

Management of Health System for Ethnic Minorities

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Abstract

The concept of ethnic minority refers to a different ethnic group, living in a residential country, with a different birth place and ethnic membership, different language, religion and citizenship, and different culture. This concept establishes as different a certain group, as well as in number and in socio-economic status; the members of this group are practicing cultural values and standards different from the majority's culture and often they have a different native language.

This paper presents some important ideas regarding the peculiarities of Romanian health systems for ethnic minorities.

Keywords: *health services, ethnic minorities in Romania, patient's level, supplier's level, system's level.*

JEL classification: I11, I18

1. Characteristics of the coordination-communication function

Ethnic minorities varies according to the sojourn and acculturation period, and there are between different ethnic minority's variant degrees of access to the majority's culture. The concept of ethnic minority includes as well as the new incoming immigrant groups as the old people groups living for hundred years on the territory like the native American Indians or the Australian aboriginals (they are in fact the original native country habitants).

The population in western industrialized countries became multi-ethnic, due to the work market industrialization and to the subsequent frontiers opening. Contrary to the folk's beliefs, the migration increase is not a new phenomenon; it had had different forms during centuries – from the growing need of work force in countries like England or France, to the colonization of the USA, Canada and Australia. It did exist also a refugee migration, running from hostilities and seeking politic asylum in countries like Sweden or USA. In the countries where they are received, the immigrants are located in the poorest city wards and they usually have a lower social status. They have a lower living standard reflected into the less fortunate accommodation and health conditions. The WHO (World Health Organization)'s objective, "Health for all by 2000", suggests that it should be taken care so that ethnic minorities could have equal access to healthcare services,

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irrespective of their social position; the equal access to medical assistance is a fundamental human right (Department of Health, 2004).

The main object today has the purpose to render us sensitive to the multitude of existent potential obstacles to access healthcare services, in order to gain a more transparent problem regarding the access of the ethnic minorities to those. To resume, there are a lot of potential obstacles, many related against ethnic minority.

Health services employment is defined as the process of requesting professional health care and submitting to regular health services application, with the intention to prevent or to treat health problems (Henderson, 2007). Health services employment is, by definition, an individual option, most of times, framed in the social context through cultural, social and familial bonds, especially for ethnic minorities. Many ethnic minorities are trying to solve on their-own or in the middle of their family and friends their health problems, and if they fail, then they call for help an “old man” of the community (preacher, spiritual healer); the regular health services are called for help only later, after the disease has aggravated.

The ethnic minorities are asking less for health services than the natives, so the services suppliers are unconcerned about these obstacles, though they are carrying too the responsibility burden. Usually their attention is captured by the language and cultural differences, which may lead to false or jaundiced conclusions. The language and the culture are not the only factors which can lift up barriers. In order to clarify the healthcare supplier about the potential risks that may appear, we need to explore the factors which create these barriers. Therefore, here are few general images over the potential obstacles and the factors that can restrict ethnic minorities access to health services.

Patients of ethnic minority are facing obstacles when addressing to healthcare services. The health services suppliers are often careless regarding these obstacles, though they are carrying in a certain aspect the responsibility of this behavior. Because we want to clarify the potential dullness in supplying medical services, we find the need to explore the different factors that are creating those obstacles (Nordhaus, 2003).

There are potential obstacles at three different levels: the patient’s level, the supplier’s level and the system’s level. The obstacles at patient’s level have been associated with patient’s characteristics: demographic variability, social structure variability, his/her conceptions and attitudes about health, personal resources that can allow the treatment, community resources that can allow the treatment, the disease perception and the practices for personal health. The obstacles at supplier’s level have been associated with supplier’s features: habituations and attitude. The obstacles at system’s level were associated with system’s characteristics, which mainly are the organization processes of the system.

The barriers can come the same to the patients, to the services suppliers and to the health care organizations, in other words to the health system. Therefore:

- in the patient's level there are barriers like the ethnicity, the sex, the incomes etc;
- in the supplier's level there are barriers like the aptitude, the attitude, the sex etc.;
- in the system level there are the organizational factors, the structural factors.

From the great number of potential barriers we have chosen to quote those regarding population's or patient's features, the behavior for the health status (the personal attitude), the results gained in health care domain (the supplier's specialty) and the environment (the organizational factors in health care system).

