

Exploring the ‘fit’ between people and providers: refugee health needs and health care services in Mt Roskill, Auckland, New Zealand

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Abstract

The needs of refugees and the struggles on the part of service providers to address this diverse population have received limited attention within the academic literature. This paper profiles Hauora o Puketapapa/Roskill Union and Community Health Centre (HoP), which is a non-profit, community owned and operated health clinic designed to deliver accessible, affordable and appropriate primary health care services to low-income groups in the Mt Roskill area of Auckland, New Zealand. The clinic's locality has undergone considerable demographic change over recent years with the arrival of refugees from diverse backgrounds. This situation has resulted in new sets of health needs and expectations which need to be addressed. The study took place in 2002–2003 and employed qualitative methods. In-depth interviews with community representatives, clinic users and health service staff members revealed that refugees face considerable barriers in accessing and utilising health services. Similarly, we found that health practitioners face the daunting task of endeavouring to meet these needs in an effective and culturally appropriate manner within a limited funding environment. We conclude that, despite these challenges, HoP has successfully established itself as a well-regarded place of primary health care. In so doing, it has strengthened the capacity of the local community to respond to the changing policy environment. However, long-term sustainability issues remain unless resourcing issues are adequately addressed.

Keywords: health care utilisation, New Zealand, primary health care, refugees

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Introduction

As Western cities become increasingly multicultural in character, health care services are facing growing pressure to respond to the needs and expectations of refugee groups. For instance, the UK government has given priority to ‘diversity awareness’ in the management and delivery of public services in response to the Race Relations (Amendment) Act 2000. There are practical and ethical, as well as legal, imperatives for attentiveness to diversity. As McGee & Johnson (2004) reminded us, ‘so much of the therapeutic relationship is dependent on the ability of two individuals to talk to one another’ (McGee & Johnson 2004, p. 380).

This emphasis on talk as the currency of health care interactions has understandably highlighted the importance of translation and interpretation in practice settings (Gerrish *et al.* 2004) given the rarity of health care practitioners speaking minority ethnic community languages.

Communication barriers are most commonly addressed by providing information in appropriate languages and by developing interpreting services (Tang 1999). However, our concern in this paper is for a wider notion of translation and interpretation. We view health care as more than the sum of the individual practitioner–patient interactions and are led to ask: How is the changing demographic composition of

the city leading to the presence of new health needs and how are local health services responding?

Employing qualitative methods, this paper reports on research that sought to reveal the barriers faced by refugees in accessing health services, and the challenges faced by providers in endeavouring to meet needs in an effective and culturally appropriate manner. While we use the singular term 'refugee', this category also includes asylum seekers and family reunification refugees. Our case study in suburban Auckland, New Zealand, while singular, is typical of the transformed 'ethnoscape' of many larger Western cities. The remainder of the paper elaborates on the study rationale, situates the analysis in relevant literature, and presents results from both user and provider perspectives before drawing some conclusions regarding the provision of primary health care to refugees within urban neighbourhoods.

Population change and service needs in Auckland

This paper can be placed within a concern for the local meanings and evidence of globalisation in Auckland, one focus of which is the ongoing ethnic diversification that has taken place in New Zealand's largest urban area (population = 1.2 million) since the late 1980s (Murphy *et al.* 1999). Throughout the first half of the twentieth century, British migrants predominated in Auckland. However, as Friesen *et al.* (2005) related, from the 1950s, an increasing number of migrants came from the Pacific Islands, especially those countries with which New Zealand had established political and economic links. By way of a radical change in 1987, a 'preferred countries' policy was replaced by a policy emphasising education, skills and investment (Bedford 2004).

Through the 1990s, there was a rapid diversification of migration into New Zealand, with the most visible new migrants being from countries within Asia and Africa. The 'newness' of migration from these continents attracted both political and media attention, and as documented by Ip & Friesen (2001), migrants and refugees have been intermittent targets of xenophobic and racist responses. Contemporaneous with these responses, there has been a strong but implicit assumption that migrants will be able to make their way in New Zealand society and economy without access to specific settlement and welfare services (Bedford 2004). While New Zealand ranks first in relation to the number of refugees accepted per capita, Zwart (2000) reports that it rates lowest in terms of refugee resettlement support and services compared with the nine other countries which also have an annual quota for United Nations mandated refugees (Australia, Canada, Denmark, Finland, the Netherlands, Norway, Sweden and the USA). Refugees experience some of the worst health outcomes

in New Zealand society not only because of pre-existing physical and mental health issues, and the trauma associated with being a refugee, but also as a result of the challenges of the resettlement process itself (Kizito 2001).

