Nat. Volatiles & Essent. Oils, 2021; 8(5): 4168 - 4175

NVEO
Natural Volatiles & Essential Oils

A study to explore the perspectives of SA patients and the members of the EM as they receive healthcare in Hong Kong

Ligang Wu[1] , Fadzilah Binti Hassan [2], Fauziah Binti Ibrahim[3]

[1]Research Scholar of Lincoln University College Malaysia
[2,3] Clinical Instructor of Lincoln University College Malaysia

Abstract

When it comes to health care, Hong Kong boasts one of the most efficient systems in the world.

Efficiency score of 87.3 and the greatest life expectancy of 84.3 years, demonstrating that the high-quality medical care does not place a significant cost on the public. Because of this, Hong Kong has increased its healthcare spending by an average of 7 percent over the previous few years, in an effort to meet the population's rising health requirements.

Keywords: Efficient systems, life expectancy, population's rising

Introduction

There Ethnic groups consist of people who share a common language, culture, or religion." shared legacy, consisting of a common culture and language. Ethos or philosophy of the group may also emphasise ancestry and religion or ethnicity as common denominators. In order to enhance their lives and employment prospects, people have migrated or had to move from one area in order to another since the dawn of civilization. Because to globalisation, the number of multi-ethnic societies in most industrialised countries has risen. "Ethnic Minority" (EM) is the name given to a group of migrants or indigenous peoples who outnumber the local ethnic majority population.

According to Wikipedia, culture may be defined as "traditional concepts that are taught, communicated, and passed down from one generation to the next". Differing cultures between two or more communities are known as 'cultural diversity', and they can be caused by racial or ethnocultural differences as well as sexist and homophobic attitudes. They can also be a result of social and economic statuses or classes as well as education and other related attributes of groups of people in society.

U.S. racial minorities include Native Americans from Hawaii and other Pacific Islands as well as American Indian and Alaska Natives. Gypsies, Asian British, and Black British are some of the major ethnic minorities in the United Kingdom (UK). Asian British is a term used to describe a group of people from Asians from India, Pakistan, Bangladesh, China, and other Asian nations for instance. There are distinct features of patients, whether they are individuals, families, or communities.

In their health practises, healthcare-seeking behaviours, and healthcare system expectations. There are a variety of features that distinguish healthcare providers such as doctors, nurses and other healthcare workers from other types of organisations and policymakers. When a patient and a healthcare practitioner communicate, and the contact should benefit both parties.

To comprehend diagnoses, make treatment decisions, and manage disease with the help of both parties. To preserve and enhance the health of its people, a successful healthcare system should meet the healthcare requirements of its population. It's just that in practise a lot of healthcare systems have trouble figuring out what the different patients' wants and requirements are.

Literature Review

When a population is able to get access to and use healthcare, it is said to have access to healthcare make use of medical services. In addition to service availability, however, access is determined by the

characteristics of persons who will utilise those services, the predisposing and enabling variables that influence human decisions to recognise and seek treatment when necessary. According to Mooney, access is determined by supply and demand. No usage equality will be achieved until demand equalises access (a supply-side issue). The provision of services should be such that it meets the needs of the people. Organizational, economical, social and cultural variables all have an impact on access to health care. According to a literature study, access may be defined as anything from entering a system to a multidimensional idea. According to Penchansky et al., (1981), access is a "fit" between the healthcare system and the population, which includes aspects such as availability and acceptability. As defined by Frenk (1992), access refers to "the population's capacity to seek and get care. Within the process of looking for and getting treatment, accessibility refers to how well healthcare services fit into people's lives".

Access, according to Lévesque et al. (2013), is the "ability to seek and acquire appropriate healthcare services in situations of perceived need." Their definition of access was "the consequence of the interaction between the individual, home, social and physical environment, and health systems, organisations, and providers". They came up with a total of five accessible, namely "approachability, acceptableness and availability" which correspond to the five capacities of the people to produce access. ". Perceive, seek and attain; pay; and engage are the five talents [55] that make up a person's abilities. Affordability refers to a person's capacity to find and access services, as well as their ability to have a positive effect on his or her well-being. When it comes to social or geographic groupings, services might be more or less well-known. There are "cultural and societal variables that affect whether people accept parts of a service (such as sex or a social group of providers), beliefs connected with medical systems, and the assessed appropriateness of an individual's decision to seek treatment". According to availability, "health services (either physical space or those working in health care jobs) can be accessible both physically and on time". For example, direct pricing of services, related expenses, and opportunity costs associated with loss of income are all factors that contribute to affordability. Fit between services and client requirements, timeliness, quality of care in diagnosing health issues and selecting right treatment, and technical and interpersonal quality of the service given are all examples of appropriateness.