2. Patient's level

If the patient's expectations or convictions are not according with what the care supplier is offering, here may appear obstacles in accessing health services. As well, these obstacles may appear when the expected result is not according with the treatment applied. The lack of a health insurance may lead to the impossibility of accessing health services and the lack of knowing the language may incapacitate the communication with the practitioner.

Another type of constraint which affects in certain circumstances or just a proportion of patients, especially from a socio-economically point of view, is irregular public transport; when there's no need for public transport (the patient has his/her own car), an irregular interurban transport does not act as a barrier more. Only in cases when public transport is a necessity, then it acts as a barrier preventing the patient to reach the medical help.

The marital status can be a potential obstacle accessing health services, though the marital status is more a need predictor, but marriage has represented a decisive factor to impulse the addressability to health system between ethnic minorities. The marital status predictive power was due to the fact that pregnancy and child birth are the entrance point in the health care system.

The education level can act as a barrier when accessing health care services, not knowing what politics and health publications are saying.

Socio-economic status may be a barrier when accessing health care services and sometimes communication deficiencies can appear between the ethnic patient and the services supplier because of the social status (Shepard, 2007). This problem has indeed an aversive effect over the patient's perception about using health care services.

Living conditions can act as a barrier, for example for pregnant women living in a neighborhood close to the drug dealers, which is an insecure environment; even if there are medical facilities in this area, the addressability is very low. In order to ease the access to health system for these women, the social protection and security must be increased, especially for ethnic women. The precarious health state due to drug dependency may be seen as a barrier against

prenatal health care; for example the drug consumers prostitutes which are pregnant get medical help against drug dependency but do not get medical prenatal assistance, because the medical facilities for drug consumers do not have this type of services.

Food customs inconsistent with diet medical recommendations, like traditional foods, can act as a potential barrier; the individuals who are regularly eating traditional high sugar and fat food cannot accept a low sugar and fat diet, about which they say it is tasteless und unappetizing.

The lack of familial support mat act as a barrier against individual health care. Clearly, the family support in patients of ethnic minority is beneficial for emotional backing. The family can offer company, assistance, stability, even when this support is seen as unconstructive in cases where collective family responsibility has priority over individual needs.

Not recognizing the patient's medical needs is another barrier to be overcome, so it can have serious consequences, the patient may not receive optimal medical care, e.g. in pregnancy. Patients from ethnic minorities believe that the mandatory participation in prenatal care is necessary only when there are problems with pregnancy.

The ethnic patient's cultural perceptions in disease describing may act as a potential barrier because of a dissimilar expression. Ethnic minority group may present classic symptoms in a different way, which may lead to a false diagnostic.

Lack of cultural knowledge is also a barrier, because cultural knowledge about traditional family patterns and values are considered essential for the provision, promotion, disease prevention and health care. Neglecting the influence of the non-involved family, the barrier appears in some ethnic minority patients who maintain strong links with traditional family values and traditional family patterns. This type family does not consider their own individual in a lower value, the main focus and the main purpose entity is the family, involving strong obligations of loyalty and commitment to collective responsibility, to maintain family unity. All family members have a duty to maintain this status throughout life, in the hierarchy of a traditional family where the model of the father rules: he is usually the strongest member of the family, takes most of the major decisions and provides financial and emotional stability, thereby protecting family of potential hazards. Therefore, it must be included in discussions about treatment of other family members (Atkinson, Wilson, 2007).

Denying the aspect of spirituality and religion for some patients by ethnicity may act as a barrier, because such influences can affect human welfare in terms of reporting to an essential element in their lives, especially of some immigrant women, which allowed them to face life with a sense of equality.

The sojourn period indicates diverse results. Some studies show that a short period may act as a barrier. The shortness staying period is a strong predictor for the behavior in seeking medical help and for the attitude about medical care. The new incoming people need education about how and when to use medical help.

They are as much vulnerable and limited in accessing medical care services as those without medical insurance, regardless of their insurance status.

The low cultural level may be restrictive and may act as a potential obstacle when addressing to medical care services. The acculturation and the familiarization with western health care system may help ethnic minority patients to gradually cope with western values and practices, together with their traditional health care ways. Hypothetically at least, high acculturation levels are reported as a strong predictor for ethnic patients to join for a long term with the medical care facilities.

