UNIVERSITY OF OXFORD

NHS RACE & HEALTH OBSERVATORY

Patient Experience and Trust in NHS Primary Care

March 2025

Foreword

The NHS Race and Health Observatory exists to identify and tackle unjustifiable variations in health access, experience and in the quality of health outcomes for Black, Asian, and ethnic minority people and communities. We do this by highlighting how those inequalities come to exist in the first place, by using that insight to drive policy change, and by working with partners to implement practical, evidenced-based actions.

Our work has shown, countless times, that a lack of trust is a structural determinant of health inequity in this country, and this is a clear finding from this report. We want to build on this learning to enable optimal access to healthcare services and interventions for all communities – built on a fundamental foundation of trust. This report is a clear reminder of the critical importance of every patient being treated as a person, listened to, and treated with respect and dignity that they deserve.

We also know that inequalities in health are not just about the experiences people have in accessing GP surgeries, hospitals or care homes, but also about the broader social factors that dictate a person's level of health risk in the first place. Forces such as racism, discrimination, deprivation, and social segregation influence a person's quality and length of life long before they encounter the healthcare system. The challenge facing us, therefore, is about understanding equity in access to services in the context of broader systemic and unwarranted disadvantage faced by Black, Asian and ethnic minority people in this country.

At the same time, we must also acknowledge how quality of care and clinical effectiveness are affected by power imbalances between patients and clinicians, and between policymakers and communities. These imbalances themselves can have subsequent impact on the levels of trust patients have in healthcare. They are also a stark reminder to us all as the focus of healthcare delivery shifts more towards communities, prevention and digital.

At the NHS Race and Health Observatory, we are very clear that our work is not just to highlight the scale of the challenge on ethnic inequalities in healthcare, but to also provide real world solutions to those challenges. That is why we will work to support the healthcare system, and partners, in making meaningful changes and reversing the patterns outlined in this critical report.

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The survey was designed and disseminated by the NHS Race and Health Observatory. The data analyses and report writing was undertaken by Dr. Joanna Demaree-Cotton and Prof. Ilina Singh from the University of Oxford.

Terminology and abbreviations

Use of the term “significantly” throughout the report refers only to statistical significance, and does not describe the size of a comparison i.e. it is not used to mean “greatly”, “a lot”, etc.

B/P = Bangladeshi/Pakistani
CI = confidence interval
MEM = estimated marginal mean
N = number of participants
OR = odds ratio
SE = standard error

Contents

Summary

- To identify ethnicity-based discrepancies in patient experience, we compared the survey responses of participants from ethnic minority groups to the responses of White British participants.
- We find evidence of poorer patient experience amongst ethnic minority participants, particularly Bangladeshi/Pakistani, Non-British White, and Black participants.
- These ethnic minority groups are more likely to feel that primary care providers do not listen to their concerns, and Bangladeshi/Pakistani and Non-British White participants are also less likely to feel that their concerns are acted on by primary care providers.
- A large percentage of Asian and Black participants feel that they are treated differently by primary care providers because of their ethnicity or personal characteristics.
- These experiences negatively impact trust, as being listened to and having concerns taken seriously are perceived as very important for quality of care and medical outcomes, such as diagnosis accuracy and the obtaining of successful treatment.
- Bangladeshi/Pakistani participants are less likely to trust that primary care providers will meet their health needs.
- We situate our findings in the context of previous research and discuss the importance of resourcing primary care in such a way that supports active, respectful listening and meaningful dialogue between providers and patients. We also highlight the importance of providing accessible medical care that responds to patient needs and concerns.

Introduction: Ethnicity-Based Inequality in Patient Experience

Health disparities based on ethnicity have been long documented in the UK (Kapadia et al., 2022). For example, Bangladeshi, Pakistani, and White Gypsy or Irish Traveller communities exhibit the poorest health outcomes, while rates of infant and maternal mortality, cardiovascular disease, and diabetes are higher amongst Black and South Asian groups (Raleigh, 2023). Recently, the disproportionate impact of the Covid-19 pandemic on ethnic minority groups served as a stark reminder of ongoing health inequalities and the role of racism and discrimination in healthcare (Raleigh, 2023; Marmot et al., 2020; Public Health England, 2020), with ethnic minorities experiencing higher mortality rates from Covid-19 as well as higher rates of disruptions to healthcare as a result of the pandemic (Maddock et al., 2022).[1]

Health inequalities based on ethnicity are largely due to a complex confluence of sociocultural and socioeconomic factors (Cooper, 2002; Darlington et al., 2015; Darlington-Pollock & Norman, 2017; Kaufman et al., 2015; Puthussery, 2016). Worse outcomes for ethnic minorities are partly explained by associations between ethnicity and socioeconomic status: minorities are more likely to suffer from socioeconomic deprivation, which in turn is associated with poorer health outcomes. Yet, ethnicity-based health inequalities persist even after differences in socioeconomic status are accounted for (Smith, Kelly & Nazroo, 2009; Evandrou et al., 2016).

One important factor lies in ethnicity-based differences in the quality of interactions with healthcare professionals in primary care, and the effects this has on patient trust and engagement with healthcare.

In seeking medical care and disclosing personal medically relevant information, and in relying on the purported expertise of healthcare professionals, patients make themselves physically and personally vulnerable. Therefore, making use of primary care, and following healthcare advice, requires trust. We can distinguish here between two important types of trust. The first kind of trust is epistemic trust—trusting the information provided by healthcare

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[1] Ethnic minorities may also have exhibited higher rates of vaccine hesitancy (Kamal, Hodson, & Pearce, 2021). However, other research suggests that ethnicity has not been strongly linked to vaccine hesitancy in the UK (see Freeman et al., 2022). Indeed, some studies have found higher rates of Covid-19 preventative behaviour hesitancy amongst ethnic minority groups (Breakwell, Fino, & Gaspal, 2022).

professionals. Epistemic trust involves the conviction that the medical information and advice provided by healthcare professionals is accurate and reliable (e.g. about what treatment options are available, treatment safety and side-effects, diagnoses, risk factors, and so on). The second kind of trust is practical trust—trusting that healthcare professionals will treat patients well, successfully address their medical needs, and provide competent medical care that helps rather than harms. For a patient to have practical trust in a primary care provider, they must believe both that the provider is medically competent, and also that they have good intentions i.e. that they want to help the patient and care about them (Murray & McCrone, 2015). For example, it's not enough for patients to trust that the provider is correct about which course of treatment is most appropriate; they must also trust that the provider will competently administer this treatment, and furthermore that the provider will treat them with due care, respect and dignity throughout the process.

Previous research has shown that trust in healthcare providers is linked to various positive health outcomes and behaviours (Birkhäuer et al., 2017). For example, trust has been linked to reduced rates of vaccine hesitancy and higher rates of vaccine uptake amongst ethnic minority populations (Acharya et al., 2021; Kamal, Hodson, & Pearce, 2021). Interview data suggest that trust impacts how forthcoming Black and South Asian women are with healthcare providers about their feelings and experiences in the context of perinatal mental health (Conneely et al., 2023). Furthermore, dissatisfaction or distrust may contribute to disengagement from primary care (Ojo-Aromokudu et al., 2023) and to the underutilisation of healthcare services amongst ethnic minority groups (e.g. Conway et al 2014).

Unsurprisingly, perhaps, trust in healthcare providers is impacted by the experience that patients have with those providers, and in particular the way that professionals behave towards patients and communicate with them (Khullar et al., 2022; Paddison et al., 2015; Smith & Smith 2018). Patient-centred communication, in particular, facilitates strong, trusting provider-patient relationships which in turn has positive health outcomes (Pinto et al., 2012; O'Keefe et al., 2016; Shon & Wells, 2020; Asan, Yu, & Crotty, 2021). This is because patients want to feel listened to, to have their questions answered, and to be involved in shared decision-making about their care; they also want healthcare providers to take into account the patient's medical history, personal circumstances, and personal needs when giving medical advice and providing treatment (Curnow et al 2021; Bosley et al., 2021; Shon & Wells, 2020 Tarrant, Stokes, & Baker, 2003). The importance of active listening in facilitating patient trust has therefore been highlighted by a number of researchers (e.g. Bradshaw et al., 2022; Haynes, Devereaux, & Guyatt, 2002). For example, a Swedish study of over 5,500 patients on long-term sick leave showed that feeling disrespected and feeling as if the physician did not listen to the patient or did not believe the patient are important drivers of feeling wronged in their healthcare encounter (Wessel et al., 2013).

Another important factor that can undermine patient trust is the experience of discrimination or prejudice (Adegbembo, Tomar, & Logan, 2006; Wessel et al., 2014). Experiences of discrimination are associated with a host of negative health behaviours and outcomes. For example, a longitudinal study of 633 UK adults founds that experience of racial or ethnic discrimination in a medical setting predicted nearly a four-fold increase in the odds of vaccine refusal during the Covid pandemic (Paul, Fancourt, & Razai, 2022), and studies of US patients suggest that experiencing discrimination by providers leads to reduced engagement with healthcare providers, which in turn results in poorer health outcomes (Lee, Ayers, & Kronenfeld, 2009; see Paul, Fancourt, & Razai, 2022, for review).

Despite the NHS's commitment to providing high standards of care to all patients regardless of ethnicity, research shows ethnicity-based inequalities in levels of trust in, and experiences with, primary care professionals in the UK (Tarrant, Stokes, & Baker, 2003). This includes lower levels of trust for non-British White ethnicities, such as European migrants (Madden et al., 2017).

One major source of evidence for ethnicity-based inequalities in trust and experience with primary care comes from the General Practice Patient Survey (GPPS, *www.gp-patient.co.uk*). Since 2007, the GPPS has collected data from around two million patients annually who are registered with a GP practice in England. The survey includes questions about patient trust in primary care and satisfaction with care received. It also includes a number of items related to the so-called "quality of communication" received by primary care professionals, such as GP's and nurses.

While the label "communication" might be taken to merely concern the transmission of information from doctor to patient, this is not so. In fact, the "communication" issues covered by the GPPS include whether the healthcare professional: gave you enough time; listened to you; explained things; treated you with care and concern; involved you in decisions; and took your problems seriously.

Studies of GPPS data have shown that compared to White British patients, patients from ethnic minority groups report worse experiences in these measures of GP communication and feel taken less seriously. Consequently, they experience lower trust in their GP and feel less satisfied with the care they receive (Croker et al., 2013; Saunders et al., 2021; Magadi & Magadi, 2022). The largest discrepancies in these outcomes are observed for Asian patients (particularly Bangladeshi, Pakistani and Chinese patients) followed by non-British White patients (Burt et al., 2017; Watkinson, Sutton, & Turner, 2021). Associations between minority ethnicity and worse reported outcomes on the GPPS have remained consistent in recent years, including over the course of the 2019-2021 GPPS surveys, spanning the onset of the Covid-19 pandemic (Magadi & Magadi, 2022). Indeed, analysis of 2011-2017 GPPS data by Saunders and colleagues (2021) found that ethnicity-based inequalities have not diminished over time, with inequalities in access to care for patients in more deprived compared to less deprived areas actually worsening from 2015 onwards.

Analysis of 2019-2021 GPPS data (Magadi & Magadi, 2022) suggests that lower satisfaction amongst ethnic minorities is largely explained by ethnic minorities being less likely to feel treated with care and concern. Poorer ratings of the ease of using the GP website to access services also contribute to the association between minority ethnicity and poorer satisfaction, possibly reflecting language barriers and lack of financial resources needed for online access (e.g. smartphones, laptops). By contrast, in this analysis, patient characteristics, such as the patient's health, age, and working status, did not account for the lower patient satisfaction scores amongst ethnic minority groups (Magadi & Magadi, 2022).

While the GPPS provides very large datasets about the experiences of patients with GP's, other studies show that ethnicity-based disadvantages in care are not limited to GP practices. For example, in NHS hospitals, Pakistani, Bangladeshi and mixed-ethnicity Black African/White inpatients are less likely to feel that they are treated with dignity and respect (Sizmur & Körner, 2013). Moreover, studies in the US suggest that racial minorities feel less listened to, receive poorer communication from physicians, and experience discrimination, and that these experiences predict poorer health outcomes and engagement (Fahmy, Schreidah, & Geskin, 2023; Reid et al., 2021)

Some, but not all, of the inequality in patient experience of primary care in England is due to the concentration of ethnic minorities in practices with overall poor scores. For example, analysis of the 2009 GPPS suggested that 82% of the discrepancy between White British and Black Caribbean experiences were due to the concentration of Black Caribbean patients in overall poor practices, while this number is around 40-50% for South Asian patients, 22% for non-British White, and 14% for Chinese patients (Lyratzopoulos et al., 2012).[2] However, ethnic minorities experience worse care even when differences in quality of care between different practices is accounted for, with the rest of the discrepancy between White British and minority patients being due to worse experiences for minority ethnic patients within their practices compared to non-minority patients at the same practice (Lyratzopoulos, et al. 2012; Saunders et al., 2021).

What explains why ethnic minority groups tend to report receiving lower quality of care? One possibility is that they experience lower quality of care compared to non-minority patients at the same practice. A second possibility is that they experience the same level of care, but respond to survey scales differently (for example, expressing the same experience using a lower point on a scale). However, research to date does not support the latter interpretation. For example, analysis of GPPS items finds no evidence that South Asian patients interpret and use the GPPS scale items differently than White British patients; furthermore, experiments have shown that when South Asian and White British participants view sample recordings of patient-GP interactions, there is no difference between these group's evaluations of the quality of GP communication. This suggests that the discrepancy in GPPS scores between White British and ethnic minority patients is due to genuinely different quality of communication received from primary care providers (Burt, Campbell, & Abel, 2017).

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[2] The main body of this paper (Lyratzopoulos et al., 2012) highlights ethnicity-based differences for 'GP communication'; analyses for trust in GP and overall care satisfaction can be viewed in the paper's appendix.

Survey: Patient Experience and Trust

Methods

An online survey was created using Qualtrics. To recruit participants, the survey was advertised via the RHO's social media accounts (LinkedIn and Twitter), and was also distributed through stakeholder networks using email and Whatsapp. It was also distributed through a GP surgery's contact list in London. The advert stated that the survey was intended to assess how Black, Asian and ethnic minority communities trust the NHS Primary Care services they engage with. The survey was first distributed in January 2022 and responses were collected until April 2022.