Our paper examines the challenges experienced by both patients and service providers at Hauora o Puketapapa (HoP), also known as Roskill Union and Community Health Centre, in Auckland. This service opened in 2000 as a not-for-profit, community owned and operated health clinic designed to deliver accessible and affordable primary health care services to low-income groups in Mt Roskill, a suburb located approximately 10 km south-west of the city centre. There are large tracts of public housing in the area, occupied by some of the most disadvantaged groups in New Zealand society (Crampton *et al.* 2000).

The site of the clinic was selected through a process of identifying the optimal locality for a health centre seeking to meet medically underserved populations in Auckland. When HoP was established, analysis of the most recent census data revealed that the surrounding area's population comprised Europeans/Pakeha (38.2%), Pacific Islanders (25.9%), Asians (18.6%), Maori (11.2%) and others (6.1%) (Exeter *et al.* 1999). Since opening, the catchment area has undergone considerable demographic change, with a disproportionately high number of refugees arriving into the area. In 2003, 46% of HoP's enrolled population was from refugee backgrounds, including people from Afghanistan, Ethiopia, Iran, Iraq and Somalia (K. Healey, personal communication). Other ethnic groups represented among those enrolled at the clinic at this time included: Pacific Islanders (32%), Maori (12%), European/Pakeha (5%) and others (5%). This ethnic diversification has resulted in the generation of new sets of health needs and service expectations within the community.

Refugee health needs and service responses

Within the considerable literature addressing refugee health service needs and their experiences of accessing health services, three key strands are evident. First, refugees have very high physical health needs. In the USA, Uba (1992) found that disproportionate numbers of South-east Asian refugees suffered from problems such as tuberculosis (TB), hepatitis B, malaria, malnutrition, conjunctivitis, trichinosis, anaemia, leprosy and intestinal parasites. Uba suggests that these health problems are a result of the conditions which refugees experience in their countries of origin, including malnutrition, poverty, abuse, overcrowded refugee camps and inadequate health care provision (Uba 1992). Research within New Zealand found that up to 46% of all refugees are

infected with TB, while the rate of the disease is over 400 times higher in refugee populations compared to the general New Zealand population (Harrison *et al.* 1999).

Numerous studies suggest that mental health problems comprise the main health issues which refugees face. Many have experienced or witnessed torture, violence, rape and death, which can result in significant psychological distress. A 1994 study conducted at the Asylum Seekers Centre in Sydney, Australia, found that 78% of participants reported exposure to at least one major trauma prior to migration, with the most common experiences being the murder of a family member or friend, being close to death, and forced separation from family members (Sinnerbrink *et al.* 1997). New Zealand research into refugee mental health has been dominated by psychological perspectives (e.g. Pernice & Brook 1996). Blakely's (1996) study differed because it used intensive interview methods with Cambodian and Vietnamese refugees in Porirua, New Zealand. Complemented by key informant interviews, the above study found undiagnosed psychiatric morbidity and problems in accessing interpreting services, particularly in primary care (Blakely 1996). Recent research by Hobbs *et al.* (2002) into the health status of asylum seekers in Auckland found that, during the period from 1999 to 2000, approximately 900 asylum seekers received health screening from Auckland Public Health, and 38.4% had symptoms or a history of psychological illness.

In addition to the weight of evidence that refugees have high physical and mental health needs, there are growing calls to address the way in which the process of resettlement itself can have an important influence on health (Watters 2001). Pernice & Brook (1996) investigated the mental health status of three refugee/immigrant groups in New Zealand. They found that demographic variables such as age, gender, educational level and marital status had little bearing on mental well-being, while resettlement issues such as discrimination, unemployment/underemployment and having a limited social network had a critical influence on mental well-being. Discrimination was indicated as the key factor associated with high levels of anxiety and depression. Unemployment was also an important factor influencing levels of anxiety, with 43% of refugees who experienced considerable emotional distress being unemployed (Pernice & Brook 1996, p. 517).