An increase in the number of emergency room visits, hospitalizations, morbidity, death and medical costs for both patients and providers can be reduced by improving access to healthcare services. It is possible to diagnose acute sickness at an early stage by having access to primary care services that focus on preventative measures. Chronic disease management and health literacy can also be improved.

Access to health care must be equalised as a result of this. Access to cheap, high-quality, culturally and linguistically relevant healthcare in a timely way, whether for preventative services, emergency treatment, or mental health assistance, can only be achieved through enhancing access to healthcare. "Access is a constantly negotiated property of individuals, subject to multiple influences from people and their socio-cultural contexts as well as macro level influences on allocation of resources and configuration of services," according to a consensus reached in the discussions about equitable access. Due to patient characteristics such as poor health literacy, limited language ability, distinct religious and cultural influences, and health habits, the EM population confronts several obstacles in obtaining healthcare services in general.

Among Taiwanese immigrants with limited language and health literacy skills, researchers found that navigating the healthcare system, communicating with healthcare providers, and accessing proper healthcare were all difficult tasks, and they emphasised the need to improve health literacy and create a health-literate environment. Similarly, EM patients have a poor grasp of how medication is used. In addition to delivering drugs, pharmacies can play a larger role in ensuring correct and timely use of medicine by imparting sufficient information. Low health literacy individuals reported more illnesses, more

physical complaints, and a higher use of healthcare services [61]. Having low health literacy is linked to a poor quality of life (HRQOL). There are a variety of health services that may be provided.

The goal is to enhance the HRQOL of EM patients by increasing their literacy.

Research Gap

It's no secret that Hong Kong has one of the greatest healthcare systems around. EMs residing in Hong Kong, however, have difficulty accessing the world's most advanced healthcare systems. Despite the fact that Asian civilization is becoming increasingly multi-cultural and multi-ethnic, little is known about the health condition, demands, and difficulties faced by ethnic minorities (EMs). Only a little amount of effort has been paid to understanding the problems that healthcare providers face when treating patients from emergency rooms. Moreover, no research have examined the disparities between the experiences of EMs and the majority ethnic patients with the healthcare services provided by the healthcare system. Determining the problems faced by EMTs in Asia in order to decrease healthcare inequities is the goal of this thesis.

Research Objective & Methodology

To understand the challenges of SA patients' data was collected using focus group discussion method. Only SA women were included in this study due to 1) easy to get their time as most of women are homemakers and can easily available during daytime. 2) Women being primary care giver of the whole family can give an insight of the experiences felt by other family members too. 3) Relatively more frequent user of the healthcare services compared to men due to their reproductive needs.

To understand the challenges of healthcare professionals' data was collected using face-to-face individual interview method. Doctors, nurses and pharmacists were included in this study due to their important, inevitable and sometimes prolonged contact time with the patients. Hence, they can provide better insight of their viewpoints than other professionals.

A survey was conducted using the questionnaire including SA and Chinese population to understand their experiences with the healthcare system. No representative sampling frame of SAs was available in Hong Kong. Hence, SAs were recruited through social networks, community centers, and cultural and religious centers. Chinese participants were recruited in a household survey by stratified random sampling based on the representative sampling frame of residential addresses obtained from the Hong Kong Census & Statistics Department. Specifically, a random sample of addresses was taken from each geographical district and type of dwellings. For each selected address, an invitation letter detailing study details was posted. When more than one eligible person resided in the household, the person with the next birthday was invited. Each eligible subject received an explanation of the details of the study and the rights regarding voluntary participation before written consent was delivered. All participants signed an informed consent form before participating in the study.

Each participant was then given a self-administered questionnaire in either Chinese or English, depending on whether they were Chinese or South African. Participant interviews in their native languages, such as Nepalese, Hindi, Urdu or Punjabi, were done for those with poor literacy or unable to self-complete the questionnaire. In a poll of 575 people, 410 completed it by themselves and the remaining 165 were interviewed in person. Consistency and accuracy were maintained by using two methods: 1) maintaining a native speaker as an interpreter during the interview to avoid any confusion; and 2) keeping an English-speaking person as an interpreter during the interview in order to avoid any confusion.

