Organisational barriers and obstacles to accessing health care services of equitable quality

The problem

Access to health care for refugees and asylum seekers is not limited to the problem of acute provision at initial reception but also involves mainstream service provision. Some health care is specifically provided in detention or reception centres, nevertheless, refugees and asylum seekers are also accessing care from the same clinics as the general population; consequently, adapting mainstream health care services is crucial. As previously explained, access to health care varies across Europe in terms of legal entitlement and formal access regulations (Bradby, Humphris, Newall, & Phillimore, 2016). Even where entitlement is established for formally resettled refugees, and regulations permit access, further impediments exist in terms of the organization of health care.

Most services tend to evolve reactively rather than proactively, adapting to the perceived or expressed needs of the population. As numbers of asylum seekers and refugees in a given area are difficult to predict, it is very hard for service providers to anticipate what needs may emerge in the near future (Bradby, Humphris, Newall, & Phillimore, 2015). Limited availability of services, difficulties in accessing general practice and an increased reliance on accident and emergency services for non-emergency treatment are often reported, even though almost all refugees are registered with a general practitioner. There is also evidence of late booking, poor antenatal care and poor pregnancy outcomes plus high rates of mental health problems. It is, therefore, necessary to improve access to primary care.

Moreover, unequal geographical distribution of facilities, and the lack of transportation and outreach interventions create further barriers to access health care for refugees and asylum seekers who often live in accommodation in areas of existing deprivation. Due to their condition of social isolation they inherit the same social determinants of ill-health as the native population yet with additional barriers to care. (Taylor, 2009)

Evidence on the barrier

Lack of migrant-friendly/sensitive health systems is the single most important factor impacting on access to health services and quality of care for refugees and asylum seekers. With no structural preparation in handling the diverse needs of refugee populations, the health sector faces important challenges that can represent real problems for service organisation and delivery. Unless new information strategies and language support services are set up, the quality of services adapted to the new needs, and innovative action and policies incorporated into regular management procedures, the very organisation of service delivery may become a further barrier to accessibility for refugees and asylum seekers. Failed adaptation of health systems creates a number of organisational dysfunctions, for example, unmet health needs tend to converge in emergency departments; unmet language needs tend to slow procedures down, and the uncoordinated adaptation of services to specific needs creates uncertainties for staff, managers and the health care setting alike.

The complex network of health and social services may seem impenetrable to recent refugees and asylum seekers (Asgary & Segar, 2011) and the availability of these services effectively out of reach. Barriers in accessing the health system often result in missed medical provider appointments and increased reliance on hospital emergency departments (Reavy, K., et al., 2012). This is also influenced by migrants' previous knowledge and experience of health systems most of which were characterised by a lack of GPs and direct access to hospital-based specialists. O'Donnell, C.A., et al.,2008)

Social and cultural isolation also emerged as significant barriers to health care for refugees and asylum seekers who live in deprived areas and lack transportation to attend medical practise. This is even more difficult for refugees with physical or mental disabilities, for the elderly and families with young children. (Cheng, Vasi, Wahidi, & Russell, 2015).

The infrequent use of specialised services or therapies by asylum seekers and refugees are also reported in the literature and confirms inaccessibility. Impediments to access are described both in terms of the organization (and geographical distribution) of health services and the wider context beyond the medical system. Obstacles in accessing specialists services may also derive from certain features of the asylum process and the management of refugees, for example an active dispersal policy may relocate refugees and asylum seekers to places where appropriate services have not been developed (Bradby et al., 2015).

These organisational barriers are connected with that of affordability, as it is widely recognized that high costs are the major factor preventing access to speciality care but also for continuity of care and preventive care that are largely unknown and unavailable to asylum seekers (Asgary & Segar, 2011). For instance, access to dental care, ophthalmology, orthopaedics, physiotherapy is sometimes hampered by the fact that in some countries the state only reimburses certain fixed amounts through the national health insurance system for asylum seekers. As a result, specialists may refuse to treat asylum seekers, or are reluctant to accept new clients who not only bring complex health needs, but linguistic challenges and complex insurance coverage(McKeary & Newbold, 2010).

