The public health agenda and minority ethnic health: a reflection on priorities

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The National Health Service priorities are dictated either by the disease and health patterns of the population and population subgroups, or by the expectations and explicit standards of public services. These priorities include: the prevention and management of disease; the promotion of health; health education; reduction of inequalities in health; high quality healthcare; cost-effective and value-for-money services delivered within budget; and respectful, sensitive and equitable service. These priorities are the core of the NHS, and though the phraseology and emphasis change, they can be found in every important NHS policy document.

Are these the right priorities for minority ethnic groups? Are there others that are crucially important to minority ethnic health, but are not on the list? Perhaps the priorities need modification or a change of emphasis. We need to ensure that minority ethnic groups are not by-passed, either because the priorities are not the right ones or because they are not being applied—perhaps because managers and health professionals perceive them to be inappropriate.

There is one central issue that drives our analysis: in what ways are the health needs of minority ethnic groups similar to, and yet different from, the majority population that the NHS has evolved to serve?

These are complex issues that have been much debated and studied. An historical analysis shows a major shift away from emphasizing differences, which are relatively small, to similarities, which are overwhelming. Differences have been exaggerated because of both the human tendency to be interested in difference and the scientific approach of using differences as the starting point for research—the basis of epidemiology.

Health needs assessments too often present data to highlight and accentuate differences at the expense of similarities. Mackintosh and colleagues' *Step-by-Step Guide to Epidemiological Health Needs Assessment*,¹ shows how to avoid this problem. A comprehensive needs assessment that has been done following these principles, is currently on the internet (it will be published in book form shortly).² This

needs assessment shows that the NHS priorities are wholly applicable to the main minority ethnic groups in the UK²; in particular, that the emphasis is on cardiovascular diseases, cancers, mental health and other health problems of modern societies. This is not to imply that no changes in approach, or that no refinements are needed. A few diseases and problems not figuring in NHS priorities deserve a place in the context of minority ethnic health, e.g. haemoglobinopathies and tuberculosis. This must not, however, be at the expense of the main priorities, but in addition to them.

A balanced and considered approach

The need for a balanced and considered approach to priority setting is well illustrated by the example of stroke and coronary heart disease in the African-Caribbean population. Stroke mortality is undoubtedly exceptionally high and, with the possible exception of Bangladeshi men, the highest of all the ethnic groups studied.² In comparison with most ethnic groups, coronary heart disease mortality rates in African-Caribbeans are low. Superficially, one may judge that for this ethnic group stroke services and prevention ought to take priority over coronary heart disease. A closer examination shows that coronary heart disease is actually a substantially more common cause of death in African-Caribbeans than stroke. Neglecting coronary heart disease in favour of stroke would miss the bigger problem and run the risk of the African-Caribbean community losing its relative advantage in regard to coronary heart disease over the population as a whole. (This happened to African Americans in the USA.)

The minority ethnic groups need services that are respectful and sensitive, as for the population as a whole, but this poses particular demands on the NHS. First, racism—overt or institutional—has no place, whether in the delivery of care, or the appointment of staff. Secondly, a sensitive service requires a workforce trained and knowledgeable on the culture of the communities it serves and able to access and make use of interpretation and advocacy services. Third, the NHS needs to have ethnic minority populations utilizing, and participating in, the NHS. This means a proper understanding of the services available and their appropriate use. It also requires the ethnic minorities to participate in consultations, apply for and be accepted in

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management roles (e.g. non-executive directors), and apply for training opportunities and appointments in a broad range of posts, including nursing.

The NHS must ensure its current priorities and policies are vigorously applied and evaluated in relation to Britain's minority ethnic groups. It must not make the mistake of imagining, assuming, awaiting or expecting a different set of priorities. Such a policy would delay the urgent actions that are required now and would be damaging and divisive.³

PUBLIC HEALTH INITIATIVES: HOW TO ENSURE THAT THESE BENEFIT AND DO NOT BY-PASS OR DAMAGE MINORITY ETHNIC GROUPS?

The history of research and practice in the fields of race and ethnicity demonstrates a shocking tendency to harm minority ethnic groups—sometimes wilfully but often through the portrayal of difference as inferiority.⁴ The safeguards are awareness, vigilance, denouncement and legal redress. There is a great danger that initiatives to prevent and control diseases and promote health (in short, public health) do not provide their full benefits in minority ethnic groups. This can happen in several ways.

First, as discussed above, those planning such initiatives may wrongly assume that the issue is not a priority in one or more minority ethnic groups. An example of this is a perception that in 'Asians' cancers, and some of the risk factors including smoking, are not a high priority. This perception and its refutation on the basis of a systematic analysis of cancer data in Britain's major minority ethnic groups are discussed elsewhere.⁵ Briefly, cancer is the foremost or second-ranking category in the causes of death, and lung cancer is one of the most common of the cancers in minority ethnic groups. The Bangladeshi male population has the highest prevalence of smoking—between 40–50% depending on which survey is examined.⁶ In running an anti-smoking campaign planners may take no steps to meet the needs of minority ethnic groups because they wrongly perceive little need.

The second danger is that any steps that are taken are inadequate, e.g. a media campaign video may be dubbed with the minority groups' languages, when it would be more effective to include in the original video some actors from minority groups, to convey cross-cultural relevance.

The third danger is that the planners are aware of the issues but decide that the campaign for the minority groups should be separate from the main one; this is a common practice. Such an action is, arguably, institutional racism, and runs counter to the duty to promote racial equality under the Race Relations Amendment Act 2000⁷ (designed to counter institutional racism)—it is deplorable on pragmatic grounds too. Pragmatically, the bulk of the required knowledge, expertise, energy, momentum and finances will lie with the planners of the main campaign.