It's also a good idea to double-check with the participants before marking the box.

Data Analysis & Findings

Qualitative research used recorded and thematically annotated interviews. A thorough investigation was carried out. In order to achieve this, we coded all of the data before selecting significant themes. Participants' opinions and motives were examined for each topic.

Using a chi-square test or Mann-Whitney U and T tests for categorical and continuous data respectively, the demographic differences were quantified. Multiple linear regression was performed once the propensity score weights were calculated. Multiple linear regressions were run on unadjusted, adjusted, and propensity score weighted data to determine the differences between two ethnic groups. 95 percent confidence intervals for all estimations and two-sided tests were run, with significance defined as p values less than 0.05 were used to determine significance. IBM SPSS Statistics version 230 was used to analyse the data. Variables were used to replace non-responded missing values.

To guarantee accuracy, all audiotapes were transcribed verbatim in English by an author with a South Asian background who is proficient in Hindi, Urdu, and English. This was done by someone who was fluent in English, Hindi, and Urdu but had no prior knowledge of the study. An a priori-informed framework approach to qualitative data analysis was used. For example, Levesque's approach was used in this investigation, which allowed researchers to dig deeper into the data while keeping an effective and visible audit trail. A two-stage method was used to prevent pushing data into preset groups. First, interviews were coded using induction. Using theme analysis, two researchers independently coded each transcript (myself and my co-supervisor Dr. Janet Wong who has thorough experience of conducting qualitative research). There was a rigorous evaluation of the codes' relevancy and appropriateness. This led to the resolution of differences in terms of coding and interpretations. In the beginning, the data was coded into categories, which were then reduced into themes. A second step was to connect the five categories of patient access to healthcare (see Figure 1) onto the themes. Various ideas were interpreted, and their interrelationships were examined and compared with other texts until a central topic emerged. Once thematic saturation was reached, each theme was given with its own qualitative quotations to better represent each topic.

Participants complained about long wait times at outpatient clinics and public hospitals, even in emergencies, which limited their access to treatment. Public hospitals were under pressure due to a lack of primary and preventive care services, which was exacerbated by a lack of staff and time limitations. Despite being widely available, private health care is pricey and inaccessible to the majority of the South African population due to overcrowding. This has a negative impact on their capacity to pay for medical treatment and other necessities. A poor socioeconomic position and a lack of knowledge are associated with a lack of medical insurance.

These findings can be used to develop a health education and information distribution plan that will be successful. Using a culturally and linguistically sensitive call/information centre that can give immediate help and through television to disseminate healthcare information.

A variety of EM languages is required for programmes and ads. Through culturally appropriate health care and social workers, community outreach may enhance health literacy and SA women's participation with the system. Healthcare organisations must enhance the quality of treatment by educating and training healthcare personnel in cross-cultural care. It is possible that bilingual or SA healthcare practitioners may enhance SA women's engagement with healthcare providers and comprehension of the procedure.

Audiotapes were transcribed verbatim and cross-checked with field notes to verify correctness of data. The four phases of data analysis proposed by Leininger were implemented. To begin with, data was collected and analysed simultaneously using raw data, recordings and transcriptions of interviews, observations and

field notes. After then, each transcript was examined and coded according to a set of rules and regulations. Both myself and Dr. Jay J. Lee, a specialist in qualitative research, independently reviewed the coded data. During frequent sessions, the code's relevancy and applicability were scrutinised. After any discrepancies were discovered, they had to be debated until they were resolved. A subset of these sub-categories was created and then reduced into categories afterwards. Data is examined for saturation and patterns of similar or divergent interpretations in the third step. To understand what individuals believe, believe about, and do in their environment, it is important to comprehend the similarities and variations of participants' opinions on a variety of topics. Interpretation and synthesis of the findings took place in the fourth step. A total of two themes developed when the categories were reduced into a single topic.

No previous research has looked at how people' hospital experiences differ.

Chinese-oriented society in Hong Kong is seen differently by the EM and ethnic majority communities. South African respondents to the PPE-15 reported a more challenging experience than Chinese respondents. South African participants had the most difficulty with two areas: continuity and transfer of care, as well as physical comfort.

