King's Fund

Improving the Health of Black and Minority Ethnic Groups

A guide for PCGs

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A guide for primary care organisations

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1 Introduction

1.1 Why this guide and who is it for?

Britain is now a multicultural, multiethnic society with many people speaking different languages, adhering to different beliefs and practices, eating different foods and seeing things within different cultural frameworks. This is not a new phenomenon as minority groups, predominantly of European origin, have been present for a long time. The post-war expansion policy led to the arrival of new Commonwealth citizens and, more recently, Britain has seen the arrival of refugees and asylum seekers from many parts of the world, including Eastern Europe. Many people from black and minority ethnic groups are now well settled in Britain, and arguably face less racism now than in the past. However, systematic inequalities continue to exist for black and minority ethnic groups in terms of their experiences of both health and health care.

Current Government commitment to reduce inequalities in health and the Macpherson Inquiry into the death of Stephen Lawrence provide added impetus to tackling inequalities in ethnic health. Primary care groups and trusts (PCG/Ts) are in a unique position to contribute to this aim in their roles as both providers and commissioners of health care. In addition, their board structure encourages closer working with both local authorities and community organisations in ways that is sometimes lacking in other NHS organisations.

Health inequalities exist between different socio-economic groups, age groups and by gender as well as by ethnic group. The particular challenge of addressing inequalities experienced by black and minority ethnic groups is described by the Social Exclusion Unit:

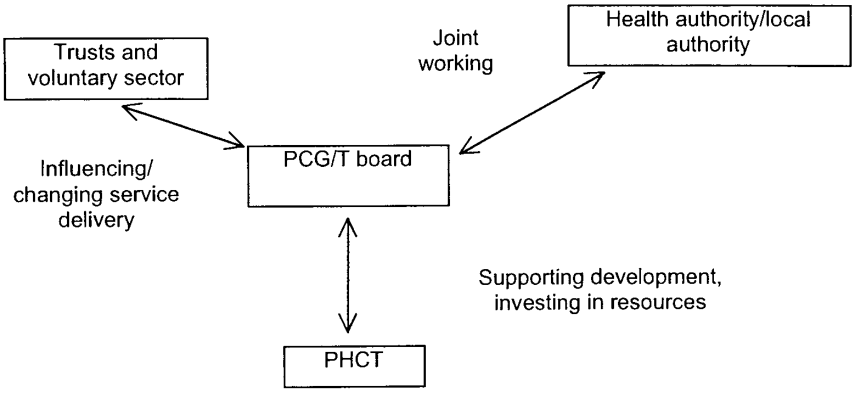
> *Ethnic minority disadvantage cuts across all aspects of deprivation. Taken as a whole, ethnic minority groups are more likely than the rest of the population to*

> *live in poor areas, be unemployed, have low incomes, live in poor housing, have poor health and be victims of crime.* (Social Exclusion Unit, 1998)

Of course, not everyone from a black or minority ethnic group experiences the same disadvantage. Ethnic groups in the UK are heterogeneous, and it is well known that particular groups have greater health needs than others. Responding to such heterogeneity means moving away from an approach that stereotypes all those from ethnic groups as passive victims, to one where health professionals and policy-makers are able to recognise and respond appropriately to social diversity in their communities. Arguably, the principles and processes required to address diversity will also benefit the majority population.

This guide is mainly aimed at PCG/T boards as they attempt to address the core Government objectives of reducing inequalities and tackling racism. It should particularly benefit those with small minority ethnic populations, who perhaps have relatively little experience of tackling this issue. Those PCG/Ts with large ethnic populations, where there has been a history of attempting to meet local needs, should also find some ideas and approaches to stimulate development. Although aimed predominantly at the PCG/T level of primary care, primary care health care teams (PHCTs) working at individual practice level should also implement many of the actions outlined. The guide predominantly focuses on those working in primary care, but they will need to work in partnership with others such as health authorities, local authorities and the voluntary sector (see Figure 1).

Figure 1: The nature of PCG/T partnerships



The Independent Inquiry into Inequalities states that:

> *...failure to make specific consideration of minority ethnic issues risks increasing ethnic inequalities by unintentionally favouring policies that benefit the ethnic majority. Thus policies to consider inequalities in health should include consideration of the application of these policies to minority ethnic groups as a matter of course.* (Acheson, 1998)

The approach taken in this guide is to highlight ways in which black and minority ethnic health needs can be addressed as part of the day-to-day functioning of primary care organisations and their constituent members.

1.2 How to use this guide

The guide is divided into five sections. The section on *Useful definitions* draws on the wealth of existing literature to provide an overview of current issues in black and minority ethnic health. It covers, albeit briefly, definitions, demography and epidemiology.

Readers familiar with definitions of race, ethnicity and health, and more concerned with finding ways of developing and implementing strategies, can move straight to Section 3, *Models for action*. This focuses on generic steps for improving the health of black and minority ethnic groups. A fourth section contains some more detailed information on *Specific diseases and client groups* as a source for reference.

This guide is intended to provide an overview, with general guidance on pointers for action. In Section 5, *Resources* – further reading, useful toolkits and web sites – are listed for those wishing to explore any aspect further.

2 Useful definitions

It is important to understand the concepts of ethnicity, race and culture to appreciate the implications of multiculturalism and diversity in British society. There is considerable ambiguity in the ways in which these terms are defined, and people may not always share the same understanding or meaning of these words.

2.1 Race

The bio-scientific concept of race is founded on an expectation of biological differences between human populations. However, all human beings belong to the same species, and it has been shown that genetic intra-racial variation is actually much greater than genetic inter-racial variation.

In the USA academics are attempting to change public understanding of the concept of 'race' from a biological one to a social one. The main argument for this is that society uses superficial characteristics – mostly physical – to create artificial groups that are then treated differently for social ends (racial discrimination). In Britain the word *race* is being replaced by *ethnicity* without any great attempt to influence public understanding of the underlying idea of 'race'.

2.2 Ethnicity

The concept of ethnicity is that human beings identify themselves as belonging to a social grouping because they differ *culturally* in fundamental ways: language, food, lifestyle, religion, beliefs and values, historical and geographical origins. An ethnic group is a social group that may share some of these features. Ethnicity is therefore primarily a social construct.

Ethnicity is not the only defining feature of an individual. People do not go through each day focusing upon the fact that they are Bengali or Afro-Caribbean. Many people have multiple ethnic identities and may choose to define themselves in a number of ways: British-Muslim, Indian, European or simply Londoner. Ethnicity, however, should not be confused with nationality or migrant status. In particular, second- or third-generation Asians or Afro-Caribbeans will be British in nationality and may see their ethnic identity as Asian-British or Black-British, although their family origins are Asian or Afro-Caribbean.

While group allegiance is dependent on *culture*, it may also encompass *physical features*. Colour, for example, is still one of the most influential factors governing societies' attitudes to members of minority ethnic groups and influencing their own self-image. In this case, the terms 'race' and 'ethnicity' are often used synonymously.

2.3 Culture

Culture, too, is a difficult term to define, as it is a dynamic entity. A simple definition covers the way people see the world and shape their behaviours, thoughts and responses to it. It covers a shared set of values: perceptions and assumptions based on shared history, language or experiences. Culture is a social construct, characterised by the behaviour and attitudes of a social group.

Culture has a profound impact on every aspect of an individual's life but affects each one of us differently. There are both visible (clothes and language) and invisible (norms, values, behaviours) aspects of culture. Culture is not something we are born with but rather something we are socialised into. Whilst the culture of the group we grew up within predominantly comes to shape and influence our behaviours and views, members of one ethnic group can (and do) adopt aspects of other cultures. Determined by upbringing and choice, culture is constantly changing and notoriously difficult to measure.

Within a cultural group there are also micro-cultures influenced by other variables like class, gender and age. Families as well as social, religious and occupational/professional groups have micro-cultures within them.

We are all members of an ethnic group, or have 'multiple' ethnic identities, and we all are subject to a range of cultural influences. Recognition of such human diversity is not harmful *per se* and, indeed, is likely to be beneficial. However, there is often a tendency for those in the majority to assume that their ethnicity and culture is the norm. This can result in direct and/or indirect discrimination against those from other minority ethnic groups.

2.4 Racism

2.4.1 The Race Relations Act 1976 – definitions

Racism is generally interpreted as the belief that some races are superior to others. The problematic nature of defining exactly what race means has already been discussed, but in the context of racism it usually refers to discrimination on the basis of physical characteristics such as skin colour. Racial discrimination occurs when someone is treated less favourably because of his or her racial characteristics.

Racial discrimination can be either direct or indirect. *Direct discrimination* includes racial abuse and harassment, as well as attempts to exclude or segregate people on the grounds of their race.

Indirect discrimination occurs when a condition or requirement is applied equally to people of all racial groups, but people of a particular racial group are unable to comply with it.

Until recently, parts of the NHS, such as small general practices, along with the police, were exempt from the Race Relations Act. The Act has since been extended to cover *all* public and statutory bodies.

Both direct and indirect discrimination are now illegal under the *Race Relations Act 1976*, although the latter may be harder to prove.

The Race Relations Act does not allow positive discrimination: an employer cannot try to change the balance of the workforce by selecting someone mainly because he or she is from a particular racial background. However, it does allow *positive action* to prevent discrimination or as redress for past discrimination. This might include providing training for people from a particular racial group, or encouraging people from that group to apply for certain kinds of work. The aim of positive action is to ensure equality of opportunity. Selection itself must be based on merit and all applicants must be treated equally.

2.4.2 Institutional racism

This phrase was first coined in the USA in 1967 to represent the systematic and more covert forms of racism perpetuated by dominant groups, social systems and institutions. It is not an indictment of individuals working within institutions, who themselves may not be racially prejudiced, but more of the systematic operation of an institution. In the UK, the Stephen Lawrence Inquiry defined institutional racism as:

> *The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin, It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people.* (Macpherson Report)

Although the Inquiry focused on the police service, it noted that:

> *It could be said that institutional racism ... is in fact pervasive throughout the culture and institutions of the whole of British society, and is no way specific to the police service.* (Macpherson Report)

2.4.3 Racial discrimination and its effects on health

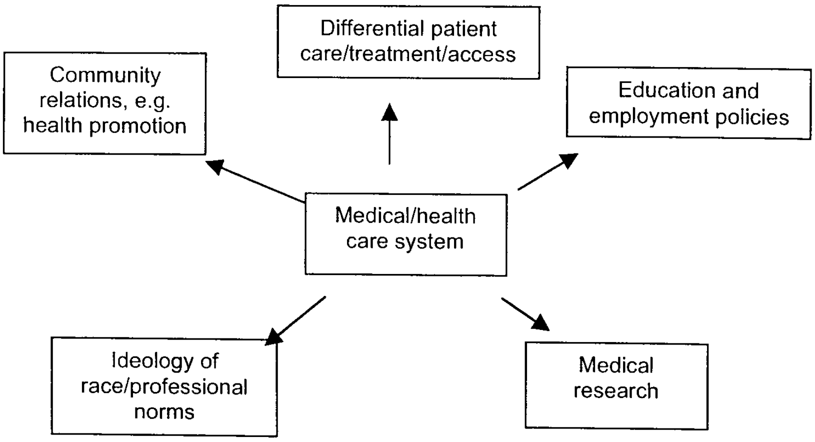
It has been argued that institutional racism and more widespread societal racism contributes to black and minority ethnic groups being over-represented among the unemployed, low income groups, school exclusions and those in poor housing. All these factors are associated with poorer health.

Overt racism from individuals is a reality in the UK today, as suggested by findings from the Fourth National Survey of Ethnic Minorities, where about a quarter of white people interviewed admitted to racist feelings against those from Asia, Africa or the Caribbean. Statistics recorded nearly 12,000 racist incidents reported to the police in 1994–95, compared with about 4000 in 1988. This is likely to be the tip of the iceberg: the 1992 British Crime Survey estimated that in 1991 there were 130,000 racially motivated crimes against Asians and Caribbeans. Racism contributes to a climate of anxiety and fear. Nearly a quarter of all minority ethnic respondents in the National Survey worried about racial harassment. Such concerns can lead to increased social exclusion, have a major impact on lifestyle and contribute to stress-related illness (Nazroo, 1997).