Participants were told that the purpose of the survey was to investigate trust in primary care and how experiences of primary care differ depending on a person's ethnicity.

The following questions assessed patient experience with primary care:

> **Concerns Acted On:** When you access primary care services, are you satisfied that your concerns are adequately acted on? E.g. you are prescribed appropriate medicine or referred to another service or offered a follow up appointment. [1=No, never; 2=No, rarely; 3=Yes, sometimes; 4=Yes, most of the time; 5=Yes, all the time]
>
> **Feeling Listened To:** When you have engaged with primary care services, do you feel that the following health care professionals listen to your concerns? [1=No, never; 2=No, rarely; 3=Yes, sometimes; 4=Yes, most of the time; 5=Yes, all the time]
>
> **Remote Consultations:** How confident are you that you receive good care via telephone or video GP consultations? [Confident; Not Confident; Not Applicable]
>
> **Perceived Discrimination:** Do you feel any of the following characteristics affect the way you are treated by your primary care services? Tick all that apply [Ethnicity; Education level; Gender; Sexual orientation; Socioeconomic status; Religion; Location; Other, None of the above]

Participants were also asked to explain their reasons for their responses regarding Remote Consultation and Discrimination.

The following was asked to assess participants' trust in primary care:

> **Practical Trust:** Overall, would you say you trust your primary care services to meet all your health needs? [1=No, never; 2=No, rarely; 3=Yes, sometimes; 4=Yes, most of the time; 5=Yes, all the time]
>
> **Trust in Covid-19 Information:** Regarding COVID-19, do you trust the information you are getting from your primary care services? [1=No, never; 2=No, rarely; 3=Yes, sometimes; 4=Yes, most of the time; 5=Yes, all the time]

Finally, participants were asked to describe what, if anything, would increase their trust in primary care; whether they had any other comments about their trust in primary care; and then asked demographic questions about their age, sex, region, religion, and ethnicity.

Ethnicity groups. Power analysis using G*Power indicated that groups of 64 participants each are required to reach 80% power to detect statistically significant differences between the means of two groups (at alpha=0.05) when there is a medium-sized effect (d=0.5). Many ethnicity groups in our sample had a smaller number of participants than this (ranging from 4 to 48). Therefore, to allow for statistical analysis comparing groups, some subcategories had to be combined, with the aim of creating groups as close as possible to a minimum of 64 for analysis, while retaining meaningful distinctions in self-categorizations as far as possible.

Groupings were made within the overarching 'White', 'Mixed', 'Black', 'Asian', and 'Mixed' supercategories presented to participants. The consolidation process was guided by a number of conceptual and empirical considerations and was in line with groupings used in previous research (e.g. Saunders et al., 2021).

For example, there were too few Bangladeshi and Pakistani participants in this sample for meaningful separate analysis. We determined that the most appropriate consolidation would be to group Bangladeshi and Pakistani participants together. This would allow us to assess inequalities noted by previous research, specifically worse outcomes for both Pakistani and Bangladeshi patients relative to other ethnicities. Detecting such patterns would not be possible if analysed separately due to small sample sizes, nor if these participants were to be placed under 'Asian Other' or a general 'South Asian' group. Moreover, Pakistani and Bangladeshi patients tend to have different language and socio-cultural needs compared to Indian patients, from whom they also tend to differ on bi-cultural acculturation (see e.g. Ahmed et al., 2015, for discussion). In addition, the Pakistani and Bangladeshi groups in our sample were majority-Muslim, reflective of this population in the UK, which was not true of other Asian groups in our sample. Thus these two groups were combined to allow for further analysis. In addition, consolidation decisions addressed wording ambiguities in subcategories. Specifically, the disjunctive 'Black or Black British' is compatible with any Black identity, thus for consolidation this subcategory was grouped with 'Black – Any other Black, African or Caribbean background'; for the same reason, 'Asian or Asian British' was grouped with 'other' Asian ethnicities that had too few participants for analysis in isolation.

Analyses

Analyses were conducted using SPSS Version 29.0.0.0.

Statistical modelling. As well as summarising the frequencies of participants giving different responses, we conducted statistical analyses to determine whether differences in responses between demographic groups were statistically significant. Statistical significance was identified by p-values of 0.05 or below.

Chi-square tests were used to assess relationships between pairs of categorical variables. All statistical models examining the relationship between Ethnicity and survey questions adjusted for Age, Sex and Region, to account for the fact that our samples of different ethnicities also significantly differed from each other in terms of their distributions of Age ($\chi 2(77,1852)=240$, $p<.001$), Sex ($\chi 2(33,1843)=118$, $p<.001$) and Region ($\chi 2(88,1845)=221$, $p<.001$). For the same reason, estimated marginal means (which adjust mean scores in light of other variables in the model, including Age, Sex, and Region) were used to identify statistically significant differences. However, unadjusted models yielded extremely similar results. For categorical data, statistically adjusting percentages yielded estimates that differed from the raw percentages by less than 1%. Therefore, for ease of interpretation, we present the raw percentages in the results section.

For Likert-scale outcome variables (e.g. survey items answered on a scale from 1 to 5 representing ‘never’ to ‘all the time’), ANCOVA models with pairwise comparisons based on estimated marginal means were used to investigate the effects of demographic factors on survey outcomes. For dichotomous outcome variables, binary logistic regression models were used. Hierarchical regression models were used to investigate the relationship between survey variables (linear for scale outcome variables and binary logistic for categorical outcome variables). ‘White British’ was used as the reference group for ethnicity, given the high sample size for that group, comparably favourable outcomes across different measures, and this precedent in prior literature investigating the effects of ethnicity on experiences of primary care (e.g. Saunders et al., 2021). ‘Male’ was used as the reference group for Sex, ’25-34’ was used as the reference group for Age, and ‘London’ was used as the reference group for Region, again due to high sample size.

Participants

We excluded participants who answered zero questions (N=555) and entries with ReCaptcha scores (a test used to distinguish human participants from bots) that were missing or lower than .50 (N=43) from further analysis, leaving a total sample of N=2682.

Approximately 70% of participants answered demographic information about themselves while 30% did not. Participants who didn’t answer the question, who selected “Prefer not to say”, or who selected “Other” but specified that they refused to answer in the free-text response (e.g. “Rather not say”) were classified as “Prefer not to Answer/Missing Data”.

Of the participants who answered the relevant demographic questions (see Table 1), the majority were Londoners (82%), female (64%), and identified as Christian (43%) or as having No Religion (35%). Participants represented a wide range of age groups, particularly between 25-64 years. The most common reported ethnicity was White British ('White – English, Welsh, Scottish, N. Irish or British') (see Table 2).

Table 1: Frequencies and percentages of those participants who self-reported demographic data.

Sample demographics		N	Percent (%)
Age (N=1874)	12-17 years old	**19**	**1.0**
	18-24 years old	**104**	**5.5**
	25-34 years old	**442**	**23.6**
	35-44 years old	**420**	**22.4**
	45-54 years old	**379**	**20.2**
	55-64 years old	**312**	**16.6**
	65-74 years old	**152**	**8.1**
	75 years old and older	**46**	**2.5**
Sex (N=1824)	Male	**645**	**35.4**
	Female	**1167**	**64.0**
	Other	**12**	**0.7**
Region (N=1864)	East of England	**39**	**2.1**
	London	**1526**	**81.9**
	Midlands	**85**	**4.6**
	North East and Yorkshire	**34**	**1.8**
	North West	**38**	**2.0**
	South East of England	**78**	**4.2**
	South West of England	**41**	**2.2**
	Other	**23**	**1.2**
Religion (N=1860)	No Religion	**649**	**34.9**
	Christian	**799**	**43.0**
	Buddhist	**12**	**0.6**
	Hindu	**61**	**3.3**
	Jewish	**10**	**0.5**
	Muslim	**179**	**9.6**
	Sikh	**25**	**1.3**
	Other	**125**	**6.7**

Table 2: Frequencies and percentages for self-reported ethnicity data. Grey cells indicate sub-categories for consolidated groups.

Sample Ethnicity (N=1864)

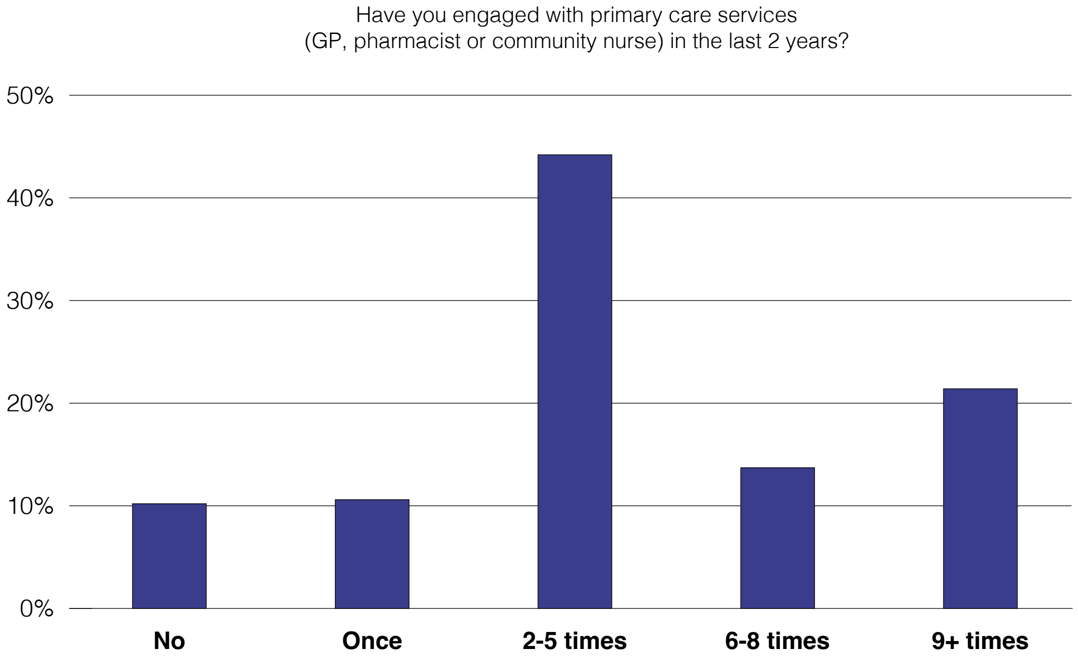
Category	Subcategories	N	%
White British	**-**	**562**	**30.2**
White Other	White – Gypsy or Irish Traveller	4	0.2
	White Irish	36	1.9
	White – Any other White Background	310	16.6
	Total	**350**	**18.8**
Mixed – White & Black	Mixed – White and Black Caribbean	29	1.6
	Mixed – White and Black African	32	1.7
	Total	**61**	**3.3**
Mixed – Other	Mixed – White and Asian	28	1.5
	Mixed – Any other Mixed or Multiple ethnic Background	32	1.7
	Total	**60**	**3.2**
South Asian – Indian	**-**	**101**	**5.4**
South Asian – Bangladeshi/Pakistani	Asian – Pakistani	40	2.1
	Asian – Bangladeshi	25	1.3
	Total	**65**	**3.5**
Asian – Other	Asian or Asian British	48	2.6
	Asian – Chinese	23	1.2
	Asian – Any other Asian background	20	1.1
	Asian – Filipino	9	0.5
	Total	**100**	**5.4**
Black – African	**-**	**167**	**9.0**
Black – Caribbean	**-**	**90**	**4.9**
Black – Other	Black – Any other Black, African or Caribbean background	18	1.0
	Black or Black British	138	7.4
	Total	**156**	**8.4**
Other	Arab	20	1.1
	Other	132	7.1
	Total	152	8.2
Prefer not to say/Missing Data		**818**	**-**
Total		**2682**	

Results

Engagement with Primary Care

The most common response was that participants had engaged with primary care services 2-5 times in the last 2 years (see Figure 1). Level of engagement with primary care was not associated with any demographic variables except for Sex ($\chi2(4,1812)=38.13$, $p<.001$): compared to male participants, female participants were slightly more likely to report engaging 6-8 or 9+ times (38.4% of female participants compared to 28.7% of male participants), and slightly less likely to report engaging once or not at all (17.2% of female participants compared to 27.3% of male participants).

Figure 1. Histogram showing recent levels of engagement with primary care services for the sample of participants who also gave demographic data regarding their ethnicity.

