

# Chapter 15

## Equity in Healthcare for Ethnic Minorities



John Lee and David Briggs

**Abstract** This chapter traverses published research about healthcare for ethnic minorities across the Asia Pacific countries from differing perspectives to identify contemporary practice, policy, and challenges in ensuring all for health and health for all in ethnic communities. Healthcare has now become a globalised concept and there has been concern in the Asia Pacific about equity of access to health services across the region with a focus on disparity between rich and poor, urban, and rural and of marginalised groups that include migrants, refugees, and other ethnic minorities, in situ within nation states. The diversity of approaches across Asia Pacific nations to the status and delivery of healthcare for ethnic communities is described using contemporary published research. Concepts around ethnic communities are diverse and complex but generally are said to be influenced by culture, behaviours, values, and the context in which they are described as being an ethnic minority. The impact on these groups based on disease category is also traversed. Lessons learned and implications for the future and the importance of leadership, technology, and empirical research are discussed. Consistent with the book title this chapter describes the experience of nation states across the Asia Pacific to analyse, compare, and contrast approaches in addressing ‘Gaps and actions in health improvement from Hong Kong and beyond’ utilising a ‘health for all’ perspective.

**Keywords** Ethnic minorities · Migrants · Refugees · Healthcare · Access and equity · Universal healthcare · Socio-economic determinants of health · Leadership · Management

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## Introduction

This chapter responds to the challenges of the title wherein it is published, that addresses ‘Gaps and Actions in Health Improvement: Health for All, All for Health’ and, as such must address issues of access, fairness, and impetus for equity across communities, populations, and nation states. These themes are addressed throughout the chapter. In this case, one of the authors has professional clinical experience of ethnic minorities access to the health system of Hong Kong and the second author has worked extensively with health systems of the Asia Pacific and from those interests we take an approach that reflects an international and inter-disciplinary approach in an Asia Pacific context. This chapter traverses published research about healthcare for ethnic minority groups across Asia Pacific countries from differing perspectives to identify contemporary practice, policy, and challenges in ensuring all for health and health for all in ethnic communities.

## The Geographic and Demographic Context of Ethnic Healthcare

Migration from low to middle income to highly industrialised high-income countries is known to have a detrimental impact on health, voluntary migrants achieve a positive ‘health migrant effect’ and the longer the duration of residence, the higher prevalence of risk factors, leading to morbidity and mortality from chronic conditions. Forced migrants can face higher risks and, for example, cardiometabolic risks are different between and within ethnic groups (Gallegos et al., 2019). Refugees are often cast in the light of being challenged about the extent of access to health and other services in the country that they have sought refuge. This is despite the nature and values of the host nation and aspirations of health professionals and health systems and governments. In fact, many health professionals are activists in asserting for the rights and freedoms of refugees to gain equivalency of access to healthcare in similar fashion to that of the majority population (Ferdowsian, 2021). Shum (2011) in an article on refugees also took the wider perspective around physical space, power relationships to space available and environment as did Wong et al. (2017), who broadened the debate by suggesting a framework based on the socio-economic determinants of health (SOECD).

Wong et al. (2017) described in an article about African asylum seekers and refugees in Hong Kong, wherein the United Nations High Commissioner for Refugees (UNHCR) suggests that 51.2 million people were forcibly displaced in 2014 and that Hong Kong, as a ‘hot spot’ for transit, has over 10,000 asylum seekers, refugees, and torture claimants (ASRs) in 2016; approximately 10% of these are from the African continent. Interestingly, this article describes this population utilising the Social Determinants of Health as a framework (CSDH) provided by Solar and Irwin (2010). The impact of extended periods of immigration detention has

been researched in several counties where detainees experienced pervasive difficulties long after their detention ended as they struggled to rebuild their lives, with poor self-esteem, depression, and anxiety amongst other experiences (Coffey et al., 2010).

Healthcare has now become a globalised concept, exemplified by the recent focus on addressing the coronavirus disease 2019 (COVID) pandemic and the need for nations states and health professionals to develop and address preventative strategies across nation state boundaries. We need to acknowledge that someone who has been defined as a minority 'ethnic' in one nation state may have come from a majority population in another country. They may also be Indigenous or Aboriginal in their own country, but a minority in the population of the present.

