Attitudes to Illness and Use of Health Services by Economic Immigrants in Slovenia

Danica Rotar Pavlič[1], Majda Brovč[2], Igor Švab[1], Janja Ahčin[2], Marinka Šlajpah[2]

[1]Department of Family Medicine, University of Ljubljana, Ljubljana, Slovenia
[2]Ljubljana Health Centre, Ljubljana, Slovenia

Aim To analyze the attitudes of immigrants from former Yugoslav republics to Slovenia toward illness, concerns about and perception of health status, and factors that influence their use of health services for the prevention and treatment of illness.

Methods We used a qualitative approach, employing the ETHNIC (Explain, Treatment, Healers, Negotiation, Intervention, Collaboration) questionnaire. We analyzed data from interviews with 27 economic immigrants who consecutively came to a general practice office from May 15 to August 15, 2005.

Results Qualitative analysis of the interview showed that health problems were largely understood as consequences of hard work, poor working and housing conditions, and stress. Fear of disability and concern about financial support for their family were important factors why they sought medical help. There were many financial and housing obstacles to leading a healthy lifestyle and following doctors' advice. Inadequate communication with health care professionals was also mentioned. Coworkers were an important source of support, whereas the worker-employer relation appeared to be a negative factor.

Conclusion Identifying factors that influence health care utilization and attitudes about illness is a first step toward improving health care among immigrants. Improving the sanitary and hygienic aspects of their lives and becoming familiar with their basic health problems will improve quality of treatment at the primary care level.

> **Correspondence to:**
Danica Rotar Pavlič
Department of Family Medicine
University of Ljubljana
Poljanski nasip 58
1000 Ljubljana, Slovenia
danica.rotar@guest.arnes.si

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Inequalities in health care have been described in relation to region, socioeconomic status, educational and marital status, and ethnicity (1,2). Because they moved from a less prosperous environment, migrants are often more disadvantaged than the indigenous population.

Rarely persons deliberately migrate to obtain better medical treatment, but most do so in order to secure employment. Many come from situations with poor health facilities and have underlying health problems that have not been adequately addressed. They bring with them cultural attitudes to health care appropriate to their own experience, and not necessarily to the host country. Also, immigrants respond less well to preventive care opportunities such as vaccination (3); they often have language difficulty (4-6); and are unfamiliar with practices of health care regulation in the host country, such as appointments and registration procedures. Racial and ethnic minorities are less likely to receive even routine medical procedures, experience a lower quality of health services, are less likely to receive appropriate cardiac medications or to undergo bypass surgery, and receive kidney dialysis or transplants (1).

The relationship of immigrants with their physicians is also rather important. Communication is an important part of health care (7,8) and immigrants' difficulties with the language of the host country may cause inappropriate investigation, lack of recognition of mental illness, and their poor compliance with therapeutic recommendations.

Slovenia has a population of 2 million people; it is a relatively prosperous country with a tradition of economic immigration from republics of the former Yugoslavia (9,10). Among the approximately 46 000 foreigners who received work permits in Slovenia in 2005, 90% were from republics of the former Yugoslavia and most were temporarily working in the construction industry. These immigrants share a common cultural and ethnic background and speak a similar language, and many have relatives in Slovenia. They live in residential groups often organized by their employers and they socialize with their compatriots in their traditional lifestyle. They commonly share their problems and difficulties, and support each other morally and psychologically.

The aim of the study was to identify immigrants' attitudes to health problems and situations in which they find medical treatment necessary. We also asked about the obstacles that they encounter while receiving primary level health care and possible adjustments that should be made to facilitate cooperation with health services.

Subjects and methods

We conducted interviews with migrants from the republics of the former Yugoslavia who sought health care at a single general practitioner's office at the Ljubljana Health Center. The study lasted from May 15 to August 15, 2005. One researcher (MB) recruited patients as they visited her office. The sampling ended when saturation of themes was reached, which occurred after 27 interviews.

Subjects

Data from 27 interviews with economic immigrants were analyzed. The only inclusion criteria were Slovenian work permit and citizenship of one of the former Yugoslavian republics. Work permits are granted based on the employee's application, depending on Slovenian labor market conditions. All subjects who obtained work permit also received a residence permit and the right to compulsory national health insurance. We interviewed 27 men ranging from 23 to 51 years of age, including 13 masons, 7 construction workers, 4 carpenters, 1 caster, and 1 manager in a con-

struction company. Twenty interviewees were citizens of Bosnia-Herzegovina, 5 of Macedonia, 1 of Serbia, and 1 of Montenegro. The interviews lasted approximately twenty minutes.

