investigate disparities in access to healthcare services among ethnic minorities in the UK. It is based on insights gained from the literature review.

CHAPTER 3: Methodology

3.1 - Introduction to Chapter

This chapter will focus on ensuring the reliability of the results through a systematic review of the literature that follows the guidelines for reporting items. However, the search strategies were conducted by databases such as:

- **ProQuest Central**
- **Google Scholar**

In this chapter, the exclusion and inclusion criteria will apply to remove articles with insufficient data that do not meet the requirements to ensure the study complies with ethical considerations when dealing with confidential information involving ethnic minorities.

3.2 Systematic Literature Review (SLR)

Systematic Literature reviews (SLRS) comprehensively synthesise existing research to help stakeholders make decisions (Redhead, 2024).

They are analyses of all relevant research on a specific topic. SLR must be comprehensive, transparent, and reproducible. They help reduce bias in searching, identification, synthesis, analysis, and summaries (Mengista et al., 2020).

3.3 Search Strategy

The University of Leeds (2022) states that a search strategy is an organised structure of key terms used to search a database, so it combines the key concepts of the search question to retrieve accurate results. The search depends on identifying topics relevant to the studies, which must be significant and relevant (MacFarlane et al., 2022).

While it is extensive and vast, the search is based on the balance between the precision and reliability of the chosen study, followed by screening of studies, analysis of evidence and synthesis of the review (Cooper et al., 2018).

Search strategies are primarily based on concept identification and are represented by topical discrete search keywords, variations of search terms, and subject headings (when applicable) (University of Leeds, 2022).

However, the concepts and keywords were combined using operators such as **AND**, **OR**, **and NOT** to initiate the search strategy; the specific search time limit used for the **study is from January 2013 to May 2025** (MacFarlane et al., 2022).

3.4 Search terms

A search term is a word or phrase that users type into a database or search engine to locate material or information, keywords and longer phrases that capture a specific inquiry or topic of interest are examples of search terms based on the aims and objectives of the research question developed, the search phrases can be either broad or specific (H Snyder, 2019).

MacFarlane et al. (2022) state that search phrases must be precisely defined and explained to convey their true meaning and give a cohesive narrative across the various health, information, and scientific domains that comprise research. Using synonyms improves the likelihood of discovering all significant research on the subject and helps do pertinent searches (Cooper et al., 2018).

Additionally, as different authors design and describe their studies using different terminology, finding synonyms for keywords allows us greater flexibility, precision, and simplifying refining when looking for the needed information (Cooper et al., 2018).

However, not using the synonyms to restrict the search can lead to unsuccessful sample collecting and the loss of significant studies. So, if it draws an incorrect conclusion regarding gaps and irrelevant research, it could produce inconsistent results or offer inaccurate proof of the effect of the outcome (H Snyder, 2019).

Table 1: PEO Framework

Population/ Problem	Ethnic minorities in the UK (e.g., Black, Asian, and Minority Ethnic communities) (Adults)
Intervention/ issue	Healthcare quality or accessibility (Culturally tailored health education programs aimed at improving healthcare literacy)
Context	Socioeconomic barriers and systemic racism are impacting access to healthcare.
Outcome	Disparities in health outcomes (e.g., prevalence of chronic conditions, mental health issues) Improved health outcomes (e.g., reduced GP and hospital admissions)

Based on the designed PEO framework, the topic raises a research question: “Healthcare disparities among ethnic minorities in the UK?” To identify answers to the research question, databases such as ProQuest Central and Google Scholar will be searched coherently using relevant keywords and operators.

The search strategy will mainly involve the combination of keywords related to the population, identification of keywords and synonyms:

- **(Ethnic minorities), "ethnic groups", "BAME", "black, Asian and ethnic minorities", (Access/quality of healthcare): "access to health care", "quality of health care", "use of health services", "health disparities",**
- **Comparison “majority ethnic groups”, “white British”, “non-minority”**
- **Health outcomes, "disparities", "inequalities", "health inequalities".**

As mentioned above, these search keywords were created and expanded using synonyms for the words. The keywords are combined using Boolean operators like **AND, OR, and NOT**. The search is essential because it helps ensure that no critical data or studies are lost during the search.

The aim is to shed light on the challenges of disparities in access to healthcare services among ethnic minorities in the UK and help healthcare providers and other members of the community understand and address the specific concerns related to the challenges and further help them receive the support they need in healthcare and the community.

3.5 Key Words

Keywords, called search terms, are the words entered into database search boxes. Because they represent the main concepts of the research topic and are the words used daily to describe the topic, without the right keywords, searchers may have difficulty finding the articles they need (Walden University, 2019; MacFarlane et al., 2022).

Table 2: Key Words

OR	**AND**	**AND**

Search operator	**Population**	**Region**
1. Healthcare disparities	Ethnic minorities	UK
2. Healthcare inequalities	Ethnic minorities	UK
3. Healthcare Access	Ethnic minorities	UK

3.6 Databases

The academic databases of electronic sources will be used to search for information, and a database search strategy will be done through ProQuest Central and Google Scholar.

The search is similar to: ("ethnic minorities" **OR** "ethnic groups" **OR** "BAME" OR "Black, Asian and Minority Ethnic") **AND** ("access to health care" **OR** "quality of health care" **OR** "utilisation of health services" OR "health disparities") **AND** ("White British" **OR** "majority ethnic groups" **OR** "non-minority") **AND** ("health outcomes" OR "disparities" OR "inequalities" OR "health inequalities").

However, it is essential to scan several databases to search, this reason, the study of this systematic review's goal is to find as many pertinent sources as it can to offer the most thorough treatment of the selected research topic when conducting a database search, it is critical to find a balance between comprehensiveness and relevancy. (Gusenbauer et al., 2019 and Pranckute et al., 2021) State that PubMed and ProQuest Central have grown significantly during the past ten years.

3.7 Inclusion/Exclusion Criteria

Inclusion and exclusion criteria are a list of pre-defined characteristics that literature must adhere to be included in a study. These criteria are important for advancing decision-making about what to review when conducting a systematic review and will also help in systematic literature reviews (Johns, 2024).

Also, it helps researchers establish inclusion/exclusion criteria during the question definition process, demonstrate the scope of the study and justify the exclusion of any information that does not meet these characteristics. Some studies stated that inclusion and exclusion criteria may result in varied answers and conclusions (Johns, 2024).

Selecting specific journal articles according to limitations and criteria allows for transparency for readers and helps them understand the literature on how it was identified, analysed, synthesised, and reported, increasing the validity and reliability of the review results (H Snyder, 2019).

3.7.1 Inclusion Criteria

Inclusion criteria for the topic Disparities in healthcare among ethnic minorities in the UK include:

- **Studies published in English,**
- **Articles published from the year January 2013 to May 2025**
- **Qualitative and quantitative approaches based on project needs**

3.7.2 Exclusion Criteria

Exclusion criteria for the challenge theme of disparities in healthcare among ethnic minorities in the UK involve studies not carried out in the UK:

- **Publications in other languages**
- **Articles focus on non-minority ethnic populations.**
- **Children's studies.**

- **Articles that are not relevant to healthcare issues.**
- **Studies with insufficient data or that do not address disparities among ethnic minorities in the UK.**

3.8 Search Results

After applying the inclusion and exclusion criteria, 12 studies were included in the review. A PRISMA (Preferred Reporting Items for Systematic Reviews) graphic was used to show how to weed out irrelevant studies. The graphic visually represents the sequence of studies from initial identification to final inclusion in the review process (Page et al., 2021).