The 'separate' campaign for minority ethnic groups may never actually come to fruition or may be of a lesser impact, accentuating existing gulfs in knowledge, attitudes and behaviours.

For these reasons we need to be aware of some key factors:

- All public health initiatives are likely to be highly relevant to minority ethnic groups, who must not be by-passed
- The needs of minority groups should be met simultaneously with the rest of the population
- Mainstream initiatives need to integrate modifications to ensure they meet the needs of minority ethnic groups
- To ensure these actions can be taken, public health needs to recruit minority health professionals as integral members of the teams developing public health initiatives
- All public health policies and plans should detail exactly how the needs of minority ethnic groups are to be met. They should not be relegated to secondary documentation.

EVIDENCE BASE FOR PUBLIC HEALTH INITIATIVES IN THE FIELD OF MINORITY ETHNIC HEALTH

The question of what works is always problematic in the case of complex initiatives. For many interventions, the evidence is inconclusive (and sometimes non-existent). The controlled trial and its most strict variant the placebo-controlled, randomized, double-blind trial, undeniably provide the most solid evidence for effectiveness of initiatives. These trials are difficult to conduct, particularly for complex interventions. The question is whether we need evidence from such studies to recommend an initiative in minority ethnic groups. If so, what do we do when there are no specific relevant studies?

Clearly, it is necessary to have such trials on minority ethnic groups and research programmes need to be encouraged. As a minimum, studies on general populations ought not to exclude people from minority ethnic groups (e.g. by excluding those who do not speak English).⁸ Building up a valid database of this kind will be a multi-million-pound endeavour and will take 10–20 years.

In the meantime, we cannot permit paralysis in relation to minority ethnic health. The principles to be adopted here are as follows:

- 1 In planning an initiative for ethnic minority groups, start with a systematic review of the evidence from all ethnic groups
- 2 If an initiative works in one or more population group, it may work in the minority group of interest. If it does

not work elsewhere it is less likely to work in your population. The essential principle here is this: human populations have more similarities than differences

- 3 If the intervention is a simple one, e.g. folic acid supplementation for pregnant women to prevent congenital abnormalities, one can have a high degree of confidence that the effectiveness will be transferable across ethnic groups. This is, however, a matter for evaluation—if only by monitoring both uptake of the intervention, which may well differ, and the outcome, which is unlikely to differ
- 4 If the intervention is complex, then take special care. For example, brief advice from the general practitioner helps smokers quit. Will this work in Bangladeshi or Chinese men and women? It would be wrong to assume it will. This intervention may be better implemented in the context of a formal trial. If this is not possible, go ahead but in a questioning manner and with evaluation (RSB is one of a team which has submitted an application to undertake such research, and this principle underlies the application)
- 5 In most instances, for the foreseeable future, the evidence that will be used, in practice, is on how to modify interventions to make them cross-culturally effective. This field of study is in its infancy but needs to be promoted.

It is worth re-emphasizing that we also need evidence on health needs so that the right priorities are chosen, and interventions meet needs.

KNOWLEDGE INTO PRACTICE—INFLUENCING THE NHS

Bringing about change in the NHS is a formidable challenge. Those who have worked to promote a more flexible NHS geared to meeting the needs of a multi-ethnic society, generally find it to be a frustrating experience. Funds have been scarce, competing priorities many, expertise sparse, and champions of the issue at a senior level too few. Organizational and other change has been too frequent to allow initiatives and experience to embed. This said, there are many successes and overall, without doubt, improvements. In the longer term, to add to the existing armamentarium of education, research, exhortation, opportunism and NHS policy documents, we need to mobilize community advocacy and create a better information base. While professionals and researchers have vociferously complained about the quality of services for minority ethnic groups, the individual and community voice is less often heard. The few community-based surveys of satisfaction levels paint an unexpectedly good picture—for example, those done in Teesside.⁹ It may be that their

expectations ought to be higher and that the minority ethnic populations need to be better informed about their needs and achievable standards of care. Ethnic monitoring of NHS databases is the key to both quantification of service use and the foundation of more in-depth studies of quality of care (by case-note analysis and questioning of patients). Ethnic coding of hospital data has not fulfilled its promise.¹⁰ We can only hope that the current proposals for ethnic coding in the NHS lead to the anticipated gains.^{11,12}

The case for a National Service Framework on minority ethnic health seems compelling. Scotland has made giant strides in this direction, by the publication and implementation of a formidable Health Department Letter,¹³ which has combined with the Race Relations Amendment Act 2000 (following the McPherson Report¹⁴) to create impetus for change. McNaught, a highly knowledgeable observer of health policy and race equality in this journal painted a bleak picture of halting progress.¹⁵ It would be foolish to be over-optimistic. Yet, the possibilities for progress are unprecedented. We now have legislation, policy, political will, expertise and an increasingly knowledgeable populace, pulling together. This may not last, so it is imperative we institutionalize our best practices (mainstreaming), so they cannot be dismantled at a whim.

CONCLUSIONS

The NHS's priorities are of central importance to Britain's minority ethnic groups. Public health initiatives must cater for the ethnic majority and minority populations simultaneously, with work of equal potential effectiveness and sensitivity. To do otherwise promotes inequality, is an inequity and is arguably unethical and institutionally racist,¹⁴ if not illegal.⁷

Pending the development of a solid evidence base for initiatives on minority ethnic health (a long-term goal), interventions effective in other populations need to be carefully adapted, implemented and evaluated. Putting emerging knowledge into NHS practice is difficult—it requires a continuation of past policies (education, exhortation, research, taking opportunities to influence management and influencing policy documents), and a greater platform for an informed community voice. Further, better information systems are needed to foster audits of quality of care. Ethnic coding of NHS records, possibly founded in primary care,¹⁶ probably holds the key for this work.

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