PCDS Question Time

Addressing ethnic and cultural inequalities in healthcare – a primary care perspective

On 10th and 17th June 2021, expert panels convened to broadcast a short PCDS Question Time series. The first webinar focused on the PCDS update for primary care on COVID-19 and diabetes. The second discussed the role of primary care professionals in addressing health inequalities, which have been so acutely highlighted by the pandemic. While the PCDS recognises that a vast range of groups experience sub-optimal care, the focus here was on the impact of ethnic and cultural inequalities. In this article, the panel's responses to questions put to them in real time are summarised.

Responses by:
Stephen Lawrence (Chair), Primary Care Clinical Lead, Chatham; Sarah Ali, Consultant in Diabetes and Endocrinology, Royal Free London NHS Foundation Trust; Nicola Milne, Primary Care Diabetes Specialist Nurse, Manchester; Sam Seidu, GP and Clinical Lecturer in Primary Care, University of Leicester

Q What is the difference between race and ethnicity?

- The terms race and ethnicity are often confused, but they are distinct. Race is a categorisation based on biological traits, such as skin colour, and is now widely regarded as a social construct.
- Ethnicity is much broader, covering a complex interaction of factors that contribute to an ethnic belonging. These factors include where a person is from and where they have migrated to; the setting they have come from (e.g. urban versus rural); socioeconomic status, including the jobs performed; their language; their religious beliefs; and so on.
- Differences in culture (such as food choices and language barriers) impact on lifestyle, chronic disease and on how healthcare is accessed.

Q What is the difference between cultural sensitivity and cultural competence?

- Understanding these terms allows us to advance the way that we provide healthcare to different ethnicities.
- Cultural sensitivity is the awareness that different cultures exist within our society. In the context of healthcare, cultural competence extends this awareness to tailoring our systems and care delivery to the needs of people with diverse values, beliefs and behaviours.
- It is important not to assign a value – good or bad – to somebody else's culture, as this will result in differential health outcomes.

Q Are health inequalities partly due to a lack of staff education in this area?

- For a health professional, knowledge of cultural competency is a starting point, but must be followed by a willingness to move their position and adapt interventions to suit a person's culture. Education is required to get to this point, but it needs to be accompanied by self-reflection.
- To facilitate this shift, part of this education process should include experience in the community, perhaps by shadowing colleagues, and working with local people and leaders.

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- The development of healthcare systems may have resulted in easier access for some people than others (e.g. someone with limited English may find it more difficult than a native-English speaker). While systems are being improved, education towards cultural competence is required to continue this progress.
- Healthcare professionals responsible for developing services need to be educated and informed by the people that use the services. Otherwise, judgements, which may be inaccurate, will be made on their behalf.

How much is health inequality, or bias, a learned behaviour?

- Healthcare professionals who have grown up within a particular culture may lack awareness of other cultures because they have not had experience of them. In such a situation, unconscious bias is likely to exist.
- Unconscious bias can result in differences in health outcomes between the majority and minority cultures. By increasing awareness of how cultures differ, perspectives can be shifted and biases addressed.
- Formal medical education may, unconsciously or otherwise, be focused on an archetypal white patient. This may be changing with, for example, the publication of new editions of textbooks.

Can we differentiate between healthy life expectancy and health inequality, and do the guidelines and evidence support this?