During the pandemic of COVID 19, the vaccination rate amongst ethnic minorities group has also shown a hesitancy to participate from the ethnic minorities community (Chua et al., 2022), which proves the diversity of all for health amongst ethnic minorities is not implanted or executed comprehensively. A recent systematic review by Chauhan et al. (2020) suggested that patients from an ethnic minority may have experienced disparity in the quality and safety of care through a range of socio-cultural influences. However, there is also available evidence about the nature of the care of this group that will allow development of safe care interventions for the future.

## **Equity of Access to Healthcare**

There has been concern in the Asia Pacific about equity of access to health services across the region with a focus on disparity between rich and poor, urban and rural, and of marginalised groups that include migrants and ethnic minorities. Fong (2021) provides an extensive and contemporary overview in a bioethics paper on equitable healthcare systems that clearly defines and emphasises the importance of equity and the dimensions of international approaches to equity. In that article, equity is defined as the absence of differences in health status of people that encompasses perspectives of socio-economic differences, including ethnicity, class, geographic location, and levels of education (p. 547).

In current contexts, most countries can also include refugees escaping conflict or persecution and economic poverty. These issues were addressed in a background paper by the UN Regional Thematic Working Group on Health (TWGH) to suggest remedies to overcome existing inequities. Key interests of this group included how to increase regional coordination, alignments, and coherence of services. As a result, health was defined as one of five priorities and created a Thematic Working Group on Health (TWGH). At that time and in that context government expenditure on health was described as one of the lowest in most Asia Pacific countries being below five percent of GDP. Malaysia, Sri Lanka, and Thailand were exemplified as demonstrating better and more efficient health spending (Durairaj, 2007).

Countries are challenged to achieve universal access to healthcare (UHC) in the Asia Pacific because improvements in policies, strategies, and activities through

greater targeted government investment accrue mostly to underserved disadvantaged countries and populations. Government and private expenditure across the region are in—equitability distributed. Out of pocket and catastrophic spending is significant and impacting on the poverty levels of some countries. Health spending is said to be low in countries where the disease burden is high. As is the case in most countries health systems, public health, and preventative services are less appropriately funded in comparison to that received by curative services. Physical access to care is also likely to be concentrated in high-income urbanised areas (Durairaj, 2007).

Fong (2021, p. 552) further addresses the earlier work of Mate and Wyatt who propose five ways to make health equity a core strategy. These authors suggest health equity is a leader-driven priority with organisation wide structures and processes that are designed to support equity, address the social determinants of health, and address all forms of discriminatory health practice and reflect practice based on partnerships with community organisations.

We now turn to address the literature of how the differing nation states of the Asia Pacific are addressing these challenges, commencing with Hong Kong and mainland China, Thailand and Cambodia, Malaysia, Australia, Singapore, Japan, Vietnam, Indonesia, and New Zealand. Given the global nature of the movement of refugees and ethnic minorities, narrative about North America and Europe is also included. Readers are encouraged to compare and contrast the differing national experiences and to identify themes relevant to your individual circumstances and contexts.

### ***Hong Kong and Mainland China***

In the last decade, the population of ethnic minority residents in Hong Kong, China, has increased by 30%, excluding those who are ‘foreign domestic helpers’ from Indonesia and the Philippines and who originate from South Asian, India, Pakistan, and Nepal. All these groups have poorer health literacy in Chinese and English, differing cultural perspectives and health literacy, making access to all aspects of healthcare more difficult. This demonstrates that health professionals and health systems need better understanding of the knowledge, understanding, and attitudes (KAP) of ethnic minorities who seek access to care and who require greater education in the use of information (Wong et al., 2017).

