

**Perceived Barriers in  
Accessing Healthcare Services:  
Asylum Seekers and Refugee  
(ASRs) and Service Providers'  
Perspectives**



**REACH**

 INTRODUCTION

This research focuses on ascertaining the perceived health needs and barriers for asylum seekers and refugees (ASRs) in accessing healthcare services within the South East Community Health and Care Partnership (SE CHCP) in Glasgow, both from the perspective of ASRs and the service providers.

Over the past decade Glasgow has increasingly become a multicultural society, as 34% of Scotland's Black and Minority Ethnic (BME) population lives in Glasgow. National Asylum Seekers Support had calculated that there were approximately 6000 asylum seekers in Glasgow. However, this figure does not include refugees—individuals that have been granted leave to remain in the country—or asylum seekers living in private accommodation. Thus, the real number of asylum seekers and refugees living in Glasgow may be far higher than the numbers reported (Scottish Refugee Council, 2003).

Asylum seekers and refugees constitute a vulnerable population and the major cause for this has been attributed to the risk factors associated with pre and post migration. The examples of post-migration factors which emerged as prominent in the literature review for this project also emerged in primary data collection. These included detention, length of asylum procedure, language barriers, discrimination, lack of social support, unemployment and lack of knowledge about the new health care system.

Asylum Seeker and Refugees and their healthcare providers were asked about their perception of perceived barriers to accessing healthcare services and their understanding and knowledge of healthcare services in Glasgow. The findings can tell healthcare professionals about the situation in Glasgow and what still needs to be done to create equal and fair access to healthcare resources for a group with particular problems.

## KEY FINDINGS

The findings presented in the full report distinguish between the experiences and perceptions of ASRs themselves and the health professionals that work with them. In this briefing paper we pull out some of the general points that arise across each. The arguments this research briefing presents are;

- There are issues about how ASRs understand the availability of, and access to free health care in the United Kingdom. The full range of services provided by primary and secondary care services were not widely known. This finding points to a role for service providers and those who have first contact with ASRs in communicating processes we might take for granted.
- The above issues can also be compounded by issues with interpretation, not just the availability of services, but also the cultural interpretations in operation that can affect its quality.
- The experience of being an ASR can also compound access issues when health concerns take lesser priority in the face of multiple problems (such as the progression of asylum cases). ASRs picking up on prejudicial views of them as drain on collective resources can also become a barrier to access.
- Certain areas with high numbers of ASRs have understandably become better placed in terms of knowledge of how to work with ASRs. This can however lead to strain as teams of allied professionals take on the burden of the problems of ASRs at a community level. Professionals additionally take on the role of city-wide experts and often are the first port of call for service providers elsewhere in the city when confronted with problems specific to ASR experience.

## AIMS AND PURPOSE

The study was designed to address the question what do Asylum Seekers and Refugees and healthcare workers (voluntary and statutory) perceive to be the attitudinal and operational barriers in accessing and providing healthcare services for ASRs?

More specific issues included

- What possible barriers are perceived by ASRs in accessing healthcare services within the boundary of the South East Community Health and Care Partnership?
- What are the barriers perceived by service providers within this CHCP?
- What recommendations can be made to the South East CHCP to develop healthcare services that are accessible and sensitive to this community?

## APPROACH AND METHODS

Both ASRs and those providing healthcare to them were asked what they saw as the main barriers to access. A method of triangulated qualitative research was used to allow exploration of topics and space for unanticipated themes to emerge. The initial phase of research was a literature review to scope the background to issues of health access amongst the ASR community. A second phase utilised in-depth interviews with 25 ASRs resident in South East Community Health and Care Partnership. A third stage used focus groups with service providers from both the voluntary (7 individuals) and statutory (9 individuals) sectors.

## FINDINGS AND CONCLUSIONS

The study gained the following understanding of the barriers to accessing healthcare as situated in the circumstances of ASRs.

- i. Knowledge and understanding of available services and how to access them,
- ii. Language and interpretation
- iii. How the experience and expectations associated with ASR status can act as an additional barrier
- iv. Job stress, lack of training on the part of service providers and absence of coordination between services

### i. Knowledge and Understanding of Health Services

ASRs themselves reported that the specific organisation and operation of primary care system in Scotland, with its systems of referrals from General Practice, is not obvious or easy to navigate. This would lead to new arrivals being unsure of what to expect from health services. In the Glasgow context, a written source of information (The 'Welcome to Glasgow' Pack) introduced ASRs to the local system of healthcare provision and access. In many circumstances this was complimented with information given verbally. However, the information reported by ASRs was limited to identifying the appointed healthcare centre and GP for the area they were to reside in. Additional information on the extent and breadth of specific services available on the NHS was not provided.