The second important strand of literature is the observation that, despite refugees having high health needs, they tend to experience many barriers in accessing health care. Burnett & Peel (2001) described some of the barriers which asylum seekers face in accessing health services in the UK. These include difficulties in

registering with a general practitioner (GP) and being given access to the full complement of health services available. Harper & McCourt (2002) found that language was the most important barrier that hindered Somali women's access to maternity services in London. Other barriers could only be addressed once language problems were resolved. In New Zealand, the 2001 Health Needs Assessment report published by the Auckland District Health Board also identified a number of factors which can act as barriers to accessing health care (Auckland District Health Board 2001). Since most refugees rely on some form of income support, cost can act as a barrier for many refugees, particularly those with multiple, complex health problems which require a variety of medical interventions. Even those who hold a Community Services Card (which qualifies the holder to a significant subsidy on health services) can find the costs of attending a GP as well as the costs of prescriptions prohibitive. Refugees may also experience physical access challenges because of a lack of transportation. Those without access to a car may find it difficult to attend appointments at various locations, while inadequate public transport and a reluctance to use the transport services available can further hamper physical accessibility. Another influence on access to health services is the way in which refugees' health-seeking behaviours and attitudes are largely shaped by the norms and practices prevailing in their country of origin. For example, some refugees may resist utilising counselling services to alleviate trauma because, in their culture, silence and forgetting are more common as coping mechanisms. Burnett & Peel (2001) described how people from Mozambique and Ethiopia employ 'active forgetting' as a way of coping with traumatic experiences, as opposed to reliving the incident through counselling.

The third strand of literature related to this study addresses the challenges which practitioners face in tackling refugee health needs. Although this issue has yet to be well documented, some important contributions have been made (Jones & Gill 1998). Burnett & Peel (2001) suggest that health workers face a number of challenges when working with refugees, including language, time pressure and cultural differences. They write, 'Refugees are perceived as having huge needs that are difficult to fulfil and as being very demanding' (Burnett & Peel 2001, p. 487). A study by Ramsey & Turner (1993) found that GPs face a number of challenges when dealing with refugee patients and expressed concern at language difficulties resulting in protracted consultations, thus placing an additional burden upon practitioners. In addition to these studies, papers have been written advising practitioners on dealing with refugee patients (e.g. Fowler 1998, Adams & Assefi 2002).

Methods

Our study employed qualitative methods complemented by analysis of census data. Special datasets from the 1991 and 2001 censuses were obtained from Statistics New Zealand in order to compare the ethnic composition of the clinic catchment zone across time, thus extending the findings of a recent social atlas of Auckland (Friesen *et al.* 2000). Interviews were then conducted with key stakeholders within the Mt Roskill study area (a list of topics covered during interviews can be found in Box 1). Since this project was the product of an ongoing collaboration between the health centre and the second author (R.K.; see Exeter *et al.* 1999), the research was supported from the outset by clinic staff and management, who recommended key organisations and individuals within the Mt Roskill area as potential participants who could provide insight into changes within the neighbourhood. Five semistructured interviews were held with community representatives who had strong links within Mt Roskill in the fields of health, education and social services. Individuals were selected based on the length of their involvement within the Mt Roskill community in order to provide an account of the changes which have taken place over the past decade.

Representatives from refugee groups were also invited to participate in the research by way of commenting on health care needs and the barriers which refugees face in accessing health services. These participants were representative of the constituent ethnic groups in the community, and were identified in consultation with clinic staff and management on account of their involvement in some official capacity within their community. An introduction from a respected community worker and HoP board member enabled access to organisations and individuals who could have otherwise been reluctant to participate. Nine semistructured interviews took place with refugee group representatives originating from countries in Africa, the Middle East and Asia. Of these representatives, eight were from a refugee background. Most interviews took place at the clinic, while the remainder occurred in the workplaces of representatives for

Box 1 Topics covered during interviews

- Ethnic composition of Mt Roskill
- Refugee health needs
- Expectations of refugees
- Barriers to access
- Responses to the health needs of patients
- Challenges of serving refugee populations
- Cultural awareness

reasons of convenience. With respondents' permission, and in accordance with the agreed ethics protocols, interviews were audio taped and transcriptions subsequently analysed thematically.

In order to consider the experiences of health practitioners, semistructured interviews were held with all seven members of staff at HoP: the manager, the five medical practitioners and the administrator. All interviews were undertaken by the first author between December 2002 and February 2003. Interviews lasted approximately one hour. Interviews with clinical staff tended to be shorter because of the time pressures they faced.

Following the approach adopted by the second author and colleagues in earlier research (R.K.; e.g. Witten *et al.* 2001), we used a research framework that was built on a critical realist theoretical base, which assumes that realities are socially, culturally and historically situated, but are, nevertheless, experienced as material, objective and stable by participants. Analytically, this stance encourages the treatment of experiential and perceptual data as having integrity, and therefore, accepts such materials as valuable in the study of social life. Our rationale for this approach is that experience is constituted in participants' accounts as they talk about their surroundings and reactions to them in ways which others can accept and understand. In-depth interviews are a suitable way of gathering and accessing such talk (Patton 1990, Edley 2001).