- In 2010, *The Marmot Review* reported that, while many in the UK were living longer, a social gradient of health inequalities existed, and it was increasing (Marmot et al, 2010). It remains the case that the lower your socioeconomic status, the earlier you are likely to die and the more years you are likely to spend in poor health.
- Guidelines reflect the evidence that is available. For certain populations, there is a lack of data. This is particularly so with black and African–Caribbean communities, from which recruitment for research is often poor. The under-representation of researchers from these populations may result in suspicion amongst potential study participants and exacerbate this recruitment problem.
- This presents difficulties for policymakers. However, the National Institute for Health Research is very focused on equality, diversity and inclusion in its research programmes. We should see guidelines reflecting this once evidence addressing these gaps in information has been gathered.
- Mandatory ethnicity coding in primary care would be helpful for evidence gathering. The COVID-19 pandemic has brought to light a lack of rigour in this area.
- Disparities can grow despite guidelines. A review of the National Paediatric Diabetes Audit (Ng and Evans, 2021) indicates that a black child is increasingly less likely to access an insulin pump or continuous glucose monitoring, despite guidelines advocating their use.
- Unconscious bias might be at work, but certain socioeconomic and ethnic groups may be less likely to come forward and ask for access to, for example, flash technology even if they qualify for it. There can be barriers that make it difficult for them to do so.
- It is important that healthcare professionals focus on providing the disadvantaged with the care that they are entitled to. Without active help, these people may never get the same level of access as more privileged groups, who will continue to add to their advantage.
- Bear in mind that many will find healthcare services hard to access. Despite 1.5 million households in the UK not having internet access, registering for up to 40% of practices is electronic-only, and much of our information and education is online. The COVID-19 pandemic showed us that basic messages, such as the continuation of primary care services, do not reach some people.

What can we do in our practices to avoid health inequalities?

- It is very easy for healthcare professionals to fall under such criticism. Ongoing and mandatory

training in avoiding health inequality should be provided for all healthcare professionals.

- The NHS in England has established the Race and Health Observatory to investigate health inequalities experienced by BAME communities. Initiatives such as this will provide the evidence needed to drive improvements forward, including those needed in diabetes care.

Q People with learning disabilities often experience health inequality. Can the panel comment?

- People with learning disabilities experience huge health inequalities, including in life expectancy (17 years and 14 years shorter than the general population for females and males, respectively; NHS Digital, 2020). This is one of many marginalised groups (others include secure and mental health care) for whom service provision should be funded. This funding needs to be ring-fenced to prevent it being used for other services.
- A compulsory field in electronic patient notes to record whether a person is at risk of health inequality, whether because of disability or any other reason, would be helpful.
- Primary care professionals must understand the needs of their populations and of individuals in order to tailor care. That includes clarifying how people with learning disabilities who have diabetes will be managed if they have special needs.
- To engage a vulnerable individual in the management of their chronic disease, it is vital to address the social, emotional or mental health issues that are affecting them at that time. Sometimes a person's immediate needs must be addressed before their other health issues, such as glycaemic control, are attended to.

Q What would a programme to prevent health inequality in the NHS look like?

- A broad approach is needed, from government policy looking at housing and education attainment through to the points discussed here that can be addressed in primary care.
- In terms of diabetes prevention, we are used to thinking about who is at risk and why. Similar principles could be applied to addressing health inequality and to help reduce the huge cost to the economy that results from increased years of poor health.
- Thousands of new diagnoses of type 2 diabetes have been missed because of the COVID-19 pandemic. Health checks and screening must be at the forefront as services are reset.
- With regard to diabetes prevention, joined-up planning from government is needed to address food policies and other areas that contribute to obesity.

Q What are your key take-home messages?

- Focus education to address unconscious bias by people from the majority culture, who are often the providers of healthcare to minority communities.
- In each consultation, ask yourself if there is a risk of this person experiencing health inequality.
- Ethnicity coding needs to be improved, along with our cultural competence.
- All healthcare professionals are responsible for the care of vulnerable people. Regardless of our backgrounds, we must educate ourselves and recognise our own blind spots. ■

Marmot M, Allen J, Goldblatt P et al (2010) *Fair Society, Healthy Lives: The Marmot Review*. Available at: https://bit.ly/3zqQ3AL (accessed 08.09.21)

Ng SM, Evans ML (2021) Widening health inequalities related to type 1 diabetes care in children and young people in the UK – a time to act now. *Diabet Med* 10 Jun: e14620 [Epub ahead of print]

NHS Digital (2020) *Health and Care of People Living with Learning Disabilities, Experimental Statistics: 2018 to 2019*. Available at: https://bit.ly/2UI7QVt (accessed 08.09.21)

"Primary care professionals must understand the needs of their populations and of individuals in order to tailor care."