British Journal of Cancer (1996) 74, Suppl. XXIX, S35-S37

Assessing the health needs for cancer services for people from ethnic groups

S Rawaf

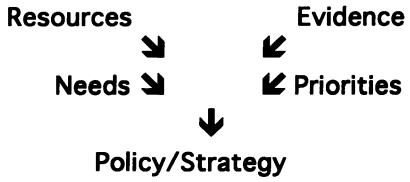
Director of Clinical Standards, Merton Sutton and Wandsworth Health Authority, London

Introduction

The assessment of the health and social needs of any given population (or a group of that population) is an essential and integral part of delivering high quality and effective health care to maintain and improve the health of that population or the targeted group (Figure 1).

The 1990 health service reforms in the United Kingdom put a major emphasis on the process of health needs assessment to use finite resources more effectively,[1] and direct efforts towards proven interventions.

Figure 1 Needs assessment as an integral part of the plan.



What is health needs assessment?

Assessing the health and social needs of the population is a complex, long term and continuous process. There has been much debate as to what 'health and social needs' are, how best to assess them, and how to influence health (and social) care delivery. This has led to many theoretical models addressing numerous conceptual and methodological issues, but problems are often encountered in their practical applications. There is a wide range of definitions of health and illness, a lack of data, and a wide variation of needs between one community and another and these needs vary over time.[2,3,4] Needs have also been categorised into normative, felt, expressed or comparative needs.[5]

Neither 'needs', therefore, nor 'health', are easy to define. Definitions of the latter have ranged from the simple absence of a disease to the multiple comprehensive notions of well-being expressed by different cultures. It is essential to distinguish between 'health needs' and 'health *care* needs'. The former is a broad term, while the latter is more specific. Health needs are related to the overall aim of a healthier population, and are influenced by many factors such as socio-economic status, housing, environment, cultural and social background, religious beliefs and customs. Health care needs, however, relate to identified health-related problems which can benefit from preventive, treatment and care measures.

Reasons for needs assessment

In practice, the purpose of any health (and social) needs assessment is to determine the range of services required with the goal of providing effective interventions to meet the identified health (and social) needs of the population who are exposed to or suffer from the condition.

However, health needs assessments are used for a variety of reasons.[6]

- to improve service planning (commissioning) and resource allocations
- to identify health matters where further improvements might be made
- to identify the most effective intervention(s) for the condition in question
- to monitor changes in relation to factors which influence and determine health
- to generate information for advocacy
- to respond to central directives
- to justify decisions already made
- to advance research and development
- to confirm or enhance information
- to display technical competence

Approaches to needs assessment

The process of health needs assessment is wider than the collection of routine data to measure the extent of a disease or disability in any given community (Table I). It also includes the assessment of the impact of that disease or disability on the individuals affected, their families and the total population; the effectiveness of interventions at the levels of prevention, screening, treatment, rehabilitation, and terminal care; the availability of health (and social) services; measurement of people's perceptions and expectations; professionals' views; social values about the condition in question; and the political philosophy and care underlying service provision.[4,6]

Table I Health Needs Assessment

- Population profile
- Measurements of disease and disability
- Effectiveness of intervention:
  - prevention
  - screening
  - treatment
  - rehabilitation
- "Measurement" of perceptions and expectations
- Social values
- Political philosophy

To achieve this, various approaches to needs assessment have been identified and embarked on at central and district levels.[1,7,8] The commonest three approaches are the epidemiological approach, the comparative approach and the corporate approach. In practice, a mixed approach of the above three, as well as other approaches, is used at local level.

The epidemiological approach is based on the interaction between the agent, the host and the environment. It combines the measures of incidence and prevalence of the condition, and the effectiveness of intervention and health care. It combines epidemiological and economical approaches to health needs assessment. The comparative approach uses process and outcome indicators in order to compare the services received by different populations in different localities. Such comparisons are powerful tools for investigating health service delivery, especially in the context of UK capitation-based funding. The corporate approach is based on the process of consultation between professional, public, and other interested parties.