Wong and colleagues (2017) in Hong Kong describe significant demographic change with rapid population ageing and immigration. They further suggest ethnic minorities find accessing services difficult in a first-time study of Nepalese older adults. While their needs are assessed as like the local Chinese, the study showed that they also faced a ‘range of structural, knowledge and attitudinal barriers’ to access to long-term care, despite access entitlement and the WHO Age-Friendly Cities framework (AFC). This framework proposes collaborative interventions based on eight domains of ‘economic, social, physical, personal, behavioural, and service factors. The domains include outdoor, spaces and buildings, transportation, housing, social

participation, respect, social inclusion, civic participation, employment, communication and information, community support, and health services (Amoah et al., 2019, p. 3). They challenge the reader to take an SOECD approach to healthcare. It will be interesting to see how well this framework also addresses its potential for ethnic minorities in communities. Both Hong Kong and China face high demand from existing populations for healthcare with differing funding and delivery systems and with no commonality about how those differences and demand for services might be met (Kong et al., 2015).

In Mainland China, a systematic review of maternal and child health outcomes of ethnic minorities in Western China suggests that minority populations across the world often have worse health social and health outcomes, although there is variability within the groups. The reasons are complex and variable but are said to relate to elements of employment, income, education, food security, policy, and systems perspectives as well as social and cultural norms. There are 55 ethnic minority populations in China that represent a highly heterogeneous population. Despite positive policy approaches and extensive data, research has been limited and a need to improve information is emphasised. This review provided strong evidence of poorer health outcomes on maternal and child health outcomes than the general population in Western China (Huang et al., 2018).

Non-communicable diseases (NCDs) are responsible for an estimated 63% of global deaths and China is facing an increased burden of NCDs when ethnicity is seen as an important risk factor, with different outcomes for cancer, diabetes, cardiovascular and respiratory disease, compared to majority populations. Zhao and Associates (2021) provide an extensive China Multi-ethnic (CMEC) study that is community based, prospective observational study aimed at understanding NCDs prevalence and risk.

### ***Thailand and Cambodia***

In contrast, in Thailand, ethnic minority populations have poorer healthcare utilisation than Thais on the Thai-Myanmar border region because of lack of health insurance coverage, geographic and physical barriers making access difficult. Various cultural differences with language, belief, and religion also impact access. Some of these beliefs extend to 'spiritual beliefs' together with a lack of Thai language for groups such as Karen and Mon, adding to these difficulties. Hu and Podhisita (2008) detail the extensive nature of these ethnic minorities in Thailand. Civil conflict in Myanmar has seen the displacement of ethnic minority groups into Thailand where an estimated 3.7 million migrants are estimated to be living, with the largest number from Myanmar. While presenting challenges in managing these types of populations, particularly in managing infectious diseases, Thailand and Cambodia have managed well, in registering migrants to provide access to health insurance and using a one stop shop model to achieve both registration and health insurance conjointly. The use of migrant's navigators to and through health systems is also suggested (Murray et al.,

2016). An inter-ethnic, cross-sectional study amongst Thai older adults and retired Japanese residents in Chang Mai into differences in body composition concluded that ethnicity had a clinically important effect on body composition. The potential differences existed between the two groups and ‘the sarcopenia prevention strategies should take ethnicity into account’ (Yoda et al., 2021, p. 6).

## *Malaysia*

In an article describing healthcare delivery in Malaysia, Thomas et al. (2011) describe a changing context in Malaysia towards greater equitable financing, a greater focus on wellness services in a context of public, private provision, traditional, complementary, and western medicine. Constituting for about 5% of the Malaysian population, a million people are described as ‘immigrant workers’, potentially harbouring communicable diseases that require specific attention to this ethnic minority. The authors also describe the Asia Pacific as the most varied region in the world that includes the country with the largest population and varying paces of transition from communicable diseases to a widening burden of chronic diseases. They also suggest that ‘various countries and the WHO are taking control of progress through primary health care (PHC)’ (Thomas et al., 2011, p. 95).