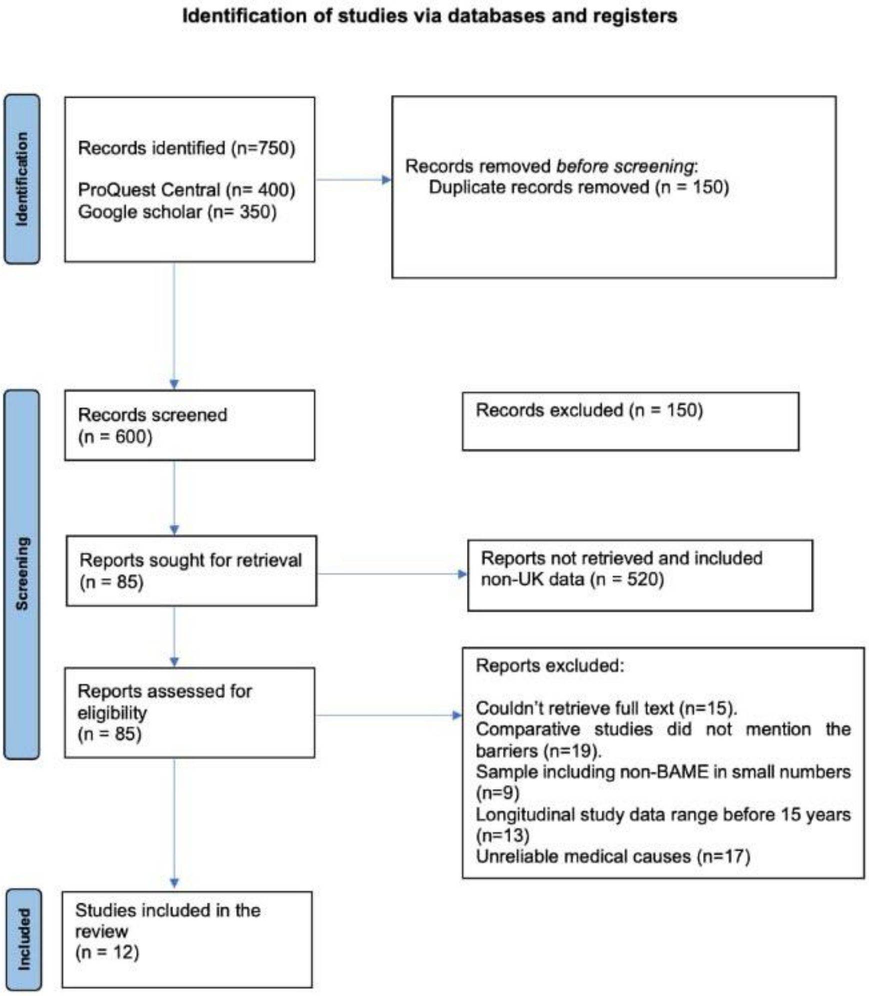
First, a thorough search was conducted across multiple databases. A variety of keywords regarding disparities in access to healthcare services among ethnic minorities in the UK were utilised in the search approach. A total of 750 articles were identified in this initial search, and after eliminating duplicates, 600 items remained for screening.

The titles and abstracts of these papers were then assessed for their relevance to the subject. Articles that did not meet the inclusion criteria were subsequently disqualified. Reasons for exclusion included studies conducted outside the UK, those focusing on ethnic minority communities and BAME, or those that failed to address disparities in accessing healthcare among ethnic minorities in the UK.

After reviewing the full texts, 12 studies were deemed eligible for inclusion in the review. These studies provided valuable insights into various challenges associated with disparities in access to healthcare among ethnic minorities in the UK, including issues related to chronic illness, socio-economic status, cultural barriers, and healthcare outcomes or disparities.

Figure 1: PRISMA flow chart

Prisma 2020 flow diagram for new systematic reviews, which included a search of databases and registers only.



3.9 Ethical Considerations

Research ethics refers to the moral principles that guide researchers in conducting their work. These principles ensure the integrity and well-being of the research process and offer a methodological perspective for decision-making (Bhandari, 2024).

These topics include confidentiality, which protects actors' data and prevents the disclosure of personal information. Integrity considers behaviours like plagiarism and data fabrication (Bhandari, 2024).

However, by evaluating ethics in systematic reviews, reviewers may be able to identify research whose ethical issues are severe enough to raise doubts about the reliability of its conclusions (Weingarten et al., 2004).

3.10 Chapter Summary

Search tactics, search terms, inclusion and exclusion criteria, and the significance of ethical issues in the systematic review were all covered in the methodology for a systematic review examining disparities in access to healthcare services among ethnic minorities in the UK.

The PEO framework guided the formulation of research questions, and a comprehensive list of keywords ensured inclusion in academic databases, which will be used for a thorough systematic review.

A PRISMA flowchart was used to present the research findings. Data extraction will be the subject of the following chapter, including instructions for methodically gathering pertinent data from chosen studies. The next chapter will attempt to synthesise and analyse outcomes to offer insightful information through careful data extraction.

CHAPTER 4: Data Extraction and Evaluation

4.1 Introduction to Chapter

This chapter on data extraction and evaluation of studies examines disparities in access to healthcare services among ethnic minorities in the UK, examines and outlines the processes for methodically gathering information from chosen studies, and critically evaluates their quality using suitable tools for qualitative and quantitative analysis. This chapter also highlights the significance of assessing methodological relevance to ensure the validity of results.

4.2 Data Extraction

Data extraction is the process of collecting relevant information from studies and organising it in a way that will help with data analysis and synthesis.

On the other hand, data extraction involves systematically capturing essential study characteristics in a structured and standardised format, using information derived from journal articles, publications, studies, and reports. This process is a prerequisite for assessing potential bias in individual studies and synthesising their results (Adams, 2024).

Data extraction, according to the study on the difficulties of disparities in access to healthcare services among ethnic minorities in the UK, will entail integrating various data from other studies, including both qualitative and quantitative investigations (Covidence, 2024).

However, this includes demographic details, study characteristics, study design, tools used in data extraction, data analysis, and study outcome. These data elements will be extracted based on a pre-designed data extraction form, such as the **Newcastle-Ottawa Scale (NOS)** tools, tailored to the specific objectives and inclusion criteria (Covidence, 2024).

4.3 Brief introduction to critical appraisal and paper quality assessment

Critical Appraisal systematically examines research to judge its reliability, value and relevance in each context. It is an essential evidence-based skill because it allows people to find and use research evidence reliably and efficiently (CASP, 2024). This procedure is significant because it is a direct, systematic, and methodological process rather than being disorganised.

In addition, as Flyybierg et al. (2012) point out, critical evaluation benefits from the reviewer's practical wisdom gained through research experience and exposure to relevant literature. It is crucial to acknowledge that researchers are inevitably influenced by their personal theoretical and contextual backgrounds, which can impact the evaluation process (Flyvbjerg et al., 2012).

Critical appraisal is integral to systematic reviews in assessing credibility and interpreting study results. It allows reviewers to understand the definition, benefits, and procedural aspects with informed insights (David et al., 2022). Petticrew and Roberts (2006) suggest that balancing critical evaluation and acceptance is crucial to avoid inaccurate interpretations of primary research (David et al., 2022).

4.4 Critical Appraisal Tools

CASP (2024) defines Critical evaluation in research as the analysis that involves carefully examining a study's methodology, results, and conclusions to evaluate its quality and validity. It is essential to avoid judgment errors and help researchers determine whether the study's findings are reliable and applicable in their research context (CASP, 2024). Critical evaluation requires specific skills, including understanding research methodology, statistics, and evidence-based practices (CASP, 2024).

Critical appraisal tools expect articles to be evaluated to provide analytical assessments of a study's quality, particularly the methods used to reduce bias, because these factors can influence study results and interpretation, reviewers must assess the credibility and relevance of study findings in a variety of contexts, including policy formulation, future research, education, and clinical practice (Katrak et al., 2004). As a result, selecting an appropriate critical appraisal tool is an essential component of evidence-based practice (Katrak et al., 2004). Critical appraisal tools, on the other hand, must assess a variety of aspects of articles, such as methodology, study design, sample selection, data collection, statistical and analytical techniques, ethical considerations, potential sources of bias and result interpretation, and transferability (Katrak et al., 2004).

4.5 Evaluation of Qualitative Studies using any appropriate tool

When using the critical appraisal tool for qualitative studies, the CASP tool (Critical Appraisal Skills Programme) helped with comprehension because it includes key questions about the clarity of study objectives, research design, recruitment strategy, data collection methods, and ethical concerns (Long, French and Brooks, 2020). This comprehensive framework helps to completely analyse the quality of qualitative research (Long, French and Brooks, 2020).