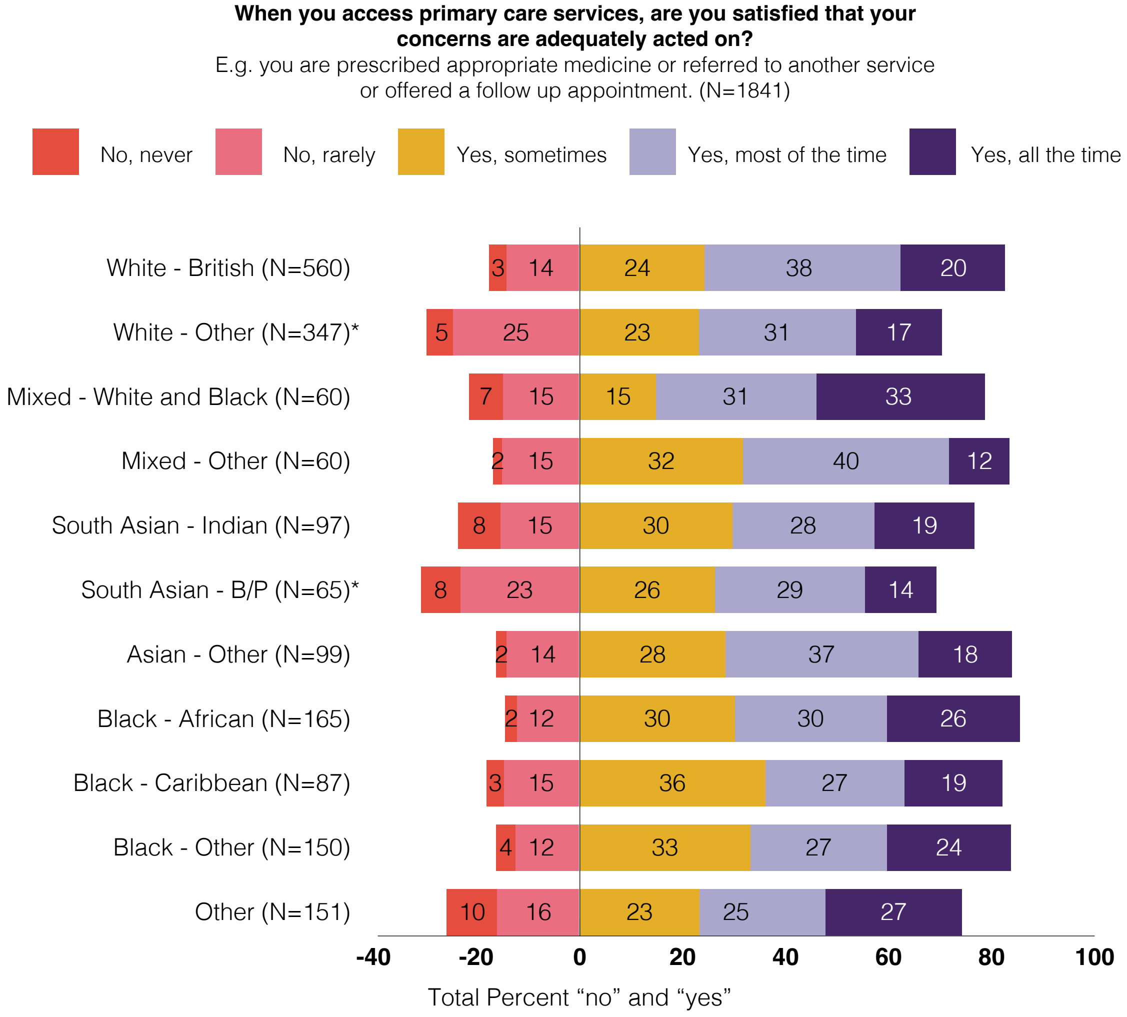


Patient Experience

Concerns Acted On

Ethnicity had a small but statistically significant association with Concerns Acted On, $F(10,1812)=2.11$, $p=0.021$, $\eta p2 = 0.01$. Pairwise comparisons showed that, compared to White British (MEM=3.54, SE=.05), South Asian Bangladeshi/Pakistani participants (MEM=3.21, SE=.14, p=.024) and White Other participants (MEM=3.33, SE=.06, p=.009) felt less satisfied on average that their concerns were acted on. In terms of percentages, while 17.5% of White British participants felt their concerns were never or rarely acted on, this was reported by nearly a third of White Other (29.7%) and Bangladeshi/Pakistani (30.8%) participants. (See Figure 2).

Figure 2 Raw percentages of participants answering "yes" and "no" to whether they feel their concerns are adequately acted on in primary care. Asterisks indicate groups for whom the mean response was lower than the White British group to a statistically significant degree.



Feeling Listened To

For questions about whether participants felt that their concerns were listened to by primary care providers, response rates differed according to provider, with 1811 participants providing responses for GP's, 1445 for Community Pharmacists, 1128 for Community Nurses, and 452 for Midwives. This was presumably due to lower levels of experience with non-GP providers among the participants.

Ethnicity had no statistically significant effect on feeling listened to by Pharmacists (p=.298).

However, South Asian Bangladeshi/Pakistani, White Other, and Black participants tended to feel less listened to by other primary care providers compared to White British participants.

For feeling listened to by GP's (N=1811), there was no main effect of ethnicity (p=.094), but in pairwise comparisons, on average South Asian Bangladeshi/Pakistani participants (MEM=3.26, SE=.14, p=.009) and White Other participants (MEM=3.44, SE=.06, p=.010) felt less listened to compared to White British (MEM=3.64, SE=.05). In terms of percentages, while 11.1% of White British participants felt GP's "never" or "rarely" listened to them, this rose to around a quarter of White Other (23.9%) and Bangladeshi/Pakistani (25.4%) participants (see Figure 3).

Ethnicity had a small main effect on feeling listened to by Community Nurses (F(10,1099)=1.99, p=.031, ηp2 = 0.018, N=1128). Compared to White British (MEM=3.75, SE=.06), on average South Asian Bangladeshi/Pakistani (MEM=3.20, SE=.17, p=.003), White Other (MEM=3.53, SE=.06, p=.028), Black Caribbean (MEM=3.33, SE=.15, p=.012) and Black Other (MEM=3.39, SE=.12, p=.009) felt less listened to. In terms of percentages, while 11.1% of White British participants felt GP's "never" or "rarely" listened to them, this rose to around a quarter of White Other (23.9%) and Bangladeshi/Pakistani (25.4%) participants (see Figure 4).

Finally, Ethnicity had a medium main effect on feeling listened to by Midwives (F(10,423)=2.99, p=.001, ηp2 = 0.066, N=452). Compared to White British (MEM=4.05, SE=.14, N=85), South Asian Bangladeshi/Pakistani (MEM=3.01, SE=.23, p<.001, N=29) and White Other (MEM=3.54, SE=.13, p=.007, N=95) felt less listened to. In addition, all Black groups felt less listened to by midwives: Black African (MEM=3.49, SE=.17, p<.012, N=53), Black Caribbean (MEM=3.01, SE=.29, p=.001, N=19), and Black Other (MEM=3.40, SE=.21, p<.010, N=37) (see Figure 5).

Figure 3. Raw percentages of participants answering “yes” and “no” to whether they feel listened to by GP’s. Asterisks indicate groups for whom the mean response was lower than the White British group to a statistically significant degree.

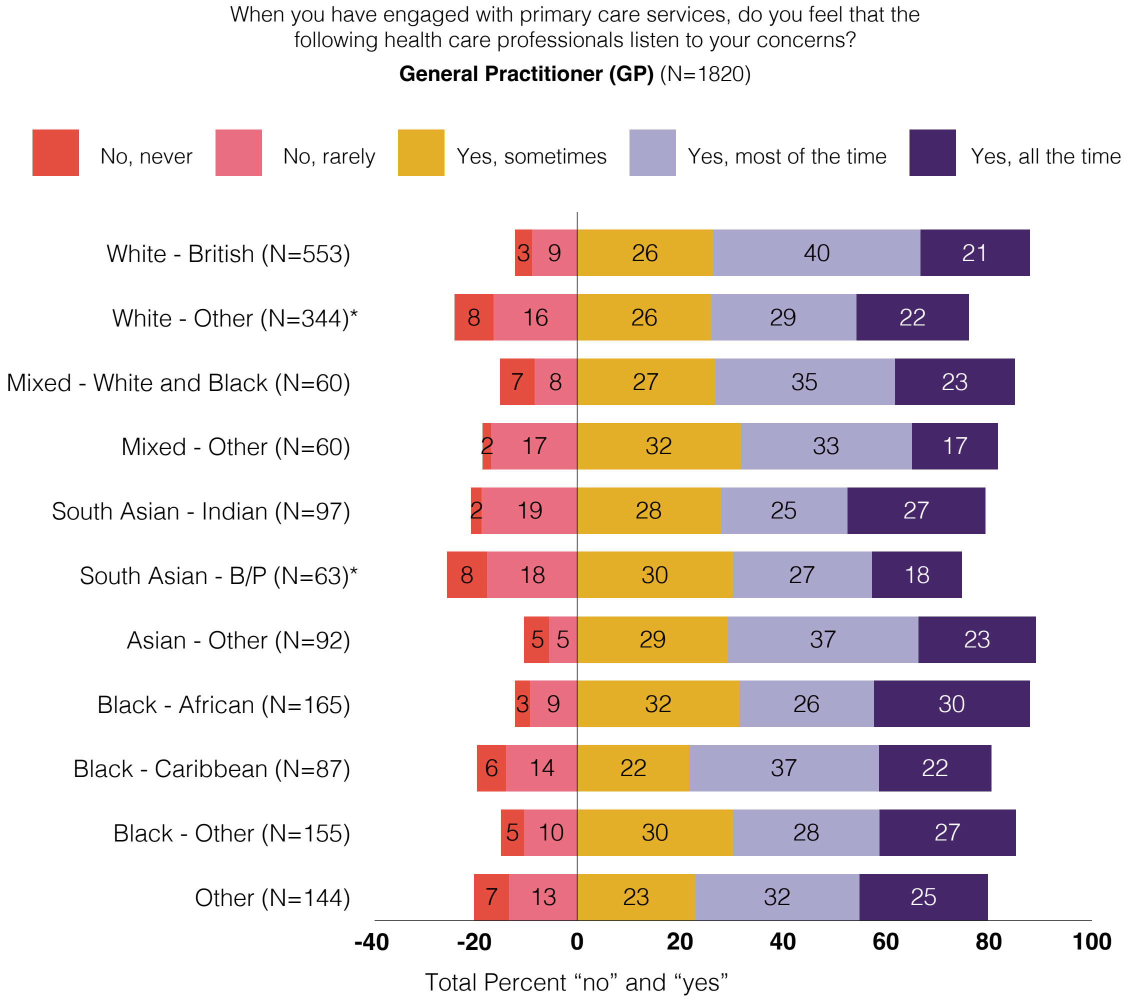


Figure 4. Raw percentages of participants answering “yes” and “no” to whether they feel listened to by community nurses. Asterisks indicate groups for whom the mean response was lower than the White British group to a statistically significant degree.

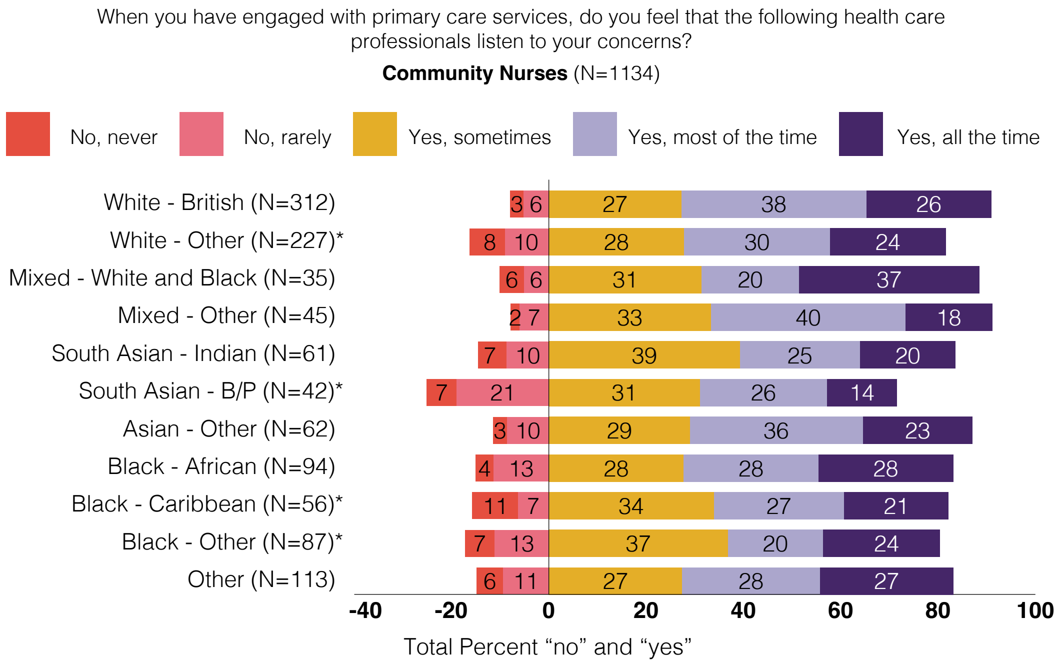
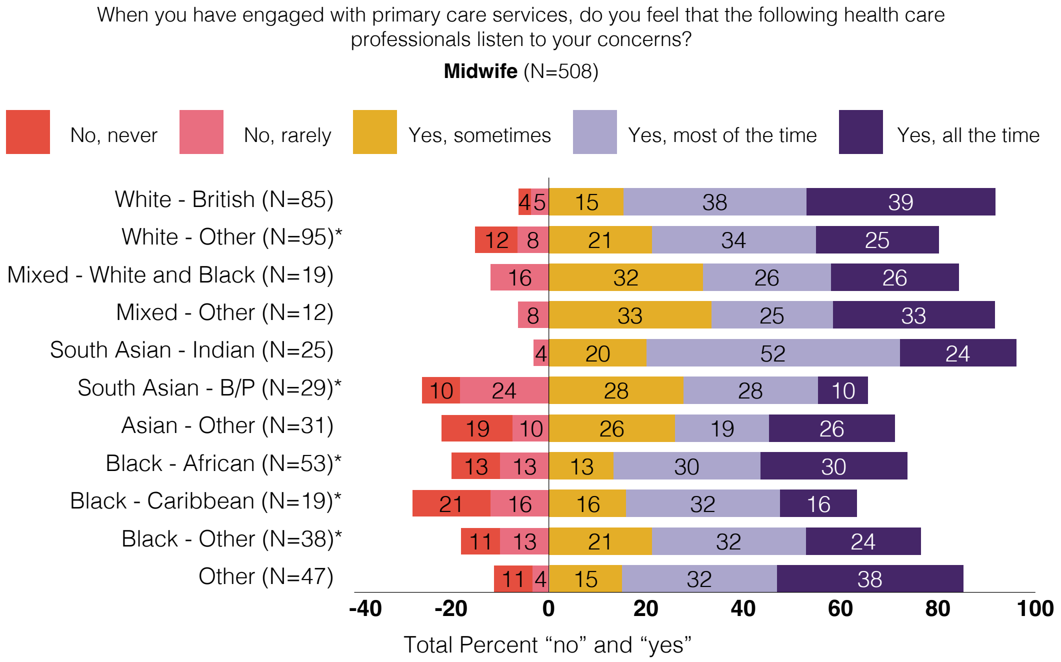
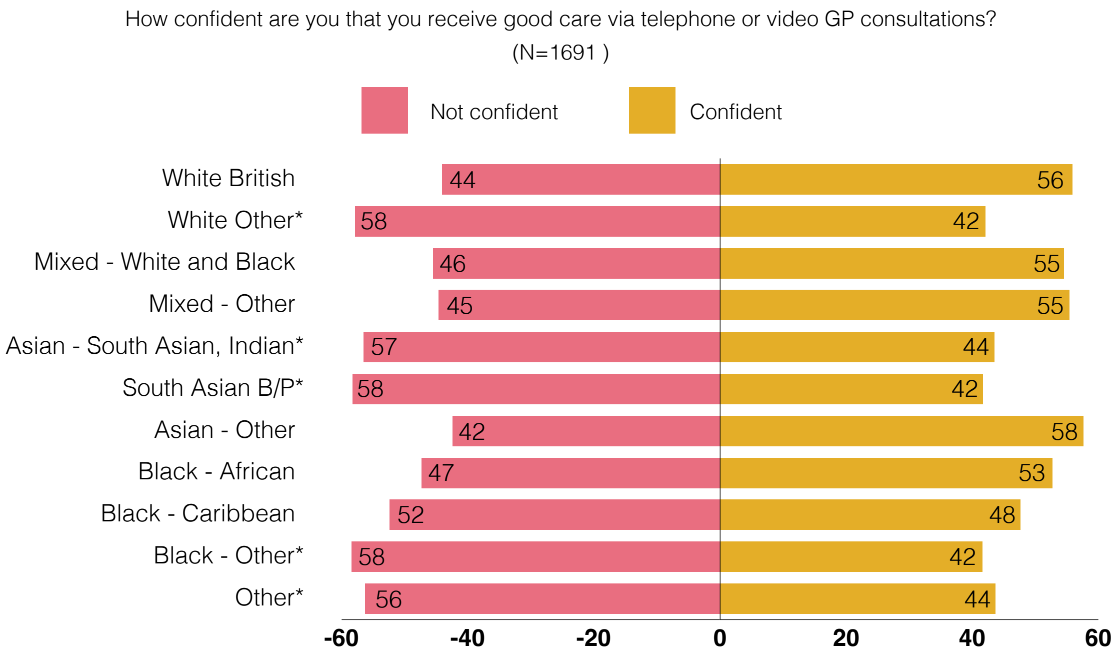