When a patient is discharged from the hospital, continuity and transition of care refers to the information and counselling he or she receives on how to manage the condition at home. Compared to Chinese patients, SA patients in Hong Kong had a perception of continuity and transition treatment that was approximately 18 percent poorer. Black breast cancer survivors in the United States expressed their unhappiness with the level of information they got on cancer-related side-effects. There was also a lower rate of sufficient follow-up for treatment for black patients with mental illness in the United States compared to white patients.

These discrepancies in Hong Kong may be traced back to three primary causes. First and foremost, the majority of patients from emergency rooms and healthcare personnel do not speak the same native language. The danger of insufficient information sharing exists when patients or healthcare practitioners communicate in their second languages. Zweitens, local healthcare providers might not be aware of patients of South African descent's culturally distinct requirements, preferences, and beliefs. Lack of knowledge of patients' sociocultural variables has been shown to affect the assistance and care they should get following hospital release.

Medical professionals' efforts to decrease patients' suffering throughout their hospital stay were blamed for increased discomfort among SA participants. "Ethnic pain" is a term used by clinicians to describe a distinct idea of pain perception. Researchers have well-documented racial variations in pain perception. Comparing African Americans with Whites, a comprehensive analysis revealed a higher prevalence of chronic pain symptoms in diseases such as chronic obstructive pulmonary disease (COPD), AIDS and glaucoma. Other studies show that those who come from ethnic minorities, as compared to ethnic minorities in their nation of residence, are more sensitive to pain.

There is a relationship between neurophysiological variables of the patient and the healthcare system's structural features that determine the individual variations in pain. They utilise a wide range of coping methods to deal with the pain they feel because of the differences in the activation of stress-related physiological reactions. A patient's ethnicity has a direct impact on the treatment decisions made by physicians. Pain-related suffering among EMs is typically heightened as a result of these causes. This might lead to a discrepancy between what a patient feels and what a healthcare practitioner believes.

A predominant ethnic group views the world. Pain may be perceived at a lesser degree by healthcare providers from ethnic majority backgrounds compared to those from an EM. Healthcare professionals may

not be sufficiently motivated to minimise pain if this is the situation. There are occasions when health care workers believe that a patient in an emergency department (ED) is lying or exaggerating their level of discomfort in order to be seen quickly. To assist patients of South African descent feel more cared for and appreciated, healthcare practitioners in Hong Kong should get a deeper understanding of this issue.

Conclusion

A comprehensive health care system is available to all inhabitants of Hong Kong under the city's health policy their government-subsidized health care system. In spite of the fact that EM women in SA confront a number of obstacles, Lack of health-related information, language, and culture. Patient-centered care is becoming increasingly important, as seen by this research.

Among health-care providers who work with EM patients. It is possible that better communication and better quality of care might encourage patients to actively participate in healthcare despite their poor literacy by fostering trust and satisfaction among them.

It is essential that the healthcare system provides adequate assistance for the design and implementation of this programme linguistically and culturally relevant information content. It is also suggested that the SA EM people be educated about health issues. Interventions that are culturally competent and effective.

There is a great need for healthcare workers to be educated and trained. Additionally, a better understanding of SA emergency medicine patients' needs, attitudes, and perceptions might be achieved by increased awareness and integration at the sociocultural level between Chinese-speaking and SA-speaking populations.

Generally, SA participants in a Chinese-oriented metropolitan culture reported Except than perceived better secrecy and basic facilities in outpatient encounters, the Chinese health system has a poorer responsiveness than the local Chinese health system. Patients and policymakers must work together on this issue.

Enhance the current healthcare system for emergency medicine patients. The focus of future study may be on producing content for cultural sensitivity training that is suitable for healthcare workers and designing promotion tactics to achieve an acceptable take-up rate.

