

Eyecare for ethnic minority groups in the UK

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1 CET point for UK optometrists (in conjunction with Styles: see p. 131)

Although in the 2011 census (Table 1) the second largest ethnic group (Asian, including Indian/Pakistani/Bangladeshi/Chinese) only accounts for 3.3% of the population (Office of National Statistics 2011), ethnicity is still an important issue when planning eyecare services, as ethnic mix varies considerably between localities. For example, in West Yorkshire, the Bradford population is more than 26% Asian – more than three times higher than the proportion in its neighbours Calderdale or Leeds (Figure 1).

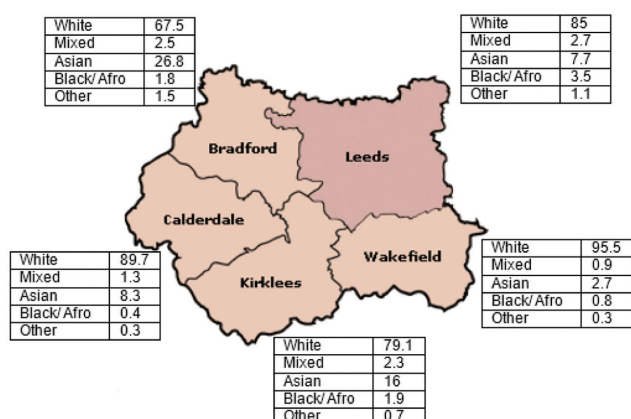


Figure 1. The ethnic mix of West Yorkshire.

Increased risk and under-registration

There is a higher prevalence of cataract (Das et al. 1994; Rauf et al. 2013) in people of South Asian ethnicity compared

to white populations. The prevalence of primary open-angle glaucoma is higher in people of African/Caribbean/Black British ethnicity (Cedrone et al. 2008; Klein and Klein 2013; Zhang et al. 2012), who are also more likely to present with more advanced field loss (Fraser et al. 1999) and to be sight-impaired as a result (Chen 2003; Klein and Klein 2013).

Both African/Caribbean/Black British (Klein and Klein 2013; Sivaprasad et al. 2012a; Zhang et al. 2012) and South Asian (Rauf et al. 2013; Sivaprasad et al. 2012a) populations have a higher prevalence of diabetic eye disease and are more at risk of being sight-impaired as a result (Pardhan et al. 2004; Sivaprasad et al. 2012b). Although these pathologies are more prevalent in minority ethnic groups, it has been shown that these groups are under-represented on the register of people with sight impairment (Morjaria-Keval and Johnson 2005; Pardhan and Mahomed 2002).

Lower uptake

Reasons commonly stated by patients for not attending for an eye test are: not having any symptoms; an expectation that reduced vision is inevitable as eyes deteriorate with age; the cost of glasses; not feeling the need for glasses; not recognising that optometrists have a wider role than spectacle prescribing (Leamon et al. 2014; Patel et al. 2006). These opinions were similarly expressed in both minority ethnic and white socially deprived populations, suggesting that reduced uptake through lack of knowledge about eye health is driven more by deprivation than race (Leamon et al. 2014). However, underlying cultural differences do contribute. Although at higher risk of eye disease, minority ethnic

Table 1. The ethnic mix of the United Kingdom according to the 2011 census

Ethnicity in UK (%)	England	Wales	Scotland	Northern Ireland	UK
White	87	95.6	96	98.2	94.2
Mixed/multiple	2.1	1.0	0.4	0.3	0.1
Asian/Asian British	7.1	2.3	2.7	1.1	3.3
Black/African/Caribbean/Black British	2.9	0.6	0.7	0.23	1.1
Other	0.9	0.5	0.3	0.13	0.5

communities are less aware of eye disease in general and are unaware of the increased risks due to their ethnicity (College of Optometrists 2011). A survey of consumer attitudes toward eye health suggested that minority ethnic populations are less knowledgeable than their white counterparts. For example, 38% of minority ethnic patients had no knowledge of age-related macular degeneration, 17% were unaware of glaucoma and 11% had no knowledge of cataract compared to 29%, 8% and 5% respectively in the general population. In addition, 74% of minority ethnic respondents did not realise that their ethnicity put them at higher risk of specific eye conditions such as glaucoma (College of Optometrists 2011).

African/Caribbean/Black British populations are more likely to see the GP as gatekeeper to all healthcare and would expect to be referred to an optometrist if needed rather than approaching an optometrist directly (Cross et al. 2007). Where community groups exist to support the local population, these are often focused on better living standards rather than healthcare, so the eyecare message is unlikely to be disseminated by them (Patel et al. 2006).

