The Ethnic Monitoring of Patients referred to the Physiotherapy Service in Parkside Health 1995/6

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Abstract

This article describes the way Parkside Health NHS Trust carried out ethnic monitoring in the 1990s. A review of the literature on access to health services by ethnic minorities is included, although there was little specific to physiotherapy. The hypothesis was set up that there is no statistical difference in the distribution of the ethnic groups between those patients referred to the physiotherapy service in Parkside and the population of Parkside as a whole enumerated in the 1991 census. The data obtained from the Parkside Community Information System (CIS) is described and the problem of missing data addressed. The data is compared with the census population. While at the aggregate level there was a good fit, when disaggregated by sex and age it was found that some ethnic groups were under-represented and others over-represented. Possible reasons for this are suggested.

Keywords: Access, clinical need, equity, ethnic monitoring, physiotherapy, quality of care.

Review of literature on ethnic monitoring

There are many references to the issues of equity and equality in the areas of clinical need, perceived need, demand, access to and utilisation of wider aspects of health care by ethnic minorities. Those published before 1994 were reviewed by Smaje (1995).

Most studies of clinical need in ethnic minorities are concerned with mortality, being easier to measure than morbidity, but less relevant to the practice of physiotherapy. An exception was

Cruickshank and Beevers (1989), who considered such major contributors to the physiotherapy workload as Rheumatoid arthritis and Degenerative Joint Disease (chapter 16).

Donovan (1986) made a study of perceived health needs of Afro-Caribbean and Asian respondents in which she found a desire for thorough examination and the opportunity to express their own views, a willingness to pay for private treatment, combined with criticisms of waiting times, short consultations and 'control' by health workers.

Fenton (1989) wrote, 'access is sometimes used to mean more than simply getting to the care centre, to include getting satisfactory care as well'. Cruickshank and Beevers (1989) added (page 185) 'Any provision which fails to take account of the proximity of the facility to the work-place or residence, the opening hours, the provision of an appointment or drop-in system, or particularly that the elderly migrant may not speak English, would in effect be withholding a service from such individuals'. Cox and Bostock (1989) saw access to service as a process, 'from contacting the health centre (using the telephone, seeing a receptionist) to following a pattern of treatment (e.g. understanding a prescription)', (page 21), or in physiotherapy terms, carrying out a home exercise programme. Norman (1985) regarded it as essential 'to make a really conscious and sustained effort to take services to the users so that they can talk about their health needs with professionals and receive advice, and in some circumstances treatment, in a place which is safe, familiar and sympathetic'. This means that health authorities must 'provide outreach health services in clubs, day centres, temples and other meeting places'.

While many writers mention the reluctance of some Asian and all Muslim women to be examined by male health workers, which is not a problem in physiotherapy, it being a predominantly female profession, Hopkins and Bahl (page 101) identify another gender issue, that elderly male Asian patients are often unaccustomed to dealing with women in positions of authority or with professional status. Sometimes they feel embarrassed and may be difficult and unhelpful with female health workers.

Balarajan and Raleigh (1993) note that 'GP consultations are higher among black and ethnic minorities, especially Asians. Data

from the General Household Survey show that consultations are highest among Pakistanis. It was not possible to determine whether these patterns reflect differences in morbidity, varying thresholds and perceptions of illness, differential uptake of services, or a combination of these factors'. They further note that Asian and Caribbean children and young adults have lower rates of hospital out-patient attendance than Whites. These findings, in conjunction with greater morbidity from some chronic diseases and higher GP consultations, suggest that levels of hospital-based care may be lower than expected among ethnic minorities.

Bhat, Carr-Hill and Ohri (1988) complained that 'more and more statistics on "race" were being collected while little or no change could be detected in the economic, social, political and other everyday problems which confront black communities'. They added (page 20) 'Ethnic monitoring, if it is to be at all meaningful, needs to be merely one aspect of a strategy for tackling the roots of institutionalised racialism'. McAvoy and Donaldson appealed to GPs for more studies to examine patterns of accessibility, treatment outcomes, and acceptability of the service to patients of different ethnic origins. Gordon in Skellington (1992) reminded readers that 'the collection of ethnic data is not an end in itself but a means to an end: that of implementing equal opportunities and racial equality. The current support for ethnic monitoring … indicates willingness to take at least the first steps in this process by identifying the ways in which minority ethnic groups may be discriminated against. But it must be remembered that these are first steps only. They will have to be followed, where the data show it to be necessary, by changes in policy and practice'.