Interview

The interviews were semi-structured and the 13 questions used were derived from the ETHNIC (Explain, Treatment, Healers, Negotiation, Intervention, Collaboration) questionnaire (11). The order of the questions was not fixed; if, at the beginning of his visit, the patient immigrant was concerned about how the illness would affect his relations at work, the physician interviewer would begin the conversation with the last part of the questionnaire. During the study, the questions were not asked in the same order, although each patient was asked all of the questions.

The following questions were asked:

1. What do you think may be the reason you have this problem?

What do friends, family, and others say about these symptoms?

3. Do you know anyone else who has had or who now has this kind of problem?

4. Have you heard about/read about/seen it on TV/radio/newspaper? (If patients cannot offer an explanation, ask what concerns them most about their problems).

5. What kind of medicines, home remedies, or other treatments have you tried for this illness?

6. Is there anything you eat, drink, or do (or avoid) on a regular basis to stay healthy? Tell me about it.

7. What kind of treatment are you seeking from me?

8. Which of the suggested measures of treatment seem less feasible or unfeasible to you?

9. Why do you find the suggested measures more difficult or unfeasible to implement?

10. Which measures would it be wise to implement during the treatment procedure?

11. Do you have any relatives/friends/other persons who will help you during the treatment?

12. How will the treatment affect your financial status?

13. How will the treatment affect your employment?

Although the ETHNIC questionnaire was developed as a practical cultural competence tool to assist busy family physicians in their daily work, in our study it served to explore the points of view, expectations, and obstacles that immigrants encountered in treatment. Written consent was obtained after the objectives of the study had been explained to potential subjects. Patients' understanding of the questions was repeatedly checked during the interview, and all questions and answers were checked for accuracy at the end of the interview. At the beginning and during the interview, the subjects were asked to interrupt the conversation if anything was unclear for linguistic or other reasons. The interviews were conducted in Serbian or in Croatian. One researcher (MB) read the responses to the subjects once again at the end of the interview. The credibility of the transcript was confirmed with a signature. A temporary written record was made and then typed and translated into Slovenian.

Qualitative analysis

The content of the interviews comprised the following themes: a) Causes of health problems; b) Reasons for visiting a general practitioner; c) Concerns about health and disease prevention methods; d) Access to health care; e) Medicines and self-treatment; f) Obstacles to better health; and g) Support from coworkers and family.

The data were analyzed by 3 independent investigators using standard established qual-

itative methods (12-14) according to the following principles: a) Identification of reasonable contextual parts (statements, quotations) and assigning appropriate codes; b) Connecting codes into reasonable central contents; c) Rechecking quotations and codes (review); and d) Final creation of Microsoft Word data files with final quotations, categories, and themes.

Three interrelated criteria were included in the analytical process, as follows: interpretation of subject meaning, description of social context, and attention to lay knowledge (15). The text analysis process was repeated several times. The results of the analysis (category codes) were harmonized at meetings between the researchers JA, MŠ, MB, and DRP. A structured coding scheme was developed in a stepwise progression. The reliability of the findings was examined using investigator triangulation (16). Two investigators with different expertise interpreted the data: MJ, an ethnologist and cultural anthropologist and MŠ, head of the Department for Non-Citizen Employment at the Employment Service of Slovenia.

The study was approved by the Slovenian National Ethics Committee.

Results

Causes of health problems

Immigrants reported working conditions as the cause of their difficulties. They were exposed to constant pressure because of the employers' need to reduce the workforce and improve productivity. Poor housing with unsatisfactory food storage, poor hygiene, poor nutrition, and dissatisfaction with the type of work and job in general were all considered the causes of illness. Protective equipment at work was of poor quality and often not used because it impeded subjects' ability to work. They were convinced that conditions at the workplace and in their home environment, as well as the fear of losing their jobs, had an influence on illness.

- "I have to stand on my feet in the foundry for 12 hours. I get a five-minute break." (Immigrant 5)
- "I was too tired. I work 10 to 11 hours a day, and 9 hours on Saturday." (Immigrant 19)
- "We've reduced the number of workers doing concrete work. The work is too strenuous now. I don't walk, I have to run. There were 10 workers before, now there are three or four. I work 8 or 10, even up to 12 hours a day. My work doesn't stop even if it rains." (Immigrant 11)
- "I have protective equipment, but I don't always use it at work because it slows me down and they want me to work faster." (Immigrant 23)
- "Fruit is too expensive; I haven't eaten any apples for six months. There's no kitchen, and the biscuits are too expensive. There are no snacks or lunch at the company now. I eat canned food and bread." (Immigrant 11)
- "We have poor housing conditions – four or five workers living together. We're not allowed to use electricity for cooking and refrigeration; it's just for light and the bathroom." (Immigrant 4)
- "I don't have a fridge, so I go to the store every day to buy food. There's no kitchen. There is one stove, two toilets, and two showers for more than 40 people." (Immigrant 17)
- "I had coronary arteriosclerosis, although I didn't feel anything. This was caused by lifting something too heavy." (Immigrant 16)
- "Lots of stress is caused by worry and fear." (Immigrant 5 commenting on emotions and their connection to disease)
- "This [disease] is caused by anger, which gets into your stomach." (Immigrant 21)
- "Health problems can also be caused by worries and distress." (Immigrant 8)