Language is often perceived to be a major obstacle to accessing healthcare by professionals, who may be concerned that medical information has not been understood and correctly translated by relatives. Patients themselves, however, appear to be comfortable with informal arrangements, with only a small number reporting that this is a problem (Patel et al. 2006). Language differences may be less in primary eyecare, especially where there are high concentrations of a particular ethnicity, as there are often local optometrists with multilingual capability working in the locality (Leamon et al. 2014).

Focus groups in a deprived area revealed that minority ethnic participants, more so than their white neighbours, identified that having a local optometrist would increase the likelihood of having an eye test (Shickle and Griffin 2014). The current business model of optometry that is reliant on the sale of spectacles is a disincentive to open a practice in areas of deprivation. This could disproportionately impact uptake in ethnic minorities.

What can be done?

Culturally sensitive intervention

There are cultural differences in awareness and belief within, as well as between, ethnic groups (Morjaria-Keval and Johnson 2005). The cultural acceptability of any interventions and recommendations must be considered (Grace et al. 2008; Ludwig et al. 2011). Interventions are most effective where services work in partnership with the individual community using community leaders to develop information and introduce service providers to habitual meeting places and culturally appropriate ways of working (Hayden 2012).

Improve eye health awareness

Ethnic minority communities might benefit most from health education about the increased risk of eye conditions. The mode of delivery of education needs careful consideration. Providing leaflets in multiple languages may not always be beneficial, as where English is not understood, reading ability may also be poor, even in a native language (Ritch et al. 1996). Community radio was a more successful alternative to deliver health messages in the Southall South Asian community (Baker and Murdoch 2008). Patients are unclear where to go to access advice about eyecare and are unlikely to think of the optometrist as a source of this information (Pardhan et al. 2000). The profession would benefit from a nationwide promotion of the healthcare role of the optometrist.

Individual optometrists may help by promoting eyecare and the healthcare role of the optometrist to community groups (Baker and Murdoch 2008) and providing information to local GPs who are more likely to be the first point of contact for some groups of patients (Pardhan et al. 2000). Strategies to address the reduced financial viability of optometry in socioeconomically deprived communities could include subsidising practices (Shickle et al. 2014) or offering targeted basic screening with subsequent referral or education about the benefits of regular sight testing.

Improve data collection

Ethnicity is often not captured on optometric patient records but is probably still taken into consideration by the optometrist due to its relevance to the examination; however it is also important for public health purposes. Improved access to these data recorded in primary care will assist evaluation of uptake and aid prevention strategies.

● Summary

There is higher prevalence of eye disease in the non-white population of the UK. A lack of awareness of increased risk and reduced uptake of eyecare services means sight loss is more prevalent. Optometrists have an important role to play in raising awareness of eye health and encouraging uptake in minority populations.

- Community optometrists can help deliver educational messages about eye health to their local community and can help patients understand and access eyecare services.
- Eye health promotion should be sensitive to the culture of the target population. The approach is likely to be different in different communities.
- Partnership working with community leaders is important to achieve maximum engagement and uptake in the community concerned.
- There is a potential mismatch between communities in need and the placement of optometric practices. Future strategy for service provision should take this into consideration.

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CET multiple choice questions

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Note: to gain your CET point, please answer the MCQs for the Styles paper (see p. 131) as well as the following questions.

1. Which area of West Yorkshire has the highest proportion of people of Black/African ethnic origin?
 - (a) Bradford
 - (b) Wakefield
 - (c) Calderdale
 - (d) Leeds

2. In the College of Optometrists survey, what percentage of the general population had no knowledge of cataract?

- (a) 5%
- (b) 11%
- (c) 8%
- (d) 38%

3. According to people from an ethnic minority background, which of the following does not discourage them from getting their eyes tested?

- (a) Lack of symptoms
- (b) Cost of glasses
- (c) Language barrier
- (d) Expectation that eyes deteriorate with age

4. Which method was most successful in delivering eye health messages to the Southall South Asian community?

- (a) Leaflets
- (b) Community radio
- (c) Newspaper advert
- (d) Word of mouth

● CPD exercise

After reading this article can you identify areas in which your knowledge of the sight test and the detection of disease has been enhanced?

How do you feel you can use this knowledge to offer better patient advice?

Are there any areas you still feel you need to study and how might you do this?

Which areas outlined in this article would you benefit from reading in more depth, and why?

● Reflection

1. What impact has your learning had, or might it have, on:

- your patients or other service users (eg those who refer patients to you, members of staff whom you supervise)?

- yourself (improved knowledge, performance, confidence)?

- your colleagues?

2. How might you assess/measure this impact?

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