After a period of familiarisation with the transcribed narratives, key themes were identified with reference to topics discussed in the interviews. Indicative narratives identified through this exercise are used to illustrate themes in this paper.

Results

Population change within the Roskill area

When key community representatives were asked about the most important change within the area over recent years, the arrival of refugees was unanimously cited as being most significant. Evidence of this was given by one participant through reference to the alteration of the spiritual fabric of the community. Mt Roskill previously had a reputation for being the 'Bible Belt' of New Zealand (Craig 2003). However, new places of worship, such as mosques, have been established now. Shopping areas have mirrored these demographic changes. Halal butcheries and specialty food outlets can now be found in proximity to HoP and within the Mt Roskill shopping area more generally (Friesen *et al.* 2005).

Another participant suggested that the clinic's vicinity is where many people 'find their first home'. This

trend was noted with early Maori occupation of the area being followed by the influx of migrant Pacific peoples during the 1970s and now refugees from the 1990s onwards. One representative cited a man for whom Mt Roskill was his first home following the Second World War. Then in the 1970s:

... [S]ome of the Pacific people [came] ... to their first home. And so now we've got the refugees and migrants coming here. They're coming to their first home ... This is the place where people are finding their first home, putting down roots.

Nevertheless, the demographic changes within the area as sketched earlier in the paper have not been universally welcomed. A number of community representatives described the underlying animosity held by some members of the community towards refugees. According to one participant:

... [I]t's a real hotbed of ethnic unrest really and it's bubbling along under the surface.

A number of reasons were offered for this hostility. One person suggested that it was partly caused by a lack of consultation with the community before the refugees arrived in the area. This failure to consult resulted in cultural misunderstandings which bred suspicion, wariness and even violence. A participant recounted that some of the first refugees in the area had rocks thrown through their windows, resulting in a sleeping baby being covered with glass. More recently, a lone-parent refugee with a number of children had their house set on fire and is currently seeking to transfer their tenancy to another Housing New Zealand Corporation property.

Other community representatives felt that the tension was a result of economic factors, with a perception that refugees were being privileged over other sectors of the community. For example, one community representative noted:

Now the refugees are coming to New Zealand, they get everything. They get what they want. But when Islanders first moved here, they didn't get anything really.

Another person agreed that it partially stemmed from financial issues, particularly in relation to the availability of public rented housing:

... [A] lot of it has to do with an economic, yeah, I think an economic reason. They [refugees] were coming in all of a sudden and taking the houses. Housing New Zealand houses. They [existing residents of Mt Roskill] didn't feel they [refugees] were entitled to them.

Others cast doubt on the genuineness of refugees' need and disadvantage:

There's a perception that there is ... an element that have got here under false pretences.

According to participants, tensions reached a crisis point in January 2002, when a young Tongan man died after a street fight between a group of Somalis, and a group of Tongan and Samoan men. Many perceive this incident as the product of a growing disharmony between refugees and existing residents. Out of this crisis, a community leaders committee was established in order to address these issues within the community and has been functioning well ever since. The committee meets monthly, and approximately 60 people attend from various organisations and ethnic communities within the local area. One participant mentioned that this committee truly embraces notions of multiculturalism, with meetings being opened with either a Maori, Christian or Muslim prayer. At the time of writing, there have been no further incidents of this nature within the area, which may indicate that the intervention of the community leaders committee has been effective in stabilising a potentially tense situation between different groups.

Refugee perspectives on barriers to accessing health services

Refugee representatives identified six main barriers which refugees face in accessing health services.

Resettlement issues

First, resettlement issues were seen as the most significant health challenge that refugees face. One participant talked about the different stages associated with refugees and stress. Before refugees had arrived in New Zealand, their main goal was survival. Once they had arrived, however, other issues which tended to be sidelined in the overarching quest for survival were seen to re-emerge. For instance, one contributor to stress and anxiety was considered to be the challenge of settling in a new country with, more often than not, no support system. One participant observed that most recipients of welfare assistance have local support networks and some belongings, but this was not the case for refugees. According to one person, when you are a refugee:

You have nothing. Nothing. And no extended support system. You may have, like, other members of the same community, but they're all in the same situation.

In conjunction with this situation, a number of participants described how refugees often expect life to be better in New Zealand, but find that things can get worse because of the stresses of resettlement. For example, one participant said:

They ran away from that country and they just carried with them all their sadness. Now they are worse.

