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Diversity, equal access and information

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ABSTRACT

The overall aim of diversity is to ensure that every individual, whatever their differences, has fair and equitable access to health care and to employment based on clinical need and merit. This has advantages for staff by allowing them to give of their best and for patients by better identifying and

meeting their needs. Evidence shows that individuals from minority groups are often not treated fairly and positive action is required to redress the balance.

Keywords: diversity, equal access, information

Diversity

The aim of diversity is to provide patients and clients with fair and equitable access to health services, whatever their differences: to provide a service based on need. For staff, National Health Service (NHS) organisations should be places where they feel valued, whatever their differences, and have a fair and equitable quality of working life.

A difference which puts people in a minority may be their age, gender, religion, ethnicity, disability, sexual orientation or any other factor that affects the way others behave towards them. It might, for example, be a male in a predominantly female working environment who is harassed due to his gender.

When all individuals are treated equitably, we can stop talking about diversity. It will be ingrained in the culture of the NHS (mainstreamed in current terminology). In the meantime, some staff and patients get a rougher deal than others because of their differences and that requires action to redress the balance.

It is important to understand the impact of difference, develop cultural competence, identify inequalities and take action to create fair and equitable access. This includes understanding how different aspects of culture affect access to health care and to employment and the issues of importance to minority groups: not to stereotype but to, for example, develop awareness, know the right questions to ask or identify appropriate avenues of investigation.

Work on diversity in the NHS is based on the assumptions that NHS organisations should aspire to being multicultural, where different cultures are valued

rather than merging into a single dominant culture, and that the NHS aspires to be a meritocracy: access to care on the basis of clinical need and priority and access to employment on merit.

Cultural factors that have an impact on access to health care and employment include:

- the rituals associated with birth, death and other life events
- diet
- the importance of festivals and the needs of individuals during these times
- presentation of symptoms, response to assessment and response to treatment
- linguistic ability, language and communication
- body language, for example personal space, eye contact, etc.
- ability to access information, for example literacy, visual and hearing impairment, learning difficulties, etc.

Unwitting offence, harassment or discrimination is built into the culture of the NHS. Discrimination is often part of normal practice which goes unrecognised, other than by those who are on the receiving end. For example, what might be considered as a valid management style which would have been taught as such in the past might now be considered as harassment or bullying.

In the report of the Stephen Lawrence inquiry, Macpherson noted: 'It could be said that institutional racism is in fact pervasive throughout the culture and institutions of the whole of British society.'¹ The *Positively Diverse* work showed that, in the NHS, this might apply to discrimination based on difference.²

Evidence of inequality

The evidence that minority groups get less than a fair deal is widespread and just a few examples are provided here. Much of that evidence relates to black and minority ethnic groups.³ Although a great deal of information is available, the data collected often does not provide a full picture of what is happening.

Example 1: General practice consultations

Registration with a general practitioner (GP) is relatively lower amongst African Caribbean men. Consultations with GPs are higher among Asians. Information is not available to say whether this is due to differences in morbidity, varying thresholds, perceptions of illness or uptake of services.⁴

Black and ethnic minority patients are more likely to:

- find physical access to a GP difficult
- wait longer for surgery
- feel time spent with them is inadequate, and
- are less likely to receive follow-up or referral
- are less satisfied with the outcome of the consultation.

Example 2: Linguistic ability

Approximately 600 000 people are unable to speak sufficient English to communicate adequately with health professionals.⁵ Despite this, provision of translation and interpreting services is limited.

Example 3: Inverse Care Law

More than 30 years ago Tudor Hart proposed the *Inverse Care Law* which states that the availability of good medical care tends to vary inversely with the need for it.⁶

In a recent study a research team in Glasgow concluded:⁷

Socio-economically deprived patients are thought to be more likely to develop coronary heart disease but are less likely to be investigated and offered surgery once it has developed. Such patients may be further disadvantaged by having to wait longer for surgery because of being given lower priority.

Increasingly, access to health services includes access to information. When providing access to information for patients and staff it is important to know that in the UK:⁸

- 8.7 million people are deaf or hard of hearing
- 7.3 million people have literacy difficulties
- 1.7 million people are blind or visually impaired
- 1 million people have learning difficulties.

Is *reasonable* access to information made available to them?

Example 4: Ethnic minorities⁹

- Asian groups in England and Wales are 60% more likely to have heart disease and five times more susceptible to diabetes. Early death is 50% higher than the UK average.
- Black African Caribbeans are five times more likely to have high blood pressure and twice as likely to die of stroke under 65 years.
- Babies born to Pakistani women are twice as likely to die within the first week of birth as babies born to white British women.
- Uptake of cervical screening amongst Bangladeshi women is less than half that of the general relevant population.
- Refugees and asylum seekers experience multiple deprivations which can have a severe impact on health and, particularly, lead to a high risk of mental ill health.

Example 5: Medical appointments

Personal reference, patronage and the 'old boy network' continue to be of prime importance in medical appointments, putting non-white people and women particularly at a disadvantage.¹⁰

If your degree is from Calcutta or Bombay, it doesn't count. You will have to sit the PLAB exam, which is more advanced than the medical finals I had to sit as a UK graduate. About two years ago, somebody tried the PLAB on 51 newly qualified British graduates in Manchester and 49, who according to the GMC were deemed to be qualified, failed.