On the other hand, the CASP's easy-to-use format makes it simple and accessible, facilitating its application by researchers and professionals without extensive training in qualitative research methods (Long, French and Brooks, 2020).

The tool emphasises the importance of rigour in qualitative research, which helped this systematic review assess the credibility and reliability of qualitative results (Long, French and Brooks, 2020).

Compared to the SQRAT (Spiritual Qualitative Research Appraisal Tool), the CASP tool has the advantage of being widely recognised and used by academic and research institutions, as well as its ability to be applied to diverse qualitative research projects and disciplines. CASP's limitations include a lack of focus on specific qualitative methods, as it does not distinguish between different types of qualitative methodology as clearly as some other tools. In contrast to tools designed specifically for narrative inquiry or ethnography, questions may not fully capture the depth of qualitative nuances (Long, French and Brooks, 2020).

Quality Assessment of Selected Studies

After analysing these 12 articles, quality assessment of the included studies is crucial for interpreting the review findings. In this review, various study designs were included. Study quality was evaluated using the Newcastle-Ottawa Scale (NOS) (Lo, Mertz and Loeb, 2014).

The Cochrane Collaboration endorses this scale for evaluating observational studies and non-randomised studies; It was created by the University of Newcastle (Australia) and the University of Ottawa (Canada) to measure the quality of non-randomised studies (Wells et al., 2021; Margulis et al., 2014).

However, it operates on a 'star system' grounded in three major perspectives: the selection of study groups, the comparability of groups, and the ascertainment of either the exposure or outcome of interest (Wells et al., 2021; Margulis et al., 2014).

The three categories include eight multiple-choice questions, and the number of available answers for each question ranges from 2 to 5.

The ‘**Selection of the study groups’** encompasses five questions, ‘**Comparability of the groups’** entails two questions, and ‘**Outcome**’ consists of three questions. Cross-sectional studies categorised as “very good” would achieve 5 points; “good” studies would receive 4 points; “satisfactory” studies would earn 3 points; and “unsatisfactory studies” would score between 0 and 2 points (Wells et al., 2021).

The summary quality assessment score corresponds to the number of stars awarded to each study and is presented in the results in the following tables.

However, when modifying it for cross-sectional studies, particularly concerning a systematic review of disparities in access to healthcare services among ethnic minorities in the UK, it would concentrate on essential criteria that assess the quality and strength of the studies incorporated.

NEWCASTLE - OTTAWA QUALITY ASSESSMENT SCALE

(Adapted for cross-sectional studies)

1. **Selection:**(Maximum 5 stars)

a) **Representativeness of the average in the target Study Population:** The study population accurately reflects the target population of ethnic minorities in the UK (all subjects or random sampling)
b) **Sampling Method:** The method of sampling is suitable for acquiring the study population.
c) **Non-respondents:** (non-respondents adequately described)
d) **Data Source:** The source of data (e.g., studies, administrative data) is suitable
e) **Outcome Definition:** the outcome (healthcare disparity) is clearly defined and measured

2. **Comparability** (maximum of 2 points)

a) **Control of Major Confounding Factors:** authors account for any significant confounding variables (e.g., socioeconomic status, age, gender).
b) **Statistical Analysis:** statistical analysis suitable for the type of data obtained.

3. **Outcome** (maximum 4 points)

a) **Assessment of the outcome:**
- Independent blind assessment.
- Record linkage.
- Self-report.
- No description.

b) **Outcome Measurement:** evaluation of healthcare disparities both valid and reliable.
c) **Statistical reporting:** the findings are statistically significant and presented.
d) **Results: The** authors offer a clear explanation of how their results connect to healthcare disparities affecting ethnic minorities.

Table 3: Qualitative Data Extraction

Author and Year	Title	Aim of the study	Study Design	Sample and Population	Key Findings Outcomes	Recommendation
Memon A, Taylor K, Mohebati LM, et al. (2016)	Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities.	In most developed countries, substantial disparities exist in access to mental health services for black and minority ethnic (BME) populations.	Qualitative	Twenty-six adults from BME backgrounds (13 men, 13 women; aged >18 years) were recruited to 2 focus groups.	The findings presented here highlighted how access to healthcare was a function of personal and environmental factors and the relationship between the service user and the healthcare provider.	BME service users need to be better informed to become enabled and empowered to engage with their mental health and well-being, as well as with services. Raising awareness of mental health can reduce stigma and help individuals to recognise symptoms; this may encourage health-seeking behaviour at an earlier stage of presentation.
Magadi JP, Magadi MA (2022)	Ethnic inequalities in patient satisfaction with primary health care in England	This paper aims to improve understanding of factors contributing to persistent	Qualitative	Participants – BAME and Ethnic minority groups or sub-groups 6 months studs	The findings show consistent negative correlations between the proportion of patients	Ethnic minorities should have more time for GP consultation, which may also help address this, enabling GPS to spend more time with their

		ethnic disparities in patient satisfaction in England.			reporting good (very or good) overall experience and each of the ethnic minority groups.	patients to understand their concerns better.
Author and Year	**Title**	**Aim of the study**	**Study Design**	**Sample and Population**	**Key Findings Outcomes**	**Recommendation**
Lyratzopoulos, G., Elliott, M., Barbiere, J.M., et al., 2012.	Understanding ethnic and other socio-demographic differences in patient experience of primary care	This study examined whether low scores of ethnic minority and other socio-demographic groups reflect their concentration in poorly performing primary care practices, and whether any remaining differences are consistent across practices.	Quantitative	Using data from the 2009 English General Practice Patient Survey (2,163,456 respondents from 8267 general practices), this study examined associations between patient socio-demographic characteristics and 11 patient-reported experience measures.	South Asian and Chinese patients, younger patients, and those in poor health reported a less positive primary care experience than White patients, older patients and those in better health.	Improving patients' experience in low-scoring practices would not only enhance the quality of care provided to their White patients. Still, it would also substantially reduce ethnic group differences in patient experience.

Author and Year	Title	Aim of the study	Study Design	Sample and Population	Key Findings Outcomes	Recommendation
Ekezie, W., Csabai, S., Czyznikowska, B., et al., 2024.	Health and social care experience and research perception of different ethnic minority populations in the East Midlands, United Kingdom	The REPRESENT study aims to explore the health and social care experiences of ethnic minorities and other minoritised populations, as well as their research interests and appropriate research practices.	Qualitative investigation and interviews in the health and social care research	Fifty-two ethnic minority members were engaged in group interviews and one-to-one interviews. Participants included representatives of the following groups: African Caribbean, Eastern European, Gypsy Travellers, Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual+, Refugee/Asylum Seekers, Somali and South	Three overarching categories were identified: health information, medical service experiences, health and social care concerns and health research. Health and social care services challenges were mainly attributed to discrimination, delayed services, poor cultural relevance and language and cultural barriers.	The consequence is that medical and social care research, which informs guideline recommendations and everyday clinical practice, is less generalisable and applicable to ethnic minority populations. More diverse research cohorts are essential for promoting equitable research and would ensure reductions in health outcome disparities.