Healthcare workers provided further evidence that there was an absence of knowledge of the structural organisation within the NHS. However, they also suggested that the absence of free, public provision of medical services in countries of origin may be a contributory factor. Service providers also identified gaps in information provision on arrival as contributing to the problem. It was noted however that with frequent use and increased exposure to the system by individuals, these problems seemed to be overcome

*"For some people it takes a while to understand the system here. Some people think you can just turn up at the health centre and be seen straight away. Don't understand the appointment system, and get really confused when told to make an appointment and come back again. So it is not really explained to people, people are just expected to find out for themselves. They may also not know services are there, and so do not know what to expect from them."*

(Focus group, voluntary sector healthcare worker)

*"When I first have to make contact they are not really aware of what my role is, because they've come from a country where the health service may be very undeveloped in the first place. They are very suspicious of you initially because they think you are a government organisation, so you have to re-assure them that you are an advocate for them."*

(Focus group- statutory sector healthcare worker)

## ii. Language and Interpretation

The barrier posed by language differences for new arrivals in Scotland was anticipated from previous research and knowledge of ASR experiences (Gamell et al, 1993). This study found that language difficulties could combine with limited knowledge of available healthcare to further impede access despite steps made to provide written and oral interpretation services. This would be further intensified in emergency situations when even those with relative confidence in everyday communication in English could find it difficult to understand and answer questions being asked of them and to communicate effectively. There was also evidence of difficulties in accessing interpreters in emergency situations.

For routine consultations there were mixed responses as to whether requiring an interpreter hindered access. Whereas many ASRs felt it slowed the process down, others had found no problems. In some instances, both for emergency and routine consultations, ASRs relied on family members or friends for interpreting; however this was not always seen as appropriate depending on the nature of the condition being presented

*There was an incident when daughter was sick and emergency services were called. They asked so many questions and not being able to understand the question – due to language problems – not being able to concentrate because of the worry, distress and anxiety of daughter being very sick and not being able to answer questions made the experience very distressing”*

**(In-depth Interview with ASR, Participant 11)**

*“Usually my son used to go and interpret for me, but then when it came to female problems I would ask for an interpreter”*

**(In-depth Interview with ASR, Participant 9)**

Both voluntary and statutory healthcare professionals considered language and communication barriers to be major obstacles. Additional to the themes emergent from ASRs themselves, health professionals questioned the quality and availability of translation and interpretation services in certain languages (e.g. Kurdish). Some translated written material, it was felt, failed to inform intended target users in cases where they could speak but not read their own language. An important issue that was raised by voluntary sector providers were incidences when interpreters had omitted information in consultations, with particular reference to an occasion when medical interventions would impinge cultural or religious prohibitions. The voluntary group also raised questions about the adequacy of the process by which someone can become an interpreter and whether it was sufficient for the sensitivity required. Issues stemming from familiarity of community based interpreters were also raised and this may impinge on the perceived confidentiality offered.

*“The doctors said that they may be able to do some treatment, and it was possible to overcome the cancer. The doctor then said he was not able to provide treatment and when asked why, the interpreter said he told the doctor that it is not allowed in Islam, Which is not the interpreter’s job to say that and told the interpreter that afterwards. But the boy did not receive treatment and he died”*

**(Focus group, voluntary sector healthcare worker)**

### iii. The Experience and Expectations Associated with ASR Status

A key theme was the low expectations of services by ASRs, linked to their having a low status and internalising negative media reporting and responses from some sections of their communities of residence. This could lead to ASRs feeling stigma about their status. Against a background of ASRs being portrayed as a drain on resources there was sense from some ASRs that they were not entitled to free health care, were reluctant to be critical of the care they did receive and did not wish to conform to a view of taking resources away from others by being heavy users of health services.

*“I have a lot of health problems but present one at a time. Do not want to overburden him since he is already helping me a lot with my existing health issues that I have related to him. Feel they may think I am taking advantage of the free health system, and so do not want to give that impression”*

(In-depth interview with ASR, Participant 12)

*“We think whatever we are getting it is fine, and not to demand for too much...This is my feeling about this, because of our status they might take offence or not take our demanding health care or various services too well.”*

(In-depth interview with ASR, Participant 9)

Many of the health issues related to ASR status are mental and emotional issues stemming from their experiences both in their country of origin and the uncertain experience of life in Scotland, with deportation of themselves or those close to them an ever present possibility. This was coupled with being unable to work that can give people a role and feeling of inclusion. Partly on account of this tenuous situation and its emotional consequences and partly on account of language difficulties, compassion, understanding and patience from health professionals were valued by respondents. The quality of relationship with health care workers was highly valued; yet was an aspect on which ASRs felt health providers could improve and become more consistent.