2.4.4 Racial discrimination in health care

The health care system is no less vulnerable to *institutional racism*, which may operate in several different dimensions to either exclude minority groups or favour white majority groups. The ways in which institutional racism can occur in health care are illustrated in Figure 2.

Figure 2: Dimensions of institutional racism and health care



Source: King, 1996.

There are three aspects to addressing institutional racism. These are:

- auditing systems and processes within an organisation
- changing to a more inclusive organisational culture
- challenging individual attitudes and behaviour.

Addressing institutional racism will lead to organisations that are 'culturally competent'. An approach to achieving such competence is through *mainstreaming.* This has been defined by the Department of Health as a:

> ... *means of automatically considering the race equality dimension of everything that is done. Getting there involves equipping staff with the skills, knowledge, expertise and attitudes to do this so that they take responsibility for this as part of their professional practice.* (Alexander, 1999: 4)

This contrasts with the notion of *special provision,* whereby services are established specifically for the use of minority ethnic groups but not integrated into core funding, planning and service development. To some extent specialist provision has its place, in that it provides a chance to pilot and develop innovative services, often using non-core funding. However, this approach means that services are often vulnerable to financial cuts, lack a sense of permanency because of relatively short-term funding and, consequently, staff morale may be low. Staff development may be more limited, and those involved in delivering special services often lack the status of those working in mainstream services. It may also result in piecemeal projects or packages, without ever stimulating a more strategic approach to the issue. Finally, it has been argued that this is a way of absolving mainstream services of any responsibility.

Thus, mainstreaming seems to be a more favourable approach, and has been adopted by the Department of Health. However, in the long list of competing issues, minority ethnic health issues may get 'lost' and become lower priority, particularly in areas with smaller ethnic populations.

Leadership and senior level commitment are vital to the success of a mainstreaming approach, in considering opportunities for reducing disadvantage and in taking account of local diversity in *all* policies and planning processes.

2.5 Minority ethnic populations in the UK – who they are and where they are

There has been a long history of migration to the UK, dating back to medieval times or even earlier. The contemporary ethnic character of Great Britain has been shaped in the last two centuries. In the 19th century, most migrants came from Australasia, Canada and Ireland, although smaller populations of South Asians and Chinese also arrived. In the latter part of the 20th century, in response to labour shortages in Britain, active migration from the New Commonwealth countries of the Caribbean, India and Pakistan took place. The Immigration Act 1962 marked the end of large-scale immigration from these former colonies. Since the 1970s, there have been small waves of migration, such as East

African Asians and Cypriots fleeing expulsion and civil war. More recently, small populations from Eastern Europe and parts of Africa have arrived from areas of political strife and conflict. Many black and minority ethnic groups now include a sizeable second-generation population who were born in the UK. However, data from the Fourth National Survey of Ethnic Minorities suggests that that the health of the second-generation black and minority ethnic groups may be slightly worse than that of their migrant parents. People who have survived migration are likely to be more healthy than those who have not (the 'healthy migrant' effect), but other explanations for this finding include different health behaviours and environmental influences during early life.

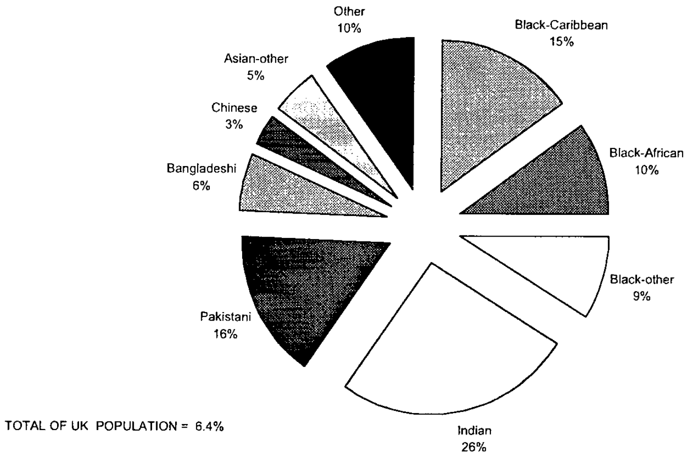
At national level, data on minority ethnic populations is collected via the population Census carried out every ten years and via the Labour Force Survey, which uses the same categories used in the 1991 Census. These categories are to be slightly refined for the 2001 Census. There are obvious weaknesses in this categorisation, including the lack of specific reference to white ethnic groups, such as white Irish or white Scottish populations and the exclusion of travellers as a distinct group. Within any one ethnic group there will be many ethnic sub-groups, differing in culture, language and religious beliefs. However, the categorisation provides a reasonable data source for quantifying the main black and minority ethnic populations, both nationally and at local level.

Ethnic group categories used in the 1991 Census and Labour Force Survey:

White
Black-Caribbean
Black-African
Black-other
Indian
Pakistani
Bangladeshi
Chinese
Other – describe

The latest estimates, based on the 1997 Labour Force Survey, suggest that there are about 3.4 million people living in Britain who consider themselves to be from a minority ethnic group. This represents 6.4 per cent of the population. Figure 3 shows the breakdown of this by ethnic group category. This is likely to be an underestimate of the true minority ethnic population because the Labour Force Survey takes place in private households only. Therefore groups such as travellers, refugees and asylum seekers are likely to have been excluded.

Figure 3: Minority ethnic groups by category, based on 1997 Labour Force Survey data



Source: Schumann, 1999.

Most minority ethnic populations are concentrated in urbanised parts of the country. Nearly three-quarters of the minority ethnic population is located in Greater London, Greater Manchester, West Yorkshire and the West Midlands. This distribution of black and minority ethnic populations does not, however, mean that the health of these groups should be the sole concern of the big cities. The myth of 'there aren't any/we're not London or Bradford or Birmingham' has been described as needs-denying. Failure to recognise that small black and minority ethnic populations have specific needs can mean that they are further marginalised and remain invisible to health and other services, thus perpetuating the perception that 'there aren't any here'.

Health planners and providers have a responsibility to address the needs of the most vulnerable, not just those in the greatest majority. Furthermore, economic factors and policies such as dispersal of asylum seekers may mean that minority ethnic groups will be increasingly spread around the country.

The age profile of black and minority ethnic groups indicates that they are younger populations than the majority population. This means that current service provision for these groups needs to focus on children, young mothers and preventative health measures. Of equal importance, however, is the need to plan future services for an emerging 'ethnic elder' population, projected to rise by a staggering 100–200 per cent over the next 15 years in London alone.

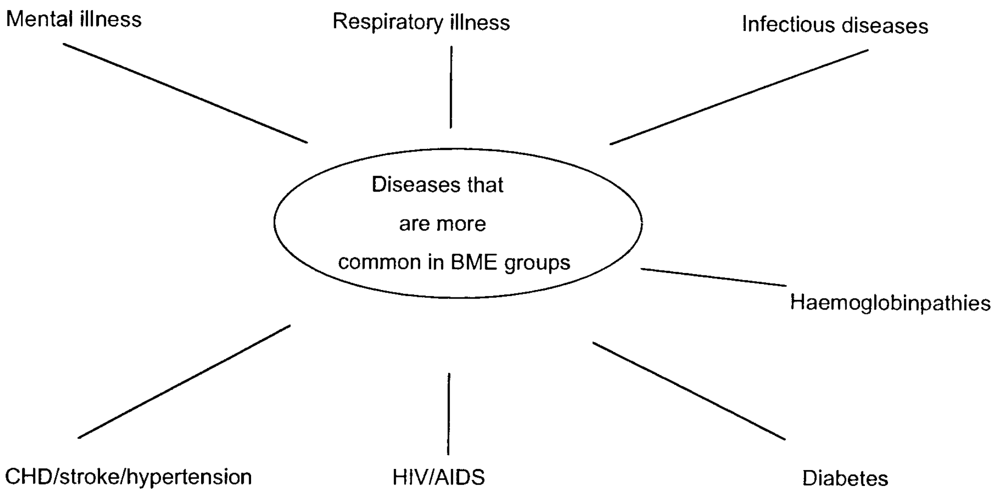
2.5.1 Patterns of health and disease in black and minority ethnic populations – similarities and differences

A growing literature exists on health inequalities experienced by those from minority ethnic groups when compared to the majority population. Local surveys of (self-reported) morbidity and the more recent National Survey findings are consistent with the impression that, for relatively young populations, people from black and minority ethnic groups experience a greater than expected burden of ill health.

The diseases causing the greatest burdens for minority ethnic groups are the same as those experienced by the white majority population in the UK. These are cardiovascular disease, diabetes, cancer, mental illness, accidents and respiratory diseases such as pneumonia, asthma and bronchitis. While cancer rates tend to be overall less common in minority ethnic groups when compared to the white population, in absolute terms they are still a significant cause of morbidity and mortality.

There are some conditions that are more specific to minority ethnic groups. These include the haemoglobinopathies, which have a genetic basis. Infectious diseases, notably tuberculosis, are also much more common in minority ethnic populations. Section 4 summarises the information on some of the important diseases presented in Figure 4 below.

Figure 4: Diseases that cause the greatest burden and/or disproportionately affect black and minority ethnic groups

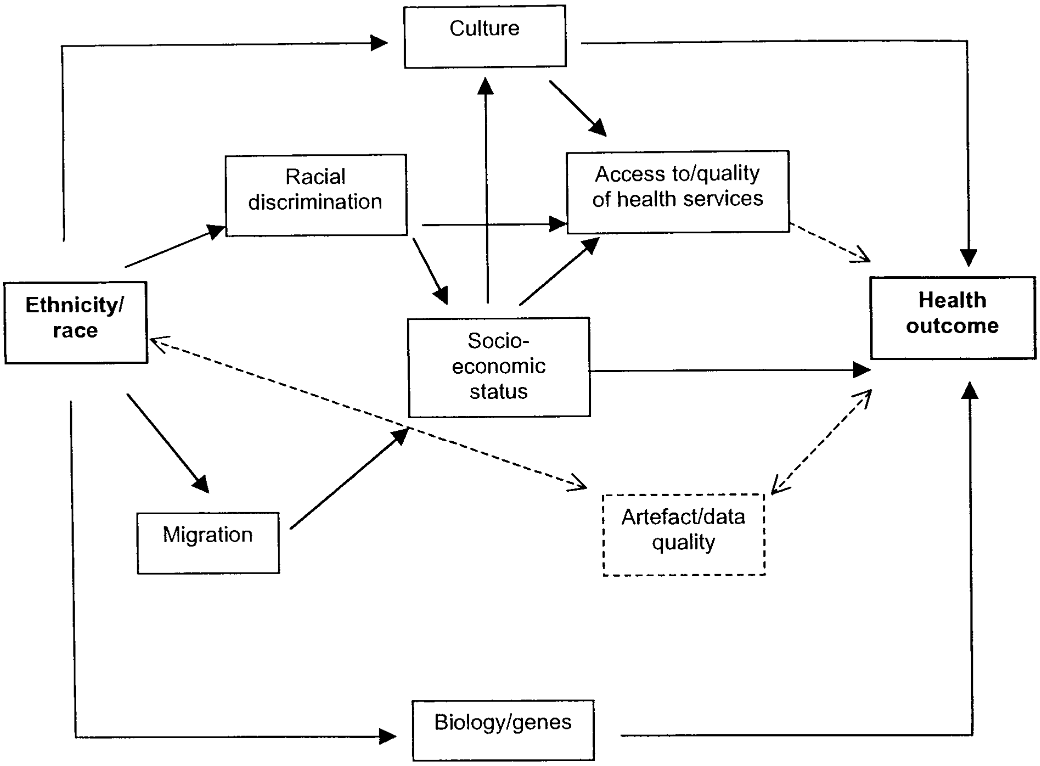


Source: London Ethnic Health Network. Internal communication.