Time and communication emerged as significant factors impacting on access to health services and quality of care (Bennett, S. and J. Scammell, 2014). Long waiting lists, complex appointment referral systems, cultural insensitivity, and visiting different care providers were also reported as negative experience for refugee patients by both EU and US studies (Asgary & Segar, 2011) (Razavi, M.F., et al., 2011). For example, one study showed that due to organizational factors affecting follow-up, referral and specialist care, only a limited number of the refugees included in the study received treatment for latent tuberculosis and with a long time delay. (Harstad, I., et al., 2010)

Measures to address the barrier

Adopting a "whole organisational approach" able to implement a comprehensive process of change and adaptation of services to appropriately respond to the needs of migrants and other vulnerable groups, has proved to be a successful strategy. This strategy requires management support and policy development in the organisation in order to enhance the capacity of the health providers, managers and administrators to address the health issues associated with refugee and asylum seekers, and to deliver quality health care services in a comprehensive, coordinated, and equitable fashion. It also entails the development of a diversity responsiveness assessment framework for measuring and monitoring service performance in order to improve accessibility, utilisation and quality of health care for refugees and asylum seekers (e.g.: Equity standards in health care; CLAS standards).

Within this framework, health care organisations need to develop specific policies and programmes that address priorities for the care of refugees and asylum seekers, adapt processes and services in the organisation and promote effective participation of the community especially the civil society.

For example, access to health care services for asylum seekers and refugees can be promoted by outreach services and free transport to and from appointments or thanks to the coordination between appointment and transport needs. A clinical model for prenatal and paediatric refugee patients has shown to be successful due to the role of C.A.R.E. (Culturally Appropriate Resources and Education) Clinic Health Advisor that was developed in conjunction with the organization (Reavy, K., et al., 2012).

Another example is the co-location of different health services such as general practice, pathology, pharmacy, counselling services, etc. in order to reduce difficulties associated with travelling to multiple sites. (Cheng, Vasi, et al., 2015). The implementation of drop-in primary health care units based in hospitals, the adoption of extended clinic opening hours or modification of timetables could be other solutions to create increased opportunities for refugees to be able to access to services and to reach them in time; moreover, telemedicine systems could facilitate the access to healthcare services overcoming geographical barrier and addressing people otherwise hard to reach due to physical and organizational problems (Berthold et al., 2014). One successful Australian model reported in the literature is the Primary Care Amplification Model (PCAM) which, has been showed, offers a flexible, yet robust framework to facilitate the delivery of continuous, coordinated and comprehensive care to migrant patients. (Kay, M, 2010)

Having a community engagement strategy in the health care organisation is a key factor to bridge the gap between community and health care services, this strategy makes it possible to identify and prioritise refugees' health needs, and define and implement solutions in a mutually acceptable way (Cheng, Wahidi, Vasi, & Samuel, 2015). Furthermore, to combat logistical concerns and organisational barriers, health care organisations must work closely with their patients' resettlement agencies and other social services to ensure that patients have access to the resources necessary to achieve optimal health outcomes (Szajna & Ward, 2015).

The existence of a clear organisational policy setting out how interpretation and cultural mediation services are provided will ensure effective access and utilisation of services. This means implementing written policy on interpretation, translation, intercultural mediation and communication support; a patients' language identification system; guidelines for staff in organising interpreters or communication support; the possibility to use a gender-concordant interpreter defined criteria for interpreting quality and interpreting codes of conduct (Bischoff, Hudelson, & Bovier, 2008; Hudelson, Dominice Dao, & Durieux-Paillard, 2013).

Finally, the development of a comprehensive training programme for staff at all levels should be embedded in the strategic training plan of the organisation. Training should include best practice guidance on how to deal with particular vulnerable groups (e.g. mental health disorders, unaccompanied minors, victims of torture and sexual violence, women with genital mutilation, etc.) including support for the implementation of a referral system for such patients (Asgary & Segar, 2011), as well as the provision of human rights education and support for administrative and health staff (Scott, 2014).