				Asian communities.		
Author and Year	**Title**	**Aim of the study**	**Study Design**	**Sample and Population**	**Key Findings Outcomes**	**Recommendation**
Small, N., Masood, Y., Stevenson, F., et al., 2024.	Exploring the experiences and preferences of South Asian patients of primary care in England since COVID-19	This study aims to understand the experiences of SA patients in accessing and using general practice in the United Kingdom since COVID-19 restrictions on accessing and receiving care were lifted.	Qualitative study using focus groups and semi-structured interviews.	37 participants (from Indian, Pakistani and/or Bangladeshi background)	The findings highlight access issues split by general issues with appointment access via any remote means and (ii) specific issues related to language barriers creating additional barriers to access and care. S	Practices need to be cognisant of the importance of SA patient communication and support needs to ensure patients with specific cultural beliefs are equitably able to access their services.
Ojo-Aromokudu, O., Suffel, A., Bell, S. et al., 2023.	Views and experiences of primary care among Black communities in the United Kingdom.	Analyse studies that investigate Black participant experiences of primary care in the UK.	Qualitative interview	Participants of mixed ethnicities, where part of their heritage is of a Black ethnicity. The review included terms that	The literature shows a negative picture of primary care experiences for Black people in the UK. This has large implications for	There is a need for primary care professionals to be culturally sensitive and to champion the decolonisation of medical training. This will improve awareness of their own biases and will result in

				captured Black people living in the UK including ‘BAME’, ‘BME’ and ‘ethnic minority	discussions about health inequalities, as communities’ views and experiences of primary care will inform whether and how they engage with the healthcare system in future.	better health outcomes for minoritised groups. Interventions to improve experiences should be co-designed with the communities they are designed to help.
Robertson, J., Raghavan, R., Emerson, E., et al., 2019.	What do we know about the health and health care of people with intellectual disabilities from minority ethnic groups in the United Kingdom?	This systematic review considers the question of what we know about the health and health care of children and adults with intellectual disabilities from ethnic minority communities in the UK.	Quantitative research, evaluation or audit	Twenty-three studies were identified, most commonly focusing on South Asian communities.	The health status of people with intellectual disabilities from minority ethnic groups in the UK. They may experience barriers to accessing specialist intellectual disability services and other forms of health care.	increasing the number of South Asian staff throughout mainstream services for people with learning disabilities (35 carers; 65%) and improving cultural appropriateness of services in terms of diet, culturally appropriate activities and same-sex carers for women (26 carers; 48%); and 13 carers (24%) stated that a support network for carers from South Asian

						communities would be helpful.
Author and Year	**Title**	**Aim of the study**	**Study Design**	**Sample and Population**	**Key Findings Outcomes**	**Recommendation**
Gardner, A., Oduola, S. and Teague, B., et al., 2024.	Culturally Sensitive Perinatal Mental Health Care: Experiences of Women from Minority Ethnic Groups	Explored the experiences of ethnic minority women with National Health Service (NHS) specialist perinatal teams and identified what culturally sensitive perinatal mental health care means to this group.	This study implemented a qualitative semi-structured interview design	Participants were recruited from NHS specialist perinatal teams and online via social media.	Research has identified how ethnic minority women experience poorer health outcomes during the perinatal period.	Perinatal teams should prioritise multiagency work, as the NHS Long-Term Plan recommends, and support women in accessing peer support and activities within the community.
Saunders, C.L., Flynn, S., Massou, et al., 2021.	Sociodemographic inequalities in patients' experiences of primary care: an analysis of the General Practice Patient Survey in	This study investigated whether inequalities in reported patient experience of primary care about age,	Quantitative	A total of 5,241,408 responses over 11 survey waves from 2011 to 2017 were included in the analysis.	Younger people, minority ethnic groups, sexual minorities and people of lower socioeconomic status report poorer	Provided financial support to stimulate innovative solutions to improve primary care access throughout England. 1

	England between 2011 and 2017	sex, deprivation, ethnicity, sexual orientation, and geographical region had widened, narrowed, or remained the same between 2011 and 2017.		It was conducted twice a year from 2011 to 2016 and once in 2017.	experiences of primary care	
Bécares, L. and Das-Munshi, J., 2013.	Ethnic density, health care seeking behaviour, and expected discrimination from health services among ethnic minority people in England	To improve understanding of factors contributing to persistent ethnic disparities in patient satisfaction in the UK.	Qualitative	This study used two cross-sectional nationally representative surveys from England: The Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC) and a merged dataset of the English samples from the 2005	Ethnic minority patients in the UK continue to consistently report lower satisfaction with their primary health care in recent years.	Ease of use of the GP website relates to issues of access and language barriers. To access the GP website, patients need access to relevant devices such as laptops, smartphones and tablets.

				and 2007 Citizenship Surveys (CS).		
Szczepura, A., 2005.	Access to health care for ethnic minority populations	Evidence on access to health care by ethnic minority populations and discusses what might need to be done to improve access to services.	Semi-structured interviews	Participants were recruited from the 2001 Census	Evidence from the 2001 and earlier censuses shows that health disparities exist in the UK and that levels of long-term illness are higher in most BME groups than in the general population, especially for older age groups.	Thus, healthcare organisations and their staff must be culturally and linguistically competent. Improved responsiveness to patients' health beliefs, practices, and cultural needs is required to provide equitable access to healthcare services for diverse populations.
Petersen, J., Kandt, J. and Longley, P.A., et al., 2021	Ethnic inequalities in hospital admissions in England	The aim of this study is thus to identify ethnic inequalities in inpatient hospital admissions for all major disease	Observational study of the inpatient hospital admission database	40,928,105 admissions were identified between April 2009 and March 2014	The study found stark disparities among ethnic minorities in hospitalisation for a range of conditions. Ethnic health inequalities are well known for	Further studies would be required to map out the relevant care pathways for ethnic minorities and establish whether preventive measures can be strengthened.

		categories in England.			conditions such as cardiovascular disease, respiratory disease and diabetes.	

4.8 Chapter Summary

This chapter comprehensively examines disparities in access to healthcare services among ethnic minorities in the UK. Various studies addressed long-term conditions, adverse health, elevated morbidity and mortality rates, access to healthcare services, quality of care, mental health impacts, health disparities, public health consequences, and economic considerations.

This modified NEWCASTLE OTTAWA quality assessment Scales assist in assessing the overall quality of the studies incorporated in the review, guaranteeing a thorough comprehension of disparities in access to healthcare services among ethnic minorities in the UK.

Progressing to the next chapter on data analysis synthesis will concentrate on the recognised themes that are systematically analysed to offer valuable insight into the challenges of healthcare disparities faced by ethnic minorities in the UK.

CHAPTER 5: Data Analysis and Synthesis

5.1 Introduction to Chapter

Data analysis involves organising, altering, characterising, modelling, and interpreting data using statistical methods (Eldridge, 2023). It helps extract valuable insights from data sets, informing operational choices or directing future studies (Eldridge, 2023).

This chapter involves collecting, performing statistical analyses, and identifying patterns to quantify disparities in access to healthcare and outcomes between ethnic minority groups and the general population in the UK. It examines whether individuals from different ethnic backgrounds have equal opportunities to access healthcare services and achieve comparable health outcomes. This encompasses articulating the research question, aims, and conceptual framework that directed the study.

Measures are implemented to ensure that the study and its outcomes are credible and provide significant insights that can serve as an evidence-based reference for future interventions.

5.2 Thematic Analysis

The thematic analysis involves recognising patterns or themes in qualitative data. Braun and Clarke (2006) propose that it is the initial qualitative method to master, as it equips researchers with fundamental skills that will be beneficial for performing various other forms of analysis.

The objective of thematic analysis is to recognise significant or noteworthy themes or patterns in the data and to utilise these themes to guide the research or comment on an issue. (Clarke & Braun, 2013). This goes beyond merely summarising the data; practical thematic analysis interprets and clarifies it (Clarke & Braun, 2013).

Thematic synthesis is used in SLRS to analyse or synthesise secondary data using thematic analysis (Guest et al., 2012). This approach focuses on deriving overarching themes from multiple studies to understand a particular topic comprehensively.

Thematic analysis is better suited for qualitative data like textual transcripts or narrative responses, not quantitative data with numerical measurements and statistical analyses, because it lacks the statistical rigour necessary for quantitative data analysis and is less suitable for analysing quantitative data (Guest et al., 2012). It can also be beneficial in quantitative contexts to help researchers uncover narratives and explanations within quantitative data, improving the interpretation of numbers (Williams, 2024).

5.3 Data analysis tool

The thematic analysis framework selected for this review is Braun and Clarke’s (2006) method, a commonly utilised and acknowledged technique for analysing and reporting themes in qualitative data. Braun et al. (2022) indicated that methodically coding data, recognising patterns or themes, and interpreting their relevance gives researchers a versatile means to reveal intricate phenomena and insightful conclusions.

This technique ensures transparency in the investigation, access to health care services in the United Kingdom, and improved outcomes.

Braun & Clarke (2006) provide a six-phase guide that is a beneficial framework for conducting this type of analysis (see Table 4). However, the phases are not necessarily linear. Move back and forth between them, especially when dealing with complex data.

