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The Right to Health: Conflicting Paradigms of Health as Commodity vs. Health as Human Right

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The Right to Health: Conflicting Paradigms of Health as Commodity vs. Health as
Human Right

by

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A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Arts
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ABSTRACT

Despite the fact that the United States spends more per capita than any other nation on healthcare for its citizens, the quality of American health outcomes lags well behind every other developed country in the world. This paper proposes that it is no coincidence that the United States is also the only developed nation that does not guarantee the right comprehensive coverage of medical services for its citizens. Instead, we rely on a fee-for-service system which functionally denies quality health care to those without the means to pay for it.

In this paper I document the experiences of various clients and staff of the Center, a torture survivor treatment and support agency, the majority of whose clients are or were refugees or political asylees, with the healthcare systems in the United States and elsewhere. I also analyze documented differences in the efficiency, efficacy, and levels of satisfaction with these foreign health care systems to that of the United States. The barriers to good quality health care experienced by the participants in this research are systemic, rather than individualistic, in nature. I therefore argue that the American ideology of health as a commodity to be bought and sold directly contributes to the inferior health outcomes of the United States health care delivery system, as compared to other nations whose ideology of health holds it to be a universal human right.

Introduction and Project Concepts

The United States indisputably has the most technologically advanced health care delivery system in the world. In 1995 alone, the United States' health care system was the recipient of over 14% of the Gross National Product, a greater percentage than that of any other country in the world, developed or otherwise (Lassey et al. 1997: 27). And yet, paradoxically, "outcomes such as the infant mortality rate and life expectancy are far from the top rank of countries," particularly developed nations of the First World (Lassey et al. 1997: 66). Why is it that other nations of the world are able to get better results from their health care delivery systems than the United States, despite the fact that we spend "twice as much per capita on health care as developed European nations and nearly forty percent more than Canada, which has the world's second-highest spending on health care" (Harvard Law Review 1995: 1325)? Despite even, if you will, the "bleeding edge" medical technology that America can boast?

In this paper I posit the existence of at least two ideological models of health care. First is the American-style model, in which health care is a business, and health is a commodity to be purchased by consumers. The other is the UN-style model, in which health and access to care are universal human rights, as spelled out in Article 25 of the Universal Declaration of Human Rights, to wit: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and *medical care and necessary social services*, and the right to

security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control,” (emphasis mine) (United Nations 1948). In comparing and contrasting the efficacy of health care systems based on one or the other of these two models, it is useful to determine whether or not there is any significant difference between them with regard to the equitable distribution of health care resources, and the health outcomes of nation-states that employ these ideologies.

Obviously, the United States is premier among nations that employ the first model. Indeed, “private health care has been largely an entrepreneurial activity since the founding of the country,” and initiatives to create any sort of national health insurance plan have been vigorously opposed and defeated by “powerful interest groups,” including the American Medical Association, since the Theodore Roosevelt administration (Lassey et al. 1997: 29-30). The situation thus created is one of stratified hierarchies of health outcomes along the lines of socioeconomic status and racial/ethnic groups. As a result, American health outcomes for “low-income and some minority members of the population” are “much poorer” than those at the other end of the socioeconomic scale (Lassey et al. 1997: 28).

Health disparities along these lines are well documented in the United States. “Differences across socioeconomic and racial/ethnic groups or combinations thereof range up to ten or more years of life expectancy and twenty or more years in the age at which significant limitations in functional health are first experienced” (Hofrichter 2003: 89). Naturally, the federal Public Health Service (PHS) and National Institutes of Health (NIH) have identified such inequitable disparities in health as a priority for improvement.

The fact remains, however, that the more negative health status indicators of the United States, relative to other advanced industrial and post-industrial nations, “are to a significant degree indicative of inadequate health conditions for lower-income mothers and children, and inadequate quality of life for many minority and lower-income” residents (Lassey et al. 1997: 27).

In contrast to the United States, “relatively poor societies (e.g., China, Costa Rica, Sri Lanka, Kerala state in India) have achieved ‘good health at low cost’ by focusing their limited resources on ensuring equal access to basic primary and preventative care” (Hofrichter 2003: 114). A cultural atmosphere such as Japan’s gives a fine example of universal access to care even in a primarily fee-for-service system, where public health initiatives are strongly emphasized and public health indicators are comparable to or more often significantly better than those of the United States, relative to population differences. This is true even in spite of the relatively modest resources Japan as a nation spends on formal healthcare systems and high-end biomedical technology (Ohnuki-Tierney 1984, Lassey et al. 1997). It seems plausible, then, that the American-style cultural model of health care as a commodity to be bought and sold creates an inherently different level of health care quality than the UN-style ideological model that views health care as a universal human right.

