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A STUDY TO IDENTIFY DIFFICULTIES IN PROVIDING EDUCATION AND CARE TO CULTURALLY DIVERSE PATIENTS IN HONG KONG

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ABSTRACT

Ethnic minorities across the world face health inequalities. Ethnic minority patients' experiences in Western nations have been the subject of a significant deal of research. The eastern world, on the other hand, is still lacking in such information. This information is crucial in Asia, as many locations are growing increasingly multi-ethnic and multicultural in recent years. When it comes to outpatient and hospital treatment, comparing minority patients' experiences with those of ethnic majority persons can prove beneficial. Quantitative as well as qualitative approaches were combined in my study. First, I conducted focus group talks with 30 South Asian women and conducted interviews with 22 healthcare professionals to gather information about their experiences (doctors, nurses and pharmacists). On top of that, I performed a cross-sectional survey with 575 South Asians and 494 Chinese individuals using the WHO health system responsiveness, Picker patient experience (PPE-15), and Veteran Rand 12-item (VR-12) questionnaires.

KEYWORDS: Health inequalities, Ethnic minority, WHO health system responsiveness

1. INTRODUCTION

Ethnic and racial tensions have increased as a result of global mobility and migration. These trends are forecasted to continue until the second half of the 21st century. For healthcare institutions that serve patients and families from a variety of ethnic backgrounds, cultural diversity has become increasingly essential. In many industrialised nations, promoting fairness in healthcare has become a serious problem. Physical and emotional health of EM persons has been found to be worse than that of their majority counterparts. Compared to the majority Caucasian population, ethnic and racial minorities in the United States suffer disproportionately from chronic illnesses and have less access to excellent healthcare in 22 important care metrics. In the United Kingdom, SAs had a greater risk of chronic illness than the majority-Caucasian population. Hong Kong's public healthcare system, which is heavily funded, is mandated to guarantee equal healthcare rights for everyone, yet EMs continue to face health challenges and inequities. As a result of cultural and language barriers, inequalities in health care may exist.

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Health inequalities can be reduced by ensuring equal access to healthcare for underprivileged ethnic or racial groups, according to Atkinson and colleagues (2001).A great deal of attention should be paid to the administration of healthcare in emergency medicine.

It is necessary to increase the population. Individuals, families, and communities rely on healthcare professionals for improved access and quality of treatment. They are also accountable for ensuring that all patients, regardless of their background, receive the best possible treatment. Health Care Providers who work with ethnically and culturally diverse patients in the United States, on the other hand, were reported to be uncomfortable in their roles as healthcare providers. The establishment of therapeutic connections with culturally diverse patients can also be difficult, resulting in less exchange of health information and less patient engagement in the medical decision-making process. Healthcare professionals have been shown to be stressed and anxious when faced with such high levels of ambiguity and doubt while crossing cultural barriers.

The fundamental objective of healthcare is to enhance accessibility and health outcomes for all patients, regardless of their socioeconomic status. There are five aspects of accessibility, as defined by Levesque, Harris, and Russell (2013). They are: approachability; acceptability; availability; affordability; and appropriateness. Care is referred to as intercultural care if both the healthcare professional and the patient come from a diverse cultural background. Ideas, beliefs and values about health and life that may be passed down from generation to generation are the building blocks of culture. When it comes to well-being and health in multicultural societies, the interrelationships between culture and care are clear, according to Leininger (2002)'s idea of cultural congruent care. By proposing particular culturally-sensitive actions or negotiations, it facilitates a group's ability to behave in accordance with its cultural values and beliefs.

Health care to help the patients alter their health behaviours to enhance outcomes while retaining their cultural values. The following are some elements that impact cultural care meanings and practises: religious beliefs; politics; economy; worldview; environment; cultural values; history; language; and gender.

2. LITERATURE REVIEW

This can minimise emergency room visits, hospitalizations, morbidity/mortality rates as well as medical costs for patients as well as healthcare providers with better access to healthcare services. Access to primary care services that focus on prevention, for example, can diagnose acute sickness at an early stage, manage chronic disease and improve health literacy.

Access to health care must be equalised as a result of this. Egalitarian healthcare implies that all people receive timely, economical, culturally and linguistically appropriate access to preventative treatments, emergency treatment or mental health assistance. This can only happen via improving access to healthcare. "Access is a constantly negotiated property of individuals, subject to multiple influences from people and their socio-cultural

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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. Patient characteristics such as inadequate health literacy, limited language ability, religious and cultural considerations, and health habits make it difficult for patients to receive healthcare services in general.