One theme that emerged from the narratives was that health outcomes and a sense of well-being for refugees were not governed by traditional medical inputs, but by wider determinants, such as immigration, employment and housing. Refugees often experience considerable stress and anxiety over insecurity regarding their immigration status and difficulties with family reunification. Unemployment and underemployment impact upon confidence and psychological well-being, while accessing affordable housing was also identified as a challenge. The connection between employment difficulties and health status is highlighted by the following quote from one representative:

No job for the parents. Mother has not job, father has not job, stay at home. After a while, after one month, 5 months they are getting depressed and the family getting sad. Sad is affecting the children. The children going to school. Child be isolated at school, no support, and in the end, child cannot do their education properly. Everything really is affecting their health and the mental health.

Differing cultural understanding of illnesses and health care systems

A second barrier is a differing cultural understanding of illnesses and health care systems. Refugees were unfamiliar with aspects of the New Zealand medical system, including the process of referral, waiting lists and the requirement to make appointments to see a GP. Participants also held different perceptions of the concept of 'health', and what constitutes an effective and valid treatment in the event of ill health. One participant mentioned that, in their home country, an injection was an accepted and commonly prescribed form of treatment that was considered to be successful. Refugees from that country often found it difficult to adjust to not receiving this kind of treatment from New Zealand GPs, and felt that the treatment and prescriptions offered tended to be less effective and useful than the injections they were used to receiving.

Refugees' health-seeking behaviour is influenced by their experience and familiarity with health service provision in their home country where, for many, a patient simply queues at an outpatient clinic rather than makes an appointment (Auckland District Health Board 2001). Furthermore, differing understandings of illnesses can also deter refugees from seeking health care services. This difference was cited by a number of participants as a difficulty, although one that was gradually being rectified through education.

The difference between Western and traditional ideas about health that prevailed in their home countries were profoundly evident. One African participant mentioned that, when they presented to a doctor in their home country, the doctor would

simply ask for their name and age, and would then treat the physical ailment, usually with antibiotics. Refugees from this particular country found that in New Zealand, however, GPs ask many questions, employ a wider definition of health, and may explore social and mental health issues, even if the problem is perceived as being 'purely physical'. According to one participant:

... [N]ow the questions are ... a lot more wider. They have to know everything.

There was also a reported differing in cultural understanding of illnesses. In particular, refugee notions of mental health are quite different from the Western model, resulting in distinct challenges for health providers. Unlike Western culture, there are no shades of grey between being mentally sound or psychiatrically unwell. Those people experiencing relatively minor mental health issues are put in the highly stigmatised latter category. Furthermore, in some refugee cultures, 'minor' mental health issues, such as depression, are not usually treated in a medical context. There is also often no system of counselling for mental health issues (although there is social counselling between the family and elders for family problems). When asked if refugees accepted counselling as a valid form of treatment for mental health issues, one participant laughed and said:

That's funny ... because people in our country, just crazy people is going to counselling, so we feel they tell us to see counsellor if crazy.

This view obviously places health providers in New Zealand in a serious predicament, given that many of the health issues which refugees face involve mental health concerns. Some clients refuse to accept they are 'sick' and feel that their symptoms are not abnormal. Others may attend one appointment and never return, while others withhold information from their counsellor.

Distrust of others

Another barrier that refugees face relates to trust, particularly when they have come from a war-torn area where one could not afford to trust others. One representative spoke of how some refugees find it hard to trust people in New Zealand. The participant discussed how at Auckland's Refugee Reception Centre, where new arrivals are domiciled before resettlement, people from the representative's home country initially regarded him with distrust. However, once the representative had established his credibility, the refugees soon started to ask about whether the interpreters present at their immigration interview for refugee status may, in fact, be working for their home country. The representative explained:

... [B]ecause in our culture we do not trust. So even though they think or maybe I'm working for immigration. They can't trust me. But when they start trusting me, they start thinking about the interview. Who is this interpreter and he's working for our embassy or not?

Trust issues become especially important given the need for interpreters. Not only do refugees need to trust and discuss their health issues with a medical practitioner, but this has to be passed on through an interpreter. In some situations, refugees are reluctant to reveal personal or medical information about themselves in the presence of someone from their own culture (cf. Gerrish *et al.* 2004). This situation can be particularly true if the refugee group is small. One participant said that, because their culture group is so small, information tends to pass through the community very quickly.