More developed nations that adhere to the UN-style ideology of healthcare have realized that in order to provide truly equitable health care to their people, it is necessary not only to deal with “individuals and their risk behaviors, but also... the inequalities in life chances and living standards which shape people’s lifestyles” (Hofrichter 2003: 523).

For people whose lives have been uprooted from all that they know by tragic events, and forced to take refuge in unfamiliar lands and cultures, this is doubly important, as such people are subjected to the most barriers to obtaining quality health care, despite the near-certainty of being those in greatest need of it. This is particularly true in nations whose health care delivery systems adhere to the American-style health-as-commodity ideology, precisely because such an ideology contributes to the continuing disparities in health experienced by the people of such nations, as I will seek to demonstrate in this paper.

Refugees (and asylees, and seekers of asylum) “escape regions or countries where genocide, civil or international war, military dictatorship, or gross violations of human rights, such as torture, have occurred” to find safety for themselves and their families (Quiroga & Berthold 2004: 5). The number of people from around the world who have chosen to settle in the United States after having to flee their home countries is growing, and testing the adaptability of the American health care delivery system. Indeed, as much as “two thirds of all refugee resettlement in recent years occurs in the USA” making it the most common country of second asylum in the world (Kemp & Rasbridge 2004: 19). A country of second asylum, in this context, refers to a country to which refugees flee and are resettled in the event that their home nation and/or the first nation they flee to are unable to offer them permanent asylum from the difficulties that caused their flight, such as Bosnians who settle in the U.S. after a period of residence in Germany, or Central Americans who do so after a period of residence in Mexico (Kemp & Rasbridge 2004).

Many refugees come to the United States with “an idealized image of a system that will take care of all their needs,” which is “rudely dispelled when they encounter the

bureaucratic maze of service fees, scheduled appointments, and insurance options that characterize medical care in the United States” (Burgess 2004: 2). This is largely due to that fact that foreign-born people in the United States face “unique barriers when attempting to benefit from health care; these include difficulties in cross-cultural communication, disparate health practice beliefs, and limited cultural awareness on the part of the provider” (Burgess 2004: 1).

Although there is “an effort to acknowledge and address linguistic and cultural barriers, learning by trial-and-error remains the most common form of education on the American medical system” for most such people (Burgess 2004: 1). This is reflected in the fact that “refugees to the United States bear substantial burdens of morbidity,” which are “exacerbated by problems of access to health care in the United States, related to the refugees’ legal status, financial resources, and differences of language and culture between them and providers of care” (Tilson 1989: 1051). Such factors highlight the inequity of the current system of health care in the United States, in that its ability to provide quality health care to its residents is self-limited, both by the reluctance of clinicians to take the time and expense to adopt standards of care that include cultural competence, and by the fee-for-service system which functionally denies quality health care to those without the means to pay for it.

Internship and Agency Description

It was, in part, to seek answers to the above questions regarding comparative health care models that I undertook an internship at an internationally and nationally recognized agency which provides services to survivors of political torture and genocide, which I will hereafter refer to as “the Center.” The Center based in Clearwater, Florida. The clients of the Center with whom I worked are almost entirely refugees, asylees, and seekers of political asylum in the United States. The unfortunate events that necessitated flight from their home countries to the United States virtually guarantee their need for some form of physical and/or psychological medical attention. And, as such, they are all in a unique position to be able to comment from the point of view of someone who has had experience with the health care systems both of the United States and of their various home countries. Such personal, qualitative insight has proven invaluable to the understanding of my fundamental research question, and its answer.

I chose this project out of interest in comparative health systems from around the world, and was fortunate to have contact with a couple of other people who are or were interns at the Center. Because of this interest, and the Center’s own interest in having a detailed description and analysis of its clients’ perceptions of the barriers to healthcare they face in the United States, it was relatively easy to design a project around them. It is to be hoped that the results of this project will serve the needs of the Center by

illustrating areas where their clients' experiences with the American healthcare system are in fact troublesome, and also where their individual perceptions, habits, and/or cultural assumptions may be making access to care more difficult than it needs to be.

