

PROBLEMS REFUGEES FACE WHEN ACCESSING HEALTH SERVICES

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Refugees settling in western countries face many difficulties in accessing effective health care. These have been widely documented by health service providers,^{1,2,3,4} and in studies of resettled refugee populations.^{5,6,7} This article describes the particular problems that refugees face in accessing effective health care and some of the ways in which health services can respond.

BACKGROUND

Some 600,000 refugees have settled in Australia since the end of World War II.⁸ Of the 12,000 people who receive humanitarian visas each year to migrate to or stay in Australia, 40 per cent settle in NSW. NSW is also home to over 2000 people released from immigration detention centres on Temporary Protection Visas, and to an uncertain number of asylum seekers who are living in the community while their applications for protection are processed.

Refugees, and people of refugee-like background, are recognised as one of the most vulnerable groups in NSW society.⁹ They have specific health care needs—which arise from the adverse effects of conflict and forced exile—with experiences of persecution, psychological trauma, deprivation, unhealthy environmental conditions, and disrupted access to health care.

Some specialised services exist to meet the health needs of those of refugee background: counselling services for survivors of torture and refugee trauma exist in every state and territory in Australia. However, the majority of health care for refugees occurs within mainstream services. Many of the barriers to refugees accessing adequate care are similar to those experienced by the broader migrant community and other marginalised groups. These include: barriers to attending existing services, such as language, cultural and financial barriers; reduced ability to trust service providers and to negotiate the health system; and, at times, the unavailability of effective health care. However, for refugees these barriers are accentuated by their prior experiences and manner of coming to Australia.

BARRIERS TO ATTENDANCE

Unlike other migrants from non-English speaking countries, English language proficiency does not play a part in the selection of humanitarian entrants. They are likely to have a greater reliance on bilingual health care providers and interpreters for communication during health care. These resources are often lacking within (or for) small and emerging refugee communities—for example, among the Dinka people from southern Sudan. While a free telephone interpreter service exists for private medical practitioners, many doctors are reluctant to use it.

Studies with refugee populations in Australia,¹⁰ and in the United States,¹¹ have found language to be a significant barrier to refugees accessing health services. Language difficulties in general practitioner surgeries in the United Kingdom have led to refugees being turned away.¹² Language barriers can also result in miscommunication, misdiagnosis, and lack of appropriate follow up.^{13,14}

Financial constraints are almost universal for people who arrive as humanitarian entrants and who have yet to find employment. Few will own a car and the cost of public transport can influence decisions about accessing care. Cost can prevent referral to services not covered by Medicare, such as allied health providers, or to private specialists who charge a fee above the Medicare rebate. These patients have to attempt to access these types of care through hospital outpatient services. Limited finances also make the use of private dentists prohibitive. Most newly-arrived refugee groups have significant oral health care needs and their reliance on public dental services is problematic.

Limited trust of health service providers can inhibit some refugees from accessing health care.^{1,14} Such mistrust may arise from experiences of human rights abuses at the hands of government authorities,¹⁵ and cultural and language barriers between a refugee and health professional.^{16,17} Fear is accentuated for those refugees who have experienced torture in which health professionals have participated.¹⁸

People of refugee background often come from countries with vastly different health systems. Access to care for some refugees is therefore hindered by a lack of familiarity with available services.¹⁹ Community consultations with refugee populations living in NSW have confirmed this, and others, as significant issues for recent arrivals (NSW Refugee Health Service and the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors [STARTTS] unpublished reports).

NON-AVAILABILITY OF EFFECTIVE HEALTH CARE

Gaps in health service provision

Newly arrived refugee patients can have complex or multiple health problems. Inadequate reimbursement—to general practitioners for the additional time required to provide medical care for patients with special needs—can provide a disincentive for providing comprehensive care.²⁰

Specialised services targeting refugees are located in major metropolitan areas. Despite outreach and training strategies, these services are less available to those humanitarian entrants who settle in rural and regional areas of NSW.

There are specific groups within the refugee population with particular health issues for whom health service provision is yet to be developed. Examples include young

refugee people,²¹ and the aged and second-generation refugees.²²

A proportion of asylum seekers living in the community are not eligible for Medicare.²³ This is a significant gap in service provision that affects, in particular, pregnant women and others needing hospitalisation.¹⁷ Holders of Temporary Protection Visas (that is, people released from immigration detention centres) are not eligible for certain Commonwealth-funded health services such as free interpreting in private doctors' surgeries and limb prostheses.

