

Language barriers in providing diabetes care



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Providing high-quality diabetes care is hard enough, but according to last year's Healthcare Commission report that assessed diabetes care from a patient's perspective, only 16% of PCTs were rated as excellent or good (Healthcare Commission, 2007). The report authors did not just assess clinical outcomes, but also screening and access to education. The highly rated PCTs were more likely to have people with diabetes meeting their clinical targets and reporting that they have jointly agreed care plans with their healthcare professional.

Although the report barely mentions diabetes care of people whose first language is not English, it does comment that Caucasians are more likely to understand what their medications are for, and what their HbA_{1c} level is, than people of black and minority ethnic (BME) groups.

Making support available to people with long-term conditions to care for themselves is central to the Government's policy for diabetes. The issue of supported self-care is highlighted in the 2001 diabetes National Service Framework (DoH, 2001) as a priority area for healthcare professionals. But supported self-care through the multitude of structured diabetes education programmes available (such as DESMOND, X-PERT and DAFNE) is much easier to achieve if the patient is able to speak adequate English.

In the joint DoH and Diabetes UK evaluation of structured patient education in diabetes (DoH and Diabetes UK, 2005), not only is the much greater prevalence of diabetes in ethnic minority groups noted (prevalence in an inner-city Pakistani population has been reported at 32% in one study: Riste et al, 2001), but many additional challenges are highlighted. For example, individuals from BME groups (particularly those of South Asian origin) are less likely to consider their diabetes as a chronic condition and are more likely to be pessimistic about the impact of diabetes and its effect on their lives. The prime challenges are seen as adapting the objectives of a disease-specific health management programme to a cultural group who not only are unable to read and communicate adequately in English, but whose

health beliefs and behaviour regarding chronic conditions may be significantly counterproductive.

For instance, smoking is much more common in Bangladeshi men than European men, physical exercise in public is culturally unacceptable for South Asian women and large body size is generally perceived as being more healthy than slim body size (Greenhalgh et al, 1998). Sylheti, a language widely spoken in Bangladesh, has no word or phrase for physical activity that has any positive connotations in terms of health or wellbeing. Even more worrying is the finding from a Newcastle-based survey that levels of physical activity did not significantly change between first and second generation South Asians (Hayes et al, 2002). Effective group education is all very well, but the positive messages are lost in the clinical setting because of inadequate or inappropriate translational services.

So how can we move on? Clearly, in order to have a non-discriminatory, equitable and effective diabetes service, it is crucial to provide trained translators whenever needed. Given the influx of Eastern Europeans from the new EU accession states, this is a significant challenge to those of us outside of London where hitherto we only had to make provision for two or three different languages at most.

In the following article Professor Trisha Greenhalgh describes the benefits of bilingual health advocates and addresses the implications for practice.

People with diabetes whose first language is not English present a challenge to all healthcare professionals. We need to devote more resources and time to even out the inherent disadvantages such people often have due to their language needs. In the US, the American Association of Diabetes Educators has over 4000 members, many of whom are bilingual and trained in advocacy. In the UK training for bilingual support workers and educators in diabetes has hardly begun.

This is a test of our true commitment to provide just and respectful diabetes care for all. A true 21st Century challenge indeed! ■

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