*“They have one particular doctor – female, I like her way of approach, character and method of interacting. Will always ask for that GP when making appointments, even if it means she has to wait a few days or have a late appointment.”*

(In-depth interview with ASR, Participant 5)

*“My physical health problems and mental health problems affect one another, to the point that I don't feel happy anymore. My physical health problems keep me worried and that causes stress and then the no decision on case for the past 5 years also keeps me worried.”*

(In-depth interview with ASR, Participant 13)

From the perspective of voluntary providers it was felt the strength of some of the peer support networks ASRs had access to led to self-reliance that could prevent accessing of services. However, there was also recognition that social support was not sufficient in the face of the stresses that accompanies the ASR experience. Consequently, developing this strength of mutual assistance by better integrating it into knowledge of, and access to, available services was seen as a way of going forward. An additional barrier was that health was not high on the agenda of many ASRs with more immediate material and economic concerns taking priority.

Health service providers also highlighted the tenuous nature of ASR status as a potential barrier: fear of deportation could lead to suspicion of services provided by the state. This perception also relates to the theme of Knowledge and Understanding of Health Services as it suggests that the confidentiality of medical services and the separation of the NHS from the Home Office is not understood by many in the ASR community.

#### iv. Job stress, lack of training and absence of coordination between services

Job stress was recognised as a factor in working with ASRs who present problems that can lead to emotional burn-out and high staff turnover, particularly for statutory sector staff. The low financial incentives and prestige involved in working with ASRs did not match the professional challenges involved. There was recognition that personal strength and a certain set of personal qualities were essential for continued performance in this role. Amongst statutory sector providers in particular there was knowledge of those who worked outside their contracted hours and gave money out of their own pocket to aid cases.

*“Most of our staff have stayed over the past 7 years, and I know there are some of our staff that give them money out of their pockets, and I say to them you can’t do that. But they say “you haven’t seen the flat or the state their kids are in” and they get frustrated when they phone the Home Office – they’re not interested, they’re just numbers to them”*

(Focus Group – Statutory health service worker)

*Lack of training* was identified from the statutory group as a barrier to effective working particularly for those who came into direct contact with ASRs (GPs, nurses and receptionists). Although there was knowledge that training course were available, the cost was considered prohibitive.

*The absence of coordination* was reported by statutory health professions. Issues such as where the first point of call for interpretation services lay or who has primary responsibility for families that have children were raised. In communities that had a high number of ASRs, the health centre could be seen as a primary reference point for knowledge and information by other service providers less used to working with ASRs. This could also impede the patient experience as services in areas not used to dealing with ASRs on a daily basis could not act as efficiently as with non ASR patients. A coordinated approach across all services and geographic areas was called for to relieve the pressure felt in areas with high concentrations of ASRs.

## RECOMMENDATIONS

- As ASRs displayed a lack of knowledge about healthcare services, this needs to be addressed in future information provision. This is related to ASRs' lack of knowledge of processes as much as information of where local services are, and should be addressed in the future.
- Important issues were raised about the quality of interpreting services, in particular relating to the way interpretation could be conducted around culturally sensitive or gender related issues. The guarantee of confidentiality could also be undermined (if not actually broken) by use of interpreters from small and localised ASR communities. Interpretation services and the way in which they are organised need to assuage such fears.
- Service users felt the interpersonal qualities (compassion and patience) of health professionals to be important. This was had particular importance given the emotional and mental strain of being an ASR and potential difficulties in communication that stem from ASR experience, skills and status. It is advised that efforts should be directed into maintaining high standards in communication and sensitivity to ASR experiences. In particular, training for healthcare staff (including the added importance of inter-personal skills) with this group is recommended.
- Mainstream and specific service providers are still learning about the issues and processes involved in providing services to the ASR community. In some instances, this leads to absence of clarity about roles and expectations between service providers. It is also the case that some areas of the city have developed greater experience than others. The report authors recommend wider availability of training and the development of an integrated strategy to assist the smooth running and delivery of healthcare and related services.

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