Lack of resources or poverty can become a barrier to health care as the economic situation affects people's lives and their ability to receive medical care when there is no financial support.

Lack of time available because of work or family commitments can act as a barrier, and stressful situations lead to banning the use of health care or prenatal care for mothers and newborns. Regional disadvantages can act as a barrier to the use of health services, urban-rural and urban-suburban conflict shows that those living in remote and less populated areas, where are no or very few suppliers of medical services. It emphasizes a negative effect on health services offered, but increased availability of outpatient services allows an increase in the number of patients (Adler, Newman, 2002).

Another impediment that affects not only minorities, but some of us is health insurance, for those vulnerable socio-economic price of health services being a barrier, so that if a health service is not covered by health insurance or is only partially reimbursed, in the socio-economic group are vulnerable, both members of the ethnic majority and ethnic minorities. Because of low levels of education, social and economic status, and because of low wages and lack of other compensation funds people cannot afford a decent care, adequate and convenient for physiological status.

We can see that not only the circumstances differ greatly, but they differ mostly for ethnic minority patients, even when the reasons for migration and immigrants' expectations in the host country are similar, there may be differences evident in their attitude in a given situation. Personal attributes, such as geographic region of origin, family size, marriage status, standard of education, occupation and social class are factors that can seriously affect the patient's attitude and his ability to cope with health problems. At the same time we must understand that the views of ethnic minority people and their evaluations of medical experience are subject to constant adjustment due to changes in their social situation. Medical care from their own experiences, in consequence, includes the barriers which impede health services usages, but there are today aspects to adjust (The Royal College of Surgeons of England, 2003).

3. Supplier's level

The lack of linguistic local qualifications can act as a barrier, being an important factor which prevents from using medical care services because it jeopardizes an efficient communication between the ethnic patients and medical care personnel. Considering that most conversations and instructions are in the local language, the patients are feeling ill at ease looking medical assistance. Ethnic minority patients are incapacitated from addressing to medical services because of their inability to express their own feelings, due to the existence of some difficulties of language and knowledge. The impossibility to communicate in their native language lead inevitably to a discrimination; the lack of a common language allows any expression of feelings and emotions to ask questions or to represent themselves or their family. This is obvious also when the medical personnel ignores the patient and keeps communicating with another member of his/her family.

Limited language skills have a negative impact on patient's confidence. They produce extra stress, besides the emotions and discomfort that often accompanies medical advice. Language difficulties can have an adverse effect and the patient's ability to understand the proposed treatments and their paths of attack. They prevent the doctor's trying to obtain the patient's medical history because the patient's ability to understand what it is prescribed is essential to prevent any misunderstanding with regard to obtaining consent for medicines and medical treatments that could pose a risk.

Authoritarian communication style of health care provider can act as a barrier, how to confront the health care staff to who address ethnic minority patients may lead to discomfort (e.g. when references are made to schedule routine and other forms of non-compliance). Another example is the fear factor generated by the medical staff, which touches those who are not attending obstetric clinics and will not be assisted at the birth.

Undiplomatic style of transmitting information and how they are expressed may act as a barrier; the prognosis, delivered directly, and the use of strict medical terminology can cause discomfort to ethnic minority patients.

Common impersonal approach of the patient is also a barrier. For certain groups of ethnic minority patients a formal and impartial approach from the care provider can discourage use of available health care facilities. In addition, recruitment and retention of study participants to treatment have embarrassing results, because these patients are waiting from professionals a dignified approach, which includes personal use of a formal, understandable and knowable language. So, for them, a dignified and personal approach means sympathy and respect, especially for male figures and older people. It encompasses an approach with mutual responsiveness which in the end will receive the gratitude for professionals who treat them.

Being bilingual, without the necessary skills to play fully the views of others, the existing barrier occurs when doctors are facing substantial difficulties

bilingual language that can affect patient communication. Although some doctors are able to treat patients without translators, interaction complex clinical problems requiring advanced levels of language fluency for an effective patient-physician communication. Language, together with matching ethnicity between patient and doctor were found as factors that reduce emergency visits.

