Community Dental Health (2006) **23,** 95-100
Received 23 September 2004; Accepted 18 April 2005

Improving access to dental care in East London's ethnic minority groups: community based, qualitative study

Ray Croucher and Ratna Sohanpal

There are few studies of access to dental care in ethnic minority groups which have compared their findings with those reported by the general adult population. Furthermore, studies have focused on either the younger or older members of these communities. ***Aim*:** this study aimed to identify barriers to the uptake of primary dental care in East London, to identify any variation in responses from the general adult population and to report ideas to improve access to primary dental care expressed by the participants. ***Methods*:** a qualitative study using community based participatory methods was adopted. Data were generated through purposefully sampled focus groups and analysed using a grounded approach. ***Setting*:** East London (UK), 2001. ***Participants*:** 68 volunteers aged 18-40 years, from the Bangladeshi, Indian, Black Caribbean communities and general adult population. ***Results*:** three inter-related themes were found to influence views on access: the structure of primary dental care, cost and anxiety. There was little evidence of differences in barriers to access based on ethnicity alone, reflecting the role of factors such as social class. Adult volunteers with young families enabled a wider perspective on barriers to access to be achieved, particularly with respect to the impact of the cost of dental care on family budgets. Proposals for reducing the barriers to accessing primary dental care were identified. These addressed a perceived need to extend services through outreach activity, develop communication skills within primary dental care practice and liaise with other primary health care services. ***Conclusion*:** this focus group study has confirmed the existence within East London's ethnic minority groups of barriers to accessing primary dental care reported within the general population for some time. That these responses are alike may be accounted for by the common levels of social disadvantage experienced. The rapid appraisal process enabled the identification of proposals to reduce access barriers. These are being implemented and their effectiveness in reducing barriers to accessing primary dental care remains to be established.

Key words: access, barriers, ethnic minorities, focus groups

Introduction

There is variation between adult members of ethnic minority groups, compared to the general population, with respect to dental care utilisation (Erens and Primatesta, 2001). For all minority ethnic groups age standardized regular dental attendance is significantly lower than for the general population; members of the former tend to visit the dentist when they are having trouble with their teeth. In addition, South Asian men and women are about three times less likely than the general population ever to visit a dentist.

Variation in service utilisation does not necessarily lead to poorer oral health. Watt and Sheiham (1999) note that, when social class and maternal ability to speak English are controlled for, there is no evidence of differences in child oral health based on ethnicity alone. Adult total tooth loss is significantly less likely amongst Chinese men and Bangladeshi women but there is no significant difference in the age standardized rates of total tooth loss comparing the general population and the other minority ethnic groups (Erens and Primatesta, 2001). These authors suggest that variation in service use might be because of differences in oral health status, cultural differences in attitudes to prevention or barriers to access such as the cost of care.

Access is a multi-dimensional concept, involving more than the availability of services within a reasonable geographic distance. Penchansky and Thomas (1981) identified the dimensions of acceptability, affordability, availability, physical accessibility and accommodation within their overall view of access as the 'degree of fit' between clients and a health system. Historically there has been a pattern of unequal access to dental services with a particular lack of information about the concerns and needs of particular groups (Gulliford *et al.*, 2001). A recent systematic review of ethnicity and health service access for London (University Warwick/De Montfort, 2001) identified five peer-reviewed papers relating to barriers to accessing dental care amongst London's ethnic minority groups. The most common barriers identified were language, fear of the dentist, cost and the perception that preventive check-ups were of low priority. Newton *et al*., (2001) reviewed the literature on barriers to maintaining good oral health and obtaining dental care by specific ethnic minorities. This literature has focused on either the older (Mattin and Smith, 1991) or younger (Paul and Bradnock, 1986) members of these communities rather than families. Focus group discussions organized by Newton *et al.,* (2001) with adult members of ethnic minority groups concluded that the barriers to accessing dental care that were identified confirmed those reported in previous research (Kelly *et al.*, 2000). The nature of these barriers varied across groups. However, no direct comparison was made between these groups and the general adult population.