Other approaches to needs assessment are attempted for specific health and social problems. For example the various qualitative methods for assessing health care needs which rely on conceptual analysis and presentation,[9] the variety of tools for health status measures,[10] capture-recapture techniques which allow accurate counts of those difficult to reach populations,[11] and the "living epidemiology" and other approaches at general practice level.[12,13]

Current problems with needs assessment

Despite extensive work both at central and local levels, methods of needs assessment have to be developed further to achieve any meaningful changes in service delivery. Current methods are merely ways of counting and describing needs but very few assess such needs (in terms of weight, values, evaluation, or priority ranking). They are heavy on database and data driven analysis but thin on interactive social processes where a range of acceptable values are expressed to define needs.

The quasi-market philosophy of the 1990 NHS reforms encourages purchasing of services based on assessed needs. However, the nature of the current market where demand far outstrips supply, left many health care purchasers (Health Authorities, GP Fundholders) with limited choices. Providers, many of whom exert a monopoly, found few convincing reasons to change current practices. Even in a free market such as the United States, the impact of formal needs assessment on some service delivery could be illusive[14] when it is based in pure numerical terms. This numerical counting, to be a meaningful process for needs assessment measurements, has to be expanded to help in deciding against competing priorities. In real terms needs will depend on benefits as well as costs. Therefore, both cost and cost effectiveness have to be taken into account when needs are assessed.[8] Such an approach entails investing in those interventions which yield the maximum health gain per unit of expenditure.[15] It also requires good quality data and analysis to assist the decision-making process. However, there is a danger of decisions made on the basis of costs alone. This is true at a time when the crude cost containment is seen as the panacea for the resource challenges confronting the newly reformed NHS. Indeed, some health economists, during the first year of the reforms, dismissed the need for health needs assessment for priority setting and advocated a purely economic approach which is based on getting the greatest benefit for each pound spent.[16]

Needs assessment in cancer care

Cancer is the second leading cause of death after cardiovascular diseases (Figure 2), and causes more lost years of life than any other disease.[18] Approximately 25% of all deaths every year are due to cancer.

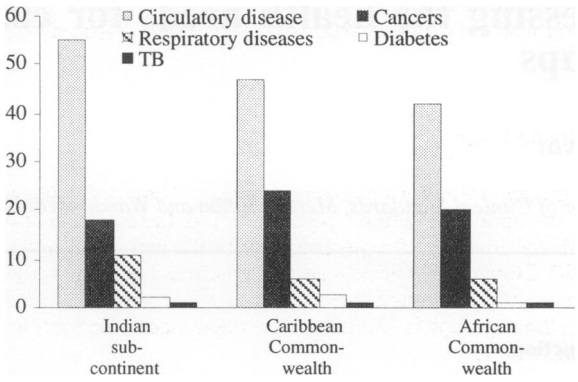


Figure 2 Causes of death by place of birth, age 20+ , England & Wales 1979-83

In recent years the management of cancer has been fundamentally changed thanks to the advances in cancer biology, diagnostic techniques and cancer staging, and new developments and applications for chemotherapy and radiotherapy. Better awareness of the problems faced by patients who are incurable, and changes in professional attitudes towards more openness with patients and their relatives has led to different practices. Such practices require a high degree of technical competence and a sympathetic insight into the feelings of the patient and frequent problems in assessing health needs.[17,21]

Interventions in cancer may be classified into a range of services from health promotion to terminal care. In assessing the health needs of cancer patients as well as the total population we have to look at the whole range of cancer interventions.