Difficulties in communication

Difficulties in communication constitute a third barrier that refugees experience. Language difficulties are not only limited to communication within the medical appointment, but impact upon every stage of the health care process. Appointments, prescription instructions and communications from hospitals are all conducted in English. This means that, at every step, those with limited English language competency struggle. This issue is particularly magnified within primary health care because professional interpreter services are not provided. However, hospitals do provide professional interpreters for each patient.

One participant gave an example of how the language barrier was particularly distressing for a woman who had a GP appointment, but was unable to find a friend to interpret for her:

She said, 'I tried to find out anyone come with me to see my GP but no one had time.' But no one had time so she go alone without interpreter. She didn't know, maybe 10 or 20 word. She went and with sign language. She said, 'I cried for 2 hours when I left GP and I walked because I don't want to see anyone ...' She said, 'All day I cried,' because no one help her. She don't know English and she was very professional [occupation] in her country but here she says, 'I am nothing.'

Another participant mentioned that they spent a great deal of time translating letters from the hospital for refugees so that they would know where to go, the time of the appointment, and what part of the body was being treated because, as one participant noted, 'From head to toe they have problems.' The participant described how they try to teach refugees keywords to watch out for in letters from hospitals in order to

'try to relieve this one stress so it's not a stress build-up. So it's not a problem with the headache and depression.'

Cost

A fourth barrier is cost. Many refugees experience considerable difficulty in accessing primary health care services because of the expense of consultations. In New Zealand, the consultation costs of visiting a GP have been partially subsidised by central government since the establishment of the welfare state in the past century. However, the proportion of the cost borne by the state has declined over time, with the balance of the fee being met by the individual patient. In some medical centres, a consultation can cost well over NZD\$50 (approximately € 28). While possession of a Community Services Card provides an additional subsidy to those on low incomes, prescription costs remain additional to the consultation cost (see Neuwelt & Crampton 2004, Prince *et al.* 2005). Although participants acknowledged that GPs are entitled to charge fees, these fees are often beyond the reach of refugees, even those who hold a Community Services Card (Barnett *et al.* 2000). One participant noted that people from their community would delay going to the doctor because of the cost or not go at all. As one interviewee said, 'I know in my community, they are not going because of the charge.' For other respondents, various parts of their household budget would have to be sacrificed in order to meet the cost of a doctor's appointment (Cheer 2000). When asked about coping strategies, one participant stated:

Sometimes they have to pay something for something else ... sometimes they paid them [GP bill] from their own food or rent money. But they have to because they are sick.

Another issue concerning cost was the idea of value for money. A number of participants expressed the idea that refugees hold the perception that doctor's appointments were not good value, particularly if they didn't come out of the appointment with a prescription or if the doctor prescribed something that can be bought over the counter.

Another angle to the cost barrier issue is the difficulty that one particular refugee group had in understanding why low-cost clinics such as HoP were so much cheaper than standard primary care clinics. Members of that group were confused as to why HoP charged an adult with a Community Services Card NZD\$5 to see a doctor while elsewhere it was NZD\$20 or NZD\$25. People from this community had to be convinced that the low-cost services were of the same quality as the more expensive clinics since they were suspicious that the doctors were not as well trained or as effective as their more expensive counterparts. In this particular example, the women were only convinced

once they were able to add up for themselves on a calculator the various subsidies from the contributing trade union and the Ministry of Health on a calculator until the total costs balanced.

Physical access difficulties

A fifth barrier is physical access difficulties, such as lack of transportation, unfamiliarity with the public transport options in Auckland and difficulties in finding the location of medical appointments. One representative attributed transport to being one of the main reasons why refugees often miss appointments. Many refugees do not own a car and are also unfamiliar with using Auckland's bus system. Clinic staff have tried to encourage patients to use bus services and educate them as to where to board and where to get off. However, this mode of transport appears to be underutilised.

While this section has described barriers, it is important not to generically portray refugees as a group of helpless, marginalised people, but rather, to acknowledge their (albeit limited) 'agency' and ability to articulate their needs and expectations. As one HoP staff member stated:

... [O]ur experience is refugees are survivors. They need to be survivors in order to be refugees. Their expectations are that they will do whatever they need to do to have their needs met because that is what they have needed to do in the past and sometimes that's difficult to deal with because in our eyes they are being unrealistic. Not through any fault of their own.

Experiences of health practitioners in delivering health services to refugees

Five key challenges in delivering health services to refugees were identified by clinic staff.

First, medical challenges were reported. Not only do refugees have high health needs, but these health problems tend to be complex, long-standing and may not have been encountered before by the GP.