Table 4: Braun & Clarke's six-phase framework for doing a thematic analysis

Step 1: Familiarise yourself with the data, **Step 2:** Generate initial codes, **Step 3:** Search for themes	**Step 4:** Review themes, **Step 5:** Define themes, **Step 6:** Producing and writing a report

5.4 Characteristics of the identified studies

Themes

1. **Access to Health Services**
2. **Socio-economic Status**
3. **Health Outcomes and Prevalence of Conditions**
4. **Healthcare experiences**

a) Access Health Services

i. Stigma and Mental Health

All studies identified a negative connection in access to healthcare services among ethnic minorities in the UK. This indicates that accessing health services continues to have disparities for people from minority ethnic groups in the UK.

Nonetheless, three studies (Memon A, Taylor K, Mohebati LM, et al., 2016; Szczepura, A., 2005 & Robertson et al., 2019) reported and recognised various obstacles to accessing healthcare services, such as language barriers, cultural perceptions of health, lack of knowledge about services, and possible discrimination within health services. They also pointed out the absence of professionals in accessing healthcare services, which can result in feelings of estrangement among ethnic minorities.

Overall, both studies emphasise the need for general changes to overcome these barriers and guarantee equal access to healthcare for those who access the healthcare services. (Memon A, Taylor K, Mohebati LM, et al., 2016; Szczepura, A., 2005).

However, several studies have found disparities in access to health services due to their poor quality, which has affected the healthcare status of minority groups of adults in the UK, causing health problems and long-term conditions (Memon et al., 2016). Some research has shown that study participants felt that in their community access to healthcare services is limited and available, which limited their opportunity to have access to an individual health care plan, as geographical factors such as distance also made it difficult for them to access healthcare services due to not having access to local services (Kovandžić et al., 2011).

Robertson et al. (2019) in their study cited that people with intellectual disabilities from minority ethnic groups in the UK may face barriers in accessing specialist health and other forms of healthcare services. Many studies were identified, focusing most commonly on South Asian communities. However, very little information was identified on physical health or healthcare, with the evidence identified tending to focus on access to specialist intellectual disability services and inpatient services (Robertson et al., 2019).

However, individuals with intellectual disabilities from minority ethnic communities may encounter numerous barriers in accessing and using services, inadequate and inappropriate services may be experienced due to policies and services that are not consistently culturally sensitive, incorrect assumptions about the values of ethnic groups, language barriers and discrimination (Robertson et al., 2019).

A systematic analysis of the differences in access to healthcare service usage among individuals with intellectual disabilities in affluent nations revealed that South Asian individuals with intellectual disabilities in the UK utilise healthcare services less than white British comparison groups (Dura-Vila and Hodes, 2012). Individuals from certain minority ethnic groups may be disproportionately represented in specific services; for instance, hospital rates for intellectual disabilities are elevated compared to the average among black and mixed black/white populations (Dura-Vila and Hodes, 2012).

The studies were conducted by Kirmayer (2012) and Claeys et al. (2020), in interviews with nurses, midwives, and healthcare students regarding their views on culturally sensitive care. They indicated that professionals encountered challenges in implementing culturally informed practices, a propensity to evaluate patients from various cultural backgrounds through their artistic lens, and a scarcity of easily accessible information concerning cultural competence (Claeys et al., 2020). Edge (2011) investigated the perspectives of NHS perinatal mental health professionals on delivering services to women from ethnic minority backgrounds and the degree to which they noticed that services addressed their needs (Edge, 2011).

ii. Cultural and Language Barriers

The research conducted by Memon et al. (2016) investigates the perceived obstacles that ethnic minorities encounter when trying to access healthcare services in the Southeast of England. The research identified and emphasised various limitations, including language and communication, with language barriers being recognised as a significant difficulty, hindering individuals from expressing their needs and comprehending the services that are accessible to them (Memon et al., 2016).

Conversely, insufficient awareness of healthcare problems and resources accessible to ethnic minorities has led to the underuse of health care (Memon et al., 2016). Specific individuals were apprehensive about experiencing discrimination or unfavourable perceptions from service providers due to their ethnicity, which dissuaded them from pursuing assistance (Memon et al., 2016).

One of the difficulties users face in accessing health services is the availability of practical obstacles, such as financial issues. The research indicates that, in many cases, the impact of family dynamics and social expectations can act as a support network or generate pressure that prevents individuals from obtaining professional assistance (Memon et al., 2016).

The study highlights the need for specific interventions to address these obstacles, increase cultural sensitivity among professionals and users, and promote the reach of minority ethnic groups to access services (Memon et al., 2016).

iii. Ethnic density

Some articles claim that due to the difficulty in accessing health services, people belonging to ethnic minorities in the UK are considered worse off in lower-density areas. Therefore, higher health-seeking behaviours are expected among ethnic minorities living in neighbourhoods with lower ethnic density (Bécares and Das-Munshi, 2013).

However, if the demand for healthcare services does not increase in areas of lower ethnic density, a possible explanation could be that people from ethnic minorities living in these neighbourhoods do not have access to services for fear of racial discrimination (Bécares and Das-Munshi, 2013). To better understand the report of the Studies, there is an ethnic density effect, according to which, as the residential concentration of an ethnic minority group increases, their health complications decrease because they do not have access to health services (Halpern and Nazroo, 2000).

Therefore, associations between ethnic density and decreased morbidity have been reported for several outcomes, although reviews of the literature state that the effects of ethnic density are generally stronger for healthcare than physical health (Shaw et al., 2012; Bécares et al., 2012a).

For example, the literature on ethnic variations in pathways to specialist healthcare services reported that blacks are less likely than whites to be referred by their general practitioner (GP) to specialist services and that, of all ethnic groups with health disorders, South Asians are the least likely to be referred to specialist care (Bhui et al., 2003).

More than 54% of black people admitted to mental health units are detained under the Mental Health Act, compared to 32% of the general population (NHS Information Office, 2009). Black Africans and Black Caribbeans are also more likely to receive medication for health problems as a primary form of treatment and less likely to receive psychotherapy (McKenzie et al., 2001).

As a result, the studies suggest, using nationally representative data from England, that ethnic minority respondents who suffer from health problems and live in areas of lower ethnic density are not more likely to seek professional help (Bécares and Das-Munshi, 2013).

However, some studies and surveys report that people from Pakistan and Bangladesh occupied the lowest socioeconomic positions, had the lowest level of education and lived in the most disadvantaged areas, unlike white British people, who lived on average in the highest ethnic density.

White Irish and black Caribbean women were the ethnic groups with the lowest ethnic density. Pakistanis and Bangladeshis reported the highest rates of doctor visits in the last month (42% and 43% respectively), while white Irish reported the lowest (27%) (Bécares and Das-Munshi, 2013).

Nationally, in England, ethnic minorities suffering from accessing healthcare services and living in areas of lower ethnic density are no more likely to seek professional help, due to factors such as expected discrimination and satisfaction with healthcare environments, so more work is needed on measures of actual racial discrimination to understand this difference (Bécares and Das-Munshi, 2013).

b) Socio-economic status

i. Access to Healthcare Services

Two investigations carried out by (Saunders et al., 2021; Lyratzopoulos et al., 2011) indicated that younger individuals of minority ethnic groups and those with lower socio-economic status report less favourable experiences of primary care. In response to the NHS goals to minimise unwarranted disparities in access to healthcare, they sought to examine whether disparities in patient experience regarding primary care had shifted from 2011 to 2017, utilising information from the General Practice Patient Survey in England.

Lyratzopoulos et al. (2011 stated that by utilising data from the 2009 English General Practice Patient Survey (2,163,456 respondents from 8,267 general practices), this research investigated connections between patient sociodemographic traits and 11 indicators of patient-reported experience.

However, it has been discovered that ethnic minorities and certain other patient groups consistently report lower scores in patient surveys, but the reasons behind this remain uncertain (Lyratzopoulos et al., 2011).

The study investigated whether the low scores of ethnic minorities and other sociodemographic groups indicate their presence in low-performing primary care practices and whether any persistent differences are uniform across practices (Lyratzopoulos et al., 2011).