Thomas et al. (2011, p. 95) describe how a large proportion of the population is transitioning through economic transition, where deaths from chronic disease are beginning to predominate. While PHC is variable across nations, accessibility of basic care and equity is improving. In Malaysia, they cite increases in diabetes, hypertension, and for women malnutrition and high morbidity in the less developed countries. Their article (Thomas et al., 2011, p. 95) identifies that ‘the populations most in need are Aborigines, the poor, the disadvantaged and disabled. In this article it is also suggested that multidisciplinary interventions are required to promote health financing, health care and disease prevention (Low 2008)’.

Again Chauhan et al. (2020, p. 25) in their systematic review conclude that ethnic minorities ‘may experience inequity in the safety of care’ have ‘higher risk of safety events’. They further conclude that health systems and services must consider ‘ethnic variations to understand where and how to invest resources to enhance equity in the safety of care’.

## *Australia*

Ethnic minorities are often described in the literature by race, language, and the capacity for English language and by the country of origin. Australia is seen as the land of Aboriginal and Torres Strait Islander peoples historically but is also defined as a nation of migrants and one that is culturally diverse with a population in excess of 25 million, coming from 190 different countries, 300 different ancestral backgrounds

and 30 separately identified languages spoken at home (Woodland et al., 2021). The Australian health system is described more fully elsewhere (Briggs, 2017) and is ranked 1st in terms of equity and health outcomes, 8th for access, and 3rd in overall rankings but is 9th out of 11 countries for a ranking for access to care. Australia demonstrates equity through a mix of spending caps that are 'lower for low-income earners, with incentives to seek primary care with 86% of citizens facing no 'out of pocket' expenses for primary care visits (Schneider et al., 2021, p. 11). There is a disproportionate burden of disease amongst ethnic groups within Australia and variability between groups of different country of origin and of different types of migrants such as 'family reunion' and 'refugee' (Gallegos et al., 2019).

Aboriginal and Torres Strait Islanders (ATSI) in Australia in demographic terms are a minority population of about 3.3% of the total population. There are diverse linguistic and cultural groups within the ATSI definition and geographically they are as much an urban dweller as rural, regional, and remote. In some cases, they are the majority population in rural regional and remote communities. Despite having 'equal' access to the Australian health system there is reluctance to engage based on cultural and colonial historical distrust of the agencies of government. Politically, there is strong commitment to improving morbidity, health outcomes, and lifestyle which are well below those of the general population. This is known as 'closing the gap' and includes a deliberate higher per capita expenditure by government for Indigenous people. There are also specific Aboriginal controlled medical services that are more culturally acceptable to that community, by being more holistic in physical, emotional, cultural, spiritual, and ecological well-being for individuals and community. While Aboriginal community controlled, they also provide services to the local general population. Access continues to be a problem in rural areas because of inadequate workforce and poor public transport. Considerable effort is made to increase the Aboriginal health workforce (Australian Institute of Health & Welfare, 2022).

It is notable that 23–32% direct home care and residential care workers in the general population were born outside Australia and 18% of providers, employ workers from culturally and linguistically diverse (non-English speaking countries). International students that have been absent from Australia during the COVID Pandemic are normally an important ingredient of both the casual health workforce and the general workforce, and Australia is increasingly dependent on an imported overseas workforce for its health and agricultural sectors (Australian Institute of Health & Welfare, 2021). Critically, Australia's rural, regional, and remote medical workforce continues to depend on overseas trained doctors, despite efforts to improve self-sufficiency (O'Sullivan et al., 2019).

A study into care sensitive conditions (ACSAs), also known as Avoidable Hospital Conditions (AHCs), conducted a systematic review that included some findings for the Asia Pacific region. The study suggests that 'avoidable hospital admissions (AHS) can be used as an outcome measure of accessibility and overall effectiveness of primary health care (PHC) for people with a range of characteristics including ethnic minorities and migrants' (Dalla Zuanna et al., 2017, p. 861). They make the point that migration, ethnicity, and race are complex and overlapping concepts and differ in the

national contexts in which they are used, sometimes they are used synonymously, or overlap in meaning. They suggest that in countries where migration is well established such as New Zealand and Australia, they cannot be considered to be synonymous. They also cannot be homogeneous, nor can rates of utilisation of healthcare be solely ascribed to ethnicity alone, but it may be access to PHC or preferences for traditional medicine and cultural considerations.