Appropriate health care

Effective care may be impeded through health professionals having incomplete skills to detect and manage unfamiliar diseases among refugees.^{14,24} This can also occur through staff failing to adopt health care techniques that accommodate past trauma and human rights violations.^{14,25} Hospitalisation or other health service interaction that is not conducted in a sensitive manner, or that utilises clinical procedures reminiscent of abuse (for example, electrocardiography) may retraumatise those under care.¹⁵ Racism and discrimination have been shown to reduce access to care in some marginalised groups,²⁶ and is likely to affect refugee groups as well.

HEALTH SERVICE RESPONSES

Health services have attempted to increase refugees' service utilisation through community education and outreach;^{13,27} employing bicultural workers to act as service brokers;²⁷ adopting strategies to increase referrals from peers,² the community,²⁷ and social welfare agencies;¹³ and collocating health services with other frequently used services for refugees.²

Multicultural health services in NSW use many of the above strategies to promote access and appropriate health care for refugees. The NSW Refugee Health Service collaborates with STARTTS on education and support around refugee health issues for the staff of area health services and general practitioners. The potential role of primary care in reducing inequity of access and quality of care has recently been described.²⁸ Other strategies used include advocacy regarding service gaps, informing relevant agencies about referral pathways, nurse advocates to assist individual access, and community education about the health system in NSW.

REFERENCES

1. Downs K, Bernstein J, et al. Providing culturally competent primary care for immigrant and refugee women: A Cambodian case study. *J Nurse Midwifery* 1997; 42(6): 499–508.
2. Fowler N. Providing primary health care to immigrants and refugees: The North Hamilton experience. *Can Medical Assoc J* 1998; 159(4): 388–91.
3. Le Feuvre P. How primary care services can incorporate refugee health care. *Medicine, Conflict & Survival* 2001; 17(2): 131–6.

4. Sinnerbrink ID, Silove M, et al. Asylum seekers: General health status and problems with access to health care. *Med J Aust* 1996; 165(11–12): 634–7.
5. Cheung P, Spears G. Illness aetiology constructs, health status and use of health services among Cambodians in New Zealand. *Aust N Z J Psychiatry* 1995; 29(2): 257–65.
6. Stephenson PH. Vietnamese refugees in Victoria, BC: An overview of immigrant and refugee health care in a medium sized Canadian urban centre. *Soc Sci Med* 1995; 40(12): 1631–42.
7. Phan T. Investigating the use of services for Vietnamese with mental illness. *J Community Health* 2000; 25(5): 411–25.
8. Department of Immigration and Multicultural Affairs. *Refugee and Humanitarian Issues: Australia's response*. Canberra: Commonwealth of Australia, 2001; 11.
9. NSW Department of Health. *Strategic Directions in Refugee Health Care in NSW*. Sydney, NSW Department of Health, 1999. ISBN 0731340795.
10. Biggs B, Skull S, et al. *Assessment of the health and vaccination status of recently arrived immigrants in Australia*. Melbourne: Victorian Infectious Disease Service, Royal Melbourne Hospital and Department of Medicine, University of Melbourne, 2000; 3.
11. D'Avanzo CE. Barriers to health care for Vietnamese refugees. *J Prof Nurs* 1992; 8(4): 245–53.
12. Jones J. Asylum seekers in UK receive poor health care. *BMJ* 2000; 320(7248): 1492.
13. Kemp C. Health services for refugees in countries of second asylum. *Int Nurs Rev* 1993; 40(1): 21–4.
14. Moreno A, Piwowarczyk L, et al. Human rights violations and refugee health. *JAMA* 2001; 285(9): 1215.
15. Sharpe I. Refugees and torture: The new global epidemic. *Australian Nursing Journal* 1996; 4(6): 18–9.
16. Allotey P. Travelling with 'Excess baggage': Health Problems of Refugee Women in Western Australia. *Women's Health* 1998; 28(1): 63–81.
17. Harris MF, Telfer BL. The health needs of asylum seekers living in the community. *Med J Aust* 2001; 175: 589–593.
18. British Medical Association. *Torture, Cruel and Degrading Treatment. The Medical Profession and Human Rights: Handbook for a Changing Agenda*. London: British Medical Association, 2001; 56–84.
19. Portes A, Kyle D, et al. Mental illness and help-seeking behavior among Mariel Cuban and Haitian refugees in south Florida. *J Health Soc Behav* 1992; 33(4): 283–98.
20. Shorne L, McCaul M, et al. 'Beam me up Scotty': Trekking from Women's Health to General Practice. *New Doctor* 2002; 76: 22–25.
21. Coventry L, Mackenzie D, Guerra C. *Wealth of all Nations—Identification of strategies to assist refugee young people in transition to independence*. Melbourne: Royal Melbourne Institute of Technology, 2001 (unpublished).
22. Centre for Refugee Research, University of New South Wales. *The Refugee Convention: Where To From Here?* www.crr.unsw.edu.au/refugee%20Conference%20Report_final.pdf.
23. Smith M. Asylum seekers in Australia. *Med J Aust* 2001; 175: 587–589.
24. Weinstein HM, Sarnoff RH, et al. Physical and psychological health issues of resettled refugees in the United States. *Journal of Refugee Studies* 2000; 13(3): 303–327.
25. Mollica RF. Assessment of trauma in primary care. *JAMA* 2001; 285(9): 1213.