Ahmad [1993] pleaded for a critical assessment of whom the existing services reach, combined with a fundamental re-appraisal of the assumptions on which policies, practices and procedures were based, in an attempt to make the service more appropriate, accessible and sensitive to the needs of all users.
Cox and Bostock wrote 'there remains an urgent need … for there to be a much greater appreciation that the National Health Service is becoming not just a two tier health service for a two tier nation but that its apparent failure to respond to multi-cultural society will lead to vastly impoverished health care for minorities' (page 3).
Among their recommendations were 'the need to monitor and evaluate present services and practices to ensure that if and when

gaps are highlighted, procedures exist to facilitate change based on these findings. … Because of the possible link between inappropriate processes and poor communication on the one hand and low uptake of services on the other, all involved in service provision and employment should evaluate the appropriateness of their present service and conduct campaigns designed to inform the minority ethnic groups of the services available, linked with outreach and support work… As part of the exercise of assessing the quality of service, an area of high minority ethnic population should be selected and that N.H.S. personnel with appropriate experience should study the relevance of the service being provided to the needs of the local minority ethnic community' (pages 12-3).

This study was undertaken as part of that assessment exercise.

Parkside Health

Parkside Health was an N.H.S. Trust, set up in 1992, following the White Paper 'Working for Patients'. It disappeared in a subsequent N.H.S. reorganisation, but in 1995 was a Community Trust without a major District General Hospital, providing care to the local population through a network of Community Hospitals, Medical Centres and Clinics. It did not provide the whole range of medical and surgical in-patient care, but did offer out-patient, domiciliary and minor accident treatment services, together with in-patient facilities for the young disabled, those with learning disabilities, those with mental health problems, elderly rehabilitation and the terminally ill.

Parkside Health served the population of the London Borough of Brent and parts of the London Boroughs of Westminster and of Kensington and Chelsea. It aimed to provide integrated health services of consistent quality, locally available and widely accessible. The strength of Parkside Health lay in being the *local* provider of health care. As medical technology advanced, many procedures which once needed hospital care could be undertaken outside large, general hospitals. Parkside Health, through its network of community hospital sites, provided local centres to support general practice and social care.

Parkside Health inherited little computing support for staff. Becoming a Trust enabled it to focus investment in the neglected area of Information Technology to improve the effectiveness of staff

and the quality of information about service provision. Its priorities were

- to make available IT at all workplaces;
- train all staff in computer use;
- maintain a system which would provide information for the running of the Trust;
- enable staff to manage their work better;
- meet customer requirements;
- assist health authorities in their task of assessing health needs.

The Community Information System (C.I.S.) enabled each professional to have local access to databases and programmes.

Ethnic Monitoring

The area covered by Parkside Health was one of the most ethnically diverse in the country. From its inception the Trust stressed the importance of ethnic issues. A professional interpreting service was developed so that people could communicate in the language with which they felt most comfortable. It offered over 40 languages and extended beyond the Trust, covering a large part of north-west London. Information about services, in the form of sign-posting and leaflets, was produced in many of the languages used in the community. A bi-lingual speech therapy service was set up for Gujarati, Punjabi and Hindi speakers.

The environment of the community hospitals was designed to be conducive to ethnic minorities through dietary arrangements, spiritual observance, and customs over death and bereavement. Training was provided to staff on religious and cultural beliefs about death and dying, so that appropriate practices could be observed. Ethnic diets were introduced throughout the Trust. There was a policy of selecting acceptable role models, e.g. Imran Khan launched a national immunisation campaign from a local clinic, which reached 86 per cent of its target population.

Ethnic monitoring began with the workforce. Four of the 13 members of the Trust Board were members of ethnic minorities. Overall the Trust achieved its objective for the workforce to match the cultural mix of the community, although ethnic groups were not represented in the expected proportions in all localities or

specialities. Figures for the ethnicity of staff in 1995 were 47.4 per cent white, 19.7 per cent Black Caribbean, 8.1 per cent Black African, 1.2 per cent Black Other, 8.2 per cent Asian (which presumably included the Census categories Indian, Pakistani, Bangladeshi and Other Asian), 1.1 per cent Chinese, 6.8 per cent Other, and 7.5 per cent Not Known.

A programme of staff training was implemented to enlist the co-operation of patients and clients to provide information on ethnicity. Information was collected manually from 1st January 1993 with the information initially retained in the client's notes. Once the C.I.S. went live the data were transferred to the Master Patient Index [M.P.I.].

Access to both medical records and computer records is subject to strict limitations concerning what information can be released and to whom. Detailed information on an individual's ethnic group is confidential, and its availability is restricted to those involved in the direct care of the patient. It was Trust policy that the aggregated information was collated, analysed and subsequently fed into the planning process.

