Meeting the needs of black and minority ethnic groups

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The first paragraph of *The New NHS* highlights the government's commitment to reduce health inequalities. Access to health services is to be based on "need and need alone." The white paper explicitly notes the importance of addressing variation in death rates and risk factors between different ethnic groups and emphasises the importance of ensuring that "black and minority ethnic groups are not disadvantaged" in their access to services.

Although the differences can be overstated, some health needs of black and minority ethnic groups differ from those of the indigenous population.¹ In addition, some, such as refugees, have specific health needs. The new arrangements need to incorporate some means of ensuring that these particular needs are recognised.

The white paper gives general practitioners and community nurses a central role in assessing need, but general practitioners are trained to identify and respond to the individual health needs of their patients, including psychosocial dimensions of health. Their understanding of these needs reflects the variety and types of illnesses that patients present and is inevitably based on patients' current use of and demand for services. Unfortunately use of and demand for services are not always directly related to need but also reflect factors such as the patient's health beliefs and knowledge, attitude to and experience of services, the doctor's interests, and the supply of services. Understanding these relations is important if a service based on need is to develop.

Service use is a particularly inadequate measure of need for black and ethnic minority groups as they are already disadvantaged in their access to services. Some have limited knowledge of health services; their health beliefs may differ from those of service providers; and services planned for the majority are not always appropriate.² Those with poor English experience particular difficulty in gaining access to care,³ since their knowledge of services, ability to make contact by telephone,⁴ and ability to communicate with doctors and nurses is limited.²

To identify the needs of all of the population for whom they are responsible, general practitioners will need information from comprehensive population based health needs assessments, specifically including disadvantaged groups.⁴ The white paper is unclear about the relative contributions of health authorities and primary care groups to assessing health needs. There is a strong argument for collaboration between the two so that the experience that has been accumulated by public health practitioners since 1990 is not lost. If this is not done the inadvertent exclusion of those groups who do not use services will compound their disadvantage.

A second way in which black and minority ethnic groups may lose out is from the increasing reliance on the telephone as a means of obtaining care, exemplified by the helpline, NHS Direct. There is little detail on how this will work but it needs to take account of the needs of those who neither speak English nor

have easy access to an interpreter.⁴ In England and Wales 23% of those whose country of birth was China, Bangladesh, India, or Pakistan are estimated to have no functional communication skills in English and 70% to have insufficient English to work and function socially in an English speaking environment—a total of almost 600 000 people.⁵

Most patients depend on healthcare providers to book an interpreter. Doctors may be unaware of interpreting services, which are anyway often unavailable for an urgent appointment or outside normal hours⁶ and have not been fully evaluated for their accessibility, acceptability, and quality. The development of NHS Direct should be based on a better understanding of the barriers faced by patients with limited English and should draw on experience from the commercial sector, such as multilingual airline booking services.

Without direct access to interpreting services, those with limited language skills are excluded from services which are accessed by telephone. As well as the new helpline these include out of hours services by general practitioners. For these groups "inappropriate" attendance at an accident and emergency department may remain the only source of medical care outside working hours.

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