Reasons for visiting a general practitioner

Immigrants feared physical disability, and cited this as the main reason for seeking consultation. They were worried that the illness might lead to the onset of disability that could cause them to lose their jobs. Their strong concern for the financial welfare of their families in their native country increased the fear they felt when the signs of illness appeared. Some shared their concerns with the family members, whereas others keep silent about their health problems. Out of 27 immigrants, 22 said that they had not received any information through the media about health and health problems. They said that they had not have time to keep up with the news and that they also had had difficulty understanding Slovenian.

- "I'm afraid of being unable to work because I'm a manual laborer." (Immigrant 4)
- "I'm scared of losing sight in my left eye too." (Immigrant 5)
- "We're all scared of losing our legs – who could take care of forty family members then?" (Immigrant 9)
- "My family members told me I should see a doctor." (Immigrant 5)
- "My family said I should see a doctor, no matter what it cost." (Immigrant 4)
- "My wife doesn't know. She'd be scared I might die." (Immigrant 16)
- "My family's at home in Bosnia – I'm not supposed to tell them anything." (Immigrant 18)
- "My co-workers told me to see a doctor, and so did my boss." (Immigrant 25)
- "I was watching a show on Bosnian TV. The doctor was telling people they should pay attention to their blood pressure between the ages of 45 and 55, because otherwise they could have a stroke. My co-workers said if my blood pressure wasn't steady I might be attacked by a certain virus." (Immigrant 7)
- "It's hard for me to understand Slovenian on TV." (Immigrant 25)
- "I don't have time for TV because I work all day." (Immigrant 9)

Concerns about own health and measures for preventing illness

Most of the patients were not concerned about their health as long as they were fit to continue working. Six subjects were interested in improving their health felt that their financial and housing situations imposed limitations. Five subjects mentioned smoking, 2 had given up alcohol, and 14 believed their health was influenced by their nutrition. Sample comments include the following:

- "I think about my health when I get sick. I haven't been sick yet." (Immigrant 4)
- "I don't pay any attention to my health – it's too difficult. I'm not hungry, but I also can't eat the food I like. I don't drink juice every day, just once a week." (Immigrant 15)
- "I haven't drunk alcohol for six years, but I drank too much during the war" (Immigrant 11)

Access to health care

Regarding accessibility of health care, workers cited difficulties due to physical accessibility and transportation costs, obstacles to affording co-pays for health care services, and lack of faith in routine physical checkups. Checkups are carried out to satisfy formal requirements expected from companies. Immigrants have no confidence in these examinations. When faced with health problems, some prefer to go to after-hours health care services in their home countries.

- "I'm not interested in going to physiotherapy. I have to change buses twice each way, and it's no use wasting the money." (Immigrant 26)

• "I don't have any extra insurance and I have to pay for every single examination." (Immigrant 2)

• "Once every year or two we go have a physical examination. But that's just a formality. I don't have any faith in it." (Immigrant 4).

• "I went to the emergency room at home; I got three injections." (Immigrant 8).

Medicines and self-treatment

Often not all treatment options are available and immigrants must rely on illegally obtained medication or self-treatment. Immigrants said that they obtained medications on the black market or from coworkers or acquaintances. They also spoke of various methods of self-treatment, of which traditional folk remedies were most frequently used. Only one subject expressed a negative opinion about this.

• "I bought medicine on the black market when I was in Germany because I didn't have any insurance. I was also working illegally." (Immigrant 19)

• "My co-workers ask me if their tablets might help me too. If they see a doctor and get Ultop (a proton pump inhibitor), they give the medicine to me if there are any tablets left." (Immigrant 21)

• "My aunt gave me Naklofen (a non-steroid anti-inflammatory drug). I take it and go to work." (Immigrant 23)

• "I'd never try to heal myself. I'm not a doctor." (Immigrant 22)

• "You heat an onion cut in half over the fire and put it on the wound – this heals the abscess." (Immigrant 18)

• "My boss's grandmother gave me the compresses. You take wax that's thick like ointment and massage it in, and then put a wet gauze on top. It helps. My wife has a green ointment that stings." (Immigrant 9)

Obstacles to better health

Apart from the observations made regarding housing and hygiene, the immigrants felt that they were treated unjustly by their employers with regard to sickness and absence. Based on the number of times it was mentioned, poor living conditions were one of the central factors influencing a poor sense of well-being.