The research (Saunders et al., 2021) examined disparities related to age, gender, deprivation, ethnicity, sexual orientation and geographic area across five aspects of patient experience: overall experience, doctor communication, nurse communication, accessibility, and continuity of care.

In this research, linear regression was used to investigate whether the extent of inequalities varied between 2011 and 2017, utilising mixed models to evaluate changes within practices and models, not considering practice to assess national trends (Saunders et al., 2021).

Therefore, a study was conducted with 5,241,408 responses in 11 survey waves from 2011 to 2017 (Saunders et al., 2021). There was evidence that inequalities changed over time ($p < 0.05$ for 27/30 models), but the direction and magnitude of the changes varied. Changes in experience gaps ranged from a 1.6 percentage point increase for access experience among sexual minorities to a 5.6 percentage point decrease for continuity, where experience worsened for older ages (Saunders et al., 2021).

Inequalities in access to healthcare services by socioeconomic status remained stable for individuals who attended the same physician practice; at the national level, inequalities in access increased by 2.1 percentage points ($p < 0.0001$) among respondents living in more/less deprived areas, suggesting that access to healthcare services is declining more rapidly in practices in more deprived areas (Saunders et al., 2021). Ethnic minorities from disadvantaged socio-economic groups highlighted long waiting times as a barrier to accessing healthcare services. (Memon et al., 2016).

They expressed frustration that services could not quickly respond to their healthcare needs. Often, the waiting list is very long. Because there are not enough people to care for it, long waiting times for assessments and services have been identified as harming the outcome for individuals, allowing a health problem to increase in severity, the first thing is that there was a four-month waiting list before they could get any support (Memon et al., 2016).

c) Healthcare Outcomes and Prevalence of Conditions

i. Disparities in Health Outcomes

The general tendency of ethnic minorities to be disproportionately dissatisfied with their health status and the primary care they receive can be attributed to several factors such as genetics or more difficult living conditions, many often associated with health problems, which can affect patient satisfaction, to an increased likelihood of experiencing stress in general, including while receiving primary health care (Magadi and Magadi, 2022).

Furthermore, primary healthcare in the UK may not typically be fully equipped to deal with the complex healthcare needs of ethnic minorities. It may be unable to effectively meet the healthcare needs of diverse ethnic groups with different origins/cultures. Therefore, NHS services have ignored the specific needs of ethnic minority sections of the community, resulting in poor outcomes (Magadi and Magadi, 2022). Following a study into individual, practice and regional differences in patients with multimorbidity (multiple long-term illnesses) of unmet needs in the context of GP consultations and support from local services, based on the 2018 English General Practice Patient Survey (GPPS), it was found that levels of unmet needs were high, especially among specific groups that included younger patients and those from ethnic minorities (Rolewicz et al., 2020).

Therefore, it is well established that ethnic minorities are more vulnerable to a range of long-term health problems. For example, South Asians are at a higher risk of diabetes, coronary heart disease, asthma and gastrointestinal diseases. In comparison, black ethnic groups are at a higher risk of hypertension and diabetes (Petersen, Kandt and Longley, 2021).

Therefore, it is plausible that ethnic minorities dealing with a variety of health issues may not have their complex needs met and report this in their patient satisfaction ratings (Petersen, Kandt and Longley, 2021).

Generally, good access to healthcare services is often seen as one of the critical elements of quality and can be classified as a dimension of healthcare. However, ethnic minorities are more likely to experience difficulties in effectively accessing healthcare services due to their lower socio-economic status.

For example, some may not be able to afford the personal computers or smartphones needed to take advantage of the online booking system for GP appointments. Others may have to rely on public transport, which can be an undesirable experience if their family doctors are not conveniently located (Kontopantelis, Roland and Reeves, 2010). Contrary to when a patient has difficulty accessing a particular healthcare service, they may negatively evaluate the entire experience, even if the healthcare service is of good quality (Kontopantelis, Roland and Reeves, 2010).

Furthermore, multilevel regression analysis identified several service-related factors in GP surgery that explain the observed ethnic disparities. Significant factors included: ease of use of the GP website; frequency of consultation with the preferred family doctor; being treated with care and concern; confidence in managing the condition; trust in the health professional; and involvement in treatment decisions (Magadi and Magadi, 2022).

Furthermore, two factors (ease of using the GP website and being treated with care and concern) explained the observed ethnic differences in patient satisfaction (Magadi and Magadi, 2022).
Concerning ethnic disparities in hospital admissions in England (Petersen, Kandt and Longley, 2021), their research revealed significant differences between ethnic minorities in terms of hospital for various conditions, and ethnic health inequalities are widely recognised and are partially attributed to social determinants, including inadequate living and working conditions, health behaviours, discrimination, social exclusion, and factors related to health accessibility (Petersen, Kandt and Longley, 2021).

Disparities are recognised for both self-reported health as well as for conditions like diabetes, cardiovascular disease, respiratory issues, and non-specific chest pain. (Petersen, Kandt and Longley, 2021). Specifically observed among South Asian, Pakistani, and Bangladeshi populations, more than Indians, they carry a comparatively elevated risk of diabetes, coronary heart disease, asthma, and some gastrointestinal diseases.

The Pakistani population is also linked with a greater likelihood of hospitalisation due to respiratory illnesses (Petersen, Kandt and Longley, 2021).

Black ethnic populations, conversely, present a higher risk of hypertension and diabetes. Previous studies indicated a higher risk of hospitalisation for asthma among black ethnic populations. In contrast, a more recent study revealed no increased risk of hospitalisation for asthma among black ethnic groups in comparison to the white British population.

d) Healthcare experiences

i. Access to primary care health

Four studies, including (Magadi and Magadi, 2022; Ekezie et al., 2023; Small et al., 2024; Oyinkansola Ojo-Aromokudu et al., 2023), referred to the healthcare experiences as well as the research perceptions of various ethnic minority groups in the East Midlands, and the disparities in patient satisfaction with primary healthcare across England. (Magadi, 2022) The results demonstrate consistent negative correlations between the percentage of patients indicating an overall favourable experience (very or good) and each of the minority ethnic groups (Magadi, 2022).

Additional analysis of patient satisfaction distribution by ethnicity, focusing on the combined minority ethnic groups, illustrated a distinct negative relationship between minority ethnic groups and patient satisfaction at both GP and CCG levels. Nevertheless, South Asian and Chinese patients, younger patients, and those in poor health reported a less positive experience in primary care compared to white patients, older patients, and those in better health.

Ekezie et al. (2023 discovered that three main categories were recognised: health information encounters with medical services, concerns about health and social care, and health research. The difficulties associated with health and social care services were primarily linked to discrimination, service delays, insufficient cultural relevance, and language and cultural obstacles.

Contrarywise, (Small et al., 2024), in a thematic analysis performed to uncover themes in the qualitative data from a study involving 37 participants (of Indian, Pakistani and/or Bangladeshi heritage), recognised access issues categorised by general challenges with accessing consultations through any remote methods and particular problems associated with language barriers that create extra hindrances to access and care.
In contrast, Oyinkansola Ojo-Aromokudu et al. (2023) depict a bleak portrayal of primary care experiences for black and minority ethnic individuals in the UK.

This carries significant consequences for conversations regarding health disparities, as the perceptions and experiences of communities regarding primary care will influence if and how they interact with the health system going forward (Oyinkansola Ojo-Aromokudu et al., 2023).
Studies further indicate that ethnic minority patients in England continue to report consistently lower satisfaction with primary healthcare in recent years. This is mainly attributable to supply factors (related to the service) rather than demand factors (patient characteristics).
Therefore, these findings have important implications for health system policy and practice in England, both at the GP and CCG levels (Magadi and Magadi, 2022).

5.6 Chapter Summary

Braun and Clarke's framework is highly regarded for its clarity and thematic analysis, supporting researchers in uncovering deep insights within qualitative data. However, it is crucial to follow each phase carefully to ensure the study is thorough and credible. The challenges of examining disparities in access to healthcare services among ethnic minorities in the UK. Chapter 5 provides a comprehensive analysis and synthesis of data. The Braun and Clarke approach was used for thematic analysis, which helped identify and interpret patterns across various studies.