2.5.2 Explaining variations in disease patterns

The Fourth National Survey identified several influences on health outcomes, as illustrated in Figure 5. The relationships are complex, and several different factors are likely to interact to influence health outcomes.

Figure 5: Understanding the relationship between ethnicity and health



Dotted lines represent possible explanations for differences in health status that were not assessed by the National Survey.

Source: Nazroo, 1997.

Generally, belonging to a certain ethnic group *per se* does not directly lead to better or worse health. There are a few diseases or conditions, such as the haemoglobinopathies (thalassaemia and sickle cell disease for example) that are strongly associated with particular ethnic groups because of their genetic basis. However, research increasingly shows that a considerable proportion of ill health in black and minority ethnic groups is more closely linked to their socio-economic status, environmental and employment conditions.

Unemployment by ethnic group

White	6%
Indian	8%
Black	9%
Bangladeshi and Pakistani	21%

Source: Khan, 1997.

It has been argued that over-representation of black and minority ethnic groups in lower socio-economic classes, poor housing and unemployment reflects wider societal racism.

Use of health services and treatments is partly affected by patients' health beliefs, which are shaped by cultural influences. Although some cultural influences and health beliefs may seem to be at odds with those held by health professionals, within every culture there will be norms and values that also promote good health; health professionals need to learn to work with the positive aspects of different cultures, and not just concentrate on perceived cultural barriers.

Minority ethnic groups experience several barriers to accessing health care services, which may in turn affect health outcomes. For example, South Asians may be less likely to receive angiography or coronary artery bypass grafts (CABG) and may experience delays in referral for CABG. Reasons for such differences are not completely understood, but it is not solely due to reluctance by patients to undergo these procedures. Poor quality or lack of accessible information and negative experiences of the health care service may be contributory factors.

Barriers to service uptake

- Language and communication difficulties
- Poor English equated with lack of ability (negative attitudes of health professionals)
- Lack of confidence in the service
- Lack of appropriate information – including knowledge about services
- Lack of sensitivity to religious and cultural needs
- Racism or prejudice in service delivery
- Negative previous experiences of the health service
- Different health belief systems

In primary care, high consultation rates have been reported amongst Asians generally and amongst Caribbean women, although lower rates of use have been found for elderly Indian and young Pakistani women. Significantly lower use has also been reported for the Chinese population and for Africans. It appears that people from ethnic groups consult more in those categories of disease for which they experience higher morbidity and mortality.

Paradoxically, poor communication could account for both high and low levels of consultation with a GP. This is dependent on whether the initial experience discourages the patient from future attendance or whether they need to make several repeat visits to resolve their problem.

Average waiting times to be seen by a GP

Ethnic group	*Mins*
Bangladeshis	50
Pakistanis	33
Indians	30
African-Carib	27
Average UK	18

Source: Health Education Authority, 1994.

Average waiting times in GP surgeries indicate that those from black and minority ethnic groups tend to wait longer to see their doctor. Many black and minority ethnic patients are registered with a GP from the same ethnic group, which helps to overcome language barriers. However, a higher proportion of black and Asian GPs run surgeries on a 'drop-in' basis than the UK average, and are single-handed, which may explain the longer waiting times (Goddard and Smith, 1998). Choice is also limited in other ways. For example, female patients may go to a male doctor who can speak their language rather than a female one who cannot, but cultural norms may make it difficult for the male doctor to address certain aspects of women's health. A recent national survey of NHS patients showed that only 64 per cent of patients who thought it important were always able to see a GP of their own sex. Eighty one per cent of those who thought it important were always able to see a GP of their own ethnic group (Airey and Erens, 1999).

3 Models for action

Progress has been made in identifying and addressing the specific needs of black and minority ethnic groups but it is perhaps slower than expected or hoped for, partly because of considerable organisational barriers to change. Primary care groups/trusts, although enthusiastic to deliver effective and accessible care, may also face such barriers. Typical issues are listed in Figure 6.

Figure 6: Barriers to action

Problems commonly raised	**Possible responses and solutions**
We (PCG/Ts) are on a steep learning curve and we have other priorities to address.	The health of minority ethnic groups should be integrated as far as possible into other aspects of PCG/T learning, development and priorities.
Diversity is not a top priority because there aren't many people here who are from black and minority ethnic groups.	Numbers alone are not the only determinant of priorities. Everyone is entitled to fair access to health care and the right to opportunities for better health – this is a founding principle of the NHS, re-emphasised in current Government policy.
We lack the resources.	In some cases, extra resources will be required, but often it is about changing the way things are done. Where resources are needed, the extra investment may outweigh the costs of not doing anything. There may also be ways of pooling or sharing resources with other agencies or the local community. Some extra 'pots' of money are available through, for example, Health Action Zones, Healthy Living Centres and Single Regeneration Budgets. As these are time-limited, plans to sustain services in the long term need to be considered.

Responding to black and minority ethnic needs is special pleading – we need to respond to the whole population's needs.	The PCG/T has a responsibility to its entire local population. It also has a responsibility to meet the needs of the most vulnerable and disadvantaged, which often include people from black and minority ethnic backgrounds. Service improvements for these groups should have knock-on effects for the rest of the local population. It has been argued that the national targets set in *Our Healthier Nation* will not be achieved if adequate consideration is not given to improving the health of those who suffer the most ill health.
We don't know where to start and we're concerned that we might offend people.	There is a wealth of information and intelligence available. You should avoid re-inventing the wheel! No-one knows everything, and skills in understanding and solving complex problems are just as important as 'cultural knowledge'.
We are not used to working with local communities and the voluntary sector.	One of the key concerns of statutory agencies is how representative local voluntary organisations or community leaders are of their communities. Local authorities, health authorities and other funding bodies should have useful intelligence on voluntary organisations. Often, those in the voluntary sector are not used to the language and culture of the statutory sector and may be more used to focusing on the needs of their members. Some attention should be paid to strengthening the capacity of the voluntary sector to work effectively with the statutory sector.
We've been working on this for years – before PCG/Ts came along; things move really slowly.	This is a long game, particularly against a background of organisational change. A clear vision and good leadership, with realistic milestones, feedback and evaluation are all important. Things do change!

Acknowledgement of the complex nature of ethnicity and health, a sound strategic approach that is followed through and commitment to stay the course are important prerequisites for success.

3.1 Getting started

3.1.1 Developing a strategic approach

A strategic overview of what you want to achieve and how you are planning to do it is important. It has been suggested that in the context of a mainstreaming approach, there should be a comprehensive management strategy that sets out strategic goals, plans and resources (money and staff) for implementation.

✓Action point

Does your organisation have processes to review policy and procedures systematically to assess their relevance for delivering culturally competent services?

A number of PCG/Ts have established sub-groups, such as ethnicity task groups, equal opportunities groups or inequalities groups, to develop and lead on the implementation of such strategies. The group is usually led by a PCG/T board member with an interest in this subject. Some PCG/Ts may choose to develop a separate strategy to address black and minority ethnic needs. This certainly seems to help in driving change, as a separate strategy can contain more detailed milestones and objectives. Other PCG/Ts may choose to ensure that other key strategic documents include reference to this issue. Such documents include:

- the Primary Care Investment Plan
- the Health Improvement Programme
- the clinical governance action plan
- the user involvement strategy
- the Information Management and Technology Strategy
- the Annual Accountability Agreement.

In Peterborough, the equalities manager based in one of the PCG/Ts is about to undertake an audit to assess the extent to which black and minority ethnic issues are reflected in key PCG/T documents and strategies. The impetus for this has come from the local council, which has already undertaken such an audit.

3.1.2 Core values

An important part of strategy development is to identify a set of core values that will underpin services and provide a clear, explicit guide for action. A statement of core values developed by the PCG/T that articulates its principles, rationale and values for culturally competent services is crucial to the process. The box below sets out an example of some guiding principles that might be used for developing such a statement. These were developed by listening to and sharing stories between GPs, district nurses, social workers and health service managers.

Explicit value statements help to define the ethos and culture of an organisation. A useful way of developing such a statement is to bring together members of a multidisciplinary group or team to share experiences and discuss core values and guiding principles.

Example of guiding principles for PCG/Ts and PHCTs

- A colour blind approach suggests prejudice:
  - we need to recognise that different people have different requirements – it is better to ask than to assume we understand and know everything
  - one person is enough – everyone is entitled to fair access and appropriate health care services.
- We cannot deliver appropriate services on our own:
  - making connections and building up links is core business
  - local (non-statutory) community organisations can help.
- Organisations are discriminatory:
  - if there are unequal patterns of care we should assume these to be due to discrimination until proved otherwise
  - it is an organisational/management requirement to uncover and engage with discrimination at the individual and institutional level
  - feedback mechanisms are needed to link individual and organisational learning.
- Communication is key to service delivery:
  - information enables individuals and organisations
  - advocates address imbalances of power.

Source: Fischer, 1999.

The PCG/T board will need to give some time to this as part of its development agenda. There may already be opportunities within the model of board meetings adopted by the PCG/T (for example awaydays or strategic/development meetings rather than business meetings) to review this.

Core values need to be reflected in actions, systems and processes. PCG/T strategic documents, action plans and monitoring arrangements should therefore include some reference to cultural diversity.

3.1.3 Monitoring, evaluation and accountability

Measuring progress is an important part of successfully implementing strategies. Being able to demonstrate success within the organisation is an important motivator. Some of the action points in this section (based on recommendations for primary care organisations in the USA) may be useful indicators for PCG/Ts and PHCTs.

Milestones by which to measure progress should include some basic structural and process indicators as well as outcome-based indicators. In deciding what indicators would be appropriate, careful thought will need to be given as to:

- what information it is important to collect
- how feasible it is to collect it.

Birmingham Health Authority's Action Plan for Black and Minority Ethnic Groups covers the following areas:

- understanding community needs
- commissioning and contracting
- Health Improvement Programme local targets
- organisational development.

The Action Plan contains targets and milestones relevant to PCGs and their staff, and cross-references to HImPs, PCIPs and clinical governance plans.

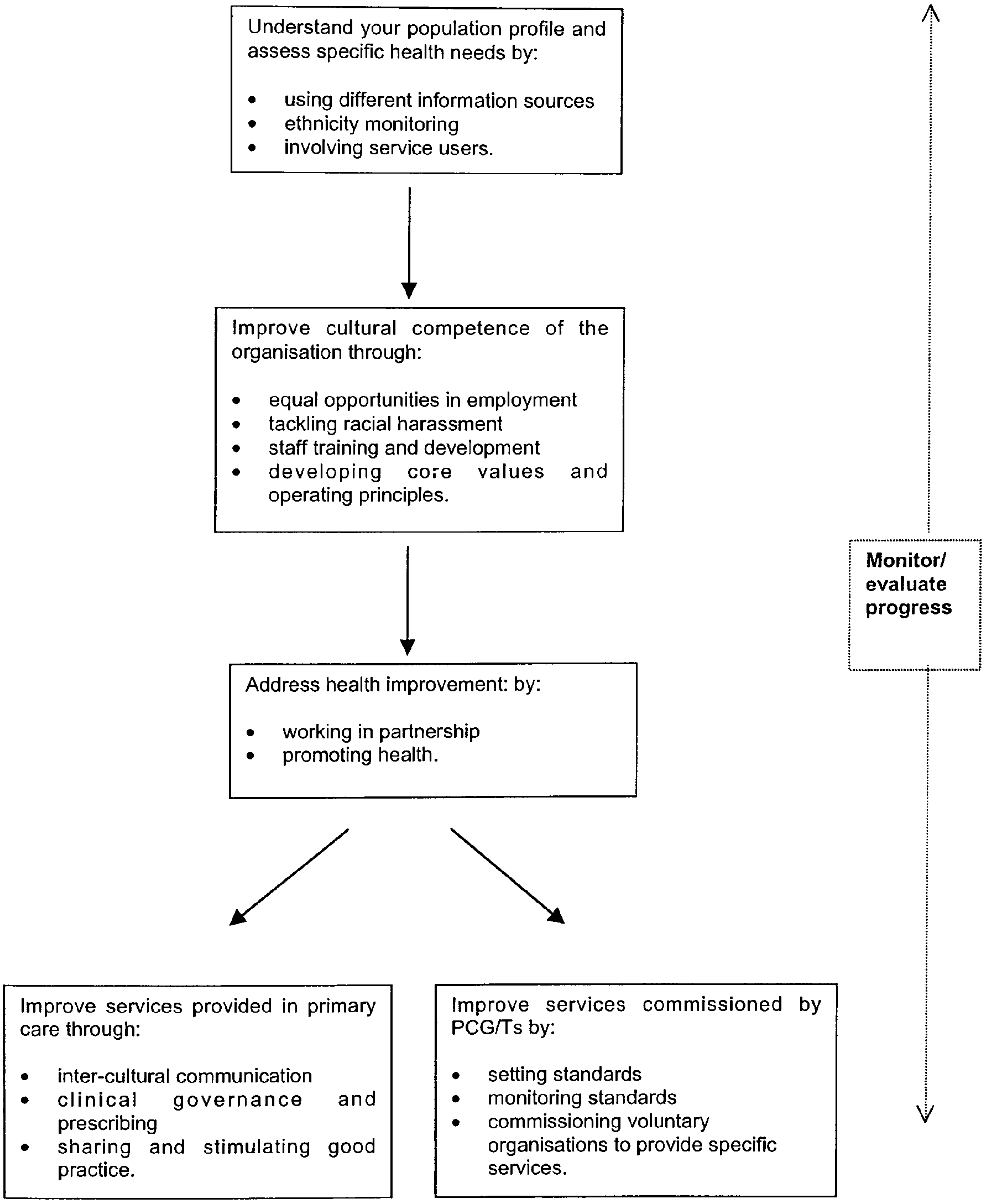
For example, health authorities may agree with their PCG/Ts to evaluate how ethnicity monitoring data are used rather than focus on what is being collected. Internally, the

