Health and ethnic inequalities in people living with type 2 diabetes: A pharmacist's perspective

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The prevalence of diabetes is rising at an alarming rate. Every two minutes, someone is diagnosed with the condition, and there are currently approximately 5 million people in the UK with diabetes, with this figure projected to rise to 5.5 million by 2030 (Diabetes UK, 2023). The cost of diabetes comprises around 10% of the NHS budget.

The integration of pharmacists in general practice is increasing and evolving. Favourable outcomes in clinical surrogate markers have been shown to occur after a pharmacist intervention, predominantly via a medication review (Tan et al, 2014). Pharmacists should have a more prominent role in managing diabetes.

The COVID-19 pandemic has arguably increased the burden of managing people with type 2 diabetes in primary care. For those in the front line managing diabetes, there have been competing priorities in dealing with the impact of the pandemic, leading to a backlog which may take 6–12 months to catch up (Brown and Diggle, 2020). For many during the pandemic, there may have been a worsening of glycaemic control, and there is data to show an increase in cases of new-onset diabetes in those with COVID-19.

Health and ethnic inequalities

Health inequalities are defined as differences in the status of people's health (Williams et al, 2020). **Health inequities** are avoidable inequalities and, therefore, arguably a social justice issue.

The UK population is increasing in diversity. **Ethnicity** is defined as a culture of people in a given geographic region, including their language, heritage, religion and customs (Bryce, 2023). Ethnic inequalities are multifactorial, with causes including migration, culture and lifestyle, genetics, access to healthcare and socioeconomic status (Bhopal, 2009). In terms of diabetes, South Asian and Black people are 2–4 times more likely to develop type 2 diabetes than white people.

The 2010 Marmot Review highlighted the stark realities of the health inequalities gap and stalling life expectancies in the English population (Marmot et al, 2010). The report highlighted strategies to tackle the social determinants of health. It showed an inverse relationship between deprivation and life expectancy, known as the social gradient. Health inequalities are felt by all across the social gradient. Ten years on, follow-up found that that health inequalities have only increased or deteriorated (Marmot et al, 2020).

The social determinants of health contribute to 30–55% of health outcomes (World Health Organization, 2023). As a profession, we therefore should be cognizant of the wider determinants of health. The most widely used example of this is the 1991 Dahlgren–Whitehead rainbow model of health (*Figure 1*), which depicts the relationship between an individual, their environment and health (Dahlgren and Whitehead, 1991). In primary care, we should try to incorporate aspects of this model in service delivery.

What can clinicians do to tackle ethnic inequalities?

Reducing inequalities in diabetes aligns with the NHS Long Term Plan recommendations. Within the NHS, more than 90% of patient contacts are undertaken in general practice, which makes this an ideal setting to target those with health and ethnic inequalities (Radwan et al, 2021). In order to tackle ethnic inequalities, practices in areas of high deprivation and ethnic diversity could be targeted. Services could be tailored by clinicians to meet the needs of their environment. Examples of tackling inequalities include:

- Delivering group education sessions on pertinent diabetes topics within the local community in a culturally and linguistically sensitive manner.

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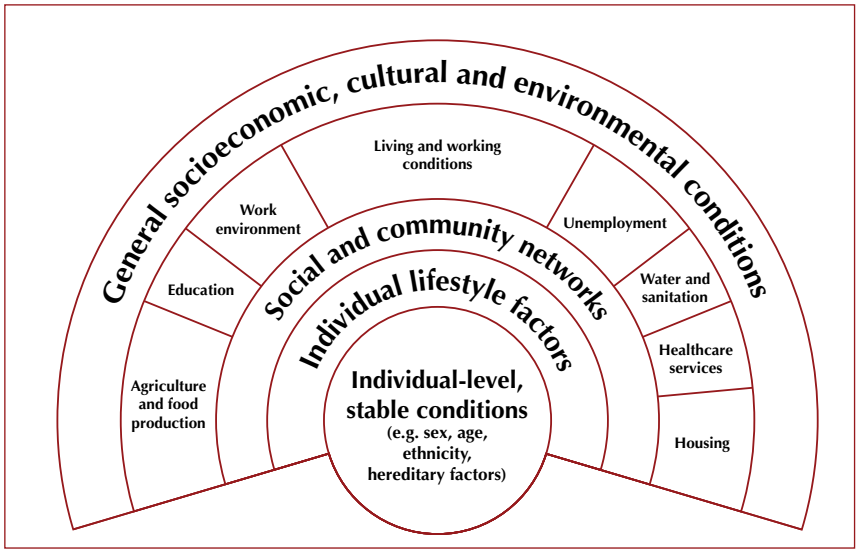

Figure 1. The Dahlgren–Whitehead rainbow model of health.

Figure 2. A pharmacist-led group education session delivered by a local diabetes consultant for South Asian individuals in a general practice waiting room.

Figure 3. A joint consultation approach in a general practice. A pharmacist conducts a bilingual review alongside a diabetes specialist nurse.

- Connect with community leaders or diabetes specialists to aid in the dissemination of health information. This will aid in building trust within the community.
- An example of this was in a general practice waiting room once the surgery closed (see *Figure 2*).