The emerging themes covered different aspects of disparities in healthcare services, such as access to health services, socioeconomic status, health outcomes, prevalence of conditions, and healthcare experiences.

The themes were explained by carefully examining individual studies, highlighting disparities, cultural factors, health inequalities, and the importance of future interventions.

CHAPTER 6: Discussion

6.1 Introduction to Chapter

This chapter thoroughly integrates the study’s results and their contributions to the discipline. Consequently, this discussion chapter examines the implications and importance of the findings shared in the earlier chapters by revisiting the research questions and summarising the main findings.

However, the broader implications of these results within the framework of current literature and theoretical models are thoroughly examined.

Additionally, any limitations faced throughout the research process are discussed, and proposals for future studies are offered to expand upon the basis of this research, along with practical advice and interventions regarding the disparities in access to healthcare services faced by ethnic minorities in the UK.

Discussion of Key Findings

a. Healthcare Access Health Services

The research conducted by Memon et al. (2016) and Bécares and Das-Munshi (2013) sheds light on the insufficiently examined domain of beliefs and practices related to disparities in access to healthcare services among ethnic minorities in the UK, particularly those facing language, poverty, and the healthcare system.

Their results highlight the stigma associated with accessing healthcare services in these groups. The unease expressed by participants, especially during consultations with physicians, emphasises structural barriers to obtaining suitable healthcare services (Memon et al., 2016; Bécares and Das-Munshi, 2013).

The comprehensive focus group discussions, guided by a thematic framework, explored various aspects of access to healthcare services, including the types of services utilised, as well as the challenges and experiences associated with using those services. Due to the selection of a specific sample of participants and the quality of the dialogue and analysis, the study achieved an adequate level of reporting power (Memon et al., 2016; Bécares and Das-Munshi, 2013).

The review emphasised that individuals from minority ethnic groups tend to experience worse health outcomes and greater challenges in obtaining healthcare services compared to the other population, regardless of the disparities in access to healthcare services (Memon et al., 2016).

Nationally representative data from England indicate that minority ethnic individuals facing in accessing to healthcare services issues and residing in regions with lower ethnic density have a higher likelihood of seeking professional assistance, resulting in a discrepancy between anticipated discrimination and contentment with healthcare settings (Bécares and Das-Munshi, 2013 and Szczepura, 2005) has pointed out that, Clearly, limited language abilities will serve as a significant obstacle to healthcare access for certain individuals.

b. Socio-economic status

Disparities in access to healthcare services among ethnic minorities in the UK are linked to their economic status. Significantly, (Saunders et al., 2021) evidence shows that minority ethnic groups, those with lower socioeconomic status, report worse primary care experiences in accessing healthcare services.

There were minimal significant alterations in the inequalities in reported experiences of primary care from 2011 to 2017, despite statutory and policy commitments to decrease disparities in care. At both the practice level and the national level, differences in patient experience continue to exist, particularly regarding age, privacy, ethnicity, sexual orientation, and geographic region. However, Lyratzopoulos et al. (2011) found that the most significant ethnic differences in patient experience were comparable in magnitude to the differences observed between patients with ‘poor’ and ‘excellent’ self-rated health (Lyratzopoulos et al., 2011).

Although South Asian and Chinese patients reported substantially more negative experiences than white patients, the differences between black and white patients were slight and inconsistent in direction (Lyratzopoulos et al., 2011).

These findings, like previous studies from the UK, suggest that language proficiency may be a determinant of ethnic differences in healthcare experiences, despite receiving the same services and reporting a worse experience (Lyratzopoulos et al., 2011).

Many ethnic minority patients in the UK are descendants of immigrants from English-speaking countries, which contrasts sharply with the distinct linguistic heritage of many South Asian and Chinese patients. However, sociocultural aspects of ethnic identity beyond language competence may also be responsible (Lyratzopoulos et al., 2011).

c. Health Outcomes and Prevalence of Conditions

Studies by Magadi and Magadi (2022) and Petersen, Kandt, and Longley (2021) have highlighted the challenges and disparities in access to healthcare services among ethnic minorities. These findings challenge existing research that highlights health inequalities, where ethnic minority patients in England continue to report consistently lower satisfaction with their primary healthcare in recent years.

This is mainly attributable to supply-side (service-related) rather than demand-side (patient characteristics) factors (Magadi and Magadi, 2022). These findings have important implications for healthcare system policy and practice in England at the GP and CCG levels (Magadi and Magadi, 2022).

Studies conducted by Petersen, Kandt, and Longley (2021) have highlighted that the high rate of disparities in access to healthcare services among ethnic minorities in the UK is causing a high incidence of diseases related to diabetes, cardiovascular diseases, respiratory diseases, and chest pain in the lives of these ethnic minority individuals. This is because they do not always have regular access to the healthcare system and spend a long time without consulting their doctors, suffering silently with this disease until it causes death or the loss of their family members.

The comprehensive findings indicate that disparities in access to healthcare services among ethnic minorities are extensive and encompass various care pathways (Petersen, Kandt and Longley, 2021). There is a well-established secondary preventive care approach within the primary and community care sectors, such as monitoring patients with diabetes or heart issues in general practice (Petersen, Kandt and Longley, 2021).

Ultimately, this research uncovered significant differences among ethnic minorities in hospital admissions for various conditions. Disparities in access to healthcare services among different ethnic groups are widely recognised for issues such as cardiovascular disease, respiratory illness, and diabetes; however, this study also identified inequalities in nutritional deficiencies, endocrine disorders, and diseases of the sensory organs (Petersen, Kandt, and Longley, 2021).

d. Healthcare experiences

Studies by Ekezie et al. (2023) have highlighted that ethnic minority populations face significant disparities in accessing healthcare services despite suffering a higher burden of disease. In contrast, this study explored the healthcare services experiences and future research priorities of ethnic and other minority populations in the East Midlands and found that challenges in accessing healthcare services were primarily linked to delays in access, discrimination, low staff competence, and information and language barriers (Ekezie et al., 2023).

Cultural constraints also made engaging in certain healthcare services activities and accessing accurate information and support difficult. Fear, mistrust, misconceptions and geographic location further influenced this (Ekezie et al., 2023).

Based on disparities in accessing healthcare experiences among ethnic minorities in the UK, Oyinkansola Ojo-Aromokudu et al. (2023) highlighted that in the UK, people with non-white ethnicities are more likely to report being in worse health and have poorer experiences of healthcare services than their white counterparts. Therefore, an individual’s propensity to access primary care is influenced by their pre-existing healthcare-seeking behaviours within and outside the UK, as well as the characteristics of the primary care system (Oyinkansola Ojo-Aromokudu et al., 2023).

It is also crucial to consider the effect of language when signing up with a GP, scheduling appointments, and comprehending the distinctions between primary and secondary care. The distrust of healthcare providers and the medical system is ingrained in primary care exchanges (Oyinkansola Ojo-Aromokudu et al., 2023).

There is an inherent social dynamic in primary care; if this is not recognised in interactions, patients will report unsatisfactory experiences. Adverse experiences in maternity care, healthcare services, and GP appointments have been linked to expectations of the service and an unfavourable experience (Oyinkansola Ojo-Aromokudu et al., 2023).

6.2 Strengths and Limitations

The systematic literature review (SLR) in this research thoroughly examines current studies on disparities in accessing health services among ethnic minorities in the UK. Adhering to a well-recognised standard like PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses), it delivers a transparent, dependable, straightforward, precise, and commonly replicated methodology without sacrificing the essence of the research.

Through a systematic investigation of databases and applying predefined inclusion criteria, the study minimises selection bias and strengthens the credibility of its findings. By incorporating a diverse range of studies addressing various topics and healthcare access methods, the review's breadth and validity are improved.