PCG/T may set milestones for developing effective systems and processes across all practices for ethnicity monitoring purposes.

3.1.4 Developing an action plan – important steps

A strategic approach to improve the health of black and minority populations should include the steps set out in Figure 7. These are discussed in greater detail in the rest of this section.

Figure 7: Steps for turning intention into action



Understand your population profile and assess specific health needs by:

- using different information sources
- ethnicity monitoring
- involving service users.

Improve cultural competence of the organisation through:

- equal opportunities in employment
- tackling racial harassment
- staff training and development
- developing core values and operating principles.

Address health improvement: by:

- working in partnership
- promoting health.

Improve services provided in primary care through:

- inter-cultural communication
- clinical governance and prescribing
- sharing and stimulating good practice.

Improve services commissioned by PCG/Ts by:

- setting standards
- monitoring standards
- commissioning voluntary organisations to provide specific services.

Monitor/ evaluate progress

3.2 *Understanding your population profile and assessing health needs*

3.2.1 Using different information sources

In order to improve the health of the local population it is essential to understand who they are, where the burdens of disease and illness are greatest and how these can best be reduced. This is the essence of health needs assessment. GPs and primary health care teams are close to the communities they serve, giving them invaluable insight into the health needs of their patients, but they tend to only see those who 'walk through the door' and demand health care. They may not be aware of those in their population with unmet needs. Also, health care professionals' perceptions of where the biggest gaps in service lie may not always coincide with patients' views on this.

✓Action point
Does your organisation have policies and procedures to review periodically current and emerging demographic trends for its area?

Traditional methods of health needs assessment are well developed and skills can be found in public health departments of health authorities. Health professionals based in the community, such as health visitors or district nurses, are also valuable sources of information and may have such skills.

Techniques for assessing needs of hard to reach groups

- Routine data from the Census, local authorities and possibly trusts
- Snowballing: certain individuals/key informants are used to identify other people to contact
- Specific registers, e.g. ethnicity monitoring
- Collecting information directly – more usually verbally, e.g. a focus group, but questionnaires (appropriately translated) may also be used

Source: Wright, 1998.

The first step is to establish a population profile that includes a breakdown by ethnicity, age and gender. The Census is usually a good starting point, but becomes out of date quickly and is limited in its categorisation. In the NHS, trusts are required to collect ethnic data, but for a large proportion of patients this is recorded as 'not specified'.

In primary care, although ethnic monitoring has been piloted for over a decade, there is currently no requirement to carry it out (though this is under consideration at the moment). In the mean time, other sources of information that PCG/Ts have used include surnames on practice registers and/or data from schools.

North Lambeth PCG recently carried out a profile of the local Portuguese population. Sources of data included:

- the Census
- the Portuguese Embassy
- GP receptionists and practice managers
- GP registers using surnames.

3.2.2 Ethnicity monitoring in primary care

Existing sources of information on ethnicity all have their limitations. One way of improving this is to introduce ethnicity monitoring into primary care in order to:

- develop a more accurate profile of the practice population, and thus identify population needs
- identify individual needs of patients and specific cultural aspects that might influence their medical care
- help equitable distribution of resources (ethnicity may eventually be included in national resource allocation formulae).

A number of nationally-funded projects have looked at how the benefits of ethnicity monitoring in primary care can be optimised, and the costs minimised. Participating practices have generally found that the collection of ethnicity data is not as problematic as some thought. Staff training and good patient information were important in asking about what could be perceived as a sensitive issue. Stressing to patients the confidential nature of the information being asked and explaining why it was being collected were particularly important.

As well as ethnic origin, questions commonly asked include:

- religious and cultural needs:
    - preference for a male or female health professional
    - particular times of year when it might be difficult to take medicines
    - particular diet required is referred to hospital
- language needs:
    - is an interpreter required? If so, in which languages?
    - does written information need to be provided in different language(s)?
    - does information need to be provided in other ways, for example pictures or videos?
- advocacy needs
- refugee/asylum seeker status
- specific health beliefs and use of other health care systems.

The collection of such information allows practices to manage patient care more effectively and efficiently, tailoring services to meet their patients' needs. An example of ethnicity monitoring in primary care, the Brent Primary Care Ethnicity Project, is described in the box overleaf. One of the chief successes of the project was that the training programme introduced as part of ethnicity monitoring helped to raise cultural awareness and allowed staff to explore wider issues in ethnicity, health and health care.

Primary Care Ethnicity Monitoring Project (PCEP) – a pilot project in 15 practices in Brent & Harrow

Staff training
The PCEP training programme for ethnicity monitoring included general rating on cultural awareness and ethnicity. Training sessions had PGEA approval as an incentive for GPS to attend. GPs themselves did not necessarily attend the training programme – other members of the practice team often represented their practice. However, commitment and support from the GPs was very important for all staff. Staff who attended the training were expected to feed back to their practices at practice meetings.

Deciding what information to collect
Considerable effort went in to designing a template for data collection. The template tried as far as possible to map categories for ethnicity, language and religion onto existing Read codes. The template was piloted in three practices before being rolled out to the others.

Deciding how to collect information
For the most part, information was collected through a self-completed questionnaire accompanied by patient information leaflets. The questionnaire was also administered by practice nurses, GPs and trained receptionists. The questionnaire included the option to NOT complete the questions.

Deciding where to start
Different practices started at different levels – some with patients attending for health checks, some with new registrations. Practices chose to start in a way they felt comfortable with. One practice did a mailshot to those on their list, so as to capture the ethnicity of those registered who may not attend the practice frequently.

Using the information
Data collection allowed practices to obtain a better understanding of their population profiles. A number of practices were surprised at the (larger than expected) size of their minority ethnic populations. Several practices identified small pockets of minorities within their populations, and are considering how they can work together to make use of economies of scale. Some practices are now linking their ethnicity data to improving the management of specific diseases such as diabetes.

Data retrieval skills are important to make full use of the information. Work has been commissioned to develop queries for MiQuest, so that practices can interrogate their data in more sophisticated ways. For example, it may be possible to track whether diabetic patients from certain ethnic groups have poor access to dietary advice and other services like chiropody.

3.2.3 Involving service users

✓Action point
Does your organisation have structures and processes to ensure representative user and community participation in the planning, delivery and evaluation of services?

Primary care groups/trusts are expected to involve users in planning and evaluating services. Information can be collected quantitatively and/or qualitatively. The latter is increasingly important in understanding why certain services, even when provided, fail to meet the local population's needs. Many PCG/Ts have established a user involvement group to address this (often led by the lay member). A user involvement strategy needs to include reference to working with groups that might be 'hard to reach'. This is likely to include some black and minority ethnic groups whose first language is not English. In areas where there are relatively small numbers of people from a minority ethnic group, their needs may not be easy to identify within the population as a whole. PCG/Ts, because of their size, should be able to pay more attention to minority groups that form a large part of their population but that are only a small part of the overall health authority population. Population profiling should have helped to identify ethnic groups within the PCG/T population. The next step is to find ways of engaging with such communities. Religious or community leaders are often a useful first point of contact. However, it may depend what question is being asked. For example, for issues relating to childbirth or pregnancy, it would be important to find out what young women think.

Assessing health needs using qualitative methods – an example from East London

GPs in Newham, where there is a large Asian population, commissioned a mental health needs assessment of young Asian women. They were interested in the management of deliberate self-harm (DSH) because there is some evidence that (nationally) suicide rates in young Asian women are higher than would be expected. The assessment used qualitative techniques, such as focus groups with young Asian women, GPs and mental health service providers, as well as in-depth interviews with women who had self-harmed.

The study found that service providers believed that the main reason for DSH in this group was due to 'culture-conflict' (balancing family traditions against the influences of Western culture to which they were exposed). However, the young Asian women interviewed did not share this view. They identified a lack of information about available services, along with a sense of not being understood and being stereotyped or stigmatised by health professionals, as barriers to using mental health services that should have been able to help them. For some women, culture-conflict was a real issue, but by assuming that this was the main cause of DSH in this group of women (and therefore not one that health services could address), providers ignored the scope for other effective health service interventions.

There may be small community groups or projects in the area, some of which might have been funded through Joint Finance, and would therefore be known to the health authority and local authority. Often a good starting point for contact with the voluntary sector is the local branch of the National Council for Voluntary Services. The PCG/T board lay member should have links into local voluntary networks, and possible ideas about where local community groups might meet formally or informally.

There are a variety of methods available to promote user involvement. The one(s) chosen will depend partly on the information being sought and the resources available. PCG/Ts are beginning to make use of a range of methods, including stakeholder events, focus groups and community meetings using a minority ethnic facilitator. When these work well, they produce good information that can sometimes surprise GPs and other health care staff. However, meetings that work well usually need careful thought and planning. Some key questions to ask are listed in Figure 8.

Figure 8: Organising a public involvement event – key questions to ask

- Is any information you intend to disseminate written in plain English and translated into appropriate languages?
- Have you 'advertised' your meeting in places where people from minority ethnic communities are likely to go (e.g. local shops, cafes, clubs, places of worship)?
- Will your chosen venue be acceptable and accessible to all potential participants? Sometimes it might be more appropriate to go to, for example, a day care centre, rather than expect people to come to you.
- Will the timing suit participants? Working people will be less likely to attend during the day, but young mothers and children are unlikely to go to an evening event.
- Do participants require training, confidence building or advocacy to take part?
- Will resources be available to provide, e.g. a trained facilitator, interpreter, crèche facilities, travelling expenses, or to cover carers' costs?

Adapted from NHSE Northern and Yorkshire, 1999.

While some special consideration should be given to involving people from black and minority ethnic groups, the general principles underpinning public involvement still apply. It is important to be clear about:

- why you are asking people to be involved
- what you are asking of them
- how you might respond to their comments
- mechanisms for feeding back what has happened as a result.