The reference system can also act as a barrier, because some patients feel comfort without monitoring procedures, which prevent them from obtaining adequate care. For example, in their own country they can go directly to a health professional, sometimes it encourages them to avoid the reference system using the services of their own country. Such decision is based on the disease and the effect of previous treatments, such we should consider the treatment that they received from nurses in their own country and influencing their attitudes toward the available services in the country of immigration.

About the complex procedures of admission a - they can act as limiting factor, therefore, simplification of admission to a program of flexible hours, especially for immigrant patients, was successful in adapting health services to the needs and expectations of these patients. Difficult process of getting an appointment with the doctor and the long waiting times can act as a barrier and therefore, difficulties in accessing services from existing health problems that persist today and the lack of programming in a reasonable time.

Long waiting times for scheduling patient's visit to the clinic to prevent use of the services is entitled. Ethnic minority patients must wait longer for a visit to specialist physicians than their majority counterparts and because members of ethnic minority groups are more concerned about symptoms and more likely to seek immediate assistance, for them or for their children, it is possible that barriers to be more related to the use of health services than their approach (Ross, 2001).

4. System's level

Lack of service availability or lack of knowledge about services available to someone can act as an obstacle to the use of health services, such as ethnic minority patients do not know about the function and availability of personnel other than the primary care physician, and so the use of primary health care will inevitably be limited and inadequate for its needs.

It was also reported that the use of diagnostic services (e.g. breast cancer or cervical cancer) is low among ethnic minorities, lack of general knowledge about such services and a different understanding about the disease prevention. However, immunization rates are generally higher among ethnic minorities, which contradicts the conclusion that ethnic minorities lack of knowledge about prevention services. High medical costs may act as a barrier which prevents the immigrants who still have no right to grant, as newcomers, to use the Services of Medical. Some people may have difficulty paying medical bills when they have to follow certain therapies. For example: therapy of high-cost and high-risk category, with special foods and dietary products, is expensive. Irregular public transport, both in cities

and suburbs, combined with the long journey, is still a barrier to healthcare for minority ethnic patients.

Treatment programs that serve a relatively small percentage of patients ethnic minorities and lack of compliance between patient and physician may act as a barrier. Programs serving minorities between patient and health care provider can make available their care by participating in programs targeted to minority ethnic groups. Such a health care program, where the relationship between doctor and patient worked, compared with patients who were not suitable on the basis of ethnicity and language, had at the end better results.

Misuse of child care includes management plans for ethnic minorities at a reduced level, decreasing possibility for assigned requirements, reduced possibility for sorting and missed vaccination. Indeed, for some ethnic minority groups to obtain an appointment from a GP is more difficult because of difficulties of access, compared with the majority population; these groups are recognized frequently reported with their symptoms resolved unsatisfactory. Consultations and treatments that can act as a barrier ends abruptly and cause a feeling of distrust and fear, so the patient feels he/she is not taken seriously, which undermines patient's confidence in his/her doctor. Trust is essential in improving relations between the two partners in health care, the patient and the physician. Ironically, in some cases, these short-term treatments have made health care more accessible to minority ethnic patients.

Discrimination can act as a barrier (and this has a negative effect on mental health (discrimination combined with perceived discrimination), placing ethnic minority group at a higher risk and more frequent use of mental health services. Some ethnic minority groups, in inpatient mental health units, are four times more likely to be compulsorily admitted than those from the ethnic majority. This finding is consistent with research done in the field of forensic and prison services, where dissatisfaction or fear of mental health services can be the main reason for admission.

5. Characteristics of the coordination-communication function

Theoretical Model of Behavioral Health Services Usage " Andersen's case shows the potential obstacles concerning access to medical services for ethnic minorities, condensed into three main groups: patient level, "level supplier" and "level system". The model presents a complete set of variables important enough to study the use of health services by the general population or ethnic minorities, and applying the results of the model brings a better understanding of the health behavior of ethnic minority population. Andersen's model explains just what is happening and why patients choose not to behave in one way or another, but nevertheless criticized in the literature for several reasons. Here are two examples, which are not included in this paradigm features: decision-making process leading to the current use of services and lack of socio-psychological characteristics of the processes involved in perceiving and evaluating health and their response (Propper C., Eachus J., Chan P., Pearson N., Davey S., 2005).