Figure 5. Raw percentages of participants answering “yes” and “no” to whether they feel listened to by midwives. Asterisks indicate groups for whom the mean response was lower than the White British group to a statistically significant degree.



Remote Consultations

Figure 6. Raw percentages of participants answering “yes” and “no” to whether they feel listened to by midwives. Asterisks indicate groups for whom the mean response was lower than the White British group to a statistically significant degree.



Excluding participants who selected “not applicable” (9%), overall, participants were evenly split on whether they felt Confident (49.0%) or Not Confident (51.0%) that they receive good care via telephone or video GP consultations.

A binary logistic regression model ($\chi2(28, N=1691)= 69.52, p<.001$) suggested that whether participants were Confident or Not Confident varied significantly by ethnicity (see Figure 6). Compared to 40.2% of White British who felt Not Confident, White Other (54.4%, OR: 1.66, 95% CI: 1.24-2.21), Indian (52.5%, OR: 1.59, 95% CI: 1.00-2.53), Bangladeshi/Pakistani (53.8%, OR: 1.84, 95% CI: 1.05-3.21), Black Other (51.9%, OR: 1.82, 95% CI: 1.23-2.71) and Other ethnicity (50.7%, OR: 1.64, 95% CI: 1.10-2.43) participants had greater odds of feeling Not Confident in remote consultations compared to White British participants.

1291 participants provided a reason for their response when asked: 736 of those who had rated themselves Not Confident, and 476 of those who had rated themselves Confident. Across all ethnicities, common themes of concern included: difficulties accessing appointments; concerns about the accuracy of remote diagnosis without being visually or physically inspected; quality of medical care (short, uncaring, rushed appointments; being “fobbed off” and “gotten rid of” quickly without dealing with the problem); and difficulties of communicating remotely, specifically with ensuring that the doctor fully understands listens to, understands, and takes seriously the patient’s concerns, symptoms and medical problems, which many experienced as more difficult over the phone. This was even more of a problem for ethnic minority participants whose first language is not English, for whom speaking on the phone rather than in person presented an additional barrier to successful communication. These patients were particularly anxious about doctors basing recommendations and diagnoses solely on their own verbal descriptions of problems, and many reported misdiagnoses, worries about misdiagnosis, or feeling not listened to due to trouble fully communicating their concerns remotely. Those who felt confident in remote consultations tended to be those who felt able to communicate well remotely, found remote consultations convenient, and felt confident they were able to access in-person treatment easily when desired or medically necessary.

Perceived Discrimination

Of 1930 responses, 49% of participants felt they were treated differently by primary care services on the basis of at least one personal characteristic out of Ethnicity, Gender, Education Level, Location, Socioeconomic Status, Religion, Sexual Orientation, or ‘Other’ (see Table 3). As detailed below, free-text responses indicated participants mostly interpreted this question in terms of perceived negative treatment on the basis of demographic characteristics, although some participants reported being treated differently in a positive sense (e.g. being taking more seriously due to being more educated).

Binary logistic regression predicting discrimination from Ethnicity, Region, Sex, and Age suggested that the odds of feeling treated differently on the basis of at least one characteristic varied as a function of participant demographics, ($\chi2(28,1853) = 132.07$, $p<.001$). In terms of ethnicity, Bangladeshi/Pakistani (OR: 1.62, 95% CI: 1.04-2.53, $p=.033$) and Black participants (Black Caribbean, OR: 1.71, 95% CI: 1.19-2.45; Black African, OR: 2.87, 95% CI: 1.76-4.89; Black Other, OR: 2.54, 95% CI: 1.73-3.73) were more likely than White British to report at least one form of discrimination.

Ethnicity-based discrimination: Discrimination on the basis of ethnicity was most frequently reported, applying to 25% of all participants and 51% of those who reported some form of discrimination.[3] Binary logistic regression showed that rates of discrimination on the basis of ethnicity ($\chi2(28,1853) = 372.32$, $p<.001$) varied across ethnicity groups (see Figure 7), with the highest rates reported by Black participants (50% of Black Caribbean and 54% of Black Other participants); all groups had significantly greater odds of reporting ethnicity-based discrimination compared to White British at $p<.001$.

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[3] This is consistent with previous research that found that ethnic minorities experience higher levels of everyday ethnicity-based discrimination compared to religious discrimination (Jaspal & Lopes, 2021).

Table 3. Percentage of participants who ticked listed options in response to the question, “Do you feel any of the following characteristics affect the way you are treated by your primary care services?” Notes refer to qualitative data from the survey question asking participants to explain their answers.

Characteristic	% of all respondents (N=1930)	% of those who selected at least one characteristic (N=929)	Notes
Ethnicity	25%	51%	See in-text discussion
Gender	18%	37%	See in-text discussion
Education Level	16%	32%	Some participants felt that being educated increased respect and quality of information received from primary care, and increased ability of the patient to advocate for themselves to ensure adequate diagnosis and treatment.
Location	14%	28%	Some participants commented on lack of access to adequate healthcare resources depending on location due to poor funding, inadequate staffing relative to population/demand, and service especially in poorer and more deprived areas. Perception of a “postcode lottery”; participants report receiving better or worse treatment respectively in locations with higher or lower SES populations.
Socioeconomic Status	12%	25%	SES was viewed as combining issues of class, economics, location, and education. Perception of poorer resources and poorer quality treatment at locations attended by low-economic groups (see ‘Location’). Perception that low SES patients are less likely to be listened to/taken seriously or receive caring treatment, while being educated, articulate, and middle class can help secure higher quality of care. Disadvantage of being unable to afford private care.
Other	12%	23%	See in-text discussion
Religion	5%	9%	Concerns about islamophobia: being regarded with suspicion, assumptions about not valuing health based on religion; wearing a hijab and misunderstanding of health impacts.
Sexual Orientation	3%	7%	Concerns about heteronormativity and prejudice against sexual minorities. Inappropriate medical advice (e.g. birth control for lesbian patient).
None of the above	52%	-	

Ethnicity and intersectionality: Rates of discrimination based on religion (χ2(28, 1853) = 113.45, p<.001), socioeconomic status (χ2(28, 1853) = 86.38, p<.001), education, (χ2(28, 1853) = 90.77, p<.001) and location (χ2(28, 1853) = 53.46, p=.003) varied according to participant demographics with statistically significant effects of ethnicity. Ethnic and racial minority participants were more likely to report these forms of discrimination compared to White British participants (see Figure 7).

For religion, compared to White British, results indicated that South Asian Bangladeshi/ Pakistani participants (99% of whom were Muslim) were much more likely to report being treated differently based on religion (OR: 31.19, 95% CI: 10.47-92.92). Indian (OR: 10.21, 95% CI: 3.18-32.80), Asian Other (OR: 9.41, 95% CI: 3.14-27.79), Black African (OR: 9.34.11, 95% CI: 3.14-27.79), Black Other (OR: 5.13, 95% CI: 1.52-17.31) and Other ethnicity (OR: 18.99, 95% CI: 6.85-52.66) participants also had significantly greater odds.

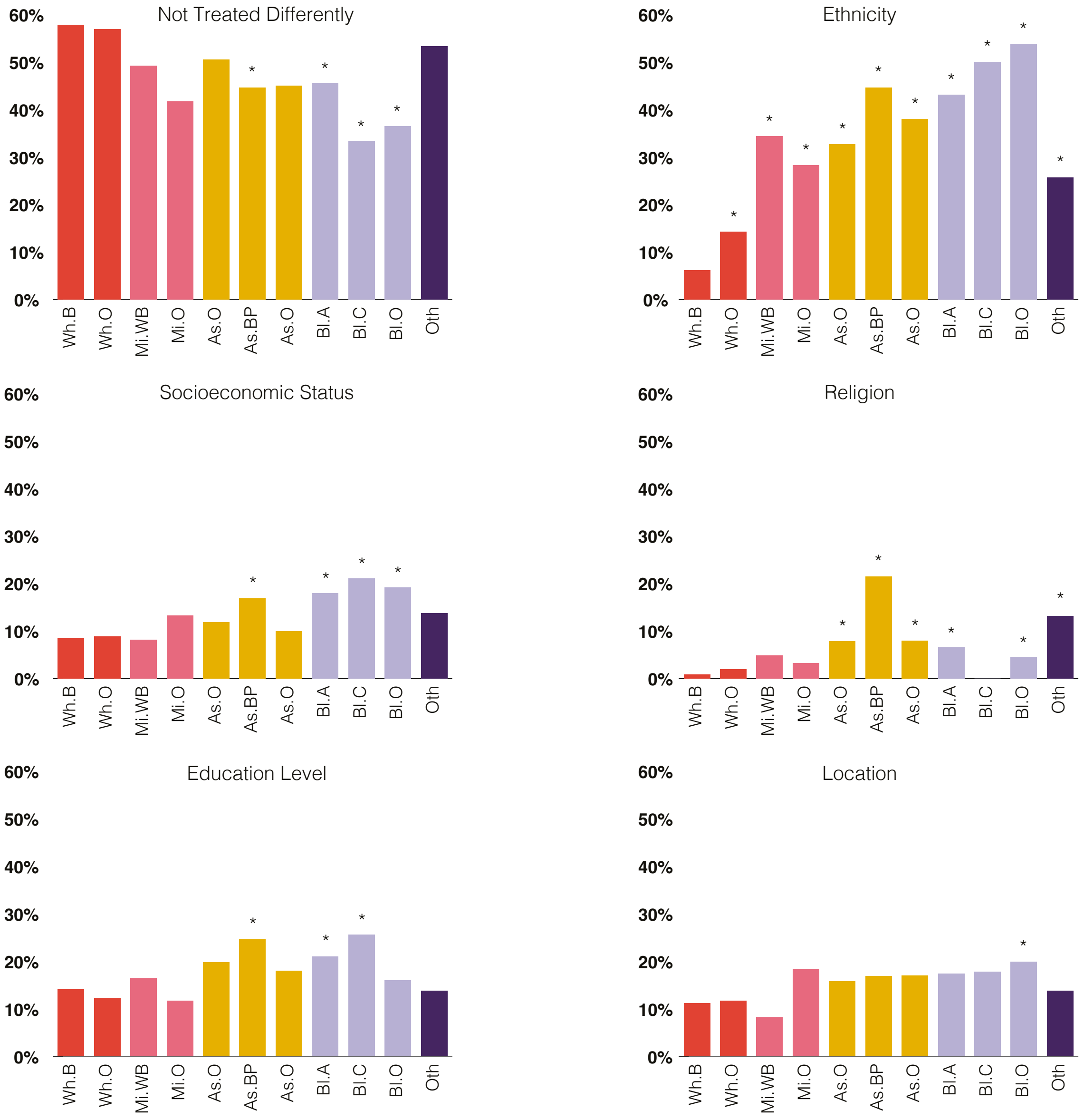
For socioeconomic status, compared to White British, South Asian Bangladeshi/ Pakistani (OR: 2.11, 95% CI: 1.00-4.44) and Black participants (Black African, OR: 2.60, 95% CI:1.56-4.33; Black Caribbean, OR: 2.98, 95% CI:1.62-5.51; Black Other, OR: 2.53, 95% CI: 1.50-4.26) were significantly more likely to report being treated differently based on socioeconomic status.

For education level, compared to White British, Bangladeshi/Pakistani (OR: 2.16, 95% CI: 1.14-4.11), Black African (OR:1.84, 95% CI: 1.16-2.92) and Black Caribbean (OR: 2.18, 95% CI: 1.25-3.80) were more likely to report being treated differently based on education level.

For location, compared to White British, Black Other participants (OR: 2.00, 95% CI: 1.22-3.27) were more likely to report being treated differently based on location.

Rates of feeling treated differently based on gender and sexual orientation did not vary by ethnicity.