Patients were asked to supply the information and had the right to decline to answer. This right was respected and in no way affected the treatment the patient received. It was intended that the proportion of people refusing to register their ethnic group was monitored as an indicator of the acceptability and effectiveness of ethnic recording.

Forms were translated into the main languages required and printed in the appropriate scripts. When patients were unable to read the form it was read to them. In cases where the patient was unable to respond, e.g. a very young, very sick or very old patient, and the ethnic group classification was made by a close relative or a member of staff, the patient could at any later stage change the category recorded.

Population

Ideally one would wish to have figures for the population of Parkside, broken down by sex, age, and ethnic group, with which to compare the referrals to the Trust's physiotherapy service.

Unfortunately these did not exist. If the ethnic origin of all patients registered with a general practitioner were recorded and passed to the Health Authority it would be possible to obtain the sex, age and ethnic origin of the base population. Enquiries to Brent and Harrow Health Authority drew the response from their Medical Demographer that only a few practices were collecting data on the ethnic group of their patients and the information was not readily available. Within the geographic area of Parkside were five general hospitals: The Middlesex, Central Middlesex, Northwick Park, St Mary's and University College, each of which has physiotherapy services. The combination of these factors makes it very difficult to state with certainty the demographic characteristics of the base population from which referrals to the Parkside physiotherapy service were received.

In the absence of ideal figures for a base population this study adopted the practice used throughout Parkside of taking the 1991 census figures, despite the fact that they were more than five years out of date.

Table 1 shows the percentage of the population of Parkside in each ethnic group.

Table 1 Residents of Parkside by Ethnic Group

Ethnic group	Number	Percentage
White	271,192	64.2
Caribbean	33,599	8.0
Black African	15,683	3.7
Black Other	8,071	1.9
Indian	45,112	10.7
Pakistani	8,473	2.0
Bangladeshi	4,513	1.1
Chinese	5,373	1.3
Other Asian	14,007	3.3
Other Other	16,304	3.9
Total	422,327	100.0

Source: information provided by the Office for National Statistics [ONS] in the form of 1991 Census Small Area Statistics and is Crown Copyright.

Data

On receiving a referral for physiotherapy the patient's details were entered onto the C.I.S. Thereafter the Master Patient Index number is the means of access to all other information stored about the patient. It is recorded manually on the treatment card and on all other documentation. To complete the registration of a new patient the CIS requests a range of information, some of which is discretionary, but certain fields are mandatory, although codes for 'not known' are accepted until the information is obtained. Ethnic grouping was among the mandatory fields. Once a new patient is registered an 'episode of care' begins, which continues until the patient is discharged.

For the purposes of this study a programme was written which would print out by MPI number of all patients registered by all the teams of the Parkside physiotherapy service during the 12 month period between 1st October 1995 and 30th September 1996. The print-out was designed to include the ethnic code, sex, date of birth, team code and source of referral.

Table 2 presents the total referrals for each ethnic group.

Table 2 Patients by Ethnic Group

Ethnic group	Number	Percentage	Percentage of assigned ethnicity
White	2,741	46.1	65.4
Caribbean	328	5.5	7.8
Black African	111	1.9	2.6
Black Other	106	1.8	2.5
Indian	520	8.7	12.4
Pakistani	114	1.9	2.7
Bangladeshi	19	0.3	0.5
Chinese	16	0.3	0.4
Other Asian	20	0.3	0.5
Other Other	214	3.6	5.1
Total assigned ethnicity	4,189	70.4	100.0
Blank	167	2.8	
No Category Assigned	1,316	22.1	
No Response	278	4.7	
Total	5,950	100.0	

Source: Parkside CIS and author's calculations

Dealing with Missing Data

It will be noted that there was a very large residual group made up of 'blank', 'No Category Assigned' and 'Not Recorded'. This was worrying for the service managers, who were liable to be financially penalised if more than 20 per cent of patients' ethnic grouping remained unrecorded. A sub-set of the referrals was examined to attempt to determine the reasons for non-recording.

This sub-set was not a random sample. It was only those patients referred to Willesden Community Hospital between 1st October 1995 and 31st May 1996. This team was chosen because of access

to the original manually-recorded treatment cards. This period was the date of the second test run of the computer programme, when this problem became apparent.