This community based qualitative study aimed to identify the barriers to the uptake of primary dental

Correspondence to: Professor Ray Croucher, Institute of Dentistry, Barts and The London, Queen Mary's School of Medicine and Dentistry, London E1 2AD. E-mail: r.e.croucher@qmul.ac.uk

care for adults with families resident in East London, to discover any variation in response between that area's ethnic minorities and the general adult population and to report ideas to improve access to primary dental care expressed by the study participants.

Methods

The study adopted a rapid participatory approach. This method obtains information without a large expenditure of time or money, acknowledging that communities should be involved in the decisions that concern them (WHO, 1978, WHO, 1986, Cornwall and Jewkes, 1995). Whilst this approach has been adopted primarily in developing countries there are examples of its successful use in the United Kingdom (Ong, *et al.*, 1991, Murray *et al.*, 1994).

Bi-lingual project workers held semistructured, in-depth discussions with 12 focus groups. The focus group discussions were based on a topic guide, including service use, the structure (the way the services were organized and their location), process (the volunteers' experience of service use) and outcomes (satisfaction with the service) of dental care (Newton *et al.*, 2001). This enabled aspects of access (Penchansky and Thomas, 1981) to be explored and suggestions for removing identified barriers to access sought. The focus group leaders familiarized themselves with the topic guide and interview process through a structured discussion with the principal investigators. Each group leader was asked to rehearse aspects of the topic guide by interviewing an individual recruited from the community with which they would be conducting a complete interview.

The groups were organized within each of the three East London local authorities. Their populations share similar high levels of deprivation and inequality. Within each authority four single gender (two male, two female) groups were held, two recruited from the general population and two from the largest minority ethnic group in each authority as identified by Census data (Bulmer, 1996). These were the Bangladeshi community of Tower Hamlets, the Black Caribbean community in Hackney and the Indian community from Newham. Single gender and ethnic focus groups were organised to respect and increase cultural acceptability. There could be up to eight volunteers in each group (see Table 1). The recruitment criteria for volunteers were:

1. aged between 18-40 years to encourage the inclusion of volunteers with young families.
2. self-reported irregular dental attendance.

Volunteers were recruited informally through community contacts from workplaces, playgroups, a recruitment agency, a community care agency and community centres. A 'snowball' recruiting technique was adopted, in which a small number of informants nominated friends, colleagues and other contacts (Burgess, 1991). The purpose of the study was explained to each volunteer and consent obtained. Each focus group discussion was held in a recruitment location at a time convenient for the volunteers.

The discussions lasted between 50 to 60 minutes. They were audio-taped, manually transcribed and anonomised before being analysed using the 'framework' approach (Ritchie and Spencer, 1993, Pau *et al.*, 2001, Pau *et al.*, 2004). Recurrent, emerging themes were identified by comparing the interview transcripts (Glaser and Strauss, 1967).

In addition to the discussion leader a scribe also attended each focus group with the role of note taking. This person offered the opportunity of triangulating the key findings identified from each group with the discussion leader. The analysis was also discussed at meetings with local community organizations and primary health care workers. Both these approaches are proposed to ensure the comprehensiveness of findings (Pope and Mays, 2000).

The study was conducted over eight weeks from June to August 2001. Ethical committee approval was sought. The transcripts are available from the lead author.

Results

Data from the categories generated by the topic guide are presented first. Secondly, data derived categories are exampled.

Three inter-related themes were found to influence views on access: the structure of primary dental care, cost and anxiety.

The structure of primary dental care

Some respondents had recently arrived in the United Kingdom and had limited experience of any dental care. One Black-Caribbean woman had needed no treatment at all on her recent first visit, a situation described as 'brilliant' by other members of her group. A Black-Caribbean man reported that he had never been before, wanted to go to a dentist because of toothache but could not afford the cost.

There was a mismatch of assumptions about attending dental services. Whilst dentists might wish for regular attendance this was not appropriate for the perceived needs of the respondents. A comparison was made between the use of primary medical and dental care, 'you do not need a doctor unless you are sick, so it is the same with the

Table 1. Ethnic group and gender of 68 focus group participants, aged 18-40 years, resident in three East London local authorities.