However, numerous limitations are recognised. While the study intended to gather a broad array of resources, there was a risk of publication bias since the review exclusively considered published literature accessible through specific databases. Additionally, the emphasis of the review on studies carried out in the UK only in journals might restrict the validity and relevance of the findings to other situations. Although the review identifies significant themes and trends in disparities in access to healthcare services among ethnic minorities in the UK, it might not fully encompass the intricate nature of these matters or account for possible intersectional factors. Overall, while the SLR offers valuable perspectives, future research should tackle these limitations to further enhance the understanding of these disparities in access to healthcare among ethnic minorities in the UK and why this inequality exists for this population.

6.3 Chapter Summary

This chapter examines disparities in access to healthcare services among ethnic minorities in the United Kingdom. While the research encompasses 12 studies on healthcare access, healthcare services access, socioeconomic status, health results, condition prevalence and healthcare experiences, cultural beliefs, and language obstacles, it generally indicates that ethnic minorities encounter various barriers and inequities.

The studies also offer several recommendations that utilise tailored and culturally considerate strategies to meet the specific needs in access to healthcare services of ethnic minorities.

In summary, this chapter emphasises the necessity for additional research and focused interventions to advance healthcare equity for ethnic minorities in the UK.

CHAPTER 7: Recommendations And Conclusion

7.1 Introduction to Chapter

This chapter outlines the systematic review results and offers practical suggestions based on the recognised gaps and insights. This chapter will emphasise the significance of tackling disparities in access to healthcare services among ethnic minorities in different areas of the United Kingdom.

Additionally, the consequences of the findings for studying healthcare practitioners, researchers, and community stakeholders will be examined.

In conclusion, the chapter will underscore the importance of culturally competent healthcare practices. It will propose future research directions and interventions to enhance equity in access to healthcare services among ethnic minorities in the United Kingdom.

7.2 implications of findings

The research results have numerous implications regarding disparities in healthcare services among ethnic minorities in the UK. The research emphasises the pressing requirement for organised health interventions and policies to tackle the disparities and obstacles encountered by ethnic minorities in various areas of inequalities in access to healthcare services, encompassing socio-economic status, health outcomes, prevalence of conditions, and healthcare experiences.

The findings from the research underscore the significance of culturally aware and feasible strategies in health care delivery to enhance access, quality, and health outcomes for ethnic minorities. In addition, the identified research gap emphasises the necessity for further investigation into the experiences and needs of various ethnic minority communities to create focused interventions and strategies.

Ultimately, it is crucial to prioritise access to healthcare services for ethnic minorities in the United Kingdom by ensuring that health policies, practices, and research are inclusive and address the existing challenges and barriers.

7.3 Recommendations for Practice

Given the comprehensive research study, several suggestions can be proposed to enhance clinical practice and healthcare services accessibility concerning disparities in healthcare services among ethnic minorities in the United Kingdom.

However, healthcare professionals must engage in cultural competence training to more effectively comprehend and tackle the distinct needs and obstacles encountered by ethnic minorities in different healthcare services. In addition, healthcare institutions ought to adopt policies and practices that foster inclusion, including providing interpretation services, guaranteeing cultural representation among staff, and delivering culturally appropriate healthcare and educational services.

Although existing challenges and obstacles may exist in the collaboration of healthcare professionals, the resources needed to implement these recommendations can assist in attaining the desired progress. Community-based initiatives should be created and pursued to engage ethnic minorities in educational and advocacy efforts regarding access to healthcare, which can strengthen both ethnic minorities and the healthcare access service system.

It is also crucial to consider circumstances such as unemployment, low education levels, and low income, as health should be appreciated and provided without compromising emotions and facilitated with more practical healthcare.

7.4 Recommendations for Future Research

Recommendations suggest that upcoming research should focus on the current literature's disparities (gaps) and limitations to enhance comprehension of inequalities in access to healthcare services among ethnic minorities in the United Kingdom. There is an urgent requirement for longitudinal studies featuring larger sample sizes and data to produce more solid and comparative evidence regarding the enduring effects of access to healthcare services and the advancements in outcomes related to ethnic minorities.

Moreover, studies should investigate the interplay of elements like socioeconomic status, immigration status, and healthcare services status in influencing health experiences and outcomes within disparities in access to healthcare services among ethnic minorities in the UK. Furthermore, a minimal systematic literature review has been performed in the UK to examine inequities in access to healthcare services among ethnic minorities in the United Kingdom (Khan, 2021). Furthermore, studies should highlight the voices and viewpoints of ethnic minorities themselves to guarantee that interventions and policies cater to their needs and experiences.

The suggestions also comprise employing various research methods that can assist in better comprehending the causes of disparities in healthcare services among ethnic minorities from diverse backgrounds.

7.5 Conclusion

The study explored the complex and sensitive landscape of examining disparities in access to healthcare services among ethnic minorities in the United Kingdom, analysing key aspects such as access to healthcare services, socioeconomic status, quality of care, language access, diversity, health conditions, health outcomes, the prevalence of conditions and healthcare experiences.

Through careful consideration and systematic review, a proper insight emerged that sheds light on the challenges faced by ethnic minorities in accessing healthcare services in the UK.

The discussion and studies on socioeconomic status revealed a deeply implanted taboo and sense of shame within ethnic minorities, showing that they are disproportionately affected by poverty, unemployment, and lack of educational opportunities, which impact health status.

On the other hand, a culture of silence and stigma around disparities in access to healthcare services, this cultural barrier poses a significant barrier to accessing the appropriate healthcare services, exacerbating disparities in healthcare services utilisation and outcomes. Moreover, the discomfort expressed by participants in seeking medical advice from doctors highlights systemic barriers within healthcare systems, further complicating the landscape of healthcare among ethnic minorities.

Quality of care and health conditions have arisen as another significant matter of unveiling evident socioeconomic and ethnic disparities leading to adverse outcomes among ethnic minorities. The research highlights not only the role of socioeconomic status but also the influence of racial discrimination and cultural and language barriers shaping healthcare experiences. Communication barriers and cultural insensitivity experienced by ethnic minorities further aggravate the healthcare inequities, highlighting the critical need for culturally sensitive, practical, and equitable healthcare services. Structural racism and health conditions in healthcare explored systemic biases and inadequate cultural competence within healthcare systems, contributing to delayed diagnosis and insufficient healthcare among ethnic minorities compared with the White British group.

Ethnic inequalities in health-related quality of life were accompanied by the higher prevalence of long-term conditions, poor experiences of primary care, insufficient support from local services, low self-confidence in managing their health, and deprivation. These findings align with the broader discourse on healthcare disparities, highlighting the urgent need for interventions to address racial bias and improve access to healthcare services.

Additionally, the significance of community support and trust emerged as a central theme, highlighting the importance of culturally adaptable interventions and accessible information resources in promoting healthcare services equity. A proper focus on building a healthcare services system that is proactive in addressing the unique needs of all ethnic minorities and provides equal access to resources and healthcare services is needed, for instance. With more future extended research studies, a curative finding can be examined for a better healthcare services facility for ethnic minorities and to reduce the challenges faced by ethnic minorities.

In conclusion, the research provides a comprehensive examination disparities in access to healthcare services among ethnic minorities in the UK, highlighting the complex interplay of cultural, access to healthcare services, socioeconomic, and systemic factors by identifying the issues, targeted interventions, culturally sensitive and practical healthcare services, policy reforms that can create a more constructive and effective healthcare system can be made.

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Appendix

Themes	**Sub-themes**	Articles where it was extracted
Access to Health Services	• Stigma and Mental Health • Cultural and Language Barriers • • Ethnic density	Memon A, Taylor K, Mohebati LM, et al., 2016; Szczepura, A., 2005; Robertson et al., 2019; Shaw et al., 2012; Bécares et al., 2012a; Das-Munshi, 2013.
Socio-economic Status	Access to Healthcare Services	Saunders et al., 2021. Lyratzopoulos et al., 201. Memon et al., 2016
Health Outcomes and Prevalence of Conditions	Disparities in Health Outcomes	Magadi and Magadi, 2022). Rolewicz et al., 2020. Petersen, Kandt and Longley, 2021. Kontopantelis, Roland and Reeves, 2010
Healthcare experiences	Access to primary care health	Magadi and Magadi, 2022. Ekezie et al., 2023; Small et al., 2024; Oyinkansola Ojo-Aromokudu et al., 2023