There are various obstacles in navigating the healthcare system, interacting with healthcare professionals, as well as getting adequate treatment according to a research on Taiwanese immigrant women with poor language and health literacy abilities. Also, EM patients have a restricted grasp of the usage of medicine as a result of their training. In addition to delivering drugs, pharmacies can play a larger role in ensuring correct and timely administration of medicine by imparting necessary information. Low health literacy individuals reported more illnesses, more physical complaints, and a higher use of healthcare services. Having low health literacy is linked to a lower quality of life (HRQOL). There are a number of ways in which healthcare services may help you. EM patients' HRQOL can be improved by improving their literacy.

In addition to poor language abilities, insufficient service provision, and underuse of clinic-based interpreters and community-based services, access to healthcare may be hampered. When seeking mental healthcare in various contexts, immigrant and refugee women from varied ethnic origins in Australia experienced several challenges, including language and communication, dissonance between participants and care providers, and a desire for alternative therapies. To ensure that patients get and comprehend appropriate advice and treatment, cultural and religious issues must also be adequately recognised. On account of their Islamic beliefs, muslim women prefer female healthcare professionals. A few cultures also impose limitations on the intake and usage of specific foods, medications, and medical treatments. After childbirth and nursing, there are cultural differences in terms of food preferences (cold or hot/ sweet or sour) and how mother and infant are handled [65]. While Hindus and Sikhs abstain from eating pork, Muslims abstain from eating beef. If a patient is removed from ventilator support (Orthodox Jews), blood transfusions (Jehovah's Witnesses), hydration and nutrition therapy (Roman Catholics), and the patient has documented brain dead (Buddhists), these beliefs may be in conflict with particular health care conditions.

Deteriorating health habits have also contributed to health disparities among emergency medical personnel (EMP). In the United States, 551 Arabs and 553 Jews, divided by gender, ethnicity, and age, were studied for their cardiovascular health habits and risk factors. Jews (10%) were found to have healthier habits than Arabs (3%). When it came to whole grains, however, Arabs were more likely to reach the requirements, but less likely to meet the criteria for sugar.

ppIntake guidelines for fruits/vegetables and seafood. They had a decreased chance of achieving optimal body mass index and physical activity levels compared to the general population. For Arab men, smoking prevalence was 57% while for Arab women, it was just 6%. The four health status markers (cholesterol and blood pressure) as well as

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hyperglycemia and smoking were found in 2% and 8% of Arab males and 12% in Arab and Jewish women, respectively.

3. RESEARCH GAP

Qualitative and quantitative researches were also piloted. We performed focus group discussions and interviews with 1- 2 individuals in qualitative research, and none of them had any concerns. We conducted 30 participant pilot studies in order to determine the length and time required to complete a questionnaire. We solved this problem by shifting a section of the questionnaire that asked participants to rate how important certain responsiveness factors were to the very end. First, the participants were asked to fill out the more important portions of the questionnaire.

The Hong Kong West Cluster Institutional Review Board of the Hospital Authority and The University of Hong Kong authorised the study. UW 16 -145 is the HKU/IRB reference number. Participants were required to give verbal and written consent before the FGD could begin. The audio recording of the session was also approved.

Healthcare disparities persist despite our best attempts to recognise them. There are a number of areas that require additional investigation and development, including the experience and HRQOL of patients of South African descent and patients who are Chinese.

There is a need to enhance health education and information that is easy to comprehend and culturally and linguistically appropriate in order to ensure that everyone has equal access to health care.

There should be more frequent use of interpretation services in order to minimise the communication barrier between patients from emergency departments (EDs) and Chinese healthcare professionals (CHPs). As a result of this, the waiting time for this service will be significantly reduced, therefore increasing its engagement.

Due to the growing number of multi-ethnic and multi-cultural patients in Hong Kong, healthcare education and service systems must adapt to a varied group of patients. As a result, we recommend that you do the following steps: inclusion of culturally sensitive training in the nursing curriculum as well as in the medical curriculum. As a result, we urge that healthcare staff continue to get training on cultural competency.

In order to improve the health system's performance, it is essential that the system's responsiveness be improved. Non-clinical factors like as attitudes and behaviours of care providers in their efforts to treat all patients with dignity and respect, especially patients from marginalised groups or emergency medical personnel (EMPs) who may have linguistic and cultural barriers, can help enhance responsiveness. Achieving this objective doesn't require a lot of money. A good place to start is by designing and executing interventions and education programmes to increase responsiveness. Hopefully, future study in this area will give useful information on how to reduce and eliminate healthcare inequalities in the future.