In Newcastle-upon-Tyne, resident community members were trained to define and conduct qualitative research in their own communities. Community health needs in addressing psychological distress were identified, and practical recommendations for the re-orientation and provision of services made. Changes implemented included:

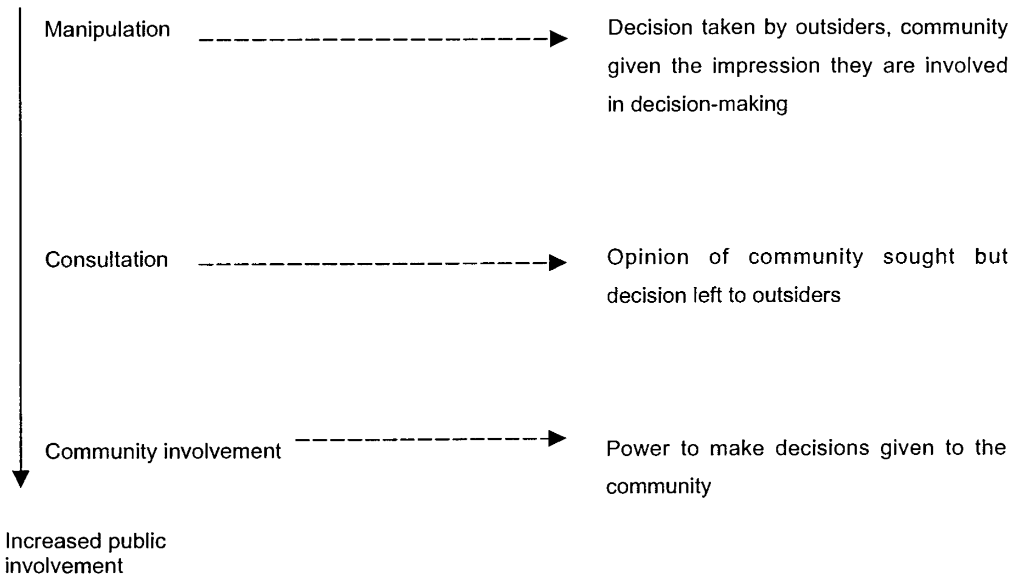
- deploying bilingual counsellors in non-general practice settings
- providing information on service provision using bilingual leaflets in GP surgeries
- proactive local programme of recruitment to expand training and availability of qualified Asian workers
- racism and diversity training for local NHS trusts' staff and primary care workers.

Source: Kai and Hedges, 1999.

Assessing population need is a means to an end of providing more effective services. It is important that the findings lead to action, which all too often has not been the case. An example of where needs assessment in primary care has led to service changes (described in the box on p.32) is an assessment commissioned by Newcastle West Primary Care Group and Save the Children Fund Healthy Communities project.

Public and user involvement will soon lose its appeal if little action is felt to come out of seeking users or local community's views on services. 'User fatigue' is likely to become a barrier and there is already evidence of this as some black and minority ethnic groups have felt that the consultation process has had little effect in bringing about change, and that their involvement has been mere tokenism (Figure 9).

Figure 9: Levels of user involvement



Source: Allen, 1997.

3.3 *Improving cultural competence in the organisation*

3.3.1 Equal opportunities in employment

✓Action points

Does your organisation have policies and procedures for staff recruitment and retention that will achieve the goal of a diverse and culturally competent workforce?

These would include:

- **equal opportunities policy**
- **racial harassment policy**
- **job descriptions and personal performance measures that include skill sets related to cultural competence.**

A marker of institutional racism in the NHS is the relative lack of black and minority ethnic people in senior and frontline positions, even in areas with large black and minority ethnic populations. It has been argued that cultural competence cannot be fully achieved whilst health care organisations fail to address this. Service delivery and staffing are two sides of the same coin. This does not mean positive discrimination but, rather, ensuring that employment and recruitment processes and policies do not unwittingly discriminate against certain groups.

Equal opportunities in PCTs – some key actions

- Set targets on equality
- Tackle racial harassment
- Take steps to have a workforce that is representative of the population it serves
- Develop an action plan for staff involvement
- Achieve targets for personal development plans
- Annual staff attitude survey
- Improve flexibility in work patterns, training and child care

Source: NHSE, 1999.

Innovation in recruitment and retention, such as the Positively Diverse initiative, has occurred in acute or community trusts (NHS Executive, 2000). Much of the learning from such projects will need to be applied in primary care as PCGs and certainly PCTs will be expected to demonstrate that they have an approach to human resources that addresses equal opportunities.

Steps that the primary care organisation should consider are:

- regularly auditing workforce characteristics – including board membership
- advertising jobs in media that are likely to be used by local community or ethnic groups
- ensuring those on interview panels have undergone equal opportunities training.

The British Medical Association has recently published guidance on recruitment practice that takes into account equal opportunities policies and sets out how to ensure fair selection processes.

The Pathways to Access project in East London is a community-based initiative that has established outreach-based careers advice and facilitated training and work placements to (successfully) attract local Bangladeshi people into working in the NHS. At the five community centres offering careers advice, people can also access the Internet to view job vacancies in East London's NHS. The web site address is: www.pathways2access.org.uk

The PCG/T may also wish to make use of the positive action allowed by the Race Relations Act, which allows training support to be provided to people or communities who, through lack of opportunity, are unable to apply for certain jobs. This is likely to involve working with the local education consortium and colleges of higher education.

3.3.2 Tackling racial harassment

66% of black and 58% of Asian nursing staff had difficulties with patients for ethnic reasons.

37% of black and Asian nursing staff had difficulties with colleagues for ethnic reasons.

Source: NHSE, 1998.

Staff from black and minority ethnic groups are unlikely to want to stay in an organisation if they are exposed to racial harassment, feel that their chances of promotion and development are reduced because of their race, and that the qualities they have to offer are not valued by the organisation. Staff within the NHS may experience racial prejudice from individual patients or from other staff that amounts to racial harassment or discrimination.

Patients, too, may experience racist attitudes or behaviours from staff. Such negative experiences can only act as barriers to seeking health care.

The NHS Executive's action plan for tackling racial harassment describes this problem as 'endemic' in the NHS. The action plan covers five key areas, each with objectives. The action plan makes specific reference to primary care groups and trusts, who are also expected to respond.

Five action areas to tackle racial harassment in the NHS:

- raising public awareness
- reporting and recording the extent of the problem
- staff of all races working together
- effective leadership and management action
- education and training.

Source: NHSE, 1998.

Where there is political will and senior level commitment, this issue can be successfully addressed. But it is not enough simply to have documents such as racial harassment policies in the organisation – they should be understood and used by people to whom they are relevant.

3.3.3 Staff training and development

All PCG/T staff, whether employed or independent contractors, managerial, administrative or clinical staff, may require training to improve their knowledge and skills in providing services to black and minority ethnic groups. The kind of training required will depend on the particular job or role of the person involved. For example, a PCG/T chief executive leading strategic

✓Action point

Does your organisation have policies and resources identified to support ongoing professional development and in-service training for culturally competent services?

Ensuring a 'good' training experience:

- check the trainers' references
- contact other organisations that have used them to find out about their experiences
- be very clear about the purposes of training – what are your aims and objectives?
- be as specific as possible in the specification you draw up
- work in partnership with the consultants to ensure that your specific needs are being met, e.g. you might want to understand more about the Race Relations Act, how to implement ethnicity monitoring, or how to communicate better with your local population, as well as developing greater understanding of what it means to value and manage diversity.

development will have different requirements from a frontline staff member such as a general practice receptionist.

Staff are most likely to respond to training if they themselves identify a need for it and if it can be used to help them solve issues that they are facing. A training and development needs audit or practice-based development plan may be a useful way into this. For clinical staff, the clinical governance action plan provides another opportunity. Whichever model is chosen, training will not be a panacea to responding to cultural diversity. It is unrealistic to expect massive organisational change to occur after a one-off training event.

There are a large number of organisations that offer training on aspects of culture, ethnicity, health and health care and it can be difficult to decide which one to use. A brief overview of types of training is provided below (Chandra, 1996).

Cultural awareness training provides information on the customs, habits and lifestyles of different cultures, religious or minority ethnic groups. It is often oriented to a health care environment (for example customs about death, birth and food). It is a somewhat limited model of training and it can enforce stereotypes. It is unrealistic for everyone to know everything about different cultures. It is probably more useful to develop the skills to ask appropriate questions.

However, many people feel that lack of knowledge about another person's culture impedes them from understanding and interacting with that person. There is a plethora of guides and training workshops that have been developed in response to this.

Race awareness training focuses on changing individual attitudes and behaviours. While this may be helpful to some, it can ignore institutional racism, and may generate guilt without necessarily providing positive solutions. Its ability to lead to behaviour change seems to be extremely limited.

Anti-discriminatory training focuses more on actions than attitudes, and the use of policies and processes to address issues of direct and indirect discrimination. This is probably the best choice of training, but the other two models also have their place.

Induction programmes for new staff should also include the opportunity to access training in cultural competence.

3.4 Health improvement

✓Action point

Does your organisation regularly review the likely impact of policies and service provision on reducing inequalities?

Health improvement is about reducing morbidity and mortality in the local population, and enabling members of local communities to improve their own health. There is a risk that many health care services and health promotion strategies are delivered in a way whereby those people who already have a better understanding of the health care system, or who already have greater opportunity to change their lifestyle and circumstances, benefit more than those who are least enabled. This can increase rather than decrease inequalities in health. Health improvement strategies therefore need to take into account their likely impact on those who are most disadvantaged (equity impact assessment). Approaches that specifically target some groups will be needed.

As health status is also strongly influenced by factors beyond the remit of the NHS, working in partnership with other parts of the local community, such as local authorities, business and the voluntary sector is important – particularly if health inequalities and social exclusion are to be addressed effectively.

3.4.1 Working in partnership

The advantages of partnership working are self-evident, but often it can become excessively bureaucratic, or achieve less than expected. Cultural barriers are often one explanation for this – in this context it is the differing cultures of organisations within the statutory sector, and between the statutory and voluntary sector, that can make working together difficult.

In Birmingham three community health co-ordinators work alongside PCG/Ts and with their local communities. Joint Finance money has also been used to support a development worker for the local voluntary services council. The development worker has been able to support small community organisations, such as the Afro-Caribbean Elders Association, in developing successful bids for funding from the Single Regeneration Budget.

Voluntary organisations in particular are an important resource, providing both advocacy and actual services for various client groups. However, there is a clear need to strengthen the infrastructure and framework within which voluntary organisations operate. PCG/Ts, in partnership with the health authority and local authority, can play a role in this aspect of capacity building.

3.4.2 Health promotion

✓Action points

Does your organisation have methods to identify and acquire knowledge about the health beliefs and practices of black and minority ethnic groups, including perceptions/knowledge of preventative services available?

Does your organisation have policies and resources to support health promotion for hard to reach groups, e.g. translation of information, community outreach initiatives?

In the past, health promotion efforts have sometimes focused too much on issues *perceived* to be of great importance to minority ethnic groups, such as birth control, rather than diseases such as cardiovascular disease, which are actually more common than these perceived health needs. The recent trend towards assessing rather than assuming need perhaps means that emphasis is now given to diseases that are important, and perceived as important, by minority ethnic groups themselves. However, the nature of health education is such that an understanding of the influence of culture and health-related beliefs on lifestyle is important in giving meaningful health promotion advice. The health promotion research base in this area is somewhat lacking at the moment, and what there is may often rely on the use of research tools that are validated for Western cultures, such as measures of health locus of control (Wrightson and Wardle, 1997).

Health education materials may need to be translated into different languages. Different media such as video and performing arts should be used appropriately. It is important to develop and pilot materials with members of black and minority ethnic communities to make sure that they are accurate and not likely to be perceived as insulting or patronising. It is important to remember that leaflets and videos are useful adjuncts to, but not a substitute for, culturally sensitive face-to-face advice (Buckinghamshire HA, 1996).

Outreach may be a useful way of ensuring some access to health promotion. In Peterborough, for example, an annual 'mela' or fair is organised, which includes opportunities for health promotion in a family-oriented fun environment.