Secondly, there are cultural challenges. Practitioners must come to terms with the challenges of working with people from different cultures. Not only do differing cultural expectations of health and health care pose difficulties for refugees, but they also present challenges for practitioners who operate within a highly structured Western health care system. While ideas concerning cultural awareness are now being addressed within the education of health professionals (Kearns & Dyck 1996, Wepa 2004), they have been slower to permeate the training of doctors. It can be difficult at times for GPs to manage the expectations of refugees and deliver services such as cervical screening to people who have had no prior exposure to the notion of preventative health care for women. One GP at HoP recounted a story of a

refugee who asked whether her cervix needed to be removed in order for it to be tested.

Thirdly, communication challenges are a major barrier for GPs, particularly because interpreting services are not funded at the primary health care level. Patients often bring along friends or a family member to interpret for them, which poses trust and confidentiality challenges, particularly in light of sensitive medical issues (cf. Gerrish *et al.* 2004). In some cases, the interpreters themselves have limited English language competence. This situation makes it difficult for GPs to determine the exact nature of the medical complaint. General practitioners have had to learn to ask questions differently in order to find out the necessary information to reach a diagnosis.

Fourthly, there are operational challenges, such as that of providing affordable, accessible health care. Resourcing for the clinic has been a continual struggle. In 2003, the clinic turned to an offshore charitable trust for assistance in funding its work. At the time this research was carried out, HoP provided services under a capitated funding regimen. Later in 2003, the clinic joined a primary health organisation, a new system for funding primary health care which has been introduced in New Zealand (Neuwelt & Crampton 2004). However, the financial difficulties faced by the clinic continue. Part of the struggle for adequate resourcing relates to the clinic's clientele. When the clinic received capitated funding, the experience was that some refugee patients (especially parents with children who are eligible for free consultations) present very frequently, thus impacting upon the financial viability of the clinic. Frequent presentation is a reflection of the clinic's efforts to reduce the barriers experienced by refugees in accessing health services, and also the high and complex health needs of refugees. As one staff member noted:

We're not seeing them four times a year. We're sort of seeing them four times maybe a week or a month, and so it becomes very costly for us as an organisation to actually service the people here.

Another resourcing issue has been the inability of the clinic's management to afford to hire additional medical staff to deal with the growing need and demand for affordable primary health care. This has meant that the clinic has been caught in a 'Catch-22' situation: under the capitation scheme which funded the clinic, additional funding to provide extra medical staff is only available once the patient register has reached a certain level. Nevertheless, it is extremely difficult to increase patient numbers when there are insufficient medical staff to see them, thus resulting in long waiting times for appointments. These long waiting times have not only affected patients, but also staff at

the front desk who face the stress and bear the brunt of disgruntled patients. As one staff member noted, '[W]e've had a really difficult year with understaffing and huge stress and it's been a real challenge.' In the words of another:

Everything's time. Its all time-consuming, teaching them how to tell the time, teaching them how to catch a bus, showing, trying to draw a map of where Auckland Hospital, Greenlane Hospital is. It takes ages, a long time.

Staff retention amid high stress levels has been an issue and one GP left for these reasons. This departure was a blow to the team and a poignant reminder that a commitment to self-care was important. Nevertheless, it was felt that, 'it's a very good team to work with. We have very much a team approach and we support each other.'

Despite the challenges and barriers described above, HoP is highly regarded both by refugee groups and members of the wider Mt Roskill community as a beacon of hope and an example of what locally grown community initiatives can achieve. The GPs at HoP have successfully adapted certain aspects of their service provision methods in order to accommodate and respond to refugees' health needs. This includes efforts to assist refugees to familiarise themselves with New Zealand's health care system, accommodating Muslim women's requirement for a female doctor, assisting patients with securing transport to specialist appointments, and the clinic's ongoing efforts to better understand and cater to its clients' needs. These efforts include the representation of refugee groups on the clinic's management board, and through commissioning research and surveys to monitor patient satisfaction levels.

The clinic has a reputation as being friendly, helpful and efficient, and has gained credibility and acceptance within the eyes of refugees over a relatively short time. A number of refugee representatives mentioned that clinic staff demonstrated high levels of cultural awareness and sensitivity. An example of this was the way in which clinic staff took the initiative to provide culturally acceptable washing containers in toilets for Muslim patients. Others valued the speed of referrals to specialist services and felt that HoP staff were more responsive to their needs compared to other health providers. Mt Roskill community representatives also demonstrated high levels of pride and ownership in the clinic, referring to it as 'their clinic' – a local service meeting the needs of local people for affordable, accessible and appropriate health care services.