Dr Neil Ashford, then Deputy Chairman of the British Medical Association Non-Consultant Career Committee

Example 6: Results of NHS staff survey (20 000 respondents)¹¹

- Many workforces reflect the diversity in the local community when considering the workforce as a whole. However, this was not reflected across grades or professional groups.
- Most staff do not feel appreciated.
- Less than a third of respondents were confident about expressing their views and concerns.
- One in five respondents had suffered harassment – more from their supervisors and managers than from any other source. Patients and colleagues are also a source of harassment. A total of 30% of ethnic

minority staff had experienced harassment and bullying due to race.

Further legislation is anticipated to cover discrimination on the bases of age and religion.

Why address diversity?

Perhaps the most compelling reason for addressing diversity is that it is the right thing to do in a multi-cultural meritocracy and in a public service that aspires to respond to the different needs of different populations and to support and value its staff.¹² It is a matter of social justice.

There are benefits for staff, patients and the organisation.¹³ For example:

- Ensuring that all staff have the confidence to raise concerns and that those concerns are taken seriously helps achieve the aims of clinical governance and improve the quality of clinical care.
- If the NHS is to employ the professionals it needs, in a time when need is increasing and the total workforce is declining, then it needs to draw staff from all communities, with the NHS becoming an employer of choice.
- If staff are not treated fairly in their working environment or not given opportunities for development and promotion, then the 'revolving door' principle applies. Staff having had a bad experience leave, taking the message of what it is really like to work in the NHS with them, making it even more difficult to recruit from some communities.
- Sickness and turnover rates are reduced in organisations that eliminate harassment and bullying.
- 'Securing and developing a workforce that reflects and understands the diversity of the population is fundamental to serving the needs of all and such diversity helps to reassure users that they will be more likely to get the service they need.'¹³

There are also legal requirements not to discriminate against minorities and now to actively promote equality. Amongst those requirements are the:

- Disability Discrimination Act (1995), including an obligation on organisations to make reasonable provision for persons with disability.¹⁴ Where access to services is increasingly linked to access to information, this includes making provision for access to that information.
- Race Relations Act (1976) and Race Relations (Amendment) Act (2000), which gives all public organisations an obligation to promote race relations with an initial requirement to have produced a Race Equality Scheme by May 2002.^{15,16}
- Sex Discrimination Act (1975) and subsequent acts relating to its application and exemption, which make it illegal to discriminate on grounds of gender.¹⁷

Information issues

The information required to identify inequalities is limited. While evidence of inequality is now increasing and the impact of measures on staffing statistics is growing, information is lacking for the impact of measures of health improvement.

The following gives some of the information issues associated with managing diversity and ensuring equitable access. For example, information is required to:

- understand the composition and views of the workforce:
 - audits to assess views on policies, harassment, bullying, confidence to express concerns, likes and dislikes, and staff attitude surveys
 - appropriate analysis of existing pay and personnel databases
- understand the patient/client and population served and their needs:
 - population and practice profiling, including data items for race, ethnicity, gender, disability, age, religion, etc.
 - disease register(s)
 - identifying needs of minority groups for service provision: language, diagnostic and treatment provision, administration (appointment times, locations, etc.)
- identify inequalities:
 - identify differences in access to services, for example consultation, referral, investigation rates of different groups
 - compare with population from which the workforce is drawn to identify groups under-represented within the workforce
 - identify inequalities within the workforce in seniority, etc.
 - compare with national *Positively Diverse* benchmarks to assess relative position of individual organisations^{2,11,18}
- improve service provision:
 - priority setting
 - using information and information systems to make services and employment more accessible to patients and staff with a disability or special needs
- monitor progress:
 - review against a baseline
 - measuring progress against objectives and targets. Diversity targets can be expected as part of national performance assessment processes.

Action

There is a great deal of activity in the areas of diversity and equal access as a result of legislation, government priorities and local action, some of which is mentioned below.

- *Positively Diverse* and *Action on Health Equality*: supporting local projects addressing equal access to employment and to health services and providing a process for assessing and improving diversity and access.^{18,19}
- *Partnerships for change*: developing cultural competence in healthcare organisations. (Bedford Health Promotion Agency)
- *Patient profiling in primary care*: the aim is to link this information to computer-based practice information systems to generate patient population morbidity and service use profiles, and it can be used to inform service planning and delivery for individuals and the whole practice. (Princes Park Health Centre, Liverpool and University of Greenwich)
- *Improving the health of hearing-impaired and deaf children and adults*: dealing with adults and children with disability takes time. Where English is a second language or there is no English spoken in the family, this increases the difficulties which arise and the time required. (Bradford Royal Infirmary)
- *Job shop/job stall*: providing access to all NHS jobs in communities under-represented in the workforce, as well as advice and support to those interested in working in the NHS. (Bradford NHS organisations, The London NHS Trust)
- *Healthcare apprenticeship and cadet schemes*: encouraging people from minority groups to consider careers in nursing by providing encouragement, information, training and personal development and overcoming real and perceived barriers. There are more than 20 schemes throughout England.
- *Recruiting refugee doctors* (Redbridge and Waltham Forest) and *overseas trained professional adaptation* (Barts and The London NHS Trust).

Conclusion

Ensuring fair and equitable access to health services and a fair and equitable working environment for all NHS staff is in the interest of patients, staff and organisations as a whole. The NHS is a long way from this ideal and positive action is required by all to redress the imbalances that exist.

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