I began my internship with the Center in January of 2006, working under the Center's Community Initiatives Coordinator. After a period of training sessions, my first encounter with actual clients of the Center came in the form of a pair of research project focus groups, one group of Bosnians and Roma and one of Colombians, on the topic of culture and what role the clients' culture played in their lives since their experiences of torture and flight from their home countries. Subsequently, I was called upon to help extrapolate themes arising from the data gathered. While gathering the materials necessary to gain IRB approval for my project, I also helped with various tasks around the Center office not involving actual client contact, such as helping to create flyers and promotional materials for events sponsored by the Center, updating training session logs for Center staff, students, and providers, and miscellaneous office work; all the while getting a feel for Center operations.

Once I gained IRB approval for my project, and submitted the necessary background check paperwork to the Center so that I might interact with clients one-on-one, it was late March of 2006. At this point, I began actively attempting to recruit participants from among the clients of the Center. I continued doing occasional miscellaneous tasks as before, but I also began attending some regular client support groups run by the local case managers of the Center, in order to introduce myself and my project to the clients who attended and solicit their participation. During this period, I

witnessed events for refugee children put on by Refugee Youth and Family Specialists from the Center. I sat in on a meeting of the Center senior staff, including my supervisor, the Community Initiatives Coordinator, with federal auditors who were overlooking Center operations, for the essential purpose of ensuring the appropriate use of federal funding. I attended the monthly staff meeting for Center personnel in July of 2006, both to gain greater insight into upcoming projects and operations, and also to present my project to the staff at the meeting in hopes of gaining additional aid to my recruiting efforts. Later that same month, I also attended a meeting of the professional interpreters attached to the Center, several of whom were themselves refugees at some point, in order to attempt to recruit staff participants and obtain their aid in finding client participants, since the interpreters have arguably the most contact with the clients and their needs of anyone on staff at the Center (with the probable exception of the case managers).

Recruiting turned out to be a much more difficult and time-consuming process than I had initially anticipated, and it was not until I had been to several of the support group meetings, which were usually every week or every other week, depending on participation, that I got my first client willing to participate my project. It was also at this time that I began recruiting from the staff members of the Center, particularly those who themselves are or had been refugees or asylees. All but two of my participant interviews took place in August and September of 2006, with one more in early October before I halted recruitment to complete my Graduate Colloquium. My final participant interview came in January of 2007, with one of the mental health providers in the Center's network.

The Center itself is a subsidiary agency of Gulf Coast Jewish Family Services, Inc., a local non-profit, nonsectarian community service organization. The Center has several offices in Pinellas, Hillsborough, Pasco, and Miami-Dade counties, but the primary office is in Clearwater. Its mission statement is to work locally, nationally, and internationally to support the integration of communities through culturally appropriate advocacy and education, to provide research education and training to expand awareness and understanding of global conflict and migration, and to promote human rights worldwide.

The Center provides linkages to comprehensive treatment and social support services to its clients, victims of political torture and genocide survivors who currently reside in the Tampa Bay or Miami-Dade areas of Florida. The Center is one of 35 organizations in the United States that together form a National Consortium of Torture Treatment Programs; however, it is the only one of the 35 in the state of Florida. The “Torture Victims Relief Reauthorization Act of 1999” enabled Congress to allocate \$7.5 million to fund these programs, which was raised to \$10 million in 2001. The Center is also the only one of the 35 to utilize the “center without walls” concept of service provision. This means that the Center acts as the hub of a network of contacts and service providers in the areas of medicine, mental health, social services, legal services, and professional interpreters, all of whom have been recruited and trained by the Center to work with its clients in a culturally competent fashion, and who provide their services at no or low cost to the clients of the Center in the communities in which they reside.

The Center receives special funding from the United States Office of Refugee Resettlement in Washington, D.C., whose responsibility it is to oversee and sponsor refugee assistance organizations and provide support and resources for refugee assimilation. The Center also receives funds directly from the United Nations Voluntary Fund for Victims of Torture in Geneva, from federal and state research grants, and from charitable private donations, all of which go to support the various services it provides to its clients.

The Center provides an in-home intake assessment for its clients, complete with psychosocial evaluation. It provides professional interpreters to accompany clients to their various sorts of appointments as needed, ongoing case management and culturally specific educational and support groups, and linkages to its network of over 120 local service providers. These providers include psychologists and psychiatrists, biomedical physicians of various types, attorneys (especially those familiar with immigration law), and social workers (especially with the Department of Children and Families, or DCF). The Center also performs research, contributing to the literature on best practices for serving torture survivors and other refugees. It was in this last regard that the majority of my internship efforts were focused.