## *Singapore*

Singapore in a recent study into a specific condition diabetes is described as a multi-ethnic country with a Chinese majority and ethnic minority groups of Malay and Indians. The country has a regionalised predominantly public health system. In the study described by the authors as one of the largest Asian studies conducted, suggested that one inter-ethnic disparity finding was that Indians and Malays comprised the highest proportion of the highest risk group of diabetes-related complications compared with the Chinese. Both these groups have also been shown to have poorer diabetes control compared with the Chinese. The authors suggest an interplay of complex environment and socio-economic factors as well as genetic predisposition to insulin disposition in these groups, defining the need for education focussed on their cultural dietary requirements (Seng et al., 2020). Riandini and colleagues (2021) undertook a 10-year observational study of diabetes, a growing epidemic of major concern in Asia into related complications in the multi-ethnic Asian population of Singapore. The study revealed important ethnic differences in the risk of diabetes-related low limb complications (DRLEC) with higher risk for Malays.

## *Vietnam*

Recent research in Vietnam suggests inequities in the ethnic minority populations, women's experience between that group and PHC professionals in remote and rural communities. These inequities persist despite progress generally in maternal and child health in recent decades. There are 54 officially recognised ethnic groups in Vietnam, who are more likely to be poorer than the majority population. These groups, while said to be 'treasured' as demonstrating the cultural diversity of the nation, and where, attempts to improve living standards, are seen to be at the expense of that traditional culture. Geographical, and distance, poor transport, together with low levels of investment in physical and human capital are defined as factors of concern. This study demonstrated scope for better two-way communication and interpersonal communication and patient centred approaches between health professionals and with pregnant women (McKinn et al., 2017).

Interestingly, there are increasing opportunities for Asia Pacific nations to come together to enable regional agenda setting and networking between health systems.



A recent example is a collaborative network for setting a mental health disaster network and agenda. This network has established five priorities of strengthening community engagement and integrating planning and evaluation; assessing capacity for disaster response; optimising emerging technologies in mental health; addressing mental health impacts of climate change; prioritising support for high-risk groups. The convenors of this network record that the Asia Pacific has the highest frequency of hazards and the greatest number of people affected disasters annually with a significant proportion of mental health need not being met. The network is open to all Asia Pacific nations with current participation from Australia, Japan, China, Nepal, Sri Lanka, India, and the USA (Newnham et al., 2020).

### *Japan*

Japan who has joined the above network does so from a base where its population is regarded as homogeneous in ethnicity and where access to mental health services is low. Those that do are likely to come from China, Philippines, Korea, and Brazil. Those that do access services suffered from neurotic and stress related disorders and required family and professional interpreter support (Takubo et al., 2020). Takenaka (2009) asserts that studies in Japan pay little attention to the mobility patterns of foreign migrants as the number of foreign migrants is estimated at 1.5% of the total population meaning that there is tendency to focus on achieved status of education and skill levels rather than an ascribed status of ethnic and national status.

### *Indonesia*

Laksono et al. (2020, p. 584) provide an article about the concept of illness amongst ethnic groups in Indonesia in a meta-ethnographic study concluding that 'the concept of illness in ethnic communities in Indonesia was different from the concept of disease in the modern medical world'. The article traverses the differences in the meaning of illness that creates a social role and behaviours of the concepts and relationships of patients, doctors, and nurses, that persist, even when they might move to other regions. In this study of the available literature, 15 different ethnicities were obtained. There are more than 1,340 ethnic groups in Indonesia with diversity in religion and local languages. The findings indicate illness is defined when individuals are unable to perform normally, 'unable to move normally', causes are ascribed to the 'supernatural or magical things' and because of the 'violation of taboos' (Laksono et al., 2020, p. 586). These metaphors define the health seeking behaviours in ethnic groups in Indonesia and the government policy recognises and regulates traditional medicine and encourages an empirical context to its conduct.