Low rates of uptake for some preventative measures such as cancer screening have been found for some ethnic groups. This is not simply a cultural barrier – in fact many minority ethnic groups highly value preventative services. Often, low attendance can be because they are ill informed about or unaware of these services. They may feel badly treated when they attend, particularly if there is no-one who can explain to them what exactly is likely to happen, for example, when a cervical smear is taken. Access to health advocates (or at the very least interpreters) has been found to be of benefit.

3.5 Service delivery in primary care

Primary care is the point of first contact for health care for most of the population, and the development of these services is a key task for PCG/Ts. The location of many minority ethnic groups in inner city areas exposes them to the inverse care law, where health needs are greatest but the health services available are often less adequate. PCG/Ts across the country will now need to lead the way in addressing this inequity in primary care.

Many of the GPs working in inner cities are themselves from minority ethnic groups, and approaching retirement. The prospect of a GP shortage in areas that are already under-supplied creates a new challenge. Innovation in new forms of primary care delivery will be vital in responding to existing and future challenges. A number of PCG/Ts accommodate Personal Medical Services pilots, some of which are nurse-led. Others have submitted proposals for walk-in centres. Finally, NHS Direct, although very much a top-down initiative, needs to be integrated into the 24-hour primary care services already offered, its shape influenced by GPs and other primary care professionals so that it can meet the needs of people whose first language is not English.

3.5.1 Inter-cultural communication

✓Action point
Does your organisation have a strategy for providing inter-cultural communication, including resources for interpreting and translation?

Inter-cultural communication at its simplest level means being able to communicate with someone who speaks a different language. The consultation in primary care is central to the establishment of a successful therapeutic relationship. There is, not surprisingly, a link between patient satisfaction and levels of explanation received during a consultation. Effective communication may have many positive outcomes, including better patient compliance with treatment, fewer returns to surgery, and better understanding between patient and doctor of how best to manage illness.

GPs in Brent & Harrow use a 'body map' to enhance communication. This is a simple flip chart that illustrates parts of the body, with words translated into different languages. The body map enables shared and confidential understanding between patient and GP, and can be used to clarify what is going to happen during physical examinations. Practices have found this useful for many patients, including children, and not just those who lack confidence in speaking and understanding English.

Communication is not entirely about the use of language alone: non-verbal communication is as important and is influenced by attitudes towards and understanding of people from different cultural backgrounds. Finally, good communication is as much about listening and hearing as it is about talking. A non-judgemental approach and avoidance of stereotyping are important aspects of communication. It is also worth remembering, however, that some cultures do not have words to express, for example, mental illness, or that some people may express physical illness in terms of general tiredness. The best way to understand more about a patient's health beliefs is to ask them.

3.5.1.1 Interpretation and translation

A significant proportion of Asian patients communicate with their GP in a language other than English. The Health Education Authority has estimated that over 80 per cent of Asians attend a general practice with an Asian doctor. Asian GPs are often single-handed GPs located in inner cities. Many of them, as already mentioned, are due to retire in the next ten years or so. 'Second-generation' Asian doctors, trained in the UK, may be unwilling or unable to communicate in Asian dialects. The need for a strategic approach to interpretation and communication is stronger than ever. It is now acknowledged that it is no longer acceptable to use family members or friends as interpreters as a matter of routine during practice consultations. Yet in many areas, even when interpreting services are available or have been purchased by the health authority, use in general practice may be variable and patchy.

Choices in interpreting and translation

Employment of interpreters – interpreters need to have received proper training; many will have NVQs or certification from the National Institute of Linguists.

Use of telephone translation – Language line is the most common example of this. However, while good for emergencies and for less common languages, it is currently felt to be an expensive service and is probably not ideal as the main or only means of inter-cultural communication.

Training of receptionists or other practice staff in languages – e.g. Lambeth Southwark and Lewisham offer Portuguese classes, which have been well attended by practice staff.

Improved access to English lessons for certain groups – a long-term strategy.

Working well with an interpreter

- Check that the interpreter and patient speak the same language
- Allow time for pre- and post-interview discussion with the interpreter as appropriate
- Ask the interpreter how to pronounce the patient's name correctly
- Allow time for the interpreter to introduce and explain their (and your) role to the patient
- Encourage the interpreter to intervene as necessary
- Use plain English, avoid jargon
- Actively listen to the patient and interpreter
- Allow enough time for the consultation
- Check that the patient has understood everything, and whether they want to ask anything else

Source: Kai, 1999.

Two issues are commonly raised. One is the cost of providing interpretation – yet the cost of not providing it in terms of patient outcome, satisfaction and repeat visits needs to be born in mind. The use of children or other family members creates embarrassment and breaks patient confidentiality. Costs can be successfully reduced by sharing services across more than one PCG/T or by pooling resources with other sectors. Social Services, the police force and possibly other parts of the NHS, such as trusts, may all be using different interpreting services.

The second issue is perhaps more difficult to tackle. Many PCG/Ts find that the sheer range of languages and dialects spoken within their population can be difficult to address. In addition, areas where an established minority population has been catered for may not be able to respond quickly to an influx of new groups from, for example, Eastern Europe. In the short term, PCG/Ts have suggested that responding to the influx of new groups of asylum seekers, for example, could be dealt with at regional or even national level (perhaps via NHS Direct). In the longer term, a community development approach that encourages training of interpreters from these communities may be the best way to address such diversity. There is of course the possibility that a patient may socialise with an interpreter from the same community, but overall this approach may be the most sustainable, effective and acceptable option.

3.5.1.2 Advocacy

Advocacy involves more than just interpreting – it is also the representation of clients' needs. It is therefore more complex than straightforward interpretation. It usually involves the advocate building up a more long-term relationship with the client, meeting with them before they meet with the professional. Advocacy tends to be more costly than interpreting, but is extremely useful in some situations, particularly for disempowered groups such as refugees or those with mental illness. In areas that have developed good advocacy projects, such as East London, they have become an essential part of good service delivery.

A recent mapping exercise of advocacy for black and minority ethnic groups in London, commissioned by the King's Fund and the NHSE London Regional Office, revealed that while there was great need for advocacy in primary care, in many cases GP practices were not receptive to using advocacy services, believing that they were not required. This included areas where the health authority was funding these services – only one PCG out of the 66 in London had taken on the commissioning of advocacy services at the time of the mapping exercise (Coker. Personal communication).

3.5.1.3 Supporting linkworkers

Key areas to address for linkworkers in primary care:

- strategic framework
- assessing local need for linkworkers
- defining linkworker tasks
- management and supervision
- funding
- monitoring and evaluation
- recruitment and selection
- training
- administration and support.

Source: Levenson and Gillam, 1998.

There is considerable ambiguity over the meaning of the word 'linkworkers'. Originally introduced as part of the national mother and baby campaign, linkworkers can be found working in many settings, for many client groups and fulfilling a range of jobs from interpreting to advocacy.

However, in many areas, linkworkers, although central to good patient/client care, are often marginal to the health care organisations in which they work. They are often supported by soft funding or project money, and their jobs are therefore insecure and low-status, with little scope for development. The King's Fund has recently produced a checklist for PCG/Ts planning to employ linkworkers, to help make them more central to the organisation (Levenson and Gillam, 1998).

3.5.2 Clinical governance

Clinical governance is essentially the framework and impetus for ensuring high quality clinical care. Clinical governance action plans should therefore take account of black and minority ethnic groups.

Health professionals can facilitate good self-management as part of chronic disease management, as well as reviewing their own clinical practice. Two examples of clinical governance in PCG/Ts that are linked to the health of black and minority ethnic groups include:

- a pilot project in Tower Hamlets to improve asthma control by teaching and training patients in asthma management
- an audit of the management of coronary heart disease in Leicester, which included recording ethnicity.

Rational prescribing is another area that can be improved, either as part of the clinical governance agenda or separate to it. It is important to note that some drug treatments are inappropriate for some minority communities – for example, gelatine-based medicines are not suitable for vegetarians. Also, compliance may be affected by fasting and other cultural factors that affect when and how medicines can be taken.

The evidence base for treatment effects in different black and minority ethnic groups is poor. Nevertheless, when it does exist, for example in the management of hypertension in Afro-Caribbeans, health professionals should be aware of this. Section 4 of this guide provides an overview of common and important conditions and client groups as a starting point.

Prescribing indicators may be used as measures of performance, but it is important to take into account population need when interpreting this data. A recent study has noted that, contrary to many common perceptions, Asian single-handed GPs do not prescribe higher volume, more expensive drugs than white doctors, or than those Asian doctors trained in the UK, once case-mix had been taken into account. However, being single-handed has been shown to be a barrier to participating in clinical audit, most commonly because of lack of time. PCG/Ts need to take account of the extra pressures on small practices when developing clinical governance strategies, and find ways of supporting them.

3.5.3 Sharing and stimulating good practice

✓ Action point
Does your organisation have support and/or incentives to promote cultural competence at board, practice and individual levels?

Resources are limited; pressures on the NHS are severe. It is important to develop ways of working within the PCG/T that allow examples of good practice to be rolled out and shared across practices. This might involve a range of communication methods (such as meetings, electronic and paper media). In some PCG/Ts it is apparent that a small proportion of practices deal with most of the black and minority ethnic patients. It may be that some practices are reluctant to take on people from groups perceived to generate extra work. Practices

South KCW PCG/T in London has developed an incentive scheme to encourage practices to register asylum seekers and refugees. Practices are awarded a small amount of extra money for carrying out a full registration and health check of people with refugee/asylum seeker status. A further amount of money is awarded to practices when a member of staff undertakes training in equal opportunities and the use of interpreting services. A primary care facilitator has been appointed for two years to support practice development across the PCG and link primary care services with other relevant services and organisations.

may need to be encouraged to take on more people from minority ethnic groups, for example by the use of incentive schemes.

Given the association between ethnicity and deprivation, with significant parts of the black and minority ethnic population living in inner city areas, extra support may need to be provided to the many single-handed or two-partner practices that serve these populations. In some areas, this may justify funding a facilitator to work across the whole PCG/T (or even several PCG/Ts), to provide support and to catalyse change. The 'change agent' model has worked in trust settings, such as in the Bedfordshire project, Partnerships for Change. The job description needs to ensure that someone with strong facilitative skills is identified. However, it is all too easy to marginalise such people, and they will need to be given authority to carry out their job effectively. Making sure that they have been provided with desk space and a telephone and have had a proper induction to the organisation is a good starting point.

Personal Medical Services pilots may also offer new models of extending primary health care to particular groups. Many are based in inner city areas and some have chosen to target minority ethnic groups as their priority. These are still under evaluation, but may provide some useful insights as to what kinds of services work best. Drop-in centres could also prove useful, especially in areas with highly mobile populations who are unlikely to register with general practices.

3.6 Commissioning health services

PCG/Ts will increasingly take on responsibilities from health authorities for contracting and commissioning services. Checklists for commissioners already exist. These include *Facing up to Difference* by Jeff Chandra and a *Health and Race Checklist* by Yasmin Gunuratnam. Both cover generic issues and specific services and disease groups.

✓Action point
Does your organisation review its commissioning and contracting arrangements to ensure that the needs of black and minority ethnic groups have been considered?

Commissioning and contracting can be a powerful tool for change, but can take a long time. A pilot study of commissioning coronary heart disease and diabetes services for minority ethnic groups in four health authorities (Unwin and Bhopal, 1999) found that:

- a strategic long-term approach is needed
- high level (executive) commitment is essential
- involving a broad group of key players early, including community members, greatly improves the chance of successful change
- locally relevant 'health intelligence' (knowledge of local health needs amongst those commissioning services) is a powerful catalyst for change, its absence a hindrance.

3.6.1 Setting standards

The National Service Frameworks (NSFs) provide standards for services in primary and secondary care, covering prevention and treatment. The NSF for coronary heart disease makes specific reference to the need to meet minority ethnic health.

