Rural and Remote Health
MEDLINE listed
Impact factor .979
FRAME
ARHEN
Wonca
RURAL HEALTH
ISSN 1445-6354
The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy

ORIGINAL RESEARCH

Factors affecting access to healthcare services by intermarried Filipino women in rural Tasmania: a qualitative study

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Submitted: *23 February2012;* ***Revised:*** *25 July 2012,* ***Published:*** *24 October 2012*

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Rural and Remote Health **12: 2118. (Online) 2012**

Available: http://www.rrh.org.au

ABSTRACT

Introduction: Access to health care services is vital for every migrant's health and wellbeing. However, migrants' cultural health beliefs and views can hinder their ability to access available services. This study examined factors affecting access to healthcare services for intermarried Filipino women in rural Tasmania, Australia.

Methods: A qualitative approach using semi-structured interviews was employed to investigate the factors affecting access to healthcare services for 30 intermarried Filipino women in rural Tasmania. The study used grounded theory and thematic analysis for its data analysis. Nvivo v8 (www.qsrinternational.com) was also used to assist the data coding process and analysis.

Results: Five influencing factors were identified: (1) language or communication barriers; (2) area of origin in the Philippines; (3) cultural barriers; (4) length of stay in Tasmania; and (5) expectations of healthcare services before and after migration.

Conclusion: Factors affecting intermarried Filipino women in accessing healthcare services are shaped by their socio-demographic and cultural background. The insights gained from this study are useful to health policy-makers, healthcare professionals and to intermarried female migrants. The factors identified can serve as a guide to improve healthcare access for Filipino women and other migrants.

Key words: Australia, cultural beliefs, health, health care access, intermarried Filipino women, migrants.

Introduction

Australia is a land of multicultural diversity with migrants who have come from many countries for differing reasons. Some come to Australia as a result of intermarriage (generally referred to as intermarriage) with Australian partners. Interracial marriage is a term used to describe a marriage of people from different racial or ethnic groups[1]. Intermarriage is a recognised topic of interest for social science research due to an ever-increasing social trend creating its own migration patterns. In the literature, the terms 'interracial marriage ' and 'intermarriage' are used interchangeably. In Australia interracial marriages are increasing as the population becomes overall more culturally diverse[2]. Intermarriage between Filipino women and Australian men rose very sharply from 1978 and peaked in 1986, and has remained high[2]. Statistically, marriages involving Filipino women in Australia are four times higher than those in Canada and three times higher than those in the USA on a per capita basis[3,4].

Filipino wives in Australia, like other migrants, generally face many difficulties in accessing healthcare services in their new land. It has been found that migrants access health services less often than Australians do because they face challenges that include poor access to healthcare services, language barrier, inappropriateness of the healthcare system, and limited knowledge about the services available[5].

From the service provider's perspective, health professionals also face challenges in dealing with migrants due to cultural and linguistic differences and possible lack of awareness. Moreover, there are many barriers for migrants in accessing health care such as language barriers, cultural differences, transportation difficulties, poverty, the lack of health insurance, immigrants' status, limited availability of providers, scheduling appointments, and long waiting period[6-10]. Among these, cultural and language barriers are the two most prevalent and have been consistently cited in research. Although research has focused on barriers to accessing healthcare services by migrants in Australia, factors affecting access to healthcare services by intermarried Filipino women are less often mentioned in the literature. This article aims to examine these factors and provide insights useful for Tasmanian policy-makers and healthcare professionals in improving available healthcare access for intermarried Filipino women in Tasmania in particular, and also other Australian migrant groups.

Methods

The following research questions were formulated about the health and wellbeing of intermarried Filipino women in rural Tasmania:

- What are their lived experiences in intermarriage in relation to their acculturation into a new cultural environment?
- What are the factors affecting their access to healthcare services?
- How do these factors affect their health and wellbeing?

A qualitative approach using semi-structured interviews was employed to investigate the factors that influence their access to healthcare services. The study used grounded theory and thematic analysis for its data analysis. To recruit participants the researchers contacted the Filipino Association of Tasmania for assistance. The selection criterion for participation was:

- Filipino women who are married to Australian men
- living in rural Tasmania
- experienced in accessing healthcare services in Tasmania.