The Center has contracts with diverse partner organizations such as Catholic Charities, Lutheran Services of Florida, Church World Services, the University of South Florida School of Medicine, Directions for Mental Health, Nova Southeastern University, and Jewish Family Services of South Florida, to aid in its mission of providing much-needed assistance to its clients. The University of South Florida's School of Medicine, in

particular, has a fruitful symbiotic relationship with the Center, in which medical students, particularly those in the psychological specialty, offer their services free of charge to the clients of the Center, and in return gain valuable experience working with real people in their field. Directions for Mental Health is a community mental health organization serving the Largo, Clearwater, and Tarpon Springs area, to which some of the Center clients with mental illnesses relating to their experiences of torture are referred.

The various faith-based groups mentioned above are humanitarian organizations which provide for or arrange for the requisite core services of resettlement, in partnership with the Center and under the auspices of the federal Office of Refugee Resettlement. These core services include housing, medical attention, job training and procurement, social security and school enrollment, etc., for a finite period of time, usually four to eight months depending on factors such as whether or not there are individuals or family groups, if the refugees are part of certain programs, etc. The Center itself provides its services to its clients for as long as they feel they need them, but always with the goal of enabling them to become self-sufficient and integrated members of society, at which point their file is labeled inactive, or discharged.

The Center adheres to the definition of torture laid down by law in the United States Code, to wit:

- (1) “**torture**” means an act committed by a person acting under the color of law specifically intended to inflict severe physical or mental pain or suffering (other than pain or suffering incidental to lawful sanctions) upon another person within his custody or physical control;*
- (2) “severe mental pain or suffering” means the prolonged mental harm caused by or resulting from— (A) the intentional infliction or threatened*

infliction of severe physical pain or suffering; (B) the administration or application, or threatened administration or application, of mind-altering substances or other procedures calculated to disrupt profoundly the senses or the personality; (C) the threat of imminent death; or (D) the threat that another person will imminently be subjected to death, severe physical pain or suffering, or the administration or application of mind-altering substances or other procedures calculated to disrupt profoundly the senses or personality (United States Code: Title 18, 2340).

Obviously, this definition intentionally covers a broad range of acts and allows the Center to offer its aid to the entire families of victims so designated, as the experience of torture to one quite naturally affects all, directly or indirectly. It also allows the Center to claim with complete validity that its clients all fall under the United States' legal definition of who may be granted residential status as a refugee or asylee, and work to help those clients achieve such status.

In order to understand the situation most of the clients of the Center find themselves in, it is also necessary to provide some background information on the immigration laws of the United States, particularly as they apply to the clients of the Center. The Immigration and Nationality Act defines a refugee as:

Any person who is outside any country of such person's nationality or, in the case of a person having no nationality, is outside any country in which such person last habitually resided, and who is unable or unwilling to return to, and is unable or unwilling to avail himself or herself of the protection of, that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion (US Citizenship and Immigration Services: INA 101(a)42A).

This definition also demarcates who may be granted political asylum in the United States. Additionally, there is an important distinction in U.S. immigration law between a refugee, someone who fits this definition and completes the legal bureaucratic process of

obtaining asylum from the United States *before* setting foot on American soil, and an asylee, someone who fits the above definition and completes the process of seeking asylum *after* having arrived in the United States.

As part of the application for refugee status in the United States, applicants must undergo a physical and mental examination in order to determine whether or not they possess certain disorders or diseases that may exclude them from entry into the United States under the Immigration and Nationality Act. Examples of such illnesses include HIV, infectious tuberculosis, pandemic influenza, Hansen's disease, syphilis, and other sexually transmitted infections. Refugees are not required to have vaccinations at the time of their entry into the United States, but are required to have proof of vaccinations when applying for permanent resident status (after a mandatory period of one year of residency in the United States). Asylees are not, for obvious reasons, screened overseas before entering the U.S. as refugees are, but like refugees, they are required to have proof of vaccinations when applying for permanent residency (CDC 2006).

Refugees are met by members of organizations like the Center and its partners as soon as they arrive in the United States. They are legally entitled to receive aid from resettlement agencies such as the partners of the Center, four months of cash assistance from the government, eligibility to work in the United States, eligibility to receive Medicaid and/or Medicare, as applicable, and Social Security benefits, including Supplemental Security Insurance (SSI).