26. Gruen RL, Bailie RS, et al. Improving access to specialist care for remote Aboriginal communities: Evaluation of a specialist outreach service. *Med J Aust* 2001; 174: 507–511.
27. Cunningham M, Silove D. Principles of treatment and service development for torture and trauma survivors. *International*

Handbook of Traumatic Stress Syndromes. Wilson JP, Raphael B (editors). New York: Plenum Press, 1993; 751–762.

28. Harris M, Furler J. How can primary care increase equity in health? *NSW Public Health Bull* 2002; 13(3): 35–37. ☒

THE HEALTH CARE DISADVANTAGES OF BEING OBESE

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People who are obese are disadvantaged socially—in public places, in employment, and in health care.^{1–2} Many obese people are afraid of approaching health professionals and attending health facilities. Problems of access and lack of suitable facilities for obese people are a problem; however, the greatest impediment is the fear of encountering judgmental and discriminatory attitudes from health professionals about a patient's obesity.

Because of an increased risk of medical illnesses such as type 2 diabetes mellitus, hypertension, cardiovascular disease, stroke, sleep apnoea, gallbladder disease, and osteoarthritis,³ the need of obese people for medical care is great. However, the recommendation of weight loss as a primary therapy may compromise and delay the management of significant medical problems. This article describes the attitude of some health professionals towards obese patients, obese patients' views about health care, myths and realities about obesity, and suggests how health care for obese patients can be improved.

ATTITUDES OF HEALTH PROFESSIONALS TOWARD OBESE PATIENTS

Many studies have described how health care professionals may adopt a negative attitude towards obese patients.^{4–5} Medical practitioners and students often regard obese patients as ugly, sad, lacking in self-control, and difficult to manage.^{6–8} Nurses may be uncomfortable with obese patients and prefer not to care for them.^{9–10} Most health care professionals believe that obese patients are responsible for their obesity.¹¹ These negative attitudes are readily perceived by obese patients.¹²

Health care professionals are often aware of poor health outcomes in the treatment of obesity; but, generally, they do not hold themselves responsible for the failure of positive health outcomes. While some health care professionals recognise the intrinsic difficulty of treating an obese patient, there is still a tendency to blame the patient for their failure to be slim.^{13–17}

OBESE PATIENTS' VIEWS ABOUT HEALTHCARE

Medical publications have given little attention to the personal experiences of obese people with health care

services. Internet sites dedicated to acceptance and support for obese people often display messages from individuals who have experienced discriminatory treatment in health care settings. A selection of messages posted on the *Big Beautiful Women Downunder* Internet site at www.dksc.ws/bbw, or on linked sites, are quoted here to give an indication of some expressed concerns.

Consultations with general practitioners, specialists, or clinics

'Without knowing my background, eating or exercise habits [the doctor] assumed me to be both slothful and a compulsive eater. [The doctor] showed no willingness to believe me when I explained I was neither. Like most fat people I have an almost encyclopaedic knowledge of the carbohydrate, fat, and caloric content of food.'

'I was perched half naked, legs dangling unsupported on your high narrow examination couch, trying to hold a tiny gown modestly over my large unfettered breast. I was far too embarrassed to be anything but hypertensive.'

'Over the past seven months I have been to two obesity specialists ... and neither of the waiting rooms had seating suitable for larger people.'

'All we really need are chairs without arms! Whenever I go for medical appointments, every single chair has arms.'

Hospital admission

'Gowns that cover one half of my body, beds so narrow you want to be careful not to roll over, thin mattresses that squish to almost nothing under my weight, and the best part of all, those damned bed pans.'

'Many [health professionals] can't help absorbing the prevailing attitudes of our society, which basically assume that if you are fat you are necessarily unhealthy and that you obviously haven't tried to do anything about it—which is generally incorrect.'

'Women's magazines are the cheapest and most convenient form of waiting room literature, and these are generally mildly size-negative at best, and positively feral about [body size] at worst.'

'I haven't seen a doctor for a general check up at any time in my life. I have a strong dislike of being lectured and hectoring and harassed and heckled about weight or treated like a particularly naughty three-year old with a penchant for sweets. I am so afraid [of health professionals] that I