## *New Zealand*

Women in New Zealand ‘experience high breast cancer incidence and mortality rates... and it accounts for nearly 28% of cancer registrations and 16% of all cancer deaths. It is worse amongst indigenous Māori women, with a 60% higher incidence. This study intended to examine barriers to access by ethnicity. Besides Indigenous Māori, it included a composite group of people self-identifying as Samoan, Cook Island Māori, Tongan, Tokelauan, Niuean, Fijian, and some from other Pacific Islands who together, comprise 7% of the population with 74% of England, European origins and 12% Asian people. The ‘non-Māori/non-Pacific women’ reported fewer barriers to access with the highest amongst Pacific women, followed by Māori women. Details to barriers to access and treatment are well described and explored in the detail of the study (Ellison-Loschmann et al., 2015). In another New Zealand study into cardiovascular disease (CVD), the burden of the disease was greatest amongst Indigenous Māori, Pacific, and Indian people. Amongst the findings, ‘Māori and Pacific people had much higher prevalence of smoking, obesity, heart failure, atrial fibrillation and prior CVD’. The study called for strong political commitment and cross-sectorial action (Selak et al., 2020, p. 14).

## *North America and Europe*

In the Northern American context, there has been recent initiatives in improving immigrant and ethnic minority healthcare using community navigators, noted by Shommu et al. (2016) in a systematic review of the use and effectiveness of community navigators in Canada and in the USA. The review suggests evidence of improved health outcomes for a range of disease groups and for the health outcomes of ethnic minority groups. In the European context, there has been a significant and growing proportion of ethnic minorities with significant inflows to most European countries. Earlier assumptions were that infectious diseases were the main concern for health services, but this has now changed to chronic disease and in higher rates than the general population. This context will require scientific and cultural training of health workers, collection of data, and culturally adapted preventative health to give greater emphasis to the health of ethnic minorities (Modesti et al., 2016).

## **Health Inequality Amongst Minorities**

Health inequalities are obvious and a defining theme throughout the narrative of this chapter, depending on the nation states and ethnic communities traversed and within urban and rural contexts and the variety of healthcare providers. These inequalities and the diversity of approaches will be discussed further in this chapter. Taking

Hong Kong as an example, some of the Non-Governmental Organisations (NGOs) in Hong Kong have introduced services focusing on ethnic minority populations for better health outcomes. For instance, the United Christian Nethersole Community Health Service in 2007 introduced a healthcare service named the 'Ethnic Minorities Health Services' to provide primary healthcare service, from preventive to clinical, amongst minorities population in Hong Kong. This should be considered as the initiation in this text of the title to aim for 'All-for-Health'. The service was funded by The Community Chest of Hong Kong, an independent, non-profit charity (<https://www.commchest.org/en>). While health inequality still exists the fundamental health of the minority's communities, has been secured at least. The initiative of the United Christian Nethersole Community Health Service is described at <https://www.ucn.org.hk/en/services/preventive-medicine-and-clinical-service/ethnic-minority-health/> and the detailed service provision is at <https://www.ucn-emhealth.org/>.

The population who received the South Asian support programme of this service has increased from 21,834 to 23,511 from the year of 2017–2018 to 2018–2019. One of the innovation highlights described in the above links is the smoking cessation service for ethnic minorities and new immigrants. That is part of the services that provide health education, prevention, and treatment measures to minorities population with tobacco abuse. The population of service receivers increased from 2017 to 2019, from 3,438 to 4,973.

In contrast to the initiative of an innovative NGO, the Hospital Authority, responsible for the public sector services provides interpreter and translation services and multi-lingual information in all public hospitals. Vandan and colleagues (2020) identified in a recent study that South Asia participants in a 'Chinese-orientated society' reported lower health system responsiveness but were positive about the care experience. These authors suggested more concerted effort from providers and policy-makers to improve systems for these groups. This contrast raises the question as to how best to provide health services to ethnic communities and are services available to the general population sufficient or should they be specific to the ethnic community? Generally, the answer might be that there is potential for public, private, and not for profit charities to play a role, and perhaps differing roles.