Figure 7. Percentage of participants selecting a characteristic in response to, “Do you feel any of the following characteristics affect the way you are treated by your primary care services?” Total N = 1864. Top left shows participants who selected “None” and did not select any characteristics. Asterisks are used to indicate those ethnicity groups whose odds of feeling treated differently on a particular characteristic were significantly different compared to the White British group at $p<.05$ when controlling for Age, Sex, and Region in logistic regression models. Ethnicity categories are abbreviated: Wh.B = White British (N=562), Wh.O = White Other (N=350), Mi.WB = Mixed White and Black (N=61), Mi.O = Mixed Other (N=60), As.I = South Asian Indian (N=101), As.BP = South Asian Bangladeshi/Pakistani (N=65), As.O = Asian Other (100), Bl.A = Black African (N=167), Bl.C = Black Caribbean (N=90), Bl.O = Black Other (N=156), Oth = Other (N=152).



Other discrimination: Participants who ticked “Other” reported being treated differently based on several characteristics. Reports included: nationality or immigration status (e.g. perception of negative treatment towards immigrants post-Brexit); accent, language or quality of spoken English (e.g. discrimination towards non-native speakers; language barriers impacting quality of care or ability of patient to self-advocate; lack of adequate provision of translation services); disability (e.g. lack of appropriate accommodation for physical or mental disability; lack of medical understanding of disabilities); body weight (e.g. shaming, biased assumptions about patients who are overweight or have high BMI, over-attribution of health issues to weight)[4], mental illness (e.g. being patronised or dismissed due to mental health status, mental illness not being taken seriously or not being adequately understood, physical symptoms being inappropriately attributed to mental health issues); age (e.g. young age associated with not being taken seriously, assumptions that they are ’young and healthy’, care delayed; for older patients, stereotyped assumptions about likely diagnoses and healthcare needed).

Finally, several participants reported their perception that being a healthcare professional or having a related educational background affected their care, mostly in a positive sense. This status was perceived as affecting the way they were spoken to and the detail with which information was explained. Being a healthcare professional, as well as being knowledgeable, articulate, confident and educated, were perceived to help participants get more respect, to be listened to more, and to enable participants to advocate for themselves.

Discrimination – qualitative responses

870 participants provided qualitative responses when asked to give a reason for their answer. The following interrelated key themes emerged:

- Intersectionality
- Not being listened to and having pain dismissed
- Negative impacts on quality of care
- Deficiencies in medical expertise regarding women and ethnic minorities

Intersectionality: Many participants explained their concerns about being treated differently in terms of a congruence of multiple demographic characteristics (e.g. being “a young black woman”, “a retired white gay man”, a “working class [M]uslim woman”). Participants perceived the combination of characteristics as leading to more negative treatment by primary care providers and as resulting in a failure of primary care providers to address their particular needs.

A number of participants noted that certain demographic characteristics partially compensate for negative discrimination due to other characteristics, and that the quality of one’s treatment is affected by the overall balance of all of these factors. Here are two examples:

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[4] For further discussion of weight discrimination in medicine, see Ulrey, 2023.

> *"As a woman I am not certain I am taken seriously but the area in which I live has a lot of highly educated people and I am a health professional. These last two tip the scales in my favour BUT none of this works for my daughter who has suffered for years because her symptoms have not been taken seriously and I have ended up paying for the surgery she needs." (Female, White British, 65-74)*
>
> *I think [my] education level advantages me as I can advocate for myself but I don't think I'm always taken seriously or treated with respect due to being a young Black woman. I think my age, ethnicity and gender nexus negative affects the way I'm treated. (Female, Black African, 25-34)*

Not being listened to: One of the major concerns expressed by many participants is that primary care providers did not listen to them due to their demographic characteristics. "Not being listened to" involved having their views dismissed; not being believed (e.g. about symptoms or causes of symptoms); not being taken seriously; not being viewed as trustworthy or credible; having symptoms ignored, dismissed or minimized; dismissing patient insight into possible diagnoses. Many perceived that primary care providers were less likely to listen to patients in virtue of being women:

> *"Being young and female doesn't always get you taken seriously (Female, White Other, 18-24)*
>
> *I feel that you are prejudged because you are female and symptoms dismissed as maybe you are exaggerating the problem (Female, White British, 65-74)*

Being an ethnic minority was also perceived to make patients less likely to be listened to, which was compounded by additional gender discrimination.

> *"Racism is clearly an issue and being a black woman [sic] adds another layer of bias. This affects the degrees to which I'm listened to and my health treatment. I often feel as though my views are dismissed, I'm patronised and silenced by health professionals" (Female, Black or Black British, 45-54)*
>
> *I do think I have been stereotypes [sic] in the past due to my age and race, and I am distrustful of health professionals as they be very condescending and seem to be a hurry to pass you over, I think […] they assume I'm just a silly Black girl most of the time. (Female, Black Caribbean, 35-44 years)*
>
> *"People from an ethnic minority background simply do not get listened to. I believe this [sic] is a huge issue for the NHS around 'BAME' health inequalities which show in local and national data. A real-life example is my mother's cancer symptoms not being taken seriously in not one but two occasions. She was told it was normal […]. On the second occasion as her translator, I felt the GP did not do all they could to rectify delays in the 2 week wait appointment. This wouldn't of changed the diagnosis but would have prevented admission into hospital as an A&E patient." (Female, Asian Bangladeshi, 45-54 years)*

A frequent complaint raised by many participants was that being a woman or a "person of colour" led primary care providers to ignore or minimize reports of pain. Many complained they weren't believed about the levels of pain they were experiencing, or that their pain was not taken seriously. In addition, some participants attributed these failures to stereotypes according to which Black patients "can handle" or "bear more" pain; and to the idea that women are simply expected to accept and experience pain (e.g. in medical procedures related to gynaecology or obstetrics). Some participants felt they had to "beg" or "make themselves cry" for their pain to be taken seriously and to secure appropriate follow-up.

> *As a Black female, my symptoms are dismissed, and pain especially is ignored. I'm never listened to and questioning my care is viewed negatively. (Female, Black Caribbean, 35-44)*
>
> *"Being of African descent and poor had made it harder to be treated adequately when you are in pain. It is often minimised or completely dismissed for us to be suffering as much as we claim." (Male, Black African, 25-34)*
>
> *"My male [C]aucasian partner gets his analgesia containing codeine, regularly from his GP, even gets more than he needs. He […], lives in affluent area in [omitted]. I live in [omitted], am black female and pretty much had to beg for my pregabalin medication monthly […] often the prescription dose was wrong […] It caused so much stress in addition to being ill" (Female, Black or Black British, 35-44)*
>
> *"We are dealing with individuals with biases, because I am a tall big man if colour [sic] any physical pain that I experience has been looked upon differently in face to face consultations as though i should be able to handle it. I am absolutely convinced that if I were not educated to a post grad level the conversations with my health practitioners would be very different." (Male, Black Other, 45-54 years)*
>
> *"As a woman I feel that our bodies are not treated with enough care and respect. We are expected to have to bare [sic] a certain amount of pain or discomfort with 'investigations'. Dealing with issues linked to periods/menopause/fibroids/post labour checks, all seem to lack the care that women need in general. But this is worse if you are a black or brown woman as you have the racism/bias on top - misconceptions about black women being able to bare more pain." (Female, Black or Black British, 35-44 years)*

Negative impact on quality of care and medical outcomes

Most participants additionally highlighted the way that not being listened to and discrimination had negative impacts on the quality of medical care they received, with direct impacts on medical outcomes. This was in addition to the unpleasantness of discriminatory interactions (e.g. "racist", "disrespectful", "uncaring", "unkind" treatment and/or offensive comments and stereotypes)[5]. For example, participants reported that

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[5] For example, one participant describes witnessing "harsh, uncaring treatment of family members during births" but white patients being treated with "different, kinder responses", and a consultant stereotyping their baby as a future "busdriver" (Female, Black or Black British, 65-74 years, No Religion); another participant complained of being subjected to religious stereotypes and prejudice due to being Irish.

as a result of not being listened to or dismissed when reporting symptoms and medical problems, they suffered results such as: failure to secure appointments when needed; not receiving any treatment, receiving insufficient treatment, or receiving inappropriate treatment for a symptom or condition; delays in having symptoms properly investigated, or a failure of primary care providers to investigate or follow up on them at all; failures or delays in correct diagnosis; misdiagnoses; being forced to self-diagnose; failure to be referred to appropriate specialist care, or delays in being referred. This was also reported to lead to a compounding of medical problems (through worsening of inadequately treated medical conditions and/or contributing to the development of additional mental health conditions) and needing to engage extra health resources (e.g. ending up in A&E due to deterioration, or repeated primary care appointments needed before being appropriately treated or referred). One participant attributed deaths in their community to a failure of practitioners to listen to medical complaints from members of that community.

> *“Women are often considered as experiencing pain more than others/exaggerating symptoms. Personally, I have been told “you are a woman and its just how it is” for a disease that is common to women but treatable in the long term and should have been investigated and I on this basis [sic]” (Female, Mixed White & Asian, 25-34 years)*

> *“It took me over 5 years to be diagnosed with vulvodynia simply because nobody believed my symptoms were real, all of the doctors I saw at my surgery kept telling me I just had cystitis and had to endure the pain sometimes for two-three weeks at a time! it got so bad that I became depressed and had to be treated for yet something else, I had to fight with distrustful doctors and a bureaucratic system to finally get a diagnosis and recover my life.” (Female, Hispanic, 35-44)*

> *“I find that sometimes the GP will make a wrong diagnose based on my ethnicity. I have also experience a rushed and disrespectful consultation [sic].” (Male, Black Caribbean, 65-74 years)*

> *“I have felt often that my race is often a reason for them not to investigate issues, and because I live in a deprived area it is assumed that my health will deteriorate quicker and that I should accept my health condition as environmental” (Female, Black or Black British, 55-64 years)*

> *“I often feel disregarded by my GP as a young female, my symptoms have been overlooked and I’ve been put on wrong medication many times. I’ve also had to come back week after week because the treatments were ineffective, which would’ve been solved the first time if I was listened to and got a face-to-face appointment” (Female, White Other, 18-24 years’*

> *“I’m a working class Muslim woman from an ethnic minority community in Haringey/Totte–ham - do you know how many au’ts I’ve lost who were unheard? uncles who stopped going to the doctors? I was misdiagnosed with serious clinical conditions. All throughout I said this is w–ong - no one listened to me […].” (Female, Turkish Cypriot, 35-44)*

> *"My partner is not as well educated as me. I come out of primary care appointments feeling satisfied. I have been able to articulate my problem, have asked all the questions I have, and I feel able to challenge the primary care if I don't understand what they are saying or if I have questions over treatment recommended. My partner often comes away unsure of what the issue or treatment should be, is less able to articulate the issue so feels less listened to, and often doesn't take treatments/tablets as prescribed because the purpose of the treatment is not understood. I feel education level, and further to this language barriers, cause severe differences in the outcome of the session, even if the session itself is the same." (Female, White British, 25-34)*

> *"Not applicable to my current GP practice, but I unluckily was at a GP practice for 4 years and they persistently ignored my requests for help. For example upon disclosure of suicidal feelings post sexual violence my doctor just handed me tissues and said there was nothing he could do. I then had to attend A&E services, where a black psychotherapist on call had to write a complaint email to my GP services for not fulfilling their duty of care. The response was a call from the receptionists to me telling me 'hat 'I should have told them it was se'ious' and not taking any accountability for their actions." (Non-binary, Black Caribbean, 25-34 years)*

> *"Once I had a rash all over my arm (now I know this was due to a pituitary tumor) and dispute [sic] having all the symptoms of this tumour, I was immediately dismissed and told I had been shaving my arms and it was a shaving rash. I have never shaved my arms and if the doctor would have looked closer like I asked, he would have seen I had long but very fine hairs and I c'uldn't have shaved my arms. I believe if a man had gone in and complained about the rash, they would have investigated further, but because I was female, the doctor assumed I would have shaved my arms for aesthetic reasons. It took me another year to self-diagnose myself (which was correct) and despite looking like a very typical case (physically and health-wise), I was still dismissed initially until [sic] the manager finally agreed to test me." (Female, Mixed Other, 25-34 years)*

Some participants also discussed the way that primary care providers based medical assessments on stereotypes rather than listening to the patient's concerns. For example, several female participants complained that their medical symptoms were inappropriately and inaccurately attributed to their menstrual cycle ("time of the month"), menstrual pain, "hormones", pregnancy, or anxiety. Similarly, a Muslim participant (Female, Asian Bangladeshi, 35-44 years) complained that primary care providers repeatedly and inaccurately attribute their medical problems to vitamin D deficiency because they wear a hijab.

Some participants described how these experiences of discrimination led them to disengage from healthcare altogether.

"As a visible racial minority individual, the eyeball test wherein I am stereotyped has been a consistent challenge, then when I speak, though educated, the first impression continues to influence the interaction such that I am perceived as either or all of the following, not credible, demanding, I am not trustworthy, a drain on the NHS resou–ces - This all invokes anxiety and stress pre & pro-consultation such that the consultation is rarely satisfactory and therefore adversely impacts my behaviour such that actively avoid accessing services, particularly preventative screening, which I know is wrong but I need to protect myself from the racial trauma that is inflicted during the interaction." (Female, Asian Pakistani, 55-64 years).

Inadequate medical expertise for women and minorities: As well as not being listened to, another factor that negatively impacted medical quality of care was a perceived inadequacy in medical understanding relating to health issues or health risks specific to women or ethnic minorities, or a lack of understanding of the way health issues manifest in women or ethnic minorities. For example, several participants complained that primary care providers did not have the training, experience or ability to properly assess or diagnose skin conditions on Black skin. In addition, female participants complained that primary care providers lack knowledge of conditions affecting women, that women's health concerns are not taken seriously or are ignored, and that there is a lack of access to specialist care for women's health needs (e.g. menopause, gynaecological issues, pain or other problems with menstruation, contraception, endometriosis, PCOS). Some perceive that women's health issues are regarded as "an annoyance", "unimportant", "trivial".