- Use interpreting services (e.g. LanguageLine) or use family members during consultations – although there can be advantages and disadvantages with both these approaches.
  - Consultation times may take longer when using an interpreter but the quality of the consultation is likely to be better; consultation times should take this into account.
- Target communities which are at high risk and hard to reach at the grass roots:
  - One example is a pharmacy model in Glasgow, in which a medication review service was delivered for ethnic minorities in general practices and, later, community venues: a mosque medication review service (Moberly, 2005). This service allowed hard-to-reach groups to be targeted and their diabetes managed in a culturally and linguistically sensitive manner. Clinical issues were addressed by the pharmacist and, when necessary, individuals were integrated into mainstream services.
- Use culturally sensitive dietary resources, such as *Carbs and Cals World Foods* or Healthy Eating Resources for South Asians (Abdool et al, 2018).
- Experienced pharmacists could adopt a mentorship role within a multidisciplinary team. The mentoring approach has many positive benefits on both personal and professional development and career outcomes (Sambunjak et al, 2006).
  - The professional governing bodies for doctors and pharmacists advocate a mentoring approach (Royal College of GPs, 2022; Royal Pharmaceutical Society, 2023).
- Chronic disease management requires a multidisciplinary approach. Forming close working relationships within the wider team is the cornerstone of managing complex patients.
  - One method is the joint consultation approach (see *Figure 3*). This example depicts a joint

working model by a bilingual pharmacist and a diabetes specialist nurse. This approach is very effective in tackling complex clinical issues by combining the expertise of healthcare professionals, thus leading to improved decision making.

- One holistic model to aspire to in type 2 diabetes care that includes integration between primary care, secondary care and community services is CoDES (Community Diabetes Education and Support) in Manchester. This pilot accessed areas where there was high deprivation and diversity and led to positive outcomes (Milne et al, 2021).
- Primary Care Networks can achieve diabetes care standards in various tiers of healthcare, based on a recently published best practice guideline (Ali et al, 2021).

Cultural competence

Current demographics show an increase in diversity of the population in the UK. This may have a bearing on service uptake, so models of care may have to be reconfigured to allow for patient engagement. Services should be culturally and linguistically sensitive to improve patient care and outcomes.

Cultural competence is the combination of the skills and knowledge necessary to be culturally aware, knowledgeable and competent. Being culturally competent does not mean having knowledge of every single culture; rather, it is about being open to different approaches and beliefs, and having mutual respect for those with different beliefs (Papadopoulos et al, 1998).

Cultural differences can be a barrier to delivering effective patient care in practice (Bhopal, 2009). Providing culturally and linguistically sensitive services in practice can ensure improved patient outcomes. In some cultures, the concept of fatalism and faith is discussed frequently during consultations, as it can be seen to play a significant role in managing conditions like diabetes (Meetoo and Meetoo, 2005). Fatalism can be a hindrance to managing diabetes in South Asians (Patel et al, 2015). This should be explored further in consultations to improve outcomes. In order to provide a more tailored approach in these areas of diverse or deprived populations, it must be noted that consultation times are likely to be longer.

Key points

- Health inequalities have increased or deteriorated over the last decade.
- There is a COVID-19 backlog in managing people with diabetes.
- There are ethnic inequalities (i.e. a higher prevalence of diabetes) in South Asian people and other Black and minority ethnic groups.
- Encourage the evolving role of the pharmacist to help tackle inequalities. This includes comprehensive and holistic medication reviews or mentorship roles within a primary care team.
- We should consider the wider determinants of health (e.g. socioeconomic status) during consultations.
- In order to target inequalities, focus on areas of high deprivation or cultural diversity.
- Allocate your multilingual healthcare professional team according to your population, supporting the delivery of a culturally and linguistically sensitive approach.
- Deliver community education at grass roots using easily accessible venues.
- Use the trickle-down effect by using local community leaders to aid the dissemination of health information.
- Work closely with the multidisciplinary team, both within primary and secondary care, to tackle inequalities. Consider a joint consultation approach.
- Embrace a new model of care if necessary to tackle inequalities.

Summary

The most recent Marmot Review observed an increase or deterioration in health inequalities over the last decade. The inverse care law, first described by Tudor Hart (1971), describes the principle that "the availability of good medical care tends to vary inversely with the need of the population served". This seminal paper depicted the ground-breaking impact in patient care provided by a GP in a Welsh mining village; Julian Tudor Hart understood the paramount importance of determining the needs of the deprived community he resided in, which ultimately, and single-handedly, led to a reduction in mortality rates in his community.

The inverse care law holds true today. We know that those from more deprived communities have greater needs, and that managing them requires more time (Watt, 2002). However, despite knowing this, there is a systemic disadvantage for patients in general practice from deprived areas (Watt, 2018). Tudor Hart pointed out that medical

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services are not the main determinant of mortality and morbidity; socioeconomic factors have to be taken into account. We need to be cognizant of this when considering service provision.

Complex patients with type 2 diabetes will require the support of specialists, so easier access to specialist nurses and consultants and their integration into care are important. However, the current climate provides ample opportunity for pharmacists to have a tangible impact on patient care; for example, by being involved in annual diabetes reviews. Job descriptions could change from behind-the-scenes roles undertaking medication reconciliation, to active diabetes management in front-line patient care. Pharmacists can have a significant impact in the increasingly diverse populations with diabetes, and we should embrace this. ■

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