Ethnicity and Healthcare Practice

A guide for the primary care team

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by

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Introduction

There is a growing body of evidence to suggest that while minority ethnic groups experience the same range of illnesses as the UK population as a whole, many within such groups consistently report worse health than the general population. There is also evidence of increased prevalence of some specific conditions within some minority ethnic groups, such as higher rates of heart disease and diabetes within South Asian populations (Sproston and Nazroo, 2000).

The precise causes of ethnic differences in health status are less well-established, although a large amount of the ill health in minority ethnic groups can be explained by high levels of deprivation (Culley and Dyson, 2005). The groups with the worst health overall (the Pakistani and Bangladeshi communities) are those who experience the greatest degree of deprivation (Platt, 2002). The extensive work of James Nazroo and colleagues has established that social and economic inequalities, underpinned by racism, are the most significant fundamental causes of ethnic inequalities in health (Nazroo, 1997, 2001, 2003). Indeed the role of racism in ethnic health inequalities is of growing academic interest both in the USA and the UK (Karlsen, 2007). Close scrutiny of ethnicity data reveals big differences within minority groups in relation to both socio-economic status and gender. Risk factors (often the focal point for interventions) are the surface causes and intervening mechanisms of wider inequalities (Bhopal, 2007).

There is also evidence that the NHS, including primary care, has not always catered well to our multi-ethnic population and does not always offer healthcare which is easily accessible and culturally competent. The evidence base on service use and quality, however, is less well developed than that on ethnic differences in health per se. Nevertheless several studies have shown that some minority ethnic users report higher levels of dissatisfaction with NHS services, especially in primary care (Department of Health, 2008) and there are some examples of serious lapses in service provision (Aspinall and Jacobson, 2004).

The UK Government has a clear commitment to reduce health inequalities, although no specific national targets have been set with respect to minority ethnic groups. Despite a range of national and local initiatives (see Randhawa, 2007), it is difficult to assess the degree of progress in reducing health inequalities in the absence of robust evaluations of many interventions. This, of course, is made more difficult by the lack of reliable ethnicity data in the NHS, especially data from primary care. A recent Healthcare Commission report pointed out that there are no data on ethnicity for 90% of all contacts that patients have with their general practitioners (Healthcare Commission, 2009).

This book aims to provide a short overview of key issues in understanding the relationship between ethnicity and health, and to provide some practical suggestions and resources for primary healthcare providers in particular to consider when working with minority ethnic communities. A book of this size cannot aim to be comprehensive, but we make suggestions for further reading and include a list of useful resources to follow up the issues discussed and related topics.

Our aim is to shed some light onto the thorny issue of how ethnicity can be addressed within community healthcare practice. As we shall see, this involves more than identifying a list of ethnic 'groups' who allegedly share the same culture and behave in predetermined ways. Ethnicity and culture are likely to be just one set of structures (among others such as age, gender and sexuality) that many of us use in making sense of our lives generally and our understandings of health and illness. Culture may play an important role in showing how individuals and groups construct their identities. Our perceptions of health and illness, how we respond to the threat of illness and to treatment regimes are all potentially influenced by the taken-for-granted ideas of our culture as well as the medical/scientific knowledge we are able to draw on by our engagement with education, the media and the healthcare system (Kelleher, 1996). This is not to deny the significance of structures of inequality or the reality of racism, but to argue for an approach which extends our knowledge of how people draw upon elements of culture to help them manage the situations they face as patients or providers. In this respect, it is important to see ethnic identity not necessarily as a 'barrier' to good health, but also as a potentially positive source of support, which can contribute to the promotion of well-being. While it is undoubtedly the case that culture may influence health in many ways, we argue in this book that we should not view culture in a deterministic way, nor should we ignore the many similarities between ethnic groups in their experience of health and illness (Culley, 2006; Phillips, 2007).

Each chapter of the book includes a brief overview of a topic, examples of good practice/resources, a list of key points and suggestions for further reading.

We begin with an important discussion of key terms. There is much confusion in the medical and popular literature on just what we mean by 'race', 'ethnicity' and 'culture' and we begin by discussing these concepts in some detail. In *Chapter 2* we provide basic data on the ethnic composition of the UK population and discuss the importance of recognising the diversity within the minority ethnic population. The main religious and linguistic groups are described and we give examples of the ways in which health beliefs might impact on the encounter with primary care services. We argue that a cultural checklist approach is inappropriate. We provide a model for thinking about culture in the interaction between patient and provider. This is followed in *Chapter 3* by a discussion of managing diversity in healthcare practice. Here we cover important organisational issues such as ethnic data collection and ethnic monitoring and make some suggestions on taking a medical history. Important changes in the law on race equality and the implications for healthcare are also outlined.

The highly significant issue of communication support is tackled in *Chapter 4*. Language differences are widely perceived by both users and providers as presenting one of the main barriers to healthcare access and to delivering a high quality service to users. We give a breakdown of language diversity and some ideas for working with professional interpreters. The significance of linguistically and culturally appropriate health information is highlighted. Specific clinical areas are discussed in the *Chapter 5*. Minority ethnic populations broadly experience the same illnesses and conditions as the White population, but there is evidence that some conditions are also particularly prevalent among certain ethnic groups. Here we explore coronary heart disease, diabetes, hypertension, cancer, hepatitis and the haemoglobinopathies (sickle cell and thalassaemia) and discuss the potential impact of culture and religion on patient attitudes to medication.

Chapter 6 explores the management of illness in the context of family and community and the use of complementary or alternative therapies. In *Chapter 7* we focus on the issue of mental health and present evidence from large-scale community-based studies, some of which challenges data on mental health prevalence based on service use. We also explore the barriers to accessing mental health services and discuss the issue of substance misuse. The book concludes in *Chapter 8*, with a consideration of the challenges faced by asylum seekers and refugees in achieving good health and accessing healthcare in the UK.

The book is focused on the established minority ethnic communities in the UK, together with refugees and asylum seekers. At the present time, there is little information about the health status and health needs of the more recent 'economic' migrants from the new European states (EU8), although anecdotal evidence suggests that knowledge of services and language difficulties may well give rise to problems accessing services. For a review of these issues from a small-scale study in Scotland, see Orchard et al (2007).

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