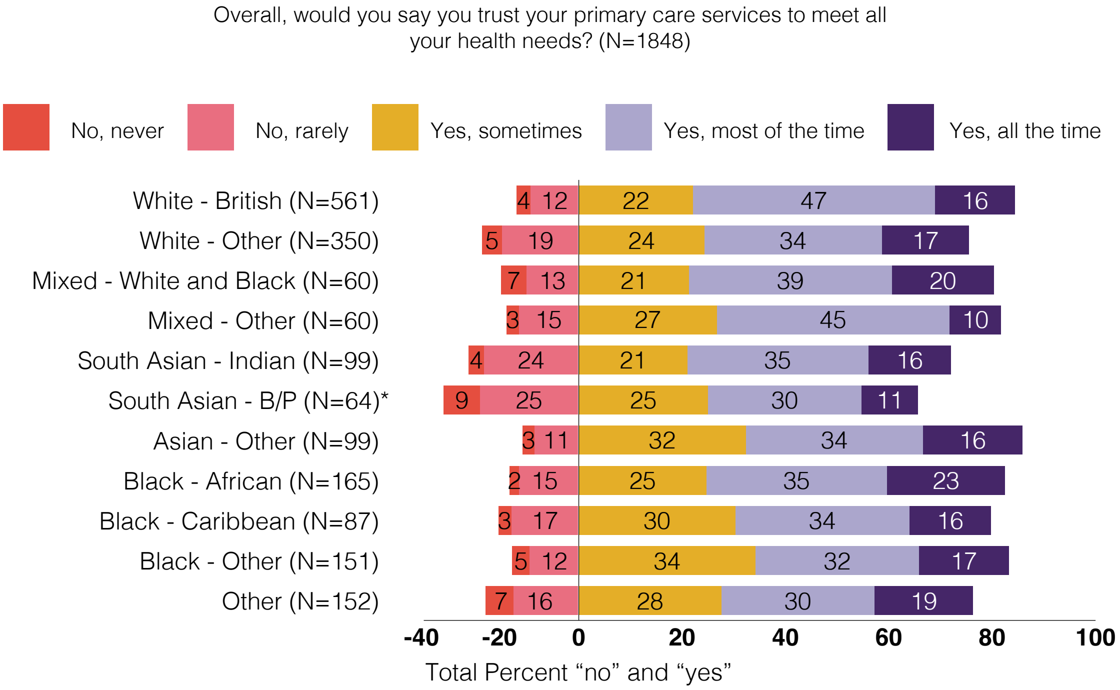
> *"It took 26 years of misdiagnoses and not being listened to, to finally be diagnosed with Endometriosis. Which at that point had left me infertile and erased any less invasive treatment options. It wrecked my life. 'omen's health is not taken seriously AT ALL. Even less so when you are non-White." (Female, Mixed White & Black Caribbean, 45-54 years)*
>
> *"For many years I was told I had gynaecological issues, despite no evidence of this. It eventually transp–red - after a de–ade - I had a food intolerance which is common amongst people of my ethnicity." (Female, Mixed White & Asian, 35-44 years)*
>
> *"As a young ethnic minority, I feel as though I am not taken seriously and I have to really emphasise and be 'dramatic' to be taken a bit seriously. I also feel like doctors don't know how especially different conditions look on darker skin which makes it hard to be treated. […]" (Female, Black or Black British, 18-24 years)*
>
> *"As a woman I feel that womens health is massively overlooked. GP's (mostly Male) will jump to conclusions around womens health, or only look at one aspect of a female and sometimes won't know much about the problem so you won't get an answer at all. [sic]" (Female, White British, 18-24 years)*
>
> *"I was having problems with periods and pain and I was told by my male GP to "talk to a woman" as "they would understand" " (Female, Black Caribbean, 25-34)*

Practical Trust

The modal response amongst participants was that they trusted primary care services to meet all their health needs “most of the time” (38%). However, approximately 20% of participants felt they “rarely” or “never” trusted primary care services to meet all their health needs.

Ethnicity: Ethnicity had a significant effect on Practical Trust, F(10,1819)=2.12, p=0.020, ηp2 = 0.012 (see Figure 8). Compared to White British (MEM=3.56, SE=.05), Bangladeshi/Pakistani participants had significantly less Practical Trust (MEM=3.05, SE=.13), p<.001, with 30% not trusting primary care to meet all their health needs. White Other participants also had lower Practical Trust on average (MEM=3.41, SE=.06) and this approached but did not reach statistical significance, p=.052.

Figure 8. Raw percentages of participants answering “yes” and “no” to whether they trust primary care services to meet their health needs. Asterisks indicate groups for whom the difference in mean response compared to the White British group was statistically significant.



Contributors to Practical Trust

Hierarchical multiple linear regression models were created to predict Practical Trust. The first model included the following four variables as predictors: Concerns Acted On; Feeling Listened To[6]; Discrimination (defined as a binary variable that coded whether participants felt treated differently based on at least one demographic characteristic); Confidence in Remote Consultations. The resulting model was significant (F(5, 1807)=720.04, p<.001) and Adjusted R Square indicated that the predictors explained 66.5% of the variance in Practical Trust. Practical Trust was most strongly predicted by Concerns Acted On (β = .482, p<.001) followed by Feeling Listened To (β = .267, p<.001), and being 'confident' rather than 'not confident' in remote consultations (β = .174, p<.001). Finally, perceived discrimination on the basis of at least one personal characteristic had a small, negative predictive relationship to Practical Trust (β = -.037, p=.009).

Adding in demographic variables of Age, Ethnicity, Region, and Sex in a second model improved the model fit (p=.017), though the improvement was very small, with a new adjusted R Square suggesting the model explained 66.8% of the variance, a slight 0.3% improvement. Over and above these variables, the following demographic characteristics negatively predicted practical trust: identifying one's ethnicity as South Asian Bangladeshi/Pakistani (β = -.031, p=.028); being Female (β = -.035, p=.014); and describing one's sex as Other (β = -.032, p=.022).

Trust in Covid-19 Information

The modal response amongst participants was that they trusted information about Covid-19 from primary care services "most of the time" (31%). However, approximately 12% of participants felt they "rarely" or "never" trusted Covid-19 information from primary care services.

Ethnicity: Ethnicity had a significant effect on Epistemic Trust, F(10,1815)=6.94, p<.001, ηp2 = 0.037 (see Figure 9). Compared to White British (MEM=4.07, SE=.04), all groups except for Mixed and Indian participants had statistically significant lower average trust in Covid-19 information, with the Black Caribbean group showing the lowest trust levels: White Other (MEM=3.82, SE=.06, p<.001), South Asian Bangladeshi/Pakistani (MEM=3.66, SE=.13, p=.002), Asian Other (MEM=3.82, SE=.10, p=0.29), Black African (MEM=3.70, SE=.08, p<.001), Black Caribbean MEM=3.44, SE=.11, p<.001), Black Other (MEM=3.49, SE=.09, p<.001), and Other ethnicity (MEM=3.71, SE=.09, p<.001).

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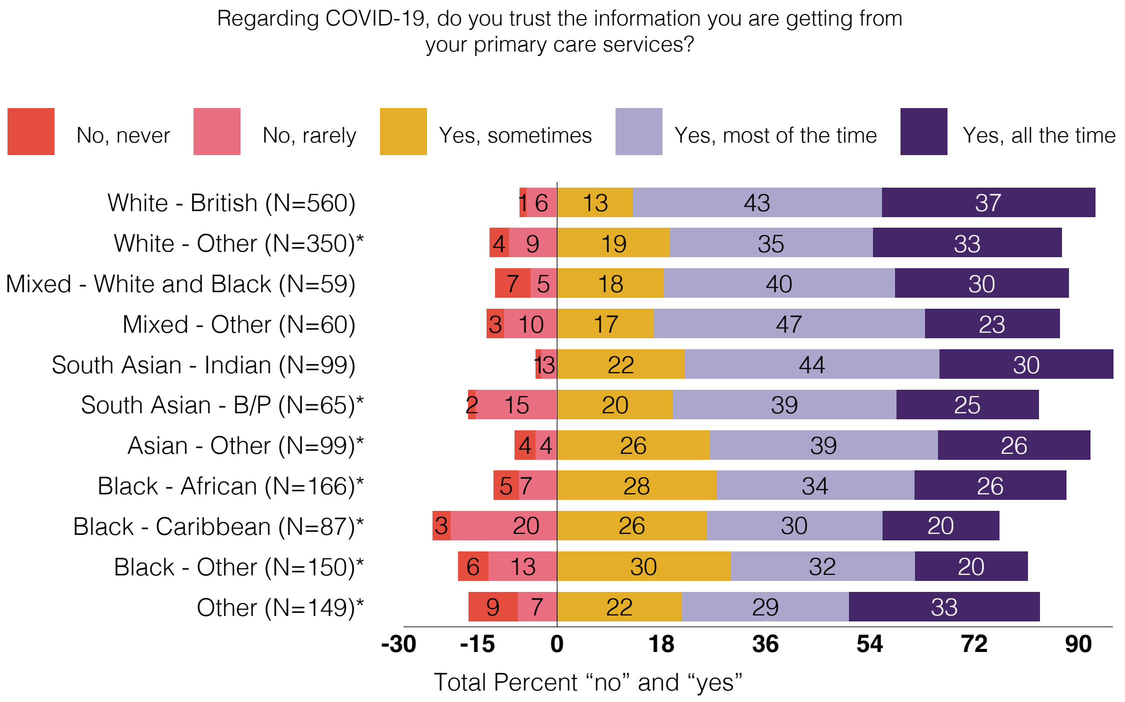
[6] A mean value of feeling listened to by GP's, Nurses, Pharmacists, and Midwives was used in the model due to low response rates, ensuring more participant data could be included in the model as a whole.

Figure 9. Raw percentages of participants answering “yes” and “no” to whether they trust Covid-19 information from primary care services. Asterisks indicate groups for whom the difference in mean response compared to the White British group was statistically significant.



Contributors to Trust in Covid-19 Information

Hierarchical multiple linear regression models were created to predict Epistemic Trust as for Practical Trust above. The first model included Concerns Acted On, Feeling Listened To, Discrimination, and Confidence in Remote Consultations as predictors. This model was significant (F(5, 1804)=98.66, p<.001) and Adjusted R Square indicated that the predictors explained 21.3% of the variance in Epistemic Trust. Epistemic Trust was most strongly predicted by Feeling Listened (β = .228, p<.001) followed by Concerns Acted On (β = .155, p<.001).

Adding in demographic variables of Age, Ethnicity, Region, and Sex in a second model improved the model fit (p<.001), with a new adjusted R Square suggesting the model explained 24.7% of the variance, a 3.4% improvement. Over and above Feeling Listened to, Concerns Acted On, and Confidence in Remote Consultations, lower epistemic trust was predicted by White Other (β = -.0148 p=.045), Asian Other (β = -.043, p=.050), Black Caribbean (β = -.101, p<.001), Black African (β = -.099, p<.001), Black Other (β = -.126, p<.001), and Other (β = -.074, p<.001) ethnicity. Lower trust was also predicted by being Female (β = -.059, p=.006).

Inequalities based on Age and Sex

Independently of Ethnicity, Age and Sex affected outcomes for Practical Trust, Concerns Acted On, Feeling Listened to, Confidence in Remote Consultations, and Discrimination. Across these measures, female participants reported worse outcomes (lower practical trust, lower trust in Covid-19 information, less feeling satisfied their concerns are acted on, feeling less listened to, less likely to feel confident in remote consultations,[7] and more likely to feel treated differently on the basis of at least one demographic characteristic) compared to Male participants. Concerning Age, young adults reported the worst experiences across ratings, with the worst ratings reported by the 25-34 age group (Practical Trust, Feeling Listened To, Confidence in Remote Consultations)[8] or by the 18-24 age group (Concerns Acted On, Discrimination); all ratings improved with age after that point, reaching a peak with those in the 75+ group.[9] An exception was trust in Covid-19 information – Epistemic Trust was not better for older age groups compared to young adults except for the 75+ group, who showed the greatest trust; the 35-44 age group in fact showed lower trust in Covid-19 information compared to younger adults.

What Would Improve Your Trust?

Participants asked “What would increase your trust in primary care services, if anything?”, and invited to answer a final question, “Is there anything you would like to tell us about your levels of trust in primary care services that has not been covered elsewhere in this survey?”. The following consistent themes emerged:

- Access to care
- Doctor-patient interactions: respectful, active listening
- Care for ethnic and racial minorities
- Care for mental health, disabilities, chronic conditions
- Other themes

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[7] Compared to 41.9% of males, females (48.6%, OR: 1.29, 95% CI: 1.04-1.59) and ‘other’ sex participants (75%, OR: 2.72, 95% CI: 1.35-5.47) were more likely to feel Not Confident.

[8] Compared to the 25-34 group, those aged 45-54 (OR: 1.51, 95% CI: 1.12-2.04), 55-64 (OR: 1.41, 95% CI: 1.03-1.95), 65-74 (OR: 1.83, 95% CI: 1.22-2.74), and 75+ (OR: 1.51, 95% CI: 1.12-2.04) were more likely to feel Not Confident.

[9] This is consistent with previous research analysing the General Practice Patient Survey finding that younger patients have worse experiences (Saunders et al., 2021; Rolewicz et al., 2020; Lyratzopoulos, et al. 2012). However, GPPS does not appear to show sex-based differences in doctor communication or overall experience (Saunders et al., 2021).

Access to Care

Access to primary care: One of the most frequently represented themes was how difficulty obtaining access to care negatively impacted trust.[10] This was overwhelmingly reported to be due to a lack of available GP appointments. Many participants describe not being able to get through to anyone on the phone, or being held in a queue waiting for a receptionist for lengthy periods (e.g. 30 minutes, an hour, or even more). Once participants make contact over the phone or through an app, few or even no appointments are available, and any appointments that are made are often far in the future. Many participants also complain of having no ability to schedule appointments outside of operating hours, thus the inconvenience of phone queues is viewed as negatively impacting patients who work during weekdays and also viewed as expressing a disrespectful, uncaring attitude towards the needs of patients as it's a "waste of people's time".

Similarly, many patients describe difficulty accessing specialist care – for example, being unable to secure a required referral, or, even when a referral is made, experiencing lengthy delays in any appointment being scheduled. One participant described trying to get a needed referral from the GP as "like pulling teeth" (Black Caribbean, Female, 35-44).