Many barriers are general problems that can affect us all: long waiting lists that prevent patients from using services they are entitled, and some potential barriers affecting us, not only in certain circumstances and affects not only some of us, especially on the socio-economically vulnerable level. As we have seen, a barrier that may affect the access to medical facilities is the irregular public transport; the public transport is often absolutely necessary, when there is a medical problem, regardless of ethnicity.

Ineffective communication is another major obstacle to the partnership that should exist between patients and practitioners. The relationship between an ethnic minority patient and a doctor is essentially vertical because of differences in language at a level uniformity forced by the social, cognitive and institutional behavior. This gap that separates doctors and patients invariably favors the physician rather than patient. Parents of child patients from ethnic minorities reported communication with their children's doctor as imperfect, compared with parents of children from the majority society (Naylor M., Bowles K., Brooten D.,2008). Differences in the experience of these parents were associated with differences in mutual understanding. Problems associated with ineffective communication caused by language difficulties often remain unresolved, leading to frustration, patients feeling neglected and abandoned.

In contrast however, it was reported that, due to language difficulties, the problems seemed smaller in some minority ethnic groups, where the ability to speak the local language is more than up to 80% of members of these groups, which made that they could be registered to a doctor of their own ethnic groups speaking the same native language.

The attitude of disapproval facing the translation by an interpreter, can act as a limiting factor. For patients of certain ethnic minority performers are usually friends, husband (wife), children or other family members. Sometimes, for lack of competence necessary to fully communicate their message, this may be insufficient to explain and correctly understand the message of the person you want to represent. The presence of a professional interpreter can improve the quality of conversation and, at the same time, provides lucid explanations to the patient about his case, hereby improving patient-doctor dialogue and patient's report (Harrison S., Pollitt C., 2006).

But there are suspicions from patients, that the interpreter can distort the truth; the suspicion arises from the abruptness with which the dialogue forwards the interpreter translating the language of patient. Patients cannot directly involve in translation accuracy, translation distorted again by the reluctance of patients to disclose to the interpreter confidential information.

Prospects for future-oriented focus on individual achievements can act as a barrier, such as future prospects in modern societies are at hand and are setting appropriate objectives with inherent aspects of the health care system. Examples of setting objectives are:

- the care plan;
- the treatment and the discharge;

➤ the implementation of quality standards, improvements etc.

Patient's concept of individual achievement is another major factor. In many Western societies the role of family and community is second to individual needs and objectives. Personal property is encouraged and efforts to achieve financial security are very much appreciated, as compared to other cultures where these characteristics are viewed differently, the ultimate goal being achieved by honor family and community through generosity, hospitality and traditions compliance (Bauer, 2007).

Differences between patient and physician beliefs and beliefs about health, explanatory model of health, illness and healing methods, can act as a barrier to the detriment of minority ethnic patients. Ethnic minority patients may have one of the following sets of models of faith - the belief that some Western concepts could be defined holistically (a holistic view of integrating body, mind and soul) - the belief that personal problems and illnesses are caused by factors external, such as family relationships rather than internal influences, such as childhood experiences - the belief that the external causes are, by their genesis, natural or supernatural. Natural in this context, means the so-called "act of God" (e.g. tsunami), the supernatural being "karma" (good deeds or bad consequences in another life), magic, witchcraft and voodoo - convinced that the concept of health (mental) should include religious and spiritual dimensions, with body size and mental illness; and so the admission to a psychiatric hospital should be avoided (Eshiett M., Parry, 2009).

The literature suggests that there is no evidence to support the traditional patterns of belief and traditional practices (cultural attributes of people) would have a negative effect on access and utilization of health services. Negative perceptions and attitudes towards health services and their staff can act as an opposition side, which is particularly evident when ethnic minority patients are skeptical about the benefits of health services or to see their benefits.

The application of health services is heavily influenced by the consumer preferences and willingness to "buy" health care. Ethnic minority patients may see health care providers as a group of distant strangers, which may make them to forbear in asking relevant questions about treatment, care instructions etc., an attitude that shows the abstract form of subordination (Commission on macroeconomics and health, 2007). Understanding different body functioning, such as metabolism and nutritional factors, limited ability to interpret food labels, can also act as a barrier to the compliance with a dietary behavior.