	Tower Hamlets		*Newham*		*City and Hackney*	
	Bangladeshi	*General Population*	*Indian*	*General Population*	*Black Caribbean*	*General Population*
Men	5	3	4	5	7	4
Women	8	5	5	4	3	5

dentist' (Black-Caribbean man). Proximity of the practice would then be important, 'I visited the dentist that was nearest to me. That's the only one I know about – if I had known there was a dentist who provided a better service I would have travelled the distance to see them' (Bangladeshi man). Personal recommendation was an important factor in changing practice.

A common perception was that practices were overworked. This might impact on the dentist-patient relationship '.. they don't care if you are coming in or not' (Black-Caribbean man) whilst an Indian man commented that 'when you go to the dentist it is sort of get him in, get him out, get the next patient'. Lack of availability of appointments would result in making arrangements to be seen as an emergency patient and waiting to see a dentist, ' its fine that they see you on emergency appointment, otherwise you wait about two months' (Indian woman). Having to book an appointment for some months in the future would lead to forgetting or not bothering to attend, so one suggestion was to send reminder cards to those with appointments (Indian man). However, a Bangladeshi woman commented favourably on the appointment waiting time for her dentist compared to that for her medical practitioner.

More clarity as to whether the practice attended was NHS or private was commonly requested. There was little understanding of the difference between NHS primary medical and dental care in terms of funding, so that the need to pay for NHS dental treatment created confusion, 'you go to a NHS dentist and we pay, so we are private aren't we really' (Indian woman).

Poor availability of appointments led to low expectations for treatment outcomes. Treatment was reported as a lengthy process due to the lack of availability of appointments and the belief that the treatment plan would become more complex. An Indian man recounted that he had been attending the dentist for an unfinished course of treatment which had lasted two years, whilst a White woman commented that going to the dentist 'triggered' treatment.

Cost and anxiety

Feelings of anxiety associated with treatment were seldom expressed. Respondents who attended on a slightly more regular basis were more likely to report moving dentists to one with whom they felt more satisfied.

Uncertainty about the cost of treatment, for non-exempt patients, created more anxiety than treatment alone. A Black-Caribbean man described this as the major barrier, 'this is a very deprived area and we all know that, so cost probably is the topmost barrier for not going to the dentist'. There were competing priorities within family budgets. Dental treatment was perceived as expensive, 'one commitment among many' (Black-Caribbean woman). In a low income area there was a complementary ceiling as to what could be afforded for dental treatment, 'it is very expensive to go. I think that is why people do put it off as well, I do sometimes, I think I cannot afford to go this week, I cannot pay £30, £40 whatever' (White woman). Another White woman commented that if she was receiving social security benefits then she would be able to go more often.

Anxiety about cost would result in respondents deciding not to attend. One Indian woman commented, 'my husband, he works full time and he got a reminder to go to the dentist and he said oh God knows how much it's going to cost me so he is not going'. An Indian man noted, 'I know this is going to sound selfish but when there is one person earning in the family, it is very hard, hard to fork out every time'.

This anxiety about the general cost of treatment was compounded by a perceived lack of clarity about the fees for individual items of treatment. There were several lengthy discussions in different groups about whether a nationally agreed scale of fees existed, 'it is all different prices at different practices, I mean you go into one dentist and they will give you a quote, you go to another down the road and they will give you a quote .. and you know there is no comparison between the two. They do not have a standard price for treatment I mean they do not have the prices up there. You know you cannot even compare dentists ..' (Indian woman).

A further possible anxiety for some respondents was whether they would receive treatment from a dentist of the same gender. Some men and women wanted to make a choice, a White woman describing treatment by a male dentist as making her feel 'uncomfortable'. Others described it as 'a little problem' (Indian woman). Men, whilst acknowledging that they would feel more comfortable with a male dentist, were also prepared to attend a female dentist if considered to offer better treatment. Women 'would not go to a man' (Bangladeshi woman) whilst an English woman noted that the opportunity to receive treatment from a female would be 'one less thing to worry about'.

