

## **Health Inequalities - Access to Services**

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For this submission “obstacles” are represented through two key perspectives.<sup>1</sup>

- The specific experience of accessing healthcare through an interpreter
- The general experience of migrant health care, irrespective of policies currently in place to support fair and equal access to health.

### **Intercultural communication in healthcare settings**

In the Scottish health service as in the rest of the UK access to interpreters is framed within the policies that focus on reducing health inequalities and tackling racism and discrimination. To address what were being reported as deficiencies in service provision and poor experiences of healthcare in Scotland, a two year research project was designed to investigate intercultural communication in interpreter-mediated health care.

Academic, policy and third sector literature acknowledges the multiple factors affecting intercultural communication. Yet language barriers are generally regarded as the patient’s problem as there is an expectation that a migrant is supposed to learn as quickly as possible the host countries’ language; and even when this occurs, it is another thing to express oneself effectively. Speaking a second language to an appropriate level can be further compounded by the complexity of the clinical information, if the patient is emotional and if the situation is stressful.

Nonetheless, because of the dominant focus on the language problem, equality and anti- discriminatory practice become principally matters of ‘race’ and language, which fails to recognise the multiple ‘non-language’ variables which affect health care access and outcomes. There is also a tendency for this focus on language to be translated into guidelines and codes of conduct to overcome the ‘language problem’. To illustrate this point our research revealed a number of obstacles which present as formal and informal barriers to accessing healthcare, and which are well evidenced elsewhere (e.g. Derosé *et al* 2007, Priebe *et al* 2011). These obstacles affect service users but also service provider in how they might deliver equitable health care, and include:

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<sup>1</sup> This submission draws from (1) a 2-year GRAMNet interdisciplinary research project into intercultural communication in health care settings, (funded by the AHRC, SFC and British council ) <http://www.gla.ac.uk/research/az/gramnet/getinvolvedactiveprojects/trainingmodel/resources/>

(2) discussions with NGO organisations Migrant Voice, Migrant Rights Network and Scottish Migrants Network in view of the submission.

Arranging care:	problems of entitlement; differentiated entitlement requires clarification; difficulty in signposting forward; maintaining care levels, especially if status is vulnerable or irregular.
Social deprivation and Trauma:	migrant status related stress; length of time in country; wide range of socioeconomic emotional, psychological stressors of life in new country all affect quality and level of care
Lack of familiarity with health care	lack of knowledge of how health care is accessed; resources underused because of lack of knowledge; different understandings of patient-clinician relationship; unrealistic expectations of clinician role
Different understandings of illness and treatment and cultural difference	can inform help seeking behaviours; can affect engagement and behaviour in consultations, sometimes resulting in refusal of care (both service provider and service user); differences in understandings of 'therapy' outside of medication; practical issues such as DNAs; timekeeping, out-of-hours service
Language-related impacts on service:	increased risks of misunderstanding and misdiagnosis; extensive testing is required to compensate for poor communication; prolonged administrative procedures; and a range of problems relating to interpreting (poor access, reliance on ad-hoc services, complex patient health care affected by dynamic, issues of confidentiality).

### **Border control in the waiting room**

The politicisation of migration is already affecting individuals' actual experience of attempting to gain access to healthcare and this looks set to worsen with the present passage of the UK Immigration Bill 2013-2014 on the refusal of health care for certain immigration statuses (Home Office 2013).

There is some evidence from our study and from anecdotal evidence from the migrant organisations contacted in view of this submission of the role of front line administrative and clinical staff in attempting to assess a person's entitlement to healthcare on presentation. This is done in response to visual and/or language cues and is at best ill timed and clumsy and at worst racist. The complexity of immigration status is not something which can be handled on discussion at the "front desk". In such instances, migrants reported being typically stigmatised related to:

- physical appearance, skin colour, dress
- cultural and religious practices
- language
- by their post code, which is linked to concentrated housing of migrants in areas of multiple social deprivations
- and increasingly their immigration status

“I've never had any problems accessing health services. My sister complains about her local practice as they always refuse to see her when she tries to make an appointment, which recently resulted with her seeking help in a hospital where she was diagnosed with pneumonia. I think it is a matter of individual approach of people at reception.” (Migrant Voice member March 2014)

Our research and subsequent discussions with migrant organisations reveals a continuing problem of Border Control creep into waiting rooms, whereby migrants are questioned on their immigration status because they present as ‘different’. With current moves for immigration policy to be further factored into the health service, this last point is one of increasing concern if fair and equitable health care is an aim. These issues feed into the wider political debates about migrants as a “drain on resources”. Our findings suggest that despite the equality, diversity and anti-discriminatory policies in place, it remains uncertain as to whether these are working for migrant service users. Moreover, our evidence suggests that for migrants, such stigmatising processes lead to concerns over complaining, for fear of putting oneself at risk of being labelled as ‘troublesome’ or ‘a problem’. This has clear implications for developing health policy – including in this policy relating to access to interpreters and translators – that is targeted at migrants.

Migration to Scotland over the last 12 years has been at historically unprecedented levels. Unsurprisingly the Scottish health care system is largely developed for and with a “local” population in mind. There are difficulties for the “local” poor and marginalised as evidenced by the other groups targeted in the submissions to this committee. As it stands, the health system functions and signposts with an underlying assumption that users broadly know the system. If you are a migrant you do not necessarily have this knowledge, nor the confidence to access it. To be able to effectively manage the diverse needs of Scotland’s population, tackle such ‘hidden’ inequalities and reduce the likelihood of institutionalised racism occurring formally and informally within our health systems, these obstacles should be addressed.

Our evidence suggests that the policies in place do some of the groundwork, but fall short in promoting better, more equal and non-discriminatory practice. This is also borne out in the limited education and learning programmes for health care providers and interpreters in the wider field of intercultural communication in health care settings.

Our research has produced a range of learning materials to address these issues, stimulating debate and reflection on practice in intercultural health contexts.

“I have watched the videos and read the materials and this is a just wonderful, wonderful resource and I want to share it with all our members. It empowers practitioners, involves the whole being and empowers people to use their judgment. It also

empowers practitioners to work with and ask for interpreters. It's very educational. Congratulations"  
(Ethel Rodrigues, Education officer for Unite the Union, 19 March 2014).

### **Ways forward for the Scottish Government and NHS Boards**

- Develop clear policy which highlights that immigration status is not the determinant of access to healthcare in Scotland.
- Emphasise the need for “front of house” respect and for all staff to be welcoming irrespective of perceived difference.
- Improve intercultural awareness training for health care providers and frontline staff which has accepting social difference at its core.
- Develop an interpreting model which moves beyond guidelines and reflects the challenges of interpreter-mediated intercultural communication.
- Invite all parties to be involved in any future developments to determine what needs to be systemically addressed together.

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