Thirty of the thirty-four Filipino women invited to participate accepted and interviews were conducted at a mutually convenient place. Phone interviews were used at participants' request. Participants were given the option of interview in the English or Filipino language because the researcher

conducting the interview was of Filipino background and the other researcher was not. Most interviewed participants chose to speak in Filipino. The interviews took between 45 and 60 min to complete. Some participant characteristics are presented (Table 1).

Data analysis

Data were analysed using grounded theory[11] and thematic analysis[12-15] with the aid of NVivo v8 (www.qsrinternational.com). These were the most suitable approaches because the data were analysed inductively which 'involves searching out the concepts behind the actualities by looking for codes, then concepts and finally categories'[16]. The categories were then linked and the connections between concepts examined, which led to emerging themes. These themes formed the basis of presentation and discussion of the analysis. Data were coded inductively to ensure the raw data were coded transparently. In other words, various minor themes were connected to a commonly shared theme and this process finally identified only major themes.

Ethics approval

Ethics approval for the study was granted by the Human Research Ethics Committee (Tasmania) Network on 15 April 2008 (#H9912). All participants in the study gave informed consent and their anonymity was maintained.

Results

The five main thematic categories that emerged from the data were: (i) language or communication barriers; (ii) area of origin in the Philippines; (iii) cultural barrier; (iv) length of stay in Tasmania, and (v) expectations of healthcare services before and after migration.

Language or communication barrier

Language is at the core of communication. Thus, when a migrant has difficulty speaking the language of the host country it impacts on healthcare service access. However, the intermarried Filipino women studied stated they did not encounter any communication barriers with Australian speakers. Nevertheless, the accent, pronunciation and the colloquialisms used by local Australians were key factors interfering with their receptive communication.

> *I have been living in Sydney and Tasmania for many years but I still find it difficult to fully understand other Australians, even my husband especially when he talks really fast. I even attended a school in Sydney and got a chance to mingle with other Australians. However, I'm still not used to their accent.* (Participant 24)

Thus, understanding Australian accents and colloquialisms may adversely impact a Filipino woman's ability to access available health services and to interact effectively with those in the community. As such, during the early stage of their migration the participants lacked the confidence and linguistic skills to contact health workers and engage in communicative interaction. This led to an over-dependence on their husbands to communicate on their behalf. This challenge was exacerbated when husbands were not home. Participants who could not drive found their situation extremely difficult especially when they were sick and needed to consult a health professional. Finally, due to over-dependence on husbands, intermarried Filipino women were less likely to attempt to learn about services available in their host country.

> *At first, I let my husband make an appointment for me to see our family doctor because I was so hesitant to make a call to the medical centre. In fact during my first pregnancy, every time I had a check-up, we made it a point that my husband would be available on the day I had the check-up.* (Participant 5)

> *I have heard from my friends about different health care services but I did not take it in because I know my husband knows where we need to go and I leave it all up to him.* (Participant 1)

Table 1: Participant characteristics

Characteristic	Participants % (*n*/*N*)
Age group (years)	
25-35	30 (9/30)
36- 45	40 (12/30)
46- 55	30 (9/30)
Length of stay in Australia (years)	
6-10	46.6 (14/30)
>10	53.4 (16/30)
Philippines location	
Rural	56.6 (17/30)
Urban	43.4 (13/30)
Age gap between wife & husband (years)	
1-5	20 (6/30)
6-10	46.6 (14/30)
11-15	16.6 (5/30)
16-20	10 (3/30)
21-25	3.4 (1/30)
26-30	3.4 (1/30)

Area of origin in the Philippines

More than half of the study participants came from rural areas of the Philippines. These participants emphasized the value of cultural beliefs and practices in shaping their health beliefs and practices, particularly in relation to access to healthcare services. For participants with a rural background, deep-rooted traditional beliefs and attitudes impacted the heath literacy awareness which was observed in their urban counterparts. Now living in rural Tasmania, these participants were perplexed when dealing with health issues and health access.

> *In the Philippines, if you are living in the province that means you are far away from the hospital. So when I am sick or any of my family member is sick we mainly rely on herbs. Anyway, we had many herbal plants. So being away from the hospital is not a big problem, plus we don't have enough money anyway to pay for the doctor*. . (Participant 29)

According to the participants, living in rural Tasmania is different from living in the rural areas of the Philippines. For instance, a town or a city in the Philippines is socially and culturally different that in Australia and this determines different social behaviours and expectations and about health care.