Successful example

Migrant-Friendly health care in the Local Health Authority of Reggio Emilia: a whole organisational approach
(Reggio Emilia, Italy)

Responsibility:
Research and Innovation Department of the LHA of Reggio Emilia

Description:
Since 2005 an overall strategy to ensure equity of access and treatment for migrants has been established at the central level of the organisation. The strategy comprises the following main areas of interventions and is coordinated by a multidisciplinary team:

Ensure the right to health care through a dedicated service for UDMs and people at risk of exclusion because of lack of legal status. *(migrants in irregular situation, asylum seekers, and failed asylum seeker)*

Improve accessibility to health services through a coordinated language support service available for all professionals and patients. *(addressing linguistic and communication barriers)*

Improve service utilization through the provision of information on health and health services. *(providing information on how to navigate the system; improve Health literacy)*

Ensure quality of care and responsiveness to migrant's health needs through systematic training embedded in the organisational training plan. *(staff training programmes)*

Foster organisational change and improvements through the assessment of quality/equity of health care services. *(HPH-TF MFH standards of equity in health care)*

Promote involvement and participation of users and community through the establishment of partnerships and networks in the community. *(Partnerships, networking with other services, out-reach interventions, formal agreements and protocols)*

Promote research to achieve change through the participation at research projects and networks at local as well as international level *(COST Actions; EU funded projects; National/Regional funded projects)*

Achieved outcomes

Improved integration of the migrants population in the health care system. Reduced inequities in health care and contributed to reduce health inequalities.

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References to know more:

Asgary, R., & Segar, N. (2011). Barriers to health care access among refugee asylum seekers. *J Health Care Poor Underserved, 22*(2), 506-522. doi: 10.1353/hpu.2011.0047

Berthold, S. M., Kong, S., Mollica, R. F., Kuoch, T., Scully, M., & Franke, T. (2014). Comorbid mental and physical health and health access in Cambodian refugees in the US. *J Community Health, 39*(6), 1045-1052. doi: 10.1007/s10900-014-9861-7

Bischoff, A., Hudelson, P., & Bovier, P. A. (2008). Doctor-patient gender concordance and patient satisfaction in interpreter-mediated consultations: an exploratory study. *J Travel Med, 15*(1), 1-5. doi: 10.1111/j.1708-8305.2007.00163.x

Bradby, H., Humphris, R., Newall, D., & Phillimore, J. (2015). Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region *Health Evidence Network synthesis report*.

Bradby, H., Humphris, R., Newall, D., & Phillimore, J. (2016). *Refugees and asylum seekers in the European Region - reviewing the research evidence* Paper presented at the 6th European Conference on Migrant and Ethnic Minority Health, Oslo, Norway.

Cheng, I. H., Vasi, S., Wahidi, S., & Russell, G. (2015). Rites of passage: improving refugee access to general practice services. *Australian Family Physician, 44*(7), 503-507 505p.

Cheng, I. H., Wahidi, S., Vasi, S., & Samuel, S. (2015). Importance of community engagement in primary health care: the case of Afghan refugees. *Aust J Prim Health, 21*(3), 262-267 266p. doi: 10.1071/PY13137

Hudelson, P., Dominice Dao, M., & Durieux-Paillard, S. (2013). Quality in practice: integrating routine collection of patient language data into hospital practice. *Int J Qual Health Care, 25*(4), 437-442. doi: 10.1093/intqhc/mzt035

McKeary, M., & Newbold, B. (2010). Barriers to care: The challenges for Canadian refugees and their health care providers. *Journal of Refugee Studies, 23*(4), 523-545. doi: 10.1093/jrs/feq038

Scott, P. (2014). Black African asylum seekers' experiences of health care access in an eastern German state. *International Journal of Migration, Health and Social Care, 10*(3), 134-147. doi: 10.1108/IJMHSC-11-2013-0043

Szajna, A., & Ward, J. (2015). Access to health care by refugees: a dimensional analysis. *Nurs Forum, 50*(2), 83-89. doi: 10.1111/nuf.12051

Taylor, K. (2009). Asylum seekers, refugees, and the politics of access to health care: a UK perspective. *British Journal of General Practice, 59*(567), 765-772 768p. doi: 10.3399/bjgp09X472539