In commissioning services from trusts, PCG/Ts can include generic quality criteria in service agreements. The provider should:

- be an equal opportunities employer
- offer cultural awareness/anti-discrimination training programmes for its staff
- improve ethnic monitoring
- provide access to interpreters as relevant, so that black and minority ethnic groups are not excluded from services simply because of language barriers
- provide appropriate signage
- cater for specific food requirements
- offer a place of worship for non-Christian faiths
- have access to appropriate spiritual and religious advice.

Some contracts may relate to specific services, some of which will be mainly used by certain black and minority ethnic groups, such as those for haemoglobinopathies. Such contracts may include, for example, requirements to maintain a register of those who suffer from sickle cell anaemia, including their usual pain treatment, offer antenatal universal screening and provide nurse specialists, counsellors and interpreters. Even in common diseases such as coronary heart disease there may be some specific issues. For example, people whose first language is not English may not be offered cardiac rehabilitation or exercise stress tests. This can be addressed through setting appropriate standards in the service agreement.

Longer-term service agreements provide an opportunity to focus on quality in contracts. In Southampton, one has been developed for coronary heart disease (CHD), which includes some outcomes specific to ethnic groups. As many of the other outcomes will not be achieved without improving care for black and minority ethnic groups as well as for the white majority patients, this form of contract could have real benefit for such patients with CHD.

Central Southampton PCG has developed a three-year outcomes-based service agreement covering both primary care provision and secondary care for coronary heart disease. Some of the standards for secondary care that are relevant to minority ethnic groups include:

- a culturally sensitive, locally based rehabilitation programme offered to all patients following myocardial infarction or cardiac intervention, or who are added to the non-urgent waiting list for intervention
- clear, written, culturally appropriate information for reference at home provided to all patients following admission for unstable angina or myocardial infarction
- 100 per cent of patients admitted to hospital recall discussing with staff their requirements for religious worship during their stay.

The PCG and Trust are also considering using a scoring system for severity of CHD in identifying candidates for revascularisation procedures like CABG and angioplasty.

3.6.2 Monitoring standards

Without an effective system to monitor performance, there is little point in setting standards. Monitoring quality proved to be one of the biggest challenges for health authorities when contracting was introduced. PCG/Ts will need to come up with new ways to address this. For example, in one PCG, a 'GP alert' system is run, whereby general practices routinely record problems with, for example, waiting times, at the local trust.

3.6.3 Commissioning from the voluntary sector

When ensuring that culturally sensitive services are provided for black and minority ethnic communities, commissioning from the voluntary sector may sometimes be an appropriate course of action. A small voluntary organisation may not always provide the cheapest care, but could provide high quality care for certain clients (for example, day care for Asian patients with dementia). Although the organisation is voluntary rather than statutory, it should still be run in a professional, organised way. Where relevant, staff should have undergone suitable training and the organisation should work to standards of good practice. It is reasonable to expect some basic monitoring information from voluntary organisations commissioned to provide services, but it is worth remembering that smaller organisations have more limited administrative capacity than many GP practices and PCG/Ts.

4 Information on specific diseases and client groups

This section provides brief overviews of important diseases and client groups in relation to black and minority ethnic health. For each, health need, issues for primary care and further reading are covered. However, the information needs to be interpreted with caution and the following have been identified as problematic (Mackintosh, Bhopal, Unwin and Ahmad, 1999):

- stereotyping. There is a risk that by focusing only on specific diseases where ethnic groups have an excess when compared with white populations, negative racial stereotypes may be reinforced. Thus ethnicity itself can become perceived as the 'problem'
- care needs to be taken in reaching conclusions on the causes of ethnic differences in health. Patterns of health and disease are influenced by genetic, socio-economic, cultural and environmental factors. The National Survey has shown the importance of socio-economic status and racism as determinants of health status for black and minority ethnic groups. Taking account of cultural factors including health belief systems may mean that different health promoting strategies are required to reduce morbidity and mortality, but this alone is unlikely to address all variations in health
- much of the data are based on broad groupings, such as 'Asian' or 'white'. This does not allow for analysis of specific ethnic groups within this category, resulting not only in crude data analysis, but wrong interpretation. For example, Pakistanis and Bangladeshis report much poorer health and are at greater risk of coronary heart disease than Indians or East African Indians. White people of Irish origin living in England, for example, experience the highest premature mortality rates of all ethnic groups
- data should be presented using both absolute numbers, and not just risk relative to the white population, if the true burden of disease within the population is to be assessed accurately

- some ethnic groups have been the subject of more research than others – the evidence for some communities such as the Chinese is considerably less than for South Asian groups.

4.1 Coronary heart disease, stroke and diabetes

4.1.1 Assessing health need

South Asians have about 40 per cent higher death rates from *coronary heart disease (CHD)* than the white population. Similar rates have been found in urban settings in India. There is increasing evidence that the poorest groups, of Bangladeshi and Pakistani origin, have the highest rates. Classic risk factors such as smoking, blood pressure and cholesterol are important in all populations, but in the Asian population insulin resistance and central obesity may also be important. The cut-off point used for body mass index (BMI) may need to be lower than that used for simple obesity if central obesity is to be detected and addressed. There is some evidence to suggest that access to services such as re-vascularisation and rehabilitation is unequal for those from black and minority ethnic groups, despite their greater risk.

Diagnosis and management of *diabetes* will be important in reducing the risk of CHD. People of Asian or African origin seem to be particularly susceptible to type 2 diabetes and complications including renal and cardiovascular disease. Good diabetic control can reduce these complications.

Stroke is an important cause of mortality and morbidity for all ethnic groups, but those of Afro-Caribbean origin have double the mortality rates compared with the white population. Hypertension, a major risk factor, is known to be more common in this group. A much greater proportion of Afro-Caribbeans with hypertension are known to health services than the white population. However, many of these may not have their blood pressure adequately controlled, particularly as some anti-hypertensive drugs such as beta blockers are less effective in this population. Good primary prevention advice, particularly on weight control, is another important strategy.

4.1.2 Issues for primary care organisations

The National Service Framework for coronary heart disease has recently been published, setting standards for primary care. These include improved identification of high risk populations, setting equity targets and improved health promotion/disease prevention in primary care. PCG/Ts that are commissioning services from acute trusts will need to monitor progress against standards set for specialist management of CHD.

A National Service Framework for diabetes is expected in 2001. This is also likely to refer to the needs of black and minority ethnic groups. Primary care organisations need to ensure that health professionals help patients with diabetes to manage their condition as well as possible. This includes using culture-specific education for self-care, which has been shown to be effective.

Clinical governance action plans provide a useful vehicle for addressing many of these issues as part of a wider agenda to improve the quality of care for patients with CHD. Health improvement plans and contracts with acute trusts can also be used to include relevant and specific targets.

4.1.3 Useful references

NHS Centre for Reviews and Dissemination, University of York. *CRD Report 5: Ethnicity & health: Reviews of literature and guidance for purchasers in the areas of cardiovascular disease, mental health and haemoglobinopathies.* York: NHS Centre for Reviews and Dissemination, University of York, 1996.

NHS Centre for Reviews and Dissemination, University of York. *Effective Health Care Bulletin: Complications of diabetes*. March 2000; 6(1). Available on the University of York web site: http://www.york.ac.uk/inst/crd

Secretary of State for Health. *The National Service Framework for Coronary Heart Disease*. London: Stationery Office, 2000. Also available from the Department of Health web site: http://www.doh.gov.uk

4.2 Mental health

4.2.1 Assessing health need

Mental illness needs to be understood in terms of the social and political context, making interpretation of findings potentially difficult. Until recently, much research has focused on admission rates to hospital for psychiatric illness, but these may not reflect population prevalence. The higher rate of hospitalisation for schizophrenia reported in those of Caribbean origin, including second-generation Caribbeans, has not been explained but is likely to be attributable to a number of factors including misdiagnosis, racism, genetic factors or inaccurate data. This phenomenon is unique to Britain – such high rates are not found, for example, amongst African origin populations in the USA. Caribbeans have lower rates of admission for conditions other than schizophrenia.

In South Asian populations, there are high rates of admission of Sikh men for alcohol problems, and a higher than expected suicide rate amongst young women of Indian origin.

Some studies have suggested that GP consultation rates by minority ethnic groups for mental illness tend to be lower than expected. However, a community study that attempted to adjust for need found less variation in rates of consultation. Overall it seems that members of black and minority ethnic groups do not consult GPs for mental disorders as much as they should. The reasons behind this are unclear and could point to a genuine reluctance to report mental health problems due to communication/language barriers, both in explaining and detecting problems or the fear of outcomes any diagnosis may have, including stigmatisation within their own community.

4.2.2 Issues for primary care organisations

A study in a West London GP surgery found that out of 100 Asian women attending a GP surgery in West London, 37 per cent presented with mental health disorders but only 17 per cent were detected by the GP. A Sainsbury Centre survey of users in Hackney, East London looked at ways of reducing the admission of young black men with mental illness, finding that GPs were not well informed about mental health issues and that they lacked knowledge about the effects of medication (side effects/benefits). This lack of knowledge was felt to be due to a lack of concern about and general uninterest in young black men as a group. The PCG/T has an opportunity to address such problems and is in a position to improve the care pathway afforded to black and minority ethnic groups. This will involve PCG/Ts working closely with mental health trusts, Social Services and local communities. The Sainsbury Centre for mental health has developed a guide for PCGs, covering many diverse aspects of providing integrated services. The guide also identifies ways of developing sustainable working partnerships, contributing to the local Health Improvement Programme and commissioning services.

The National Service Framework on mental health sets out standards of care. For primary care, particular issues are related to improving the identification of mental illness in the Asian community and recognising that certain groups such as refugees and asylum seekers are particularly vulnerable.

4.2.3 Useful references

Bhugra D and Bahl V, editors. *Ethnicity: an agenda for mental health.* London: Gaskell, 1999.

Cohen A and Paton J. *Workbook for Primary Care Groups – Developing an integrated mental health service.* London: The Sainsbury Centre for Mental Health, 1999.

NHS Centre for Reviews and Dissemination, University of York. *CRD Report 5: Ethnicity & health: Reviews of literature and guidance for purchasers in the areas of cardiovascular disease, mental health and haemoglobinopathies.* York: NHS Centre for Reviews and Dissemination, University of York, 1996.

Secretary of State for Health. *The National Service Framework for Mental Health.* London: Stationery Office, 1999.

4.3 Infectious diseases

4.3.1 Assessing health need

Tuberculosis accounts for a small number of deaths but, relative to the white population (where the incidence of TB is much lower), minority ethnic populations have a much greater standardised mortality ratio. Tuberculosis is also a major cause of ill health. The reasons for this may include travel, migration, immunity and overcrowded living conditions in the UK. Rates seem to be increasing amongst the Asian population in areas such as Birmingham.

There is some evidence that suggests that rates of *congenital rubella* are higher than expected amongst babies of mothers of Asian or Oriental origin. This may be because women who have come to the UK as young adults miss out on the routine MMR vaccination programme. These women need to be identified and have their immune status checked when they register with a general practice, prior to becoming pregnant.

Little is known about the incidence and prevalence of *HIV* infection among black and minority ethnic groups in the UK. Although the AIDS epidemic in the UK has been avoided, the high prevalence of HIV/AIDS in Africa and Asia means that people travelling abroad are still at high risk of acquiring the infection. Heterosexual transmission and mother-to-baby (vertical) transmission are significant means of spread in African and Asian populations. The introduction of antenatal screening for HIV should help to reduce significantly the number of HIV positive children, as long as it is implemented properly. However, a recent study of London hospitals indicated variable uptake, including low rates among women of African origin. Further work is needed to understand the reasons for this and how they might be addressed to improve uptake.

4.3.2 Issues for primary care organisations

Primary care teams need to ensure that those from black and minority ethnic groups are aware of preventative measures such as immunisation and are offered these. Where this has happened, rates of immunisation uptake have been found to be higher in South Asian groups (Indian, Pakistani and Bangladeshi) and in Caribbean groups than in the white population. Traveller populations have been shown to have much lower uptake rates, which may not only reflect the mobility of this group but health beliefs about infection and illness.