> *It's quite hard at first because I cannot find the herbal medicine that I need when I am sick like in the Philippines when I had cold and flu I just drink a hot water with 'Atis' leaves and I am healed. Because I am not used to biomedicine, even though there are lots of medicines available here in Tasmania for cold and flu, I don't seem to like it and even trying it.* (Participant 5)

Cultural barriers

Traditional beliefs and practices hinder participants' access to health services, particularly those from rural areas of the Philippines. They find it hard to adopt the new health practices of the host country. For instance, it was mentioned that 'their traditional practices have been part of their lives since birth' (Participant 13). Thus, accepting and adopting new health practices affects their accustomed ways of

maintaining health and wellbeing, as well as accessing the new health services.

> *It was quite hard at first because I am shy and I felt so hesitant to approach the doctors or any health care professionals or ask questions. There was a time that I wasn't treated well. I don't know if it was because of racism or because I was only quiet and not expressing myself.* (Participant 14)

> *If I am sick I would rather observe my condition first before consulting a doctor as I am not used to it. As long as I drink a lot of water and have some rest, I should be fine If I am sick in the Philippines, then I will easily get some herbal medicine.* (Participant 11)

Length of stay in rural Tasmania

Participants' length of stay in rural Tasmania also affected their health and access to healthcare services, but in a positive way. Their length of stay facilitates knowledge about healthcare services and enhances their health and wellbeing because they have established social connections within their ethnic group.

> *I love living in Tasmania and I have been here for 30 years. It takes a while to settle in but everyone is helpful and friendly over the years.* (Participant 13)

> *At first it was necessary for me to know more how to access the services in Tasmania since this is now my home land yet I was hesitant but as years go by I am very comfortable and can easily ring up the medical centre for an appointment with my GP .*(Participant 15)

Expectation of healthcare services before and after migration

Participants' expectations about healthcare services is a reflection of their cultural identity. Before coming to Tasmania, they held high expectations and views about Australian healthcare services in terms of resources, standard of medical equipment, healthcare professionals, and the services offered in comparison to those in their country of origin. From the Philippines perspective, Australia is an advanced country with modern facilities; thus, they expected health services of high standard that were easy to access. These expectations continued after migration.

> *I expect that Australian health care services are a lot better than those in the country I come from and especially the service from the doctors, nurses and other health care professionals.* (Participant 3)

> *I learned from school before that countries like USA, Australia and China had very good health care services. So I have expected that Australian health care services are as good as USA but I was wrong because Australian health care services are much better than USA.* (Participant 5)

In addition to participants' high expectation of the healthcare services, their views, beliefs and attitudes and previous experiences influenced how they were accessing the services now.

> *In the Philippines, nothing is free and before you are entertained by the doctors and nurses you have to pay a down payment first. So that is why, for me I am not used to access health care services because I always thought that money down first and that is what happen here, especially that I also need to make an appointment before seeing the doctor which I am not used to before. So I'd rather stay home and take tablets.* (Participant 17)

Discussion

The study initially focused on general health issues and access to health care in particular. However, the data analysis widened the scope of the study to include participants' lived experiences in a new cultural environment. Thus, other factors intertwine and influence the health and wellbeing of intermarried Filipino women and, to some extent, affect their Australian partners.

The study found that intermarried Filipino women's behaviours when accessing healthcare services is shaped by their sociodemographic and cultural background. Other contributing factors include communication barriers, cultural barriers and differing expectations. This is consistent with the literature, which suggests an individual's socio-demographic background, health beliefs, experiences and expectations may all influence decision-making in accessing healthcare services[17]. The study findings revealed communication difficulties, area of origin, cultural views, length of stay and beliefs significantly affect intermarried Filipino women's means of accessing the available healthcare services.