The impact of access to care on trust can be interpreted through a number of mechanisms. First and foremost, problems with access to care mean that patients do not trust they will be able to receive medical treatment when they need it. As one participant wrote about what would improve their trust:

> *"Being confident that a range of appointments - either telephone, video or face to face were going to be available when myself and my family with LTCs [long term conditions] need them. Whilst I rate GP and primary care clinicians very highly, i am in a state of anxiety that they will not be there in a timely way if needed" (White British, Female, 55-64)*

Secondly, the difficulty and inconvenience of securing appointments, referrals and ultimately treatment is experienced as a "battle", a "fight", or "hard work", leading to an adversarial relationship between patients and primary care. GP receptionists are viewed as "gatekeepers", primary care is experienced as "reluctant" to provide services, and patients, are made to "feel like a burden they [primary care] would rather be rid of", "an inconvenience", "a nuisance", or "like you don't matter" and "they don't care", unless they are experiencing an emergency or a "crisis" that demands prioritisation.

In some participants, lack of access is linked to suspicions that the health service doesn't care about patients, is using fake excuses to justify not providing appointments, or is motivated in its access and treatment decisions by financial concerns and internal targets rather than patient welfare. For example, one participant said that "[b]eing upfront about what options we have when given an issue" would improve their trust, and

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[10] GPPS data indicates that access to care has worsened over time since 2011 (Saunders et al., 2021).

that they “feel that practitioners are purposefully told not to make referrals to services like scans etc as it costs money. I have personally been told that they are limiting when and how many people they send for an MRI scan, which is shocking” (Asian or Asian British, Male, 25-34). Another writes, “I feel that my health care needs are more about the cost of any treatment rather than what is good for my health” (Black or Black British, 45-54).

Participants describe various practical consequences of not being able to trust in access to care, including going to A&E, going abroad for treatment, seeking private treatment, or simply “giving up”.

Follow-up care: Beyond securing an initial appointment, many participants feel unable to access follow-up care. Many express feelings as if obtaining one appointment, having one test conducted or receiving one prescription has “ticked the box”, leaving patients with a feeling of being abandoned after only superficial engagement with their problems. This further contributes to the sense that accessing sufficient care to “fully resolve” a medical problem (e.g. to the point of securing a diagnosis, or finding a successful medication) is a battle, and that primary care services don’t truly care or aren’t truly “dedicated” to helping patients resolve their medical problems. For many patients, living with undiagnosed symptoms or experiencing misdiagnoses seriously undermine trust; there a sense that there is little motivation to figure out “what is wrong” with them unless it’s indicative of something very serious or life-threatening, even if it negatively impacts quality of life.

Preventative care: As well as access to care when medical problems arise, participants feel they would trust primary care more if they were able to access to preventative care – for example, many participants expressed the desire to have access regular check-ups. There is a worry that without capacity for preventative care, patients will suffer from preventable medical problems, and that “you can only get an appointment when [there’s] something already seriously wrong”; one participant wrote, “NHS 111 only cares if you’re dying”.

The doctor-patient interaction

For patients to trust that primary care will be able to offer them appropriate treatment and support, much hangs on the quality of the doctor-patient interaction once it does occur.

One very important theme involves the idea that, to receive adequate treatment, patients need to trust that doctors care, and patients need to trust that doctors will be adequately informed (about their symptoms, relevant medical history, and personal needs). Achieving this requires a two-way dialogue that involves respectful, active listening to patients.

Participants felt that doctors need to have sufficient time to devote to reviewing a patient’s “notes” or relevant medical history, and most importantly the appointment needs to allow for sufficient time for patients to explain the problems they are experiencing and give relevant background information. Trust is therefore undermined for many patients who feel that their care is "rushed" and that doctors are under pressure to "see as many people as possible", as they do not believe that they are able to communicate sufficiently under these conditions to accurate diagnosis or appropriate medical solutions that are sufficiently tailored to the individual's medical needs.[11] Relatedly, many participants feel that a "holistic approach" to their care is important, as "just treating individual symptoms" can lead to misdiagnosis and failures of care. As one participant wrote, "overseeing my symptoms and responses to treatment would join up problems earlier and save valuable NHS resources".

> *"A part of my lack of trust is down to the fact that primary care and healthcare in general look at the one issue you raise and not the wider picture. They don't look at your whole health picture. Therefore, they treat symptoms and not the cause. Or they simply see you have a chronic condition and put everything down to that." (Asian or Asian British, Female, 35-44)*

> *"[What would increase my trust is] A more holistic approach to physical health issues rather than a brief symptom-targeted appointment. I don't believe that GPs are given enough time to be able to think about patients as a whole. I feel discouraged to go to the GPs unless there is a clear issue that can be addressed (e.g. a cough) due to fear of not being taken seriously." (White British, Female, 25-34)*

Many participants feel these problems are exacerbated by a lack of continuity of care, i.e. being unable to see the same doctor or nurse over time, and value continuity of care insofar as they help to facilitate better patient-care.[12] Repeated interactions are seen as one way of supporting the ability to establish a caring, "collaborative", therapeutic "relationship" – for example, seeing the same doctors or nurses can help patients feel "that people are actually invested in you as a person, and [sic] you trust that they genuinely have an interest in your wellbeing" (White British, Female, 25-34, Christian). In addition, patients say that lack of continuity of care means that crucial information is lost, and appointment time is taken up re-providing information. As one participation wrote, "having continuity with a GP [would improve my trust] so I don't have to spend the bulk of my 6-minute appointment giving them the rundown of my medical history" (White British, Male, 35-44). This can also contribute to a sense of depersonalisation or lack of humanity.

> *"I don't trust my primary care trust [because] I never see the same doctor twice, so they don't know anything about me and I have to explain my medical history, which takes up half the visit. [Because] they haven't had time to read my chart. There is no relationship, and I have no expectation that they care about my well-being." (White Other, Female, 45-54, No Religion)*

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[11] While existing research links increased consultation length with positive medical outcomes, it is less clear whether or when patient trust and experience is impacted by length per se. More important may be how well that time is used e.g. with greater relative amounts of time during the consultation spent on attentive, active, informed listening. See Elmore et al., 2016, and Ogden et al., 2004; van Maren et al., 2021; Laurant et al., 2018.

[12] See Tarrant, Stokes, & Baker, 2003. Patient valuing of continuity of care has been documented in previous research, e.g. Aboulghate et al, 2012. Furthermore, Bangladeshi, Pakistani, Black African, Black Caribbean, and other Black background patients experience lower levels of continuity of care in GP settings even after accounting for area derivation and practice (Stafford et al., 2023). However, analysis of GPPS data from 2019-2021 by Magadi and Magadi (2022) suggests that experienced continuity of care does not play a big independent role in explaining ethnicity-based discrepancies in overall care satisfaction.

> *"Nowadays you never see the same doctor. There is a worry about continuity. Doctors or nurses spend most of the consultation looking at a screen to find out about you instead of the patient." (White British, Female, 65-74)*

One of the main themes in participant responses was that trust in primary care requires a two-way dialogue that involves respectful, empathetic, active listening to patients.[13] Participants repeatedly emphasise the importance of doctors "genuinely listening" or "actually listening", where this involves taking their reports seriously – believing them, showing care, and acting accordingly (e.g. offering appropriate treatment, referrals, or follow-up tests). At the extreme, not being listened to involves having one's medical preferences directly overridden, as described by this participant:

> *"I used to have high levels of trust until I got pregnant and was passed from pillar to post with no continuity of care and no consistency in my treatment. On several occasions I was not listened to and even bullied into things I wasn't happy with. My postnatal care was also incredibly patchy, and I had to push to see specialists to deal with issues which had been undetected but had left me in significant pain." (White British, Female, 35-44)*

When patients feel their questions or concerns are "not taken seriously", "brushed off", "dismissed" or "fobbed off", this is seen as highly damaging to trust, as it can lead to genuine medical problems being overlooked, misdiagnosed, and not investigated, and patient needs being ignored. When patients aren't listened to, they feel that treatment is based on "assumptions", "guesswork", and "generalities" that may not apply or work for each individual.

Care for ethnic and racial minorities

> *"Primary care services feel increasingly removed from the people and communities they serve. I was born in and live in a shire town; over the years ethnic diversity has increased. The NHS has experienced huge and impactful reductions in resources but though there have been many medical advances in my lifetime, healthcare for some remains poor. The poorer you are, the more minoritized you are the worse your outcomes are likely to be. The NHS is supposed to be there for us all - equally but it does not feel like it is" (Black or Black British, Female, 45-54)*

As reflected by the earlier discussion of discrimination, a consistent theme was the need to improve the medical care received by racial and ethnic minority patients.

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[13] Similar findings are reported by Curnow et al., 2021.

One barrier to this includes experiences of discrimination and explicit racism in primary care. While patients want to be treated and seen as “individuals” and given care appropriate to them, minority patients report being subject to racist and offensive stereotypes, feeling as if they are treated more poorly or deprioritised because of their minority ethnic status, or feeling as if they are more readily dismissed and not listened to because of their ethnicity.

At the same time, improving trust requires primary care to address issues of race and ethnicity. For example, one barrier to trust is that primary care providers are seen as having a poor understanding of how ethnicity can affect medical problems or risks, resulting in poorer outcomes for minorities. For example, there was a concern about a lack of medical competence, understanding, and resources in primary care regarding medical issues that disproportionately affect minorities (e.g. thalassemia, sickle cell, lupus, diabetes), and competence in giving appropriate medical advice or diagnoses for non-White patients (e.g. competence to diagnose skin conditions for black skin, advice from NHS 111 to monitor “turning blue in the face” where this is not appropriately tailored for black skin).

Participants offered different views on what would improve trust for ethnic minority groups. While some participants feel that better representation of minorities in healthcare positions would improve trust (e.g. “More GPS who look [sic] and sound like me”; Mixed White and Black African, Female, 55-64), others report experiencing discrimination from receptionists or practitioners who are themselves racial minorities. The latter participants feel that this reflects “institutional racism” and discrimination that is internalised and perpetuated throughout the healthcare service. Some participants feel that training on bias, “cultural competency”/“cultural awareness” would be beneficial. Others emphasise the importance of implementing reasoned changes, communicating in response to evidence of inequality, and emphasising relevant values (e.g. a “0 tolerance approach to Racism/ discrimination and demonstrating this”).

> *“Due to recent media coverage for instance maternity mortality rates and Black Lives matter it would have been good to see the primary services stand on this and what was being done to tackle and challenge this. Many people struggle to trust primary care, because they don’t believe trusts care about them” (Black Caribbean, Female, 25-34)*

> *“Demonstrated improvement in racial and gender equity in healthcare access. Even though it’s not my personal experience, when I hear friends [sic] experiences or read articles in the news (eg the report by Royal Society of ObGyn on black women’s experiences of healthcare) I am appalled, and it makes me trust the system less.” (White Other, 35-44, Female)*

Other themes

Mental health, chronic/long-term conditions, and disabilities: participants emphasised that care for mental health, chronic conditions, or disabilities was especially poor. This ranged from prejudiced or uncaring attitudes towards mental health issues, poor medical understanding regarding certain conditions (e.g. ignorance about the symptoms and causes of ME,[14] FMD), and failures to accommodate disabilities in care.

Communication and information sharing: one common theme centred around inadequate communication undermining trust. For example, participants feel frustrated that test results are not directly communicated to them or that they are unable to access their own medical records, and report breakdowns in communication that interfere with care and undermine trust, for example not receiving a promised call back, or receiving no explanation for a rejected medical request. Relatedly, many participants complained that co-ordination and communication between different branches of healthcare was poor (e.g. between hospitals, GP's, and pharmacies), resulting in improper care, mistakes, wasted time, delays in treatment, patients receiving contradictory instructions or recommendations from different sources, prescriptions being missed.

Funding, staffing and resources: many participants reported the perception that the root problem behind problems in access to or quality of care was driven by underfunding, in particular in insufficient staffing, and the consequent problem of healthcare professionals being overworked and underpaid, leading them to have insufficient time or energy to provide good medical care.[15]

Technology: For many participants, face-to-face care felt important for trust, either because they feel it's important for building a trusting relationship, and/or because they are mistrustful of the ability of healthcare professionals to adequately diagnose over the phone. Others emphasised the positive role that technology could play in improving access to care and communication (e.g. online appointment systems and access to information; electronic communications rather than letters), while others noted that poorly implemented technology impedes accessibility and quality of care (e.g. being told to use an appointment app to book types of appointments that the app does not cover).

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[14] For further evidence on ME patient experiences of epistemic injustice due to scepticism and medical ignorance about CFS/ME amongst GP's, see Blease, Carel, & Geraghty (2017).

[15] For evidence that increased per-patient funding of General Practices is associated with improved patient experience, see L'Esperance et al., 2021.

Discussion

The results of our survey highlight ongoing problems with personal and institutional discrimination in the experience of primary care patients and suggest that ethnic and racial minorities have worse experiences in their interactions with healthcare professionals in primary care and have lower levels of trust in primary care. Negative experiences include feeling not listened to or disbelieved by providers, feeling discriminated against in primary care, and feeling that care for ethnic and racial minorities in primary care is inadequate. In our quantitative data, we found that Bangladeshi/Pakistani participants and White Other participants less often felt satisfied that their concerns are acted on, and had less overall trust in primary care; Bangladeshi/Pakistani, White Other and Black participants felt less listened to by providers; South Asian, Black Other, and Other ethnicity participants felt less confident in remote consultations; and Bangladeshi/Pakistani and Black participants were especially likely to report being treated differently in primary care on the basis of their personal characteristics. Overall, our data underscore the importance of every patient being treated as a person, listened to, and treated with respect and empathy by primary care providers (Murray & McCrone, 2015).

The methodology of this survey has limitations that should be noted. Firstly, this survey was distributed by the RHO via social media, with the stated goal of assessing trust with NHS primary care amongst ethnic minority communities. It is possible that ethnic minority patients with pre-existing concerns about primary care or ethnic and racial discrimination would have been more likely to encounter advertisements for the survey and to participate compared to ethnic minority patients with positive experiences. Any such response bias could mean that the ethnic minority participants in our survey experience negative encounters or discrimination at higher rates than the population at large. Secondly, we had limited sample sizes for ethnic minority groups. This necessarily limits the representativeness of those samples. In addition, it limits statistical power for detecting inequalities in those groups relative to others, meaning that it is possible that some real disadvantages faced by certain groups could have been overlooked in this survey. Thirdly, and conversely, we did not correct for multiple comparisons in this analysis; statistically significant differences therefore need to be investigated confirmed by future research to reduce the possibility of false positives.