• "There's no refrigerator and no ice in the efficiency apartment." (Immigrant 24)

• "You might get fired when you come back from sick leave." (Immigrant 4)

• "My boss doesn't give me any money when I'm gone for a few days. I'll make it up by working extra hours." (Immigrant 7)

• "My boss gave me half an hour off before surgery. I took a shower and was 15 minutes late for my operation. Private employers are like that." (Immigrant 18)

• "When I'm sick I don't like to stay home because my pay is immediately cut." (Immigrant 11)

• "My former company didn't pay for the days I spent on sick leave, but my current company does." (Immigrant 3)

Support from coworkers and family

Fellow workers are an important resource that helps immigrants during illness. Eight immigrants were assisted by family members to take appropriate health care steps and to visit their general practitioner.

• "We come from the same town and take care of each other." (Immigrant 13)

• "I have a father-in-law. He visits me every day and asks how I'm feeling." (Immigrant 6)

Discussion

This study examined immigrants' attitudes to health and the influence of such attitudes on their poor sense of well-being, absenteeism, failure to use protective equipment at work,

and fear of disability and losing their job. None of the immigrants stated that they spoke about health problems as part of their regular checkups. We did not expect that difficult social and living conditions would be the topic mentioned in the interviews, but this turned out to be an important finding of the analysis. Immigrants were exposed to poor sanitation, cramped living conditions, low-quality food, and a lack of hot meals, but fear of job loss prevented them from more actively asserting their rights. They preferred to seek solutions for health problems among their coworkers and acquaintances, and they resorted to traditional methods of alternative medicine. Transportation costs prevented some of them from seeing a physician more often or to take part in rehabilitation, such as physiotherapy. Linguistic barriers also represented an obstacle.

The technique of individual interview is appropriate to examine participants' cultural beliefs and values (14). The possible effects of language difficulties related to interpretation were reduced in our study by using a restricted number of interpreters (17-19).

A limitation of this study was that it was carried out only at a single practice. Even if the participants represented a typical group of economic immigrants to Slovenia, immigrants from other practices would maybe yield even more information. The method of interview and its analysis, as well as the fact that immigrants lived in residential groups often organized by their employers does not permit generalization of our findings. However, we feel that even this small-scale study revealed the main difficulties experienced by immigrant workers in Slovenia.

The immigrant workers greatly feared disability. They perform jobs with higher rates of occupational hazards and live in areas with great environmental hazards (20). The pressure to keep earning money made them feel dissatisfied with other aspects of their lives such as nutrition and housing. In general, they did not seek a healthy lifestyle, but when they got ill they were willing to give up smoking and reduce alcohol intake even though this was not a pattern of behavior that might be expected in their native countries. Slovenian media did not play a significant role for immigrants because of their lack of time and difficulties in understanding Slovenian.

Alternative forms of medication, such as herbal preparations, were maintained as a form of treatment. This type of behavior probably has its origin in limited opportunities to obtain adequate health care in their countries of origin. They tend to seek health care advice only for more serious conditions or because their self-medication had been unsuccessful. Immigrants' individual beliefs about health and illness are culturally determined and may affect health, self-care practices, the type of health care sought, and the degree of compliance (21). Beliefs are essential for self-care practice and care-seeking behavior, and must be considered when planning clinical care (22).

Modern approaches to health care give the patient an active role and characterize the relationship between the physician and patient as a partnership (23-26). The immigrants were inclined to accept illness as part of their fate, they had difficulty in discussing their problems with a medical advisor in a manner that would give them a shared role in health management, and sometimes they had language difficulties (27,28). Their fear of inability to work and its inevitable economic consequences for the welfare of their families dominated their behavior during consultation. They felt vulnerable in their new environment and tended to be emotional about particular difficulties during consultation because of worry and distress.

In general, the immigrants felt that financial and housing problems were the most important factors in their life, followed by the

strenuous nature of their work. Communication problems negatively affected the optimal use of health care facilities.

Employers differed greatly; some directed sick immigrants to see a doctor, whereas others maintained an atmosphere of intimidation in which workers did not dare to express a need to see a doctor. Opportunities for preventive care were seldom received and even the use of protective clothing such as special footwear was not adopted if it would negatively affect productivity. The results of qualitative research have been confirmed by means of quantitative research (29).

Further research is needed to validate the findings of this study through quantitative methods. Increasing the sample size and conducting the research in other settings might provide us with additional ideas. Research that includes observation at the workplace and in the home environment would provide more reliable ethnographic information.

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