In the meantime, the lack of support in clinical communication amongst ethnic minorities in Hong Kong is always an issue which the stakeholders of ethnic minorities are fighting for. This also includes refugees and asylum seekers who need medical service. Although some of the NGOs in Hong Kong keep developing interpreter service in out-patients and community health services, the demand from the minorities is always greater than the actual availability of services. In contrast, proficiency in Cantonese, English, and even Mandarin is always expected and is often included in the job requirements of healthcare providers, but not even mentioning ethnic minorities languages. This latter context is reflecting the lack of understanding of the importance of both communication and effective engagement of healthcare personnel with demanding language skills in Hong Kong, result in immature primary healthcare support to a multi-diversity community.

Friel et al. (2012) address the social and environmental determinants of health inequity in the Asia Pacific and go to the centrality of NGOs in those approaches. They suggest that ‘tackling health inequalities is a political imperative’ (p. 897). The article goes to the broader needs of ethnic minorities to the physical living environment for healthy living, improved workplace, and social protection, reducing workers vulnerabilities, providing universal coverage, comprehensive PHC, and equitable access to medicine. These approaches need to be delivered in a way that promotes social inclusion and equity in governance and, a greater emphasis on education, amongst other things. This also implies intersectoral action and active community participation, the involvement of civil society and advocacy. These concepts emphasise ‘health for all and all for health’ rather than a focus on health systems and services.

The discourse in this chapter also goes to greater consideration of innovation to address the health needs of ethnic minorities as described in some nation states. As cited, Shum (2011) in an article on refugees also took the wider perspective around physical space, power relationships to space available and environment, also currently being considered as an approach in wider health service planning in Australia. Wong et al. (2017) also broadened the debate by suggesting a framework based on the socio-economic determinants of health (SOECD). Using community navigators as described by Shommu et al. (2016) in a systematic review of the use and effectiveness of community navigators in Canada and in the USA, is another example of innovation in healthcare, one that is currently being explored as an approach in primary healthcare in Australia. The potential for specific use of non-government organisations, across sectors and alongside public and private sector providers as described in Hong Kong above and occurring in Australia into commissioning similar organisations in primary healthcare as providers are notable in their innovation. These initiatives reflect a wider emphasis on health reform through innovation, technology, leadership, and across sectorial approaches as discussed below.

## **Health Reform Through Innovation, Technology, Cross-Sectorial Approaches, and Leadership**

One approach for all to consider is to adopt a more innovative approach to service provision. Technology is quickly improving access through telehealth, miniaturised and wearable monitors, and biotechnology and digitalised data are relatively new as is the use of artificial intelligence (AI), but rapidly advancing in use. In the regional and rural context in Australia where communities both general, first nation as Aboriginal & Torres Strait Islanders, and ethnic migrant refugees there is an emphasis on developing innovative approaches that are beginning to see the insertion of navigator positions into local communities to assist individuals to gain access to healthcare and to help them ‘navigate’ their way through and around service providers. There is also a focus on ensuring that providers are connected through networks of practice (NOP) locally and through distributed networks of practice (DNOP) across wider

regional areas (Briggs et al., 2019). This places the emphasis of health reform on how best to deliver and access services across organisational barriers and sectors, rather than attempting to change the structure of the organisations. To achieve this objective, we need well-educated and experienced health professionals, managers, and leaders we need to engage in collaborative research that allows engagement with others in the analysis of data to allow us to move forward utilising evidence based to best practice.

Leadership and management need to be empowered to engage, make sense of what they see in the complexity before them and work across boundaries to deliver or extend services. Leadership requires strategic capacity and critical skills of being flexible, being a systems thinker, being focussed, and an influencer. In the sense-making role leaders should understand the diversity of need, differences in geographic location of populations, culture of ethnic communities and populations and be able to achieve intersectoral collaboration (Briggs, 2021). This suggests the need for authentic leadership that requires self-awareness, relational transparency, balanced processing, and having an internalised moral perspective (Olley, 2021).