In addition, current research into the health status of migrants suggested that upon arrival recent immigrants (< 2 years residence in the host country) are generally healthy, with notable exceptions for some health conditions, such as certain infectious diseases[18-20]. This complements the results of the present study where participants' health status in their first 2 years of stay in rural Tasmania was reported to be generally good. The data demonstrated that intermarried Filipino women, as all migrants, must undergo a medical examination prior to their entry to Australia. Some had to wait for visas for 8 to 11 months or even a year just to receive health clearance. However, after several years of stay in rural Tasmania their health started to decline as they encountered the challenges of a new cultural environment. Vissandjee et al confirm that the 'healthy immigrant effect' disappears over a period of time[20], finding that women who had migrated to and resided in Canada for 10 years or more were more likely to report poor health than Canadian-born women.

The present participants reported the most difficult barriers to accessing healthcare services in Tasmania were communication and cultural issues. Communication or language barriers have long been identified as factors affecting migrants, especially in seeking access to healthcare services. In common with other English-speaking countries, Australia has experienced a dramatic increase in the number of people migrating from non-English speaking countries. Language proficiency is critical to health care as it is the key to communication and integration. According to Roxon, many migrant women experience a double disadvantage due to their lower level of English proficiency, compared with male migrants[21]. Low English proficiency impacts on their ability to access health related information, health services, and more broadly, education, employment and income.

Healthcare providers surveyed in Los Angeles, New York, Houston and Miami found an inability to speak the dominant language was a major barrier to immigrants' access to health care. They observed it was also a serious threat to the quality of care for individuals from non-English speaking background because doctors could not obtain the information needed to make an accurate diagnosis, and patients often did not understand their doctor's instructions[22].

Furthermore, communication is considered to be one of the most important prerequisites for safety in health care. Studies have clearly demonstrated poor language proficiency to be associated with reduced access to health services and preventive services. Language barriers also contribute to an inability to book appointments or to follow advice on prescriptions, and contribute to overall lower quality of care and poorer outcomes[23]. It has been suggested that language remains the largest barrier to accessing healthcare services due to the shortage of trained bilingual service providers[19]. Thus, in order to remove this barrier and improve healthcare access for migrants, there should be more trained bilingual service providers to assist migrants who have difficulties in communicating in English.

The communication barrier is also linked to migrants' cultural health views and beliefs. This study found that participants' cultural views, beliefs and attitudes affected their ability to access healthcare services, particularly when dealing with healthcare professionals. Thus, it is anticipated that miscommunication creates barriers to effective treatment. In addition, Eshiett and Parry found that healthcare professionals may not always understand the beliefs and culture of those from a cultural and linguistically diverse backgrounds[24]. As such, they may be unable to anticipate likely behaviour during illness. However it is

important for healthcare professionals to understand the behaviour of patients before dealing with them.

It is also necessary for intermarried Filipino women to find information about the services available to be able to understand the system when they seek treatment. Learning about available healthcare services is to acquire 'health literacy, which means more than being able to read the pamphlets and successfully make appointments'[25,26]. The study findings suggest the intermarried Filipino women found health information in the media which included newspapers, magazines, television and radio.

Conclusion

This study found that cultural and socio-demographic background were significant barriers to accessing healthcare services for intermarried Filipino women in rural Tasmania. Migration in itself is a health determinant, because movement from one culture to another involves changes in daily routines, lifestyle and culture. It also implies a larger adjustment and requires important knowledge to survive. Thus, a the lack of knowledge about what services are available, along with the cultural beliefs and attitudes of migrants, can hinder their ability to access the healthcare services of their host country.

The study findings suggest that language or communication barriers are a key issue for intermarried Filipino women when attempting to access the health care they require. Therefore, it is vital that all migrant women are offered or have access to interpretation services. However, due to the vast differences reported between the healthcare services in their home land and that of the host country, this migrant population may not be aware of such services. Interpreting services must be more easily accessible with reduced waiting times to obtain access to this essential service. Finally, cultural barriers may be reduced through cultural sensitivity training for healthcare staff. An improvement in staff knowledge of cross-cultural beliefs and practices relating to health and health care could reduce misunderstandings, mismanagement and the stress experienced by both healthcare providers and migrant women.

It is anticipated the findings of this study will provide some insights for health policy makers, healthcare professionals and intermarried female migrants and ultimately improve Filipino women and all migrants' access to healthcare services.

Acknowledgement

The authors are grateful to the University Department of Rural Health, University of Tasmania for granting CH a 'write-up' scholarship to write this article.

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