Proposals for improving access

Access to primary dental care would be improved by extending opening hours, 'most shops and services are flexible .. I am not suggesting that they should be open 24 hours but a big practice, there is no reason why a dentist cannot be available after five o'clock in the afternoon ...' (White man). More flexibility could be built into the appointment system, with 'drop in' triage sessions proposed, 'if you are in pain .. you should be seen to, or quickly checked by a dentist that you do need treatment .. I will try and fit you in, rather than leaving you to sit there till they can see you' (White woman).

Dental mobile surgeries could be sited on schools, estates or factories, moving in rotation around locations: 'like they do with the Libraries, the mobile Libraries'(Black-Caribbean woman). Other respondents commented that siting mobile surgeries at shopping centres would either not be 'convenient' because 'you want to shop' (White woman) or were concerned about loss of privacy (White man). Mobile surgeries were especially recommended for use with children: 'maybe then it (treatment) should be done at school, where they all have the same thing done', but their value for adults was also recognised: 'dentist going to the workplace, men can go in and get their check up at work' (White woman).

Information about the structure and cost of NHS dental care was also proposed. One participant, who

had never attended a dentist before, commented on the need for 'a dental shopping guide, as to how to reach people, going to the dentist' (Black –Caribbean woman). Greater clarity of charging would improve expectations, 'maybe they should have like a set price, or to say when you are going to have a root canal treatment, it is going to come to about ..' (White woman).

Better quality information might be made available through liaison with other primary health care workers such as their doctors, 'get dentists and doctors to work together', 'if somebody is registering in the GP's office it should be OK for a GP to say this is a dental problem, I am not your dentist but he could tell me a place to go to a dentist'. A Black-Caribbean man described how when he went to his doctors he was advised to see a dentist, 'and I said I do not know how to find a dentist, she laughed and said go to your Yellow Pages..' .

Treatment would be improved if staff in dental practices were friendlier and able to speak local community languages: 'if there was an increase in staff it would be more helpful – Bengali staff' (Bangladeshi woman). In addition to speaking local community languages further communication skills training was proposed, 'you could give them some sort of training where they are aware of some of the patients feelings, they need to give a little bit of TLC' (Black-Caribbean woman). It was also suggested that receptionists could have their skills developed to answer basic questions about treatment and cost so 'they know what they are talking about' (Indian woman).

Service extension and skill development would combine to create a total quality package, generated by respondents from their observation of good practice outside primary dental care. This comprised 'the atmosphere, the prices, the quality, quality of the product recommendation, presentation', 'quality is not just about the product, it talks about technology, public relations, the money spent, the up front staff' (Black-Caribbean woman). Other participants had a concept of a 'clean' practice. This not only referred to an obvious adherence to infection control protocols but also a generally responsible approach to patients. This contrasted with the 'unclean' practice: perceived as impersonal, uncommunicative and apparently unhygienic.

Whilst most respondents were able to offer suggestions for change, a minority questioned the value of this as, 'my view is I will have no benefit by giving my opinion to you, it will make no difference, nothing will ever be done to make things better .. they won't listen' (Bangladeshi man).

Data derived categories

One data derived category generated through the analysis was the impact on quality of life of prolonged pain. A Black Caribbean man described that he had been to the dentist a month earlier, for the first time since his childhood. He was told that he had cracked his teeth due to something he had chewed. Despite receiving treatment the pain was described as like 'something running around in me .. I am not in control'. Courses of treatment could become lengthy, 'I have been going for the last two years now .. he is finished with (treatment), but I still get pain now and then, he is still telling me I am alright, he thinks he has done a good job but I do not think so' (Indian man).

A White woman told how:

'about eighteen months I started complaining about my bottom tooth on the left-hand side. And he could not seem to find anything wrong with it. Every time I went back for a check up, he could not find anything wrong .. I had had enough and I changed my dentist because I knew there was pain in my tooth'.

After unsuccessful treatment the pain became 'ten times worse' and this respondent was referred to hospital for an extraction.

In circumstances like these self-medication might be tried, 'I will have a few whiskies, the pain will go away' (Indian man).

A second example of a data derived category was feelings of deference to the dentist's opinion. A Bangladeshi man described it as a 'duty' to visit the dentist, as he had been requested to make an appointment. An Indian woman also reported, 'we always think they're right, if they say you might need this, OK, then you think I might as well have it done ..'.