Lack of working with legal papers in the labor hierarchy may act as a barrier, because it may have a limited impact on the utilization of health services or sources of funding. Patient- immigrants fear that health providers are associated with law endorsement agencies such as police and government. Consequently, these patients, with or without chronic sickness, consider that their chances of obtaining citizenship can be jeopardized if they seek help from the health system, the state or the government (Carpenter I., Gladman J., Parker S., Potter J., 2007).

The opportunity to purchase health insurance can act as a barrier to prenatal care and, in order to prove that they qualify for such medical benefits,

ethnic minority patients must first submit a significant number of documents and personal information, which include proof of residence, annual income, together with the required documentation that makes the main goal. Even when ethnic minority patients are eligible for state funding, there is a risk that they may not be familiar with the rules and eligibility purposes in this particular context.

Lack of health insurance is another impediment into seeking or receiving health care and therapy. Insured status is the determining factor in relation to the type and amount of care and binds with the person's vulnerability on payment limits and cost of health care. Even when someone is insured, he/she may face barriers, if particular services are not covered or deductibles, and are set at levels inaccessible. Among ethnic minority patients, the percentage of uninsured is higher than among the population.

Non-professional advice and the lack of regular source of care can act as barriers which obstruct minority ethnic patients and their children. Health practitioners believe that their patients are strongly influenced by myths and the recommendations from friends and family members are not always true. As a result, patients resist medical dose increases, based on the misconception that their illness might worsen or that there will be complications. It was reported that having a regular source of care is one of the best indicators to use preventive health care (Mueller K., Patil K., Boilesen E., 2001).

Different perceptions of ethnic minorities on the severity of symptoms may act as a barrier, such as the validation of symptoms influences the degree of urgency in seeking care. Compared to most people, ethnic minorities are concerned with certain symptoms (e.g. chest pain), thus are more likely to seek immediate assistance when other ethnic minorities are more likely to seek emergency assistance when their child is light sick. Although this is not a barrier to the obvious meaning, it affects the workload of the health care provider.

Means of self-medication and traditional medicine prevents acceptance of health services by ethnic minority patients and can act as a barrier, but we have not found the evidence to suggest that traditional health practices had a negative effect upon the access and the use of preventive health services. Intrusive medical procedures and standard practices applied with insensitivity upon the patients can act as a barrier into using health services. Making certain medical tests and examinations may act as a barrier when ethnic minority patients are frightened or fearful of the unknown.

A diagnosis given, taking into account only to the grievance, may be considered as an obstacle to treatment the health problems. It happens often when in the country of origin of ethnic minority patients, the doctor evaluates the patient more from a holistic perspective. Evaluation of exploring family ties, along with social and other health problems may be taken into account. To supplement conventional treatment, his/her questions may include natural healing resources that were used: mineral water baths, sulfur baths etc.

Poor communication skills and unfair practices may themselves become barriers. If your doctor is unable to reach a correct diagnosis, the result of

consultation may be wrong, being influenced by patient characteristics (including social class) and provider characteristics. It is not easy to arrive at a correct diagnosis when symptoms of cultural perceptions may differ, such as an erroneous perception of the physician can direct the patient to an inadequate treatment. It may be a tendency of family when the doctor sends patients to another specialist if it is difficult to understand the symptoms of ethnic minority patients.

People from certain minority group scan through more complex steps to achieve mental health treatment than the majority ethnic group. Some of these differences could be explained by changes in initial assessments and the involvement of primary care. These patients are less likely to be referred to specialist services because of non-recognition of psychiatric problems, labeling and methods for managing problematic behavior have shown a significant differentiation based on ethnicity, such as assigning labels. The diagnostic and the reference of the patients to other specialists led to ethnic differentiation in the use of mental health services.

Inappropriate care behavior and stereotypical attitudes towards ethnic minority patients can act as a barrier and they can have a negative effect, because ethnic minority patients are not fluent like the majority and often they are treated differently than other patients. It is known that the use of racist language explicit in the medical staff, whose hostile attitudes are clearly influenced by social status and ethnicity of those in their care.