References

1. Miller, L.J. and W. Lu, Hong Kong's healthcare system beats Singapore as the world's most efficient: Bloomberg, in Bloomber Business. 2018: Hong Kong.
2. Leung, G.M. and J. Bacon-Shone, Hong Kong's health system reflections, perspectives and visions, G.M. Leung and J. Bacon-Shone, Editors. 2006, Hong Kong : Hong Kong University Press: Hong Kong.
3. Masi, R., Multiculturalism, Medicine and Health: Part VI. Canadian family physician Médecin de famille canadien, 1989. 35: p. 537.
4. Smedley, B.D., Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, ed. A.Y. Stith, et al. 1900, Washington: Washington : National Academies Press.
5. Kagawa-Singer, M. and S. Kassim-Lakha, A Strategy to Reduce Cross- cultural Miscommunication and Increase the Likelihood of Improving Health Outcomes. Academic Medicine, 2003. 78(6): p. 577-587.
6. Brown Speights, J.S., et al., Engaging African American women in research: an approach to eliminate health disparities in the African American community. Family Practice, 2017. 34(3): p. 322-329.
7. Raglan, G., et al., Racial and Ethnic Disparities in Preterm Birth Among American Indian and Alaska Native Women. 2016, Springer Science & Business Media: New York. p. 16-24.

8. Tang, L., Snapshot of the Hong Kong Population, H. Census and Statistic Department, Editor. 2017: Hong Kong.
9. Liesbet, D., et al., How do ethnic minority patients experience the intercultural counter in hospitals? A systematic review of qualitative research. 2017.
10. Region, G.o.t.H.K.S.A., Hong Kong Poverty Situation Report on Ethnc Minorities 2016, C.a.S. Department, Editor. 2018: Hong Kong.
11. Murray, C.J. and J. Frenk, A WHO Framework for Health System Performance Assessment, in Evidence and Information for Policy World Health Organization.
12. Hofmarcher-Holzhacker, M.M., Indicators for structured monitoring of health system performance in Europe, in iHEA conference. 2017: Boston.
13. WHO, Key components of a well functioning health system, in WHO. 2010.
14. Rice, S.R.N. and P.C. Smith, Health systems' responsiveness and its characteristics: a cross-country comparative analysis. HEDG Working Paper 10/29, 2010.
15. Anand, A.S., The Mental Health Status of South Asian Women in Britain: A Review of the UK Literature. Psychology & Developing Societies, 2005. 17(2): p. 195-214.
16. David, C. and D. Kendrick, Differences in the process of diabetic care between south Asian and white patients in inner-city practices in Nottingham, UK. Health & Social Care in the Community, 2004. 12(3): p. 186-193.
17. Zust, B.L. and K. Moline, Identifying Underserved Ethnic Populations Within a Community: The First Step in Eliminating Health Care Disparities Among Racial and Ethnic Minorities. Journal of Transcultural Nursing, 2003. 14(1): p. 66-74.
18. Ma, S., et al., Associations of Diabetes Mellitus and Ethnicity with Mortality in a Multiethnic Asian Population: Data from the 1992 Singapore National Health Survey. American Journal of Epidemiology, 2003. 158(6): p. 543- 552.
19. Nelson, A., Unequal treatment: confronting racial and ethnic disparities in health care. 2002. p. 666.
20. Karlsen, S. and J.Y. Nazroo, Relation between racial discrimination, social class, and health among ethnic minority groups.(Abstract). The American Journal of Public Health, 2002. 92(4): p. 624.
21. Fiscella, P.K., et al., Disparities in Health Care by Race, Ethnicity, and Language Among the Insured: Findings From a National Sample. Medical Care, 2002. 40(1): p. 52-59.
22. Bhopal, R., et al., Ethnic and socio-economic inequalities in coronary heart disease, diabetes and risk factors in Europeans and South Asians. J Public Health Med, 2002. 24(2): p. 95-105.
23. Yang, S., et al., Racial and ethnic disparities in health care–associated Clostridium difficile infections in the United States: State of the science. AJIC: American Journal of Infection Control, 2016. 44(1): p. 91-96.
24. Dagogo-Jack, S., Ethnic disparities in type 2 diabetes: pathophysiology and implications for prevention and management. Journal of the National Medical Association, 2003. 95(9): p. 774, 779.
25. Paz-Zulueta, M., J. Llorca, and M. Santibáñez, Disparities in Access to Prenatal Care Services for African Immigrant Women in Spain. Journal of Immigrant and Minority Health, 2015. 17(5): p. 1355-1363.
26. Ganle, J.K., Ethnic disparities in utilisation of maternal health care services in Ghana: evidence from the 2007 Ghana Maternal Health Survey. Ethnicity & Health, 2015: p. 1-17.
27. Savas, L., et al., Effect of Acculturation and Access to Care on Colorectal Cancer Screening in Low-Income Latinos. Journal of Immigrant and Minority Health, 2015. 17(3): p. 696-703.
28. Gray, L. and G. Johnson, A Study of asthma as a socio-economic health disparity among minority communities. Race, Gender & Class, 2015. 22(1/2): p. 337-357.
29. Orgera, K. and S. Artiga Disparities in Health and Health Care: Five Key Questions and Answers. 2018.
30. Hawley, S.T. and A.M. Morris, Cultural Challenges to Engaging Patients in Shared Decision Making. Patient Educ Couns, 2017. 100(1): p. 18-24.