Discussion

This study has identified barriers to accessing care in the United Kingdom faced by its ethnic minority groups. The barriers reflect those encountered within part of the United Kingdom's health system. It should be noted, however, that the international literature reports similar themes in different populations, health interventions and health systems (Heijinders, 2004, Furber *et al.*, 2004, Fiscella and Williams, 2004).

The results show some similarities with other studies of barriers to accessing the United Kingdom's primary dental care system. These have been conducted in both the general population and ethnic minority groups (Finch *et al.*, 1988, Kelly *et al.*, 2000, Newton *et al.,* 2001). The key barriers identified in all these studies have been anxiety and cost. This study also highlights some important clarifications and differences. The findings must be interpreted with regard to the sampling procedure adopted and the participatory nature of the research. Working with the members of the ethnic minorities during the research, as recommended in the literature, has increased the validity of the findings.

Despite an established variation in dental care utilization between the participating ethnic minority groups and the general population (Erens and Primatesta, 2001) few differences were found between the reported barriers to access in this study. Newton *et al.,* (2001) argued that there was variation between different ethnic minority groups in the emphasis placed on the reported barriers to access. The homogeneity of the findings reported here may be explained partly by socio-economic factors and common levels of social disadvantage. Care was also taken in the recruitment process to ensure representation of possible participants such as working men by arranging discussions when they would have an opportunity to attend.

This study has also contributed new information. Firstly, recruiting focus group participants from the

general population offered the opportunity of collecting comparative data. There was, however, little evidence of differences based on ethnicity alone, reflecting the control of factors such as social class in this study by recruiting from similarly disadvantaged areas. Secondly, the sampling of employed adult volunteers with young children enabled a wider perspective on barriers to access to be achieved, especially with respect to the impact of the cost of dental care on family budgets. Competing demands within these budgets suggest that parents would place a low priority on meeting their own dental needs. Thirdly, a preference to be treated by same gender dentists has been reported here, whatever the ethnic minority or gender of the volunteer. The preference of Muslim women to be treated by a woman dentist has been reported previously. It should also be acknowledged that culture may play an additional and important role in influencing attitudes and behaviour, as in the case of Moslem women, in addition to this general preference. Fourthly, proposals for reducing the barriers to accessing primary dental care were identified. These addressed the need to extend services and develop skills within primary dental care practice. Opportunities for liaison with other primary health care services were also proposed. The ending of the current General Dental Services contract and the introduction of a range of new working arrangements for primary dental care, such as Personal Dental Services, within Primary Care Trusts will allow these opportunities to be addressed (Department of Health, 2004).

A recent review recommended that user involvement should not stop when their views have been obtained (Crawford *et al.,* 2004). Indeed, Tones and Tilford (2001) note the importance of initiatives such as the one described here in developing social inclusion and social capital.

One local outcome of this rapid appraisal has been the introduction of a Community Dental Access Project which has attempted to incorporate the proposals for reducing barriers to accessing primary dental care identified in this study. A dental screening programme, using mobile dental clinics staffed by bi-lingual workers sited in residential estates and shopping centres, has been implemented. Community workers and volunteers from two of East London's ethnic minority groups have been trained to offer oral health advice and facilitate improved access to primary dental care services following screening. Outcomes of this initiative are being assessed.

In conclusion, this focus group study has confirmed the existence within East London's ethnic minority groups of barriers to accessing primary dental care reported within the general population for some time. That these responses are alike may be accounted for by the common levels of social disadvantage experienced. The rapid appraisal process enabled the identification of proposals to reduce access barriers. These are being implemented and their effectiveness in reducing barriers to accessing primary dental care remains to be established.

References

Bulmer M (1996) The ethnic question in the 1991 Census of Population. In, Colemaan D and Salt J (eds) Demographic Characteristics of the Ethnic Minority Populations. *Ethnicity in the 1991 Census series*, **Volume 1**. London: HMSO.

Burgess RG (1991) In the field: *an introduction to field research*. London: Routledge.

Cornwall A and Jewkes R (1995) What is participatory research? *Social Science and Medicine*, **41**, 1667-1676.