Effective interventions are possible, offering significant scope for improvement in health. The *Health of the Nation* approach makes it possible to set objectives and targets for reducing the incidence of cancer in the total population.[22] Targeting some of the well known risk factors such as smoking, obesity, excessive alcohol intake, sexual habits, excessive sun exposure, and exposure to toxic materials is one of the main preventive strategies. Detecting cancer at presymptomatic stages through screening is now possible and effective for many cancers.[23] Early recognition of symptoms of cancer and high quality treatment services will ensure the best available life expectancy and quality of life. Current services for cancer treatment were criticised in a recent report by the Expert Advisory Group On Cancer.[21] The report proposed major changes in the provision of cancer services to respond to the substantial changes and demands from existing technology, emerging therapies, new research findings, and patients' needs. The implementation of

Table II The ethnic difference

- Different disease patterns (incidence and prevalence)
- Different cultures
- Different perceptions and expectations (health and illness)
- Services may not be sensitive to needs
- Racism and discrimination
- Inequalities
- Lack of peoples' involvement in planning and organisation of their health services

these recommendations, with many alternative demands being placed on resources, is one major challenge to needs-based health care.

Ethnicity and cancer

Ethnic groups are not a homogenous group. They differ in their genetic susceptibility, culture, exposure to risk factors, perceptions of health and illness, and expectations of health and social services (Table II). Ethnic differences in health and disease patterns are well documented.[24] The limited data on the incidence of various cancers among ethnic groups is discussed elsewhere and is one guide to assessing their needs.

Mortality data show that deaths from cancer are lower for both sexes among minority ethnic groups, with the exception of the Irish, than among the general population.[25,26] (Figure 3) The data, however, show considerable ethnic differences for different cancer sites[26] (see also this volume). There are many theories and assumptions about the reasons for the low incidence and the variations between groups. None of these are proven. Nevertheless, the picture is changing and cancer incidence among these groups, especially those born in the UK, is approaching the national average.[27]

Despite the growing data on cancer among many ethnic groups, and in particular Asians and African Caribbeans, little or no data is

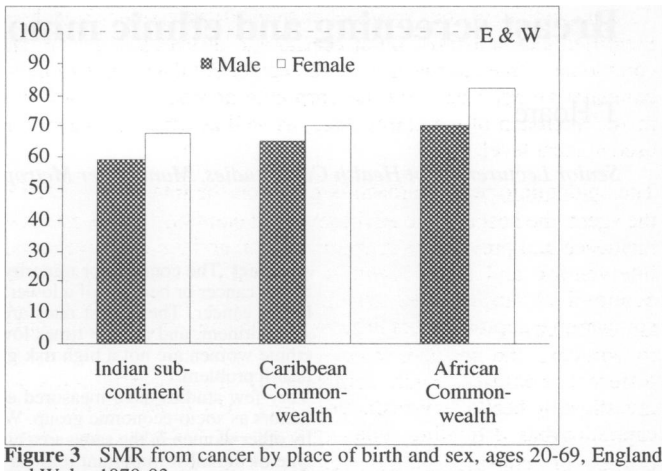


Figure 3 SMR from cancer by place of birth and sex, ages 20-69, England and Wales 1979-83
Source: Balarajan & Bulusu (1990)

available on several minority ethnic groups, including the Chinese, Arabs, Turks, Greeks and new immigrants from around the world.[28] All these groups, whatever the level of disease burden, need similar preventive, screening, diagnostic, treatment, rehabilitation and terminal care services as the rest of the population. Such services should be sensitive to their specific cultural and religious beliefs and to their needs.

