

Demographic characteristics and primary health care utilization patterns of strictly orthodox Jewish and non-Jewish patients

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Background. The importance of providing health care services that are acceptable to different cultural groups is widely acknowledged. Strictly orthodox Jewish communities have particular health care needs that reflect their religious teaching and beliefs.

Objective. To describe the demographic characteristics and health care usage patterns of the strictly orthodox Jewish population of Gateshead.

Methods. Registration and claims data were used in combination with encounter data from computerized and manual practice records. Jewish patients were identified and comparisons made between Jewish and non-Jewish populations registered at the same practices.

Results. The orthodox Jewish population was predominantly young (69% aged under 20). The birth rate in orthodox Jewish women aged 20–44 was much higher (294 per 1000) than non-Jewish women. Rates of uptake of cervical screening and childhood immunizations were significantly lower in the orthodox Jewish population. Uptake of breast screening and attendance at diabetic clinics did not differ significantly. The average number of consultations and home visits per annum was higher in Jewish than in non-Jewish patients.

Conclusions. The demographic and health care utilization patterns of orthodox Jewish and non-Jewish patients in Gateshead are different. There are implications for the provision of primary care services, particularly with regard to preventative health care.

Keywords. Primary health care, cross-cultural comparison, utilization.

Introduction

Providing health care services sensitive to the needs of cultural and ethnic groups is clearly important.¹ Gateshead, Tyne and Wear, has one of the lowest ethnic minority populations in the UK.² However, it does have a growing very strictly orthodox Jewish community of ~3000 people. Members of this community adhere strictly to Jewish law, conducting their lives according to the dictates of the Torah and Talmud. The Gateshead community is regarded as strictly devout and is renowned throughout the orthodox Jewish world for its

educational institutions. One of the few areas in which the community has contact with non-Jewish people is health care. Two orthodox Jewish doctors serve the community, but both work in practices with non-Jewish colleagues.

The strictly orthodox way of life can impact on many aspects of health and health care. On a practical level, many medicines are derived from non-kosher sources, or may cause problems with the milk and meat food laws.³ There are differences in what is considered to be appropriate for health education and prevention programmes. For example, it is not considered appropriate for young women who are not married to receive invitations for cervical screening (unpublished data).

Little published research exists about the primary care health needs of strictly orthodox Jewish people. The aim of this study was to describe the demographic characteristics and primary health care usage patterns of the strictly orthodox Jewish population of Gateshead.

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Method

Two general practices in Gateshead serve the majority of the Jewish Community. Registration and claims data from the then South of Tyne Health Commission were used, together with encounter data from computerized and manual practice records. Ethical and rabbinical approval was obtained for the study. For each data set, Jewish patients were identified (by two members of the community). Where appropriate, comparisons were made with an age- and sex-matched population of non-Jewish patients from the same practices.

Results

At the time of the study, one practice had 1414 Jewish patients and the other had 620 patients (total 2034). These practices had 3603 and 6714 non-Jewish patients, respectively (total 10 317). The orthodox Jewish population was predominantly young (Table 1).

The birth rate in 1993–1994 for women aged 20–44 years was much higher amongst Jewish women (294 per 1000) than non-Jewish women (76 per 1000) registered with the two practices. The cervical screening rate for Jewish women (60%) was significantly lower than for non-Jewish women registered with the practices (83%) (chi-square $P < 0.001$), and in Gateshead in general (83%), over the period 1989–1994.

Rates of uptake of all childhood immunizations in 1994 (diphtheria, *Pertussis*, tetanus, polio, *Haemophilus influenzae* and measles/MMR) were lower for children from appropriate age groups in the orthodox Jewish community. Rates for *Pertussis* (Jewish 63%, non-Jewish 81%; chi-square $P < 0.001$), *H.influenzae* (Jewish 54%, non-Jewish 87%; chi-square $P < 0.001$) and measles (measles and MMR Jewish 66%, non-Jewish 79%; chi-square $P < 0.001$) were markedly lower. The rate of uptake of breast screening among orthodox Jewish women in the three and a half years prior to December 1993 (69%) was not statistically significantly different compared with non-Jewish women (76%).

The prevalence of diabetes (those receiving medication for diabetes) was similar in Jewish (total 14, 1%) and

non-Jewish populations (total 171, 2%), and attendance at diabetic clinics was not statistically different between Jewish patients with diabetes (43%) and non-Jewish patients (59%).

Analysis of annual consultation rates for one practice, for the period 1993–1994, showed that the average number of consultations for orthodox Jewish patients was higher (3.96) than for the non-Jewish population (3.08). The rate of daytime home visits was markedly higher in the orthodox Jewish population (1.19) than for their non-Jewish counterparts (0.41).

Conclusion

The strictly orthodox Jewish community in Gateshead has particular primary care health needs related to religious beliefs, the age distribution of the population, health risks and use of services. The high percentage of young people and children reflects the very high value that is placed on having children within the orthodox community. Generally, Jewish law permits contraception only when medically necessary.³

The ways in which primary care services are accessed differ from the non-Jewish population. Consultation rates are higher than for non-Jewish patients. Yet the use of certain health promotion and preventative services is lower than for the non-Jewish population. The low cervical screening rate may be attributed to a perceived lower level of risk within the community. The high birth rate, and the need to observe a period of abstinence followed by a ritual bath (niddah) after any vaginal bleeding, may also contribute to the observed difference in cervical screening uptake.

Rates of uptake of childhood immunizations were consistently lower in orthodox Jewish children, despite attendance at the same practices as the non-Jewish children with which they were compared. This may be attributable in part to the practicalities of keeping up with the immunization status of several closely spaced young children in a family. Rates of uptake in other strictly orthodox communities in the UK have been shown to be variable.^{4,5} However, the low uptake of preventative health care did not extend to attendance for breast screening. This may be attributable to the

TABLE 1 Demographic characteristics

Age band (years)	Practice population orthodox Jewish	Practice population non-Jewish	Gateshead population (FHSA data 1993)
0–19	1405 (69%)	2305 (22.3%)	24%
20–64	579 (28.5%)	6067 (58.8%)	60%
65 and over	50 (2.5%)	1945 (18.9%)	17%
Total	2034 (100%)	10 317 (100%)	100%

provision of a special breast cancer education event for women in the strictly orthodox Jewish community prior to the study period.

Good health is valued very highly within Judaism.³ It is therefore surprising that the levels of uptake of certain preventative health measures, particularly childhood immunization, were so low. A detailed study of the perceptions of the community about health beliefs, existing health care services and additional services that might be useful is under way. These findings emphasize the necessity for health professionals, and those involved in commissioning and developing services, to be aware of the needs of culturally distinct communities which are not recognized centrally as ethnic minority groups.

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