Crawford M, Rutter D and Thelwall S (2004) *User involvement in change management across a range of sectors to identify factors that promote successful user involvement*. London, National Co-ordinating Centre for NHS Service Delivery and Organisation Research and Development.

Department of Health (2004) *NHS Dentistry: Delivering Change. Report by the Chief Dental Officer*. London, Office of the Chief Dental Officer, Department of Health

Erens B, Primatesta P and Prior G (eds) (2001) Health Survey for England. *The Health of Minority Ethnic Groups.* **Volume 1**. London: The Stationery Office.

Fiscella K and Williams DR. (2004) Health disparities based on socioeconomic inequities: implications for urban health care. *Academic Medicine*, **79**(12): 1139-1147.

Furber AS, Hodgson IJ, Desclaux A and Mukasa DS. (2004) Barriers to better care for people with AIDS in developing countries. *British Medical Journal*, **329**(7477): 1281-1283.

Glaser B and Strauss AL (1967) The discovery of grounded theory. New York: Aldone de Gruyer.

Gulliford M, Hughes D, Figeroa-Munoz J, Hudson M *et al.,* (2001) Access to Health Care. Report of a Scoping Exercise for the National Co-ordinating Centre for NHS Service Delivery and Organisation Research and Development. London: King's College London.

Heijnders ML. (2004) An exploration of the views of people with leprosy in Nepal concerning the quality of leprosy services and their impact on adherence behaviour. *Leprosy Research*, **75**(4), 338-347.

Kelly M, Steele J, Nuttall N, Bradnock G *et al.,* (2000) Adult Dental Health Survey. Oral Health in the United Kingdom 1998. London: The Stationery Office.

Mattin D and Smith JM (1991) The oral health status, dental needs and factors affecting utilization of services in Asians aged 55 years and over, resident in Southampton. *British Dental Journal* **170**:369-372.

Murray SA, Tapson J, Turnball L, McCallum J and Little A (1994) Listening to local voices: adapting rapid appraisal to assess health and social needs in general practice. *British Medical Journal*, **308**: 698-700.

Ong BN, Humphris G, Annett H and Rifkin S (1991) Rapid appraisal in an urban setting. *Social Science and Medicine*, **32**: 909-915.

Newton JT, Thorogood N, Bhavnani V, Pitt J, Gibbons DE and Gelbier S (2001) Barriers to the use of dental services by individuals from minority ethnic communities living in the United kingdom: findings from focus groups. *Primary Dental Care*, **8** (4): 157-161.

Paul PF and Bradnock G (1986) The dental health of Asian and Caucasian four and five year old children resident in Coventry. *Community Dental Health* **3**:275-285.

Penchansky and Thomas (1981) The concept of access: definition and relationship to consumer satisfaction. *Medical Care,* **1**:127-140.

Pau AK, Croucher R Marcenes W (2001) Perceived inability to cope and care-seeking in patients with toothache: a qualitative study. *British Dental Journal*. **189**:500-502.

Pau AKH. Croucher R. Muirhead V. Sohanpal R. Seymour K. (2004) Emotional intelligence and stress coping in dental undergraduates. *British Dental Journal*. **197**:205-209.

Pope C and Mays N (2000) Qualitative Research in Health Care. (Second edition) London, BMJ Books.

Ritchie J and Spencer L (1993) *Qualitaive data analysis for applied policy research*. Pp173-194, in Bryman A and Burgess R (eds) *Analysing qualitative data*. London: Routledge.

Tones K and Tilford S (2001) Health Promotion: effectiveness, efficiency and equity. (Third edition) Cheltenham, Nelson Thornes.

University of Warwick, Centre for Health Services Studies and De Montfort University, Mary Seacole Research Centre, (2001). *Systematic Review of Ethnicity and Health Service Access for London*. Coventry: University of Warwick.

Watt R and Sheiham A (1999) Inequalities in oral health: a review of the evidence and recommendations for action. *British Dental Journal*, **187**: 6-12

World Health Organisation (1978): *Report of the International Conference on Primary Health Care Alma-Ata*. Geneva: World Health Organisation.

World Health Organisation (1986): *The Ottawa Declaration. Geneva*: World Health Organisation.