Sources acknowledged as disparities are local variations in clinical practice and service provision, contextual effects (e.g. a lower ethnic density), may lead to higher rates of schizophrenia, which requires greater use of services, such as some minority ethnic groups were more likely to be in contact with mental health services than members of most ethnic; the main reason can be that the care providers fear the perceived risk.

Doctors do not really agree with the role of translators, translation preferred as coherent and concise and only a small part prefer interpreters during the consultation, such as certain cultural aspects in the definition of somatic and psychiatric problems are substantial. A patient-provider poor intercultural communication leads usually to unsatisfactory arrangements (Oliver A., Mossialos E., 2004).

Ignoring the existence of parallel sets of beliefs and practices can become a barrier to the use of health services, because faith and commitment does not prevent the perception of traditional practices (learned) about the fact that health services may be beneficial. Ethnic minority patients may accept the same sets of beliefs and practices on one hand, and traditional health practices, on the other hand. Strictness medical paradigm can act as a barrier, even if it is based on bio-medical explanatory model of health, the disease and methods of healing. And why some ethnic minority patients are dissatisfied with this approach and how much the influence of culture and religion over health and healing, it is not recognized (Kleiman, 2006).

If there is a lack of common language of communication, ethnic minority patients seem unable to convey their inner feelings and they need the confidence to put important questions, especially when they are admitted to hospital and are separated from their families and communities, feeling a deeply marked isolation. One can feel the ignorance of other patients and medical staff; in such cases one needs the religion as a source of support and calls for such services when one feels neglected and helpless.

A consumer approach that would be technical and an impersonal attitude of the physician can act as a barrier, which makes the patients feeling that doctors have forgotten their responsibility for patients' health. Patients need assertiveness against ethnic minority where the elderly are most vulnerable. There are complaints that the doctor treats patients in a too formal way and the emotional attitude is contrary compared to the relationship with the patient used in his/her native country.

Impersonal communication through printed materials and other forms of media can act as a barrier and in this case is preferably a personal and direct contact with minority patients, spouses, friends and family rather than on printed materials or other forms of mass media, which seem to discourage ethnic minority patients to find out more information about the types of services available (International Council of Nurses, 2003).

Conclusions

So, there are potential obstacles which usually affect ethnic minority patients, who retain their culture and traditional explanatory models, but there are also "cultural differences" even between explanatory models of patients and doctors with the same cultural background. For example, the causes of cultural differences between patient and doctor are: social class, education, gender or generation. The potential barrier between two members, apparently the same culture, can be caused by the difference in perception of clinical reality, perception in reality that is perhaps secular about the illness (a subjective certainty), other than the doctor's clinical reality, which is represented by the professional assessment of the disease (objective certainty).

Barriers can only be understood with reference to the specific situation in which the individual patient is; there are contexts that differ, e.g. in some countries, the health system uses a reference system, in others not. Ethnic minority patients may see health care as a luxury rather than a necessity, so any reason, which directs patients to specialized services, is also an obstacle. And waiting lists schedules creates barriers and is therefore important to identify a specific context obstacle to the use of health services.

Lack of appropriate translated information and educational materials can be disruptive, especially when information and education are critical to the immediate needs of the patient. Information and education of ethnic minority patients must take into account the different expressions and different levels of

literacy synchronous within ethnic subgroups, which must recognize the value of traditional practices, to explain technical procedures and to justify them, to respond to the concerns reported by the patient and to inform them about their legal rights (World Bank, 2010). Linguistic and cultural translations are seen as problematic, especially in light of different sets of values which relate to methods of health care, treatment and cure of the diseases.

This analysis shows that there are potential obstacles to the use of health services among ethnic minorities, which are administered in many countries and used by patients of many different ethnic minorities. A large number of potential obstacles were identified, ranging from country to country and what is an obstacle to an ethnic group is not necessarily an obstacle to another.

This review aims to increase awareness of the many potential barriers, so that the issue of barriers to care for different ethnic minorities becomes transparent. Contextualize the content provider-patient interaction, taking into account barriers to development, requires a need for quantitative research, to determine whether a hypothetical barrier achieved its full potential or if a potential barrier remains as it is and therefore does not adversely affect ethnic minorities in its entirety.

In conclusion, there are many different potential barriers, some of which are related to ethnic minorities, and others are related to the particular situation of each patient and is a subject to constant adjustment, generalization is not applicable.

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