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To reach the EM population, a community-based participatory research approach should be used. Before, this sort of outreach to African American women was proven to be successful for community and patient involvement.

According to this thesis, patients of South African descent lack the understanding on how to access and use the healthcare resources and services available, and as a result, they delay seeking care, which has a detrimental impact on their health. These projects are created in Canada and the United States to help underprivileged people. [254] Community navigators are healthcare workers that assist people who have difficulty accessing healthcare and support them in obtaining appropriate healthcare services. As a result of future studies on Hong Kong's EM services, patients can benefit from them in the future.

A dramatic rise in Hong Kong's population of different ethnicities has happened, however no provisions have been made for data gathering based on ethnicity. As a result, it is difficult to determine the health condition of different nationalities. According to the thesis' recommendations, the data collecting systems should be improved in order to better understand multi-ethnic populations and create suitable treatments.

4. RESEARCH OBJECTIVE & METHODOLOGY

Quantitative approaches were utilised to generalise findings based on qualitative investigations, followed by quantitative methods to gain a deeper knowledge of issues.

There is a thorough literature analysis in Chapter 2 on subjects like as Patients' experiences and health-related quality of life are all factors that influence access to healthcare. The technique used to attain the goals of this thesis is described in Chapter 3. On the other hand, Chapter 4 explores the problems and experiences women members of SA EM have in Hong Kong when it comes to accessing healthcare services. Six focus group talks were held in order to better understand the difficulties faced by South African women. Patients and healthcare professionals must work together to deliver quality care. It's for this reason that In Chapter 5, healthcare professionals, including physicians, nurses, and pharmacists, are interviewed in-depth about their experiences.

Quantitative research will be conducted to compare the SA experience with that of local Chinese people when it comes to using outpatient care and inpatient healthcare services. In qualitative research, the findings pointed to topics linked to the responsiveness of the healthcare system. Adapting the World Health Organization's health system responsiveness questionnaire, Chapter 6 compares the health system responsiveness in out-patient and in-patient care settings between South Africans and Chinese. A comparison is made in Chapter 7 between the experiences of South African and Chinese patients who have been hospitalised in the last 12 months. In order to perform this comparison analysis, we used the Picker Patient Experience-15 questionnaire. In Chapters 8 and 9, we compare the self-perceived Health-Related Quality of Life of SA and Chinese participants, and assess the influence of out-patient and in-patient

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responsiveness, and patient hospital experience on Health-Related Quality of Life, using a questionnaire called the Veteran Rand-12 (VR-12).

Chapter 10 concludes with a summary of the thesis and its relevance, along with a list of possible avenues for additional study.

In general, the physical and mental health of most EM patients has deteriorated over time.

Compared to the majority if you look at 22 important care indicators in comparison to Caucasians, EM patients in the United States suffer from more chronic illnesses and receive less quality treatment. Chronic illnesses such as type 2 diabetes and cardiovascular disease were more prevalent among South Asians in England than among White Europeans. On the other hand the indigenous Chinese and Malay population in Singapore were more vulnerable to both type 2 diabetes and coronary heart disease.

Population of SA EMs in Hong Kong grew from 35,368 in 2006 to 84,875 in 2016, with 41,460 of them being women. There were 6.3% of people with diabetes, 30.3% with hypertension and 80.3% with obesity among South Asians according to the South Asian Health Support Program's Annual Report 2010/2011. When compared to local ethnic Chinese people with diabetes, EM diabetes patients were younger and more fat. Among five main EM populations in Hong Kong, Pakistani patients had poor glycemic control, and Nepalese patients had the lowest diastolic blood pressure. A smaller percentage of South African women participated in cervical and breast cancer screening programmes than did local Chinese women in Hong Kong. As a result of this, social rank inequality and subordination in their civilizations offer a number of problems.

To be treated fairly. As a result, these women represent a vulnerable population whose needs, concerns, and impediments to healthcare access must be addressed.