31. Fiscella, K. and M.R. Sanders, Racial and Ethnic Disparities in the Quality of Health Care. Annual Review ofPublic Health, 2016. 37: p. 375–94.
32. Takeuchi, D.T., et al., Racism and Health I. American Behavioral Scientist, 2013. 57(8): p. 1152-1173.
33. Markey, K., M. Tilki, and G. Taylor, Understanding nurses' concerns when caring for patients from diverse cultural and ethnic backgrounds. Journal of Clinical Nursing, 2017.
34. Wohler, Y. and J. Dantas, Barriers Accessing Mental Health Services Among Culturally and Linguistically Diverse (CALD) Immigrant Women in Australia: Policy Implications. Journal of Immigrant and Minority Health, 2017. 19(3): p. 697-701.
35. Benderly, M., et al., Cardiovascular health among two ethnic groups living in the same region: A population-based study. International Journal of Cardiology, 2017. 228: p. 23-30.
36. Penney, D.S., Experiences and perceptions of Iraqi Muslim refugee women and health care providers in the health care encounter, ed. N. University of Utah. 2015.
37. Binder-Finnema, P., et al., Determinants of marginalization and inequitable maternal health care in North–Central Vietnam: a framework analysis. Global Health Action, 2015. 8(1).
38. Arthur, R.M., et al., Racial Disparities in Mortality Among Adults Hospitalized After Injury. Medical Care, 2008. 46(2): p. 192-199.
39. Hung, M.-C., et al., Racial/ethnicity disparities in invasive breast cancer among younger and older women: An analysis using multiple measures of population health. Cancer Epidemiology, 2016. 45: p. 112-118.
40. Graham, G., Population-based approaches to understanding disparities in cardiovascular disease risk in the United States. International journal of general medicine, 2014. 7: p. 393.
41. Kenik, J., M. Jean-Jacques, and J. Feinglass, Explaining racial and ethnic disparities in cholesterol screening. Preventive Medicine, 2014.
42. Vyas, A., et al., A pilot randomized trial in primary care to investigate and improve knowledge, awareness and self-management among South Asians with diabetes in Manchester. Diabetic Medicine, 2003. 20(12): p. 1022- 1026.
43. Yeo, K., et al., Ethnicity modifies the association between diabetes mellitus and ischaemic heart disease in Chinese, Malays and Asian Indians living in Singapore. Diabetologia, 2006. 49(12): p. 2866-2873.
44. Chen, C.X.R. and K.H. Chan, Type 2 diabetes management in Hong Kong ethnic minorities: what primary care physicians need to know. Hong Kong medical journal = Xianggang yi xue za zhi / Hong Kong Academy of Medicine, 2014. 20(3): p. 222.
45. Kapai, P., The Status of Ethnic Minorities in Hong Kong 1997-2014. 2015: Hong Kong.
46. Vandan, N., J.Y.H. Wong, and D.Y.T. Fong, Accessing health care: Experiences of South Asian ethnic minority women in Hong Kong. 2018.
47. So, W.K.W., et al., The uptake of cervical cancer screening among South Asians and the general population in Hong Kong: A comparative study. Journal of Cancer Policy, 2017. 12: p. 90-96.
48. Chan, C.W., et al., Innovative Health Promotion Program on Breast Cancer Screening for Ethnic Minority Women in Hong Kong. Journal of Obstetric, Gynecologic, & Neonatal Nursing, 2015. 44(s1): p. S1-S1.
49. Wilson, C., et al., Patient access to healthcare services and optimisation of self-management for ethnic minority populations living with diabetes: a systematic review. 2012: Oxford, UK. p. 1-19.
50. Penchansky, R. and J.W. Thomas, The Concept of Access: Definition and Relationship to Consumer Satisfaction. Medical Care, 1981. 19(2): p. 127- 140.