Conclusion

This paper has contributed to an understanding of the increasingly diverse relations between culture, place

and health (Gesler & Kearns 2002). Previous studies have tended to focus on one component of this equation or the other (i.e. services or users). A key contribution of our paper is the contemporaneous consideration of both perspectives within the same neighbourhood setting.

We began by insisting that there are practical as well as ethical (and sometimes legal) imperatives for responsiveness to diversity in primary care. While much discussion in the primary care literature has focused on transactional communication issues in the doctor–patient relationship, we have argued for a broader need for attentiveness to change in primary care settings and our evidence has supported this case. The changing social landscape of larger Western cities is increasingly reflecting transnational flows of people, practices and ideas about health. This situation demands a greater attentiveness to the health needs of a population and the health services in place at a neighbourhood level. In Mt Roskill, providing a discounted, community-owned service such as HoP has clearly been a sound beginning. Further adjustments in terms of funding, staffing, training and the style of patient/professional contact seem a necessary prerequisite for advancing health and social care in the community.

We conclude that there are challenges for all participants in primary health care activities within the neighbourhoods of rapidly changing and ethnically diverse Western cities. The challenges for refugees and other new migrants centre on issues of access to care. Many such people have a limited grasp of the intricacies and complexities of the health system within their country of arrival. In many cases, this is because the system in countries such as New Zealand is vastly different to that present in the refugees' country of origin. There is clear need for funded health educators to provide a comprehensive orientation on such matters at the time of their registration at a service like HoP.

The challenges for primary health care professionals centre on the funding of care, the provision of translators and the training of health professionals. First, both capitated and fee-for-service regimes for the funding of general practice can lead to pressure to keep consultations within specified time frames (frequently 15 minutes). If countries such as New Zealand are to remain committed to welcoming and resettling refugees, then there should be a commitment to reimbursement structures which take account of the time demands which the needs of refugee patients place on doctors and nurses. As our study has shown, these demands arise through not only the challenges of communication, but also through the complexity of the symptoms and conditions presented. Secondly, many of the delays and frustrations experienced by both the users and providers of services would be addressed by the funding of

appropriate translation services. This point relates to that made earlier concerning health educators. The need is not only for the literal translation of matters spoken within health care communications, but also for a broader translation of health beliefs and expectations between the participating parties. Thirdly, the commitment to developing awareness of cultural diversity and its implications within medical education has lagged behind that of nursing in New Zealand (Kearns & Dyck 1996). Even in a clinic that is self-consciously dedicated to serving a diverse population, there can be a measure of dissonance between the world views of doctors and patients. Therefore, concern for the quality of communication behind the closed doors of a consultation room is a necessary but not sufficient element of a culturally appropriate primary care setting (Wepa 2004). We advocate an enhanced commitment to developing cultural awareness through incorporating social-scientific perspectives to complement biomedical knowledge in medical education.

More generally, the challenges for those involved in health and social care at a neighbourhood level are to remain vigilant to the shifting social dynamics in their midst. Our paper has highlighted the necessity of being aware of any dissonance between needs and response at the level of neighbourhood within areas of rapid population change. In the case of our study area, the demographic composition changed rapidly within the short time between when the clinic was planned and its first year of operation. Being responsive to change requires both an 'ear to the ground', and ongoing monitoring and research. To achieve this responsiveness, maintaining an elected board comprising both community and clinic representatives, as well as developing relationships with sympathetic researchers, can assist in bridging what otherwise might be a gulf between clinic and community.

The health needs and challenges experienced by refugees have received limited attention at the policy level, with only a small number of refugee-focused initiatives having been established at the District Health Board level. There remains much work to be done. This research has made an unanticipated contribution in its use by the authors and others to lobby decision makers within the Ministry of Health to include refugee groups within the 'high health needs' list on the current primary health care access funding formula.

While the particularity of the experience and situation of HoP is distinctive, other primary care practices in New Zealand serve similar population groups, but few make such efforts to cater for their health needs. We acknowledge the limitations of our study, focussing as it does on a singular clinic and neighbourhood in one diversifying city. Comparative research between this

case study and other locations would clearly yield valuable insights. However, lessons can be learned from this case example. We believe the study highlights the richness of insight that using qualitative approaches in primary care research can yield. As international mobility and migration increases, populations and practices are becoming increasingly diverse. Therefore, the findings are relevant for the primary care sector both in New Zealand and internationally.

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