While the US government has identified six variables that might help improve health outcomes for minorities, these are insurance coverage, healthcare access, health literacy, resource usage and quality of treatment as well as linguistic discrimination. Healthcare access has been identified as the most significant obstacle to fair care and the primary source of health inequality among them. There are many different ways to conceive healthcare access ranging from admission into the system through availability, accessibility, acceptability, cost, and accommodation. As a result of these limitations, individuals may encounter difficulties in their quest for health care. Levesque, Harris, and Russell (2013) integrated multiple models of healthcare access into a framework that characterised healthcare access as the ability to obtain and get adequate healthcare services when required, regardless of where you live. Using Levesque's paradigm, he analyses the multidimensionality of healthcare access, assigning five aspects to healthcare providers: approachability, acceptabilty, availability and accommodation, affordability, and appropriateness of service. Health care usage can be affected by problems in any of these areas. When it comes to dealing with these issues patients should be able to do five specific tasks: perceive, seek, reach and pay. Health literacy, healthcare knowledge, and ideas about health and disease impact the capacity to identify the need for healthcare. Variables connected to the desire for care influence the ability to

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seek healthcare: personal autonomy, the ability to make a decision to seek treatment, and other factors.

Understanding of alternatives and rights of the individual. Healthcare accessibility is dependent on personal mobility, transit accessibility and awareness of available options. To be able to pay for healthcare, you must be able to produce enough money. As a result of the client's involvement in the decision-making process, they are able to engage in healthcare. When examining characteristics related with these skills among SA EM women, Levesque's paradigm focuses on patient-centered ability to receive proper healthcare.

5. DATA ANALYSIS & FINDINGS

The conversations were conducted by me, who is proficient in Hindi, Urdu, and English, and is from South Asia. Participant health condition and knowledge were discussed as well as attempts to seek preventative care services during FGDs with the facilitator and just the participants in attendance. It began with a series of probing questions to learn about the participants' experiences using healthcare services, followed by an exploration of their decision-making autonomy in seeking healthcare, and the participants' interactions with healthcare professionals. 2–10 women participated in FGDs, which took place in the language of their choice (s). Before the EGD, participants were informed of the study's objective, confidentiality of their names, and their responsibilities and rights to quit the study at any time. It took 60–75 minutes for each FGD to take place. There was enough of time and a welcoming atmosphere to ensure that the participants were able to express themselves in their original tongue. Each focus group was recorded by the primary investigator. It was necessary to gather data indefinitely until data redundancy could be established.

I conducted all interviews in English at convenient places for the participants. In addition, participants' duties and rights to withdraw were outlined. Knowledge of South Asians and SAs living here in Hong Kong was discussed in the interviews as well as difficulties to care provision and the usage of interpretation services. Participants were also asked about their knowledge and support for cultural competence education. Discussions focused on the healthcare of SA EM patients and the patients' knowledge and views about care. A series of exploratory questions was posed in order to better understand how to communicate with SA patients in the future. These audio-recorded interviews lasted from 30 to 75 minutes, and the interviewer also took handwritten notes throughout each session. The collecting of data proceeded until the data saturation point was reached, at which point the gathering of data ceased.

Between 21 and 72 years old, the average age of the participants was 39 years old. Most of them were housewives; only one Pakistani woman and six Indian women had a college degree. There were 13 people (43 percent) with different degrees of skill in English, but no one possessed fluency in Chinese.

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Women in South Africa's health care system are disengaged, according to the research. Patients suffer and become vulnerable because of their lack of involvement with the healthcare system. It is only feasible to properly participate with the healthcare system if you have a good grasp of the facts available to make decisions to enhance health. Five themes arose in regard to Levesque's five abilities: attitude and awareness, sociocultural issues, time limits, financial load, and insufficient contact. Aspects of perception, seeking, reaching and paying for health treatment were all addressed.

6. CONCLUSION

Generally, SA participants in a Chinese-oriented metropolitan culture reported their out-patient encounters are regarded to be more confidential and to have a greater level of basic comforts than the local Chinese. 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 material for cultural sensitivity training that is suitable for healthcare workers, and designing marketing tactics to ensure an acceptable adoption rate. Proper education and training are effective steps that may be used.

Healthcare practitioners need to improve their cultural competency. It is possible to reduce the communication problem to a large extent by involving patients of South African descent as partners in their treatment through patient-centered communication and frequent use of interpretation services, and to better understand their unique needs, including their preferences and expectations of healthcare providers. Patients of South African descent may benefit from improved health literacy, self-care, and illness management during hospitalisation and after release from a hospital if enough information exchange and linguistically and culturally relevant patient education are provided in hospitals.

In our study, we found that after controlling for demographic factors such as age, ethnicity, and gender, Patient experience and responsiveness, as well as education level, illness status, and Cantonese-speaking competence, were major influences on HRQOL. In light of this conclusion, more research are needed to discover modifiable characteristics that might increase patient satisfaction in outpatient and in-patient treatment settings.

Hong Kong's SA population needs to enhance their HRQOL. Kong. This should be taken into account while creating and dispersing health information in order to promote health literacy and ultimately HRQOL.

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