The subset comprised 807 records. 11 of these were 'blank', 174 'No Category Assigned' and 14 'Not Recorded', a total of 199 unsatisfactory records (24.7 per cent). Searching each MPI number revealed that in only 6 cases (0.7 per cent) the patient had been unwilling to reply to the question on ethnic origin. Under the terms of Parkside's ethnic monitoring policy this is perfectly valid and must be accepted. It is also a measure of the acceptability of ethnic monitoring. For the remaining 193 unsatisfactory records a total of 39 patients had been discharged because they 'Did Not Attend', i.e. there had never been a face-to-face contact with the patient. In these case there had never been an opportunity to carry out ethnic monitoring under the terms of the Trust's policy, i.e. that the ethnic group is nominated by the patient. That such a high proportion (4.8 per cent) of patients referred to the physiotherapy service never attend is clearly a clinical cause for concern. If it could be shown that there was an ethnic bias to these non-attenders it would be an even greater cause for concern.

Five patients were recorded as 'Inappropriate Referral', one was marked 'Other Problem Intervened', two were marked 'Patient Refused Treatment' and two were marked 'Full Recovery'. In these 10 cases there would again have been no face-to-face contact.

55 of the 199 unsatisfactory records are thus accounted for, leaving a further 144 records which were either marked 'Treatment Complete' or 'Active', with the implication that they were still receiving treatment. The next stage was to make a manual search for the treatment cards of these patients. 127 treatment cards were traced but the remaining 17 could not be found. Most of these missing cards were among those marked 'Not recorded'. Of the 127 traced treatment cards, 47 were indeed blank; the ethnic monitoring question did not appear to have been asked. The failure rate is thus reduced to 47 out of 807, i.e. 5.8 per cent, though it could be as high as 7.9 per cent if all the untraceable cards were also blank. The other 80 cards that were traced did show evidence that ethnic monitoring had been undertaken, but the outcome had not been entered on the computer. Questions remain as to why in 5.8 to 7.9 per cent of cases the physiotherapist failed to carry out

ethnic monitoring, and why in a further 9.9 per cent of cases the results of ethnic monitoring were not entered in the computer. Manually tracing all the missing entries for the other teams was unlikely to improve the quality of the data sufficiently to justify the labour involved. The analysis that follows is therefore limited to the 4,189 patients whose ethnicity was entered on the CIS.

Analysis and Discussion

Table 3 presents the percentages of patients in each ethnic group compared with the population of Parkside in 1991.

Table 3 Comparison of Patients with Population of Parkside

Ethnic group	Patients %	Population %
White	65.4	64.2
Caribbean	7.8	8.0
Black African	2.6	3.7
Black Other	2.5	1.9
Indian	12.4	10.7
Pakistani	2.7	2.0
Bangladeshi	0.5	1.1
Chinese	0.4	1.3
Other Asian	0.5	3.3
Other Other	5.1	3.9
Total	100.0	100.0

Sources: as tables 1 and 2

Initially the comparison appears to show a good fit. However, once the total figures were disaggregated by sex and age group discrepancies emerged. For more detail of these demographic discrepancies see Jones (2007).

Table 4 Source of referral by ethnic group

Source of referral Ethnic group	GP %	Consultant %	Accidents %	Other %
White	51.0	29.3	0.8	18.8
Caribbean	53.0	35.7	0.0	11.3
Black African	57.7	30.6	2.7	9.0
Black Other	62.3	34.0	0.0	3.8
Indian	59.2	34.4	0.0	6.3
Pakistani	55.3	37.7	0.0	7.0
Bangladeshi	52.6	21.1	0.0	26.3
Chinese	62.5	37.5	0.0	0.0
Other Asian	50.0	40.0	0.0	10.0
Other Other	59.3	32.7	0.0	7.9

All referrals	53.3	31.1	0.6	15.1

Source: Parkside CIS and author's calculations

It will be seen from Table 4 that over 50 per cent of all patients were referred to the physiotherapy service directly by their GPs and that there is no evidence of discrimination against any group. Similarly, just over 30 per cent of all patients were referred to the physiotherapy service by consultants, and again there is no evidence of discrimination against any group.

The very small number of referrals received directly from the accident service may be a reflection of Parkside only having Minor Accident Treatment Services. It is possible that patients presenting to the A&E departments at Northwick Park, Central Middlesex, St Mary's, etc. were encouraged to attend physiotherapy departments at those hospitals rather than being transferred to the local Parkside Trust department. It could also reflect deliberate policy by the accident service of referring minor accidents back to the GP to arrange physiotherapy and of referring major accidents to orthopaedic consultants before requesting expensive investigations and therapies.
However, what does require an explanation, and could be a cause for concern, are the varying percentages in the 'Other' category, which are much higher for Whites and Bangladeshis than for the other groups. The very small total number of Bangladeshi referrals could be distorting their percentage and be having a similar effect in the opposite direction for the Chinese and Other Asians groups. To examine the source of these 632 referrals in more detail the results for all the Non-white groups are combined. These 'other sources' include health professionals other than doctors, e.g. district nurses, school nurses, health visitors, residential care workers, occupational therapists and referrals from one team of physiotherapists to another.