## Discussion

The research traversed above provides the authors and readers of this text with complex context, a term of 'ethnic minorities' that is not easily defined and, in fact is a term, that has multiple meanings to us all. Ethnic minorities can in fact be Indigenous, such as in Australia where increasingly they are referred to as 'First Nations' and in New Zealand, Māori and Pacific Islands and Indonesia with extensive ethnic minority groups. Hong Kong and Mainland China have extensive ethnic minority groups as part of its domestic workforce, while it is also challenged by refugees in transit and others like Thailand and Cambodia have extensive ethnic minorities who have escaped persecution and war in surrounding countries such as Myanmar, formerly called Burma.

The lesson here is that there is not a simple definition of the term and that it has a range of meanings within and between countries. The provision of healthcare to these groups is also variable and, even where intentions are good, the health outcomes are generally not as good as that of the majority population in each country. In some cases, the variability is seen as disease specific but generally there are poorer outcomes across the chronic diseases. There is also variability of health outcomes based on predisposition for some groups. As ably demonstrated in the article from our colleagues from Indonesia culture, beliefs, and values, heavily influenced health behaviours and how healthcare behaviours need to be socially constructed to be effective (Laksono et al., 2020).

This brings us back to the question as to the value of mainstream services versus specific ethnic healthcare services and their respective effectiveness and our readers will have formed some views about that from having read this chapter. Again, a complex question with no simple answer. Most national health systems, even those

with positive policies of universal access tend towards one service model that fits all circumstances. However, the evidence in the research we have presented suggests that a variety of approaches are implemented in different countries to respond to the perspective that the effectiveness of healthcare outcomes is influenced by culture, genetic disposition, the environment, health behaviours and the values, beliefs, training, and education of both health professionals and of the recipients of healthcare.

The authors that have been quoted in this chapter clearly understood the importance of empirical evidence by measuring the effectiveness of health outcomes for ethnic minorities and comparing those results with that of the majority population (Dalla Zuanna et al., 2017, p. 861). In Australia, health pathways are developed to inform clinicians, health systems, and patients of the appropriate health pathway for their specific needs. This is a reasonably simple way, using an empirical approach to measure and determine where health improvements can be identified, and solutions adopted, either individually by clinicians or by health systems. It is an opportunity to use collaborative or participatory action research (CAR/PAR) or continuous qualitative improvement methodologies to secure improved care.

Thailand has been impressive in its more systems approach to health reform by adopting innovation in the use of socio-economic determinants, district health services, millennium development goals, and then sustainable development goals to place general practice and PHC as the centrepiece of access to local health service instead of at hospitals. Collaborative research with a focus on social determinants and SDG3 is central to 'ensure healthy lives and promote well-being for all at all ages. This approach requires a platform to integrate health and social services and encourage participation of all sectors to work together to improve their local people's quality of life (Tejativaddhana et al., 2018, p. 44).

Friel and Associates (2012, pp. 897–899) provide a comprehensive review of policy approaches to address the social and environmental determinants of health inequity in Asia Pacific and propose translating a global vision into regional and local action. They propose that inequities are not inevitable and present an action framework to move forward. Briggs and Isouard (2016) suggest that the language of health reform plays an important part in how we make progress in improving, reforming, and developing both health services and health systems. They suggest that we need to ask the critical questions when considering health reform as what problem are we attempting to address (and) whose interests are being served? They traverse the multiple directions that past frameworks and declarations have influenced and affected our progress. Importantly, they emphasise the importance of localism and the principle of subsidiarity in effecting change, 'locally' where services are being delivered. Briggs (2020, p. 1) in asking where to from here, suggests:

health development and health reform (should occur) within a framework that encompasses a wider societal context that is based on trusting relationships within a wider community and organisational settings that place valuing health above healthcare and that have a wholistic, patient centred focus.

This is the challenge that we place before those involved in delivering ethnic healthcare in their endeavours to both progress the access and quality of that care

and in demonstrating improved outcomes. This chapter demonstrates the importance in ethnic healthcare that culture and our respective values are central to the success of that healthcare and to a concept of holistic care which acknowledges the close relationship between ‘body, mind and soul or spirit’ (Briggs, 2020, p. 1).

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