Nevertheless, our findings are corroborated by a larger body of research, described in the introduction, including research that uses nationally representative samples of millions of participants through the GPPS. For example, relatively poor experience for Pakistani and Bangladeshi patients in NHS care as well as non-British White patients has also been documented in other research (Darlington et al., 2015), including our finding that these patients receive poorer doctor-patient communication in the sense of being listened to and treated with care and concern (Trenchard, McGrath-Lone, & Ward, 2016; Ahmed et al., 2015; Brodie, Abel, & Burt, 2016; Burt et al., 2016; Saunders et al., 2021) even compared to patients of other ethnicities within the same GP practice (Lyratzopoulos et al., 2012). In addition, previous research has found greater levels of mistrust of health information amongst Black and South Asian ethnicities (Wellcome, 2020; Magee et al., 2022) and indicates that race-based prejudice leads to less patient-centred care by impacting the extent to which the patient is listened to (Cooper et al., 2012, discussed by Puddifoot, 2019), and that communication about the needs, medical history and personal circumstances of the patient are important for patient trust (Tarrant, Stokes, & Baker, 2003). Specifically, previous research with GPPS data corroborates our finding that ethnic minorities – particularly non-British White, Bangladeshi/Pakistani, and Black patients – feel less listened to by primary care providers (Croker et al., 2013; Burt et al., 2017; Watkinson, Sutton, & Turner, 2021). Our data highlights the way in which not feeling listened to is a core component in the perception of being discriminated against by ethnic minority groups. Not only does active listening communicate respect and care for the patient, but it also ensures that patients are able to communicate the information needed to be accurately diagnosed and for appropriate treatment decisions to be made (Epstein & Beach, 2023).

Considering the participant responses in our survey, we can interpret "genuine listening" as involving an epistemic and a motivational component: epistemically, it involves giving credence to patient reports in ways that enhance the doctor's understanding of their problems; and motivationally, it involves acting to attempt to address the concerns they express (e.g. through appropriate treatment, referrals, or follow-up tests). Therefore, a large part of being listened to concerns listening to the patient's reports of symptoms and medical concerns, as well as expressions of personal preferences and needs regarding treatment options. While this does not mean automatically agreeing with patient views, it does mean respecting the patient treating their reports as credible (e.g. of pain, symptoms, that there is something wrong) and respecting the patient's expertise when appropriate (e.g. regarding what feels "normal" for their body; for sufferers of rare or chronic conditions about which the patient has highly developed, specialised knowledge).[16]

Our finding that women and ethnic minorities are more likely to feel that primary care providers do not listen to them can be interpreted as a form of testimonial injustice (Blease, Carel, & Geraghty 2017). Not only does this leave patients feeling wronged, disrespected and discriminated against (Wessel et al., 2013), it has the potential to have deleterious medical outcomes for these groups, as it can lead to the receipt of inappropriate care, or to the disengagement of the patient from healthcare. Indeed, discrepancies between the patient and the physician's perception of the importance of the patient's concerns can lead to misdiagnosis and disengagement from further healthcare (Amelung et al., 2020).

A specific variant of this theme that emerged was the perception that women and ethnic minorities were especially unlikely to have their pain listened to and taken seriously. This concern may include the seeking of pain-relief medication, but more broadly it involves a desire for acknowledgement that the patient is suffering and that their concerns and

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[16] See Popowicz (2021) for further discussion of the role of medical expertise in doctor-patient relationships.

requests for follow-up (e.g. treatment, diagnosis, or medical investigations) are justified. The high rates of ethnic minorities not feeling listened to by midwives reported in our survey are especially concerning. These results should be interpreted with great caution given our very limited sample size for this question, and, again, we cannot rule out the possibility of sampling bias. Nevertheless, this is a critical area for future research, as previous research has documented ethnic disparities in experiences of maternity care. For example, ethnic minority women in the UK report poorer patient experiences in maternity care (MacLellan et al., 2022) including being less likely to feel spoken to so they can understand, to be treated with kindness, and to be sufficiently involved in decisions (Henderson, Gao, & Redshaw, 2013). Furthermore, the rate of maternal mortality is four times higher amongst Black women and two times higher amongst Asian women compared to White women (Knight et al., 2020), and problems in care received in cases of maternal death are especially likely to include lack of nuanced individualised care for Black women and microaggressions for Asian women (Knight et al., 2022). Communities of Black women using maternity services in the UK have reported feeling pressured into caesarean sections or experiencing other problems due to disconnects between the way care is provided or communicated and their own cultural practices (e.g. Straus et al., 2009; Ojo-Aromokudu et al 2023). Further, a review by Higginbottom and colleagues (2019) suggests that immigrant women in the UK who have poor experiences in maternity care are especially concerned by perceived discrimination and lack of care for the cultural or social needs and may disengage from care as a result.

Problems faced by ethnic minorities in terms of having their concerns taken seriously and feeling listened to also needs to be addressed specifically in the context of remote GP consultations. Remote consultations may be beneficial and convenient for both providers and patient when used appropriately. Nevertheless, face-to-face consultations may be superior in gathering relevant information about the patient and building a trusting relationship (Hewitt, Gafaranga, & McKinstry, 2010; McKinstry et al., 2010; Hammersley et al., 2019). Yet, some data suggests that Black, Asian and Other ethnic groups switched from face-to-face to telephone consultations at a higher rate than other groups over the course of the pandemic (McGreevy et al., 2023).

In a remote context, special care must be taken to ensure that patients are able to communicate their concerns, that they are adequately listened to without being rushed, and that their concerns are adequately and appropriately acted on in a timely manner, and special attention must be paid to the way that language, accents, and sociocultural needs can cause additional barriers for some ethnic minorities. In our survey, ethnic minorities were less likely to feel confident in remote consultations, and those who were not confident in remote consultations were concerned about the possibility of misdiagnosis and the likelihood of successful communication about medical problems based on purely verbal descriptions, especially in cases where English is a second language. Similar themes were identified by Small and colleagues (2024) in interviews with Bangladeshi, Indian and Pakistani patients about their experience with remote appointment systems since Covid-19.

In our data, feeling treated differently due to one’s personal characteristics was associated with trust in primary care, though the relationship was small. Experiencing poor overall quality of care may be more impactful on trust, irrespective of whether the individual perceives this to be attributable to discrimination. Regardless of the relationship between perceived discrimination and trust, experiences of discrimination are highly concerning in and of themselves. Our sample reported worryingly high rates of feeling treated differently by primary care providers on the basis of ethnicity. Discrimination on the basis of ethnicity was the type most frequently reported, applying to 25% of all participants and 51% of those who reported some form of discrimination. Furthermore, ethnic minorities were also more likely to feel treated differently on the basis of other characteristics. Other research suggests that experiences of racial or ethnic discrimination in a medical setting affects engagement in healthcare and adherence to medical advice, such as vaccine uptake (Paul, Fancourt & Razai, 2022).

A more direct link between discrimination and medical outcomes is seen when patients experience primary care that is simply not equipped to provide equitable care for members of their demographic. A repeated theme in our survey was the perception of inadequate care for medical problems specific to women and ethnic minorities. One repeated issue regarded the clinical assessment of skin conditions for non-white patients, for which primary care providers receive inadequate training (Mukwende, Tamony, & Turner, 2024; Ooi et al., 2021). However, previous research has documented inequalities beyond only the assessment of non-white skin, and differences in medical presentation in ethnic minorities extends to other conditions (Barakat et al., 2003). Furthermore, research suggests that ethnic minorities are at higher risk of misdiagnosis (Metersky et al., 2011). Importantly, our participants highlight the way that overcoming discrimination in healthcare is decidedly not a matter of “colourblind” treatment, but rather a matter of competency in dealing appropriately with ethnic or cultural differences. Specifically, patients want their healthcare providers to take personal characteristics into account in open and medically relevant ways – for example, considering personalised risk factors. Problems arise when healthcare professionals are unfamiliar with conditions that disproportionately affect minority groups, are not as competent in recognising or treating conditions in minority groups (for example, due to lack of familiarity with how symptoms present in ethnic minorities), when stereotyping leads to inappropriate treatment, or when patients feel less cared for, less listened to or taken less seriously due to their personal characteristics (Puddifoot, 2019).

The results of this survey reflect findings of previous research that suggest that patient experience and trust is strongly influenced by the quality of the interpersonal interaction had with providers (like the GP) as well as the responsiveness of the practice (e.g. ease of making appointments) (Hudson Smith & Smith, 2018). In our data, feeling satisfied that your concerns have been acted on and feeling listened to by primary care providers accounted for a large amount of the variance in trust, while concerns about accessing adequate care services (especially GP appointments as well as adequate follow-up care) was a consistent theme in the qualitative responses. Indeed, previous analyses of the GP Access Survey data suggest that Asian patients are least likely to be satisfied with accessibility of services (Kontopantelis, Roland, & Reeves, 2010).

Our data were not able to quantitatively assess the extent to which poorer experiences in ethnic minority groups were due to attending practices that offer poorer quality of care to patients in general or due to differential treatment of ethnic minorities at the practices they attend (though the descriptions offered by participants that attest to differential treatment should be taken very seriously). Nevertheless, as discussed in the introduction, GPPS data suggests that both factors contribute negatively to the experience of ethnic minorities in primary care (Lyratzopoulos et al., 2012), with a larger proportion of the discrepancy in care (though not all) explained by practice quality for Black patients, while discrepancies in care received by Asian and non-British White patients are more greatly attributable to unequal treatment.

This suggests that a two-pronged approach is needed to address discrepancies in quality of care between ethnic and racial groups. Firstly, improving the ability of the worst performing practices to address and act on the health needs of patients and to better engage in respectful and responsive shared decision-making with patients will be one factor in addressing quality of care disparities. In terms of the ability of practices to address health needs, funding may be a contributor, as there is evidence that increased funding is linked to better patient experience due to an increase in the number of available GP's (Salant et al., 2024). Secondly, beyond that, it will be necessary to tackle the unequal care received by ethnic minorities by primary care providers in otherwise well-performing practices, for example through addressing problems of practitioner bias, cultural competence, and translation services (Ahmed et al., 2015).

Our research also underscores the heterogeneity of experiences with care between specific ethnic groups (Ojo-Aromokudu et al 2023; Raleigh, 2023; Watkinson, Sutton & Turner 2021; Robertson et al., 2021). For example, non-British White patients (e.g. including White immigrants and Gypsy or Traveller populations) consistently report worse experiences than British White; Bangladeshi and Pakistani patients consistently report worse experiences and have distinct linguistic and sociocultural needs compared toother ethnic minority groups (Paddison et al, 2015). Consequently, broad categories like “White, “Asian”, and “Black” are inadequate for detecting, understanding and addressing health inequalities and inequalities in experience of primary care. In addition, inequalities experiences by minorities are intersectional (Paddison et al., 2015). For example, Bangladeshi and Pakistani patients are especially likely to experience discrimination on the basis of their religion, Islam. Furthermore, previous research suggests that older female Bangladeshi and Pakistani patients are especially likely to suffer discrepancies in primary care, while, amongst non-British White minorities, the discrepancies are largest for younger patients (Burt, Lloyd et al., 2016; Burt et al., 2017; Evandrou et al., 2016). In our survey, many participants expressed their difficulties in having primary care providers take them seriously or listen to them in terms of an intersection of multiple characteristics (e.g. black and female), and ethnic minorities were more likely to experience discrimination on the basis of religion, socioeconomic status, and education.

One consequence of heterogeneity and intersectionality is that addressing inequalities suffered by different groups may require tailored solutions that are sensitive to different needs and concerns (Danso & Danso, 2021; Kamal et al., 2021). In addition, research must make a concerted effort to engage with sufficient samples of different minority ethnic groups, so that the challenges faced by specific groups can be detected and their needs better understood. While diversity amongst primary care staff is to be supported, simply having providers who share the ethnic or cultural background of their patients does not in and of itself solve inequalities in patient experience (Conneely et al., 2023). Ultimately, primary care providers need to be supported in improving their understanding of their patient community, including how to respond competently in light of their patient's cultural and social needs (Darko, 2021; Patel & Hanif, 2022).

Recommendations

1. Integrated Care Systems should work with local communities to improve levels of trust in accessing primary care services in local communities, with a focus on areas where data indicate challenges, e.g. vaccination uptake. (NHS England and Integrated Care Systems)

2. Raise awareness amongst healthcare professionals about racial and ethnic disparities in patient experience of primary care, and its impact on health outcomes including through existing resources and interventions where these exist. (NHS England, Royal College of General Practitioners, Royal College of Nursing)

3. Independently led and co-produced practical guidance for healthcare professionals, including those within primary care settings, on undertaking sustained and effective engagement with ethnic minority communities. (In conjunction with NHS England)

4. Continue investment in cultural competency and cultural safety training and development for primary care professionals, both within healthcare educational curriculum and within professional developmental courses. Including building on existing programs and interventions to enhance inclusivity, accessibility, and representation across the curriculum. (NHS England, Royal College of General Practitioners)

5. Disseminating guidelines and resources that address structural barriers in accessing primary care services, such as access to interpreters and translated materials, longer appointments for non-English speaking patients with interpreters, and improved digital access and enablement. (NHS England)

6. Development and implementation of practical tools to increase culturally appropriate communication on perinatal health in primary care settings. (NHS England to lead and the Royal Colleges to support)

7. Development of a framework to assess, evaluate and hold healthcare providers accountable for addressing ethnic health disparities, such as trust metrics, patient feedback loops, and transparency within performance metrics. (Care Quality Commission, NHS England)

8. Improve the quality of ethnicity coding for patients in primary care, including:

    a. Ensuring the latest guidance is being implemented
    b. Routinely monitoring the quality of ethnicity coding
    c. Continuously identifying how ethnicity coding can be improved and putting in place actions to achieve this. (NHS England)

9. Further research on the development of evidence-based strategies to improve trust between ethnic minority communities and the healthcare system. (National Institute for Health and Care Research)

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