References

1. NATIONAL HEALTH SERVICE (1991) Management Executive. *Assessing health care needs.* Department of Health: London
2. BUCHAN H, GREY M, HILL A, COULTER A. (1990) Right place, right time. *Health Service Journal* ; **101**:400-1.
3. STEVEN A, GABBAY J. (1990) Needs assessment, needs assessment. *Health Trends*;**23**:20-3.
4. RAWAF S. (1993) Purchasing for the health of black and ethnic minority people: some practical considerations. In *Access to health care for people from black and ethnic minorities.* Hopkins A & Bahl V (eds). London: Royal College of Physicians.
5. BRADSHAW J. (1972) A taxonomy of social need. In *Problems and progress in medical care.* McLachlan G (ed). Oxford University Press: Oxford.
6. RAWAF S. (1995) Health needs assessment: Theoretical framework. In *Assessing the health needs of people from ethnic groups.* Rawaf S & Bahl V (eds). RCP: London. (In Press).
7. CROWN J. (1991) Needs assessment. *Brit J Hosp Med;***46**:307-8.
8. STEVENS A, RAFTERY J. (1994) *Health Care Needs Assessment: the epidemiologically based needs assessment reviews.* Radcliffe Medical Press: Oxford. (Two volumes).
9. FITZPATRICK R, BOULTON M. (1994) Qualitative methods for assessing health care. *Quality in Health Care*; **3**:107-13.
10. DONOVAN JI, FRANKEL SJ, EYLES JD. (1993) Assessing the needs for health status measures. *J Epidemiol Community Health*; **47**:158-62.
11. LAPORTE RE (1994) Assessing the human condition: capture-recapture techniques. *BMJ*; **308**:5-6.
12. SHANKS J, KHERAJ S, FISH S. (1995) Better ways of assessing health needs in primary care. *BMJ*;**310**:480-1.
13. GILLAM SJ. (1992) Assessing the health care needs of populations- the general practitioner's contribution. *Brit J Gen Pract*; **42**:404-5.
14. KIMMEL WA. (1983) *Needs Assessment: A critical perspective.* Office of Program Systems: Washington.
15. DRUMMOND MF, MAYNARD A. (1993) *Purchasing and providing cost-effective health care.* Churchill Livingstone: Edinburgh.
16. DONALDSON C, MOONEY G. (1991) Needs assessment, priority setting, and contracts for health care: an economic view. *BMJ*;**303**:1529-30.
17. SOUHAMI R. (1994) Cancer Medicine. In: *Text Book of Medicine.* Souhami R & Moxham J (eds). Churchill Livingstone: Edinburgh.
18. SECRETARY OF STATE FOR HEALTH. (1991) *The Health of the Nation.* HMSO: London.
19. SHANMUGARATNAM K, HIN-PENG L, DAY NE. (1989) Cancer in migrant population: a study in Singapore. In *Ethnic Factors in Health and Disease.* Crushank JK & Beevers DG (eds). Wright: London.
20. HAENZEL W, KURIHARA M. (1968) Studies of Japanese migrants. 1 Mortality from cancer and other diseases among Japanese in the United States. *J Nat Cancer Inst*; **40**:43-68.
21. DEPARTMENT OF HEALTH, WELSH OFFICE. (1995) *A policy framework for commissioning cancer services. A report of the Expert Advisory Group on Cancer to the Chief Medical Officers of England and Wales.* Department of Health: London.
22. DEPARTMENT OF HEALTH. (1993) *The Health of the Nation. Cancers: Key Area Handbook.* Department of Health: London.
23. MILLER AB, CHAMBERLAIN J, DAY NE *et al* (eds). (1991) *Cancer Screening.* Cambridge University Press: Cambridge.
24. DEPARTMENT OF HEALTH. (1992) *On the State of Public Health: the annual report of the Chief Medical Officer of the Department of Health for the year 1991.* HMSO: London.
25. BALARAJAN R, RALEIGH VS. (1993) *Ethnicity and Health: A guide for the NHS.* Department of Health: London.
26. BALARAJAN R, BULUSU L. (1990) Mortality among immigrants in England and Wales. In *Mortality and Geography: A review in the mid-1980s, England and Wales.* M Britton (ed). HMSO: London
27. BARKER RM, BAKER MR. (1990) Incidence of cancer in Bradford Asians. *J Epidemiol Comunity Health*; **44**:125-9.
28. RALEIGH VS. (1993) Epidemiological data: the critical gap. *Share*; (**6**):6.