PCG/Ts commissioning maternity services need to ensure that providers are implementing programmes like antenatal screening for HIV and neonatal BCG and Hepatitis B vaccination.

4.3.3 Useful references

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Smaje C. *Health, 'Race' and Ethnicity – Making Sense of the Evidence.* London: King's Fund, 1995, Chapter 3.

4.4 Haemoglobinopathies

4.4.1 Assessing health need

The prevalence of haemoglobinopathies such as sickle cell disease and thalassaemia in minority ethnic populations is higher than that of phenylketonuria (for which all babies are screened at birth) and cystic fibrosis amongst the white population. At present there are about 9000 cases of sickle cell disease and over 600 cases of thalassaemia major in the UK. Ethnic groups affected include Africans, Afro-Caribbeans, Asians and those of Mediterranean origin.

While certain minority ethnic populations are concentrated in certain parts of the country, there is no region that does not have some minority ethnic populations at risk from haemoglobin disorders. Approaches may need to be different in high prevalence and low prevalence areas, but service quality should not be compromised. The following issues have been identified in service provision:

- strategies for screening for haemoglobinopathies that are appropriate to the population need to be adopted. For example, in high prevalance areas universal screening is appropriate; in low prevalence areas, selective screening may be offered. Screening to identify carriers needs to be followed up with counselling about reproductive choices

- most health workers have little knowledge of genetics or genetic counselling
- information for the public is available, but often not disseminated. It needs to be available in a range of appropriate languages
- few genetic counsellors speak relevant languages and the provision of genetic services to the Asian population remains poor
- experiences of primary care by patients with haemoglobinopathies are very mixed. Where it has worked well, patients have felt that they have been able to remain out of hospital and manage at home for longer.

4.4.2 Issues for primary care organisations

The Standing Medical Advisory Committee published recommendations on the management of haemoglobinopathies in 1993. The recommendations were aimed at purchasers, hospitals and primary care health professionals. PCG/Ts have a role in implementing these recommendations. In particular, the patchy nature of screening services has implications for PCG/Ts as they take on increased responsibility for commissioning. In low prevalence areas, several PCG/Ts may work together via a lead commissioning arrangement to purchase services from a single centre offering high quality, specialist services. Better integration between primary care, secondary care and Social Services is needed to improve care in community settings and recognise the chronic nature of these conditions.

4.4.3 Useful references

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Health Education Authority. *Sickle Cell and Thalassaemia: achieving health gain. Guidance for commissioners and providers.* London: HEA, 1998.

NHS Centre for Reviews and Dissemination, University of York. *CRD Report 5: Ethnicity & health: Reviews of literature and guidance for purchasers in the areas of cardiovascular disease, mental health and haemoglobinopathies.* York: NHS Centre for Reviews and Dissemination, University of York, 1996. (This includes the guidance from the Standing Medical Advisory Committee.)

Streetly A, Maxwell K and Mejia A. *Sickle Cell Disorders in Greater London; a needs assessment of screening and care services.* The Fair Shares for London Report, 1997. Available from Bexley and Greenwich Health Authority.

4.5 Mothers and young children

4.5.1 Assessing health need

Although rates of sudden infant death syndrome appear lower in most ethnic groups compared with the majority population, neonatal and infant mortality rates are particularly high in Pakistani and Caribbean born mothers. A major risk factor for infant mortality is low birthweight. This in turn is associated with:

- mothers' age and parity
- length of time between pregnancies
- parental socio-economic status.

Uptake of family planning services may therefore contribute to improving health outcomes for infants from certain minority ethnic groups. Knowledge of and access to family planning advice may be influenced by a number of factors. A study of 235 Asian women in Leicester (Kubba, 1998) found that:

- 73 per cent were able to acquire family planning advice if they wanted *but* 41 per cent did not know that this was available from their GP

- over 80 per cent wanted a female doctor
- 37 per cent could not read family planning literature written in English and a further 5 per cent did not understand it
- 55 per cent preferred to discuss family planning in their mother tongue
- 20 per cent wanted information available in the work place.

Health in childhood and infancy is the basis of the health of the population as a whole. In many areas minority ethnic status is associated with deprivation, and children of black and minority ethnic parents will suffer the same risk of increased ill health as white children living in deprived areas. The National Household Survey suggested that parents of minority ethnic children consulted GPs more frequently than parents of white children, especially those classed as South Asians. Paradoxically, children from minority ethnic groups have a lower use of hospital services. This may be explained by the relative inexperience of these parents in using the system, communication difficulties, negative views of the hospital services, cultural differences of expectations and concerns between GP and parent and/or discriminatory practices by GPs.

Afro-Caribbean children have a higher rate of exclusion from school than any other group. While this is mainly an issue for schools and local education authorities, better access to health services such as psychology, speech and language therapists and other child development services may be important in helping to address this.

4.5.2 Issues for primary care organisations

Primary care has a key role in ensuring the provision of good child health services, good antenatal care and culturally sensitive family planning services.

Ignorance of the NHS, its organisational structure and mode of operation (including GP appointment systems) are thought to be obstacles to children receiving appropriate health care, resulting in a lower uptake of other primary and preventative services. Primary care teams are amongst the best placed of those working in the health service to tackle this issue.

Working in partnership with schools and local communities in deprived areas will be important if PCG/Ts are to have an impact on child health.

4.5.3 Useful references

Chandra J. *Facing up to Difference – A Toolkit for Creating Culturally Competent Health Services for Black and Minority Ethnic Communities.* London: King's Fund, 1996, Chapter 19.

Department of Health Research and Development in Maternal & Child Health. *Primary Health Care Services for Children from Ethnic Minority Groups: Executive Summary.* Available at: http://www.doh.gov.uk/research/mch/studies/execsum20-07.htm

Kubba A. Sexual and reproductive health. In: Rawaf S and Bahl V, editors. *Assessing health needs of people from minority ethnic groups.* London: Royal College of Physicians, 1998.

Kurtz Z. Women and children. In: Rawaf S and Bahl V, editors. *Assessing health needs of people from minority ethnic groups.* London: Royal College of Physicians, 1998.

4.6 Elders

4.6.1 Assessing health need

The ethnic elderly population is set to increase over the next 10–20 years. It is often assumed that most people from ethnic populations live as part of an extended family or have strong community support systems that they can rely on. In fact this is not the case. Many ethnic elderly people live alone.

Many older people, regardless of their ethnic origin, may feel 'ashamed' of making use of Social Services or meals on wheels or other such facilities, but specific barriers to providing care to those from black and minority ethnic groups include lack of knowledge about such services and lack of sensitivity and choice in the provision of services, such as food and bathing, which are very important culturally. Language and communication may be a particular issue for older people. The research evidence indicates low uptake of community health and Social Services among those from black and minority ethnic groups.

4.6.2 Issues for primary care organisations

Primary care organisations need to be aware that there may be considerable unmet need among their black and minority ethnic population. They will need to work with Social Services to improve and develop culturally sensitive services. The use of linkworkers in primary care to carry out, for example, the over-75s health check may be another possible model.

Culturally appropriate community services like day care may best be provided by black/minority ethnic voluntary organisations. Some ethnicity-specific housing associations, for example, already exist. PCG/Ts, along with Social Services, should consider how community resources can best be utilised.

PCG/Ts need to plan for future service provision, as this part of their population is likely to increase over the next two decades.

4.6.3 Useful references

Department of Health/Social Services Inspectorate. *They Look After their Own, Don't They? Inspection of Community Care Services for Black and Ethnic Minority Older People.* London: DoH, 1998. Also available on the Department of Health web site: http://www.doh.gov.uk

Pharoah C. *Primary Health Care for Elderly People from Black and Minority Ethnic Communities.* London: Stationery Office, 1995.

Samadian S. The elderly. In: Rawaf S and Bahl V, editors. *Assessing health needs of people from minority ethnic groups.* London: Royal College of Physicians, 1998.

4.7 Refugees and asylum seekers

4.7.1 Assessing health need

Refugees and asylum seekers have some of the greatest health needs, but are often least likely to have those needs met because of their status. The tendency for refugees to be registered as temporary rather than permanent patients means that they may be more likely to miss out on preventative measures such as childhood immunisations. Yet many refugees or asylum seekers are often less mobile than perceived by GPs, with up to 70 per cent remaining in one area for a year. Those working in primary care also need to be aware of mental health problems in asylum seekers and refugees, although these may often present as physical rather than psychological symptoms.

Many refugees may be unaware of their health care rights and will lack knowledge about how to access health services appropriately. Language difficulties are an obvious barrier to using services, as is lack of awareness and understanding about the cultural background of some refugee groups by health professionals. The recent Asylum Bill may exacerbate the vulnerability of asylum seekers, as they are dispersed to parts of the country not used to dealing with such groups. The shift to a voucher system, and possibly more constraints on access to accommodation, are likely to add to the problems faced by refugees and asylum seekers.

4.7.2 Issues for primary care organisations

Primary health care team members, including health visitors, are likely to be the first point of contact for health reasons for many asylum seekers and refugees. It is important that all staff, including receptionists, understand that refugees and asylum seekers are entitled to free treatment in the NHS.

As refugees and asylum seekers experience considerable barriers in health care access, new models of primary care may be called for. PCG/Ts have a role to play in assessing the health needs of their refugee population and developing appropriate services. For example, a rapid appraisal in Croydon (Vallely *et al.* 1999) led to the following service developments:

- interpreting services jointly commissioned by health and local authorities
- a guide for refugees and those from black and minority ethnic groups on using health care services
- a one-stop refugee centre provided by both statutory and voluntary agencies.

In East Kent, a GP service has been established specifically for refugees and asylum seekers. The GPs running this service have found that a willingness to communicate, even in the absence of interpreters, and a positive non-judgemental attitude towards refugees are important aspects of providing good quality, essential health care and preventative services to people who are going through profoundly traumatic experiences (Le Feuvre, 2000).

4.7.3 Useful references

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Le Feuvre P. How we specialise in care for refugees and asylum seekers. *GP Magazine* 3 March 2000: 67.

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Vallely A, Scott C and Hallums J. The Health Needs of Refugees: using rapid appraisal to assess needs and identify priority areas for public health action. *Public Health Medicine* 1999; 1(3): 98–102.

5 Useful resources and references

5.1 Key references

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Buckinghamshire Health Authority. *Communicating with our Ethnic Minority Communities – How should we do it?* Aylesbury: Buckinghamshire Health Authority, 1996.

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Gardenswartz L and Rowe A. *Managing Diversity in Health Care.* San Francisco, California: Jossey-Bass, 1999.

Goddard M and Smith P. *Equity of access to health care.* York: University of York Centre for Health Economics, 1998.

Gunuratnam Y. *Health and Race Checklist.* London: King's Fund, 1993.

Health Education Authority. *Health and Lifestyles: Black and Minority Ethnic Groups in England.* London: Health Education Authority, 1994.

Health Quality Service. *Primary Care Group Standards.* London: King's Fund, 1999

Henley A and Schott J. *Culture, Religion and Patient Care in a Multi-ethnic Society – Handbook for Professionals.* London: Age Concern, 1999.

Hindley J. *Social Services Institute – Exploding Myths, Exploring Realities – Uncovering the Health and Social Care Needs of Minority Ethnic Residents in Mid Essex.* Colchester: University of Essex, 1999.

Kai J. *Valuing Diversity. A resource for effective health care of ethnically diverse communities*. London: Royal College of General Practitioners, 1999.

Kai J and Hedges C. Minority ethnic community participation in needs assessment and service development in primary care: perceptions of Pakistani and Bangladeshi people about psychological distress. *Health Expectations* 1999; 2: 7–20.

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5.2 Useful web addresses

King's Fund: http://www.kingsfund.org.uk

Department of Health: http://www.doh.gov.uk

Centre for Research in Ethnic Relations: http://www.warwick.ac.uk/fac/soc/CRER_RC/

Racial Equality Unit: http://www.reunet.demon.co.uk

Commission for Racial Equality: http://www.cre.gov.uk/cre

Office of Minority Health (USA): http://www.omhrc.gov

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