It will be seen from Table 5 that, with the exception of Education, the Independent Living Team and Community Physiotherapists, there is a marked difference in the percentage of White and Non-white patients who are referred. It may be that part of this difference is due to the age structure, e.g. most of the patients referred by district nurses and from homes will be elderly and therefore more likely to be White than Non-white. However, one

would expect the opposite to be true of health visitors, whose patients are mainly children and therefore more likely to be Non-white than White. Again clients referred by occupational therapists both from the health service and from social services are likely to be elderly. Similarly physiotherapists in hospital-based teams are more likely to call on their community-based colleagues for assistance with elderly patients than with young ones. The category 'Self Referral' is possibly the most suspicious. These are not people who just walk in off the street, but patients who have had a previous course of treatment at the request of a GP or consultant for a condition that is likely to recur (e.g. back pain) or relapse (e.g. arthritis) and have been told by their physiotherapist that if this happens within a certain period of time they can return for further treatment without another doctor's referral. It does, however, count as a new 'episode of care'. The question is whether physiotherapists are offering this service more to White than Non-white patients; or whether more White than Non-white patients are taking advantage of the offer; and if so why?

Table 5 Referrals for White and Non-white patients by 'other' source

Other source of referral	Patients referred		% of total referrals	
	White	Non-white	White	Non-white
District Nurse	113	19	4.1	1.3
Education	4	2	0.1	0.1
Health Visitor	7	1	0.3	0.1
Independent Living Team	1	1	0.0	0.1
Other Community Source	29	7	1.1	0.5
Occupational Therapist	56	14	2.0	1.0
Patients' Home	19	1	0.7	0.1
Physiotherapist Community	6	3	0.2	0.2
Physiotherapist Hospital	118	32	4.3	2.2
Self-referral	58	9	2.1	0.6
Social Services	105	27	3.8	1.9
Total	516	116	18.8	8.0

Source: Parkside CIS and author's calculations

Conclusion

Initial aggregative analysis showed less than 3 per cent difference between the ethnic distribution of the patients and the population of Parkside. However, on disaggregating by sex and by age it was found that there was a significant mis-match between patients and population. The groups that appear to be under-represented are Bangladeshi children, Chinese adults and Other Asians of all ages. The groups that are over-represented are African and Pakistani babies, Pakistani and Black Other adults and Bangladeshi elderly. Chinese males, African, Bangladeshi and Other Asian females are particularly under-represented. Unless these groups have less need for physiotherapy, which is not suggested anywhere in the literature, the physiotherapists of Parkside were failing to provide an equitably- distributed service. While admittedly difficult to undertake, some investigation ought to be made into the 4.8 per cent of patients referred to the physiotherapy service who never attend.

As the analysis progressed to further levels of disaggregation the problems of missing data became more apparent. Managers need to investigate why in up to 8 per cent of referrals physiotherapists failed to carry out ethnic monitoring and why in a further 10 per cent of cases the results of ethnic monitoring were never entered on the CIS.

It became evident that with this proportion (30 per cent) of missing data even 5,950 cases were insufficient from which to draw valid conclusions when disaggregated by age. Administrators should be wary of drawing conclusions from the ethnic monitoring of single teams. For example, it was estimated that it would take the neurological outpatients team 20 years to amass sufficient referrals to carry out a meaningful analysis. If analysis is to be undertaken on a locality basis rather than Trust-wide it must span a wide range of services (e.g. occupational therapy, speech therapy, chiropody, dietetics) to give sufficient cases for analysis.

Physiotherapy managers recognised the need to raise the awareness of GPs about the potential benefits of physiotherapy for their patients, but more could be done to raise the awareness of other health professionals and the general public. It is obvious from the analysis of the other sources of referral and from the work of McCalman (1990) that this could be selectively targeted towards the non-white groups.
There was an attempt to move treatment nearer the residents of Parkside by locating an increasing number of physiotherapists in doctors' surgeries.

I would end by repeating the plea of Gordon (1992) that where the data shows it to be necessary there must be changes in policy and practice, since ultimately access depends on quality of care.

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