By contrast, most of those who seek asylum after having arrived in the United States are technically illegal immigrants, and must plead their case to the Asylum Office

of the Immigration and Naturalization Service (INS) and its immigration judges to have their status changed from illegal alien to asylum seeker, from thence to be considered for asylee status. Others enter the country legally via certain visas such as student, work, or visiting visas, and once inside the United States begin the process of applying for asylum from persecution. In the event that applicants are granted asylee status, a process which often takes years and is highly unlikely without professional legal assistance, they then, and only then, receive the above-mentioned legal benefits that refugees start out with. In the meantime, they have few legal rights in the United States, no access to Medicaid or Medicare, and must wait one year to apply for permanent residency and before they can be legally authorized to work. It is critically important for an individual seeking asylum to be successful, because U.S. immigration law allows them only one try to attain asylee status, and deports the unsuccessful.

Additionally, all new applicants for either refugee or asylee status after 1996 must contend with changes to American immigration law that came during that year, requiring refugees and asylees to pass a citizenship test within seven years of the granting of their status as a refugee or asylee, or lose their entitlements to SSI, Medicaid and/or Medicare, and other public assistance programs. For those who are unable to pass the test, for whatever reason, this means that they must live and work in the United States without aid or support of any kind from government agencies, including and especially Medicaid and Medicare, until such time as they can meet the requirements for citizenship (although they are not deported, and may still legally reside and work in the U.S. indefinitely, for as long as they fit the above definition of a refugee). There are waivers

for this requirement under certain circumstances; for example, the N648 form exists for those who may be considered incompetent or otherwise mentally unable to pass the test. Such waivers generally require a good deal of bureaucratic finesse, however. Needless to say, this can make life extremely difficult.

The Center primarily caters to clients of these three categories (refugee, asylee, and asylum seeker) that require assistance in adjusting to life in the United States, and/or coping with the physical, mental, and emotional consequences of their flight from their home country. In particular, those for whom English is not a primary or even secondary language may have difficulty assimilating to life in the United States. Many clients are referred to the Center from one of its affiliated agencies mentioned above. Others come to the Center by word of mouth from current or previous clients. Still others are referred by medical, legal, or social service providers in the Center's network, particularly those who have experienced one of the Center's periodic provider training sessions on identifying and working with survivors of torture. Unfortunately, one of the biggest challenges I have observed the Center to face is self-promotion, which is a shame considering all the good they do for their clients.

Nevertheless, the Center certainly does not lack for clients. Indeed, there are at this writing 160 clients in the torture treatment program, and 200 in the refugee youth and family program (although there is certainly some overlap between the two groups). The Center deals with clients from all over the world, but the client nationalities with the greatest concentration in the Tampa Bay area are Colombians, the various ethnicities of former Yugoslavia, and then Cubans. Though fewer than those previously mentioned,

there are also numerous clients of various West African and Southeast Asian nationalities in the Tampa Bay area. The Miami-Dade office of the Center has a greater concentration of clients from Cuba, Haiti, Colombia, and various other Caribbean and Latin American ethnicities.

Materials and Methods

Data was gathered for this project in a series of in-depth interviews with various clients and staff of the Center, as well as a mental health practitioner to whom the Center sends a number of clients. The goal of this research was to assess the participants' perceptions of barriers to care faced by the clients of the Center, either from the direct experience of the clients themselves, or that of the staff members and provider who work closely with many clients. In addition to demographic questions involving immigration status and length of time in the United States, participants were asked about the barriers they (or their clients) face in getting health care, how much experience they have had in trying to get health care, how the American health care system compares to others they may have experienced in the past, and what, in their opinion, might be done to improve the American system (see Appendices A and B below for sample interview questions).

The participant pool for this project includes nine clients, five staff members, and one mental health provider in the Center's network. Client participants were identified and recommended to the primary investigator by the staff of the Center. Clients were then contacted by the primary investigator, either by phone, or in person at one of the regular client support group meetings the Center offers, whereupon the project was explained to them and informed consent obtained. All but one of the client participants were from the Tampa Bay area, the exception being from Miami. Staff participants included staff

interpreters and program specialists from the Clearwater, Tampa, and Miami-Dade offices of the Center.

Client and staff participants were given the option to interview individually or in focus groups. Five of the nine client participants chose to interview with the primary investigator in a focus group (all were clients meeting at one of their regular support group meetings in a local Hillsborough County church's meeting room). The other four clients, who chose to interview individually, were interviewed in their homes.

Professional interpreters from the Center accompanied the primary investigator as needed for clients of limited or no English proficiency. All the staff members and the provider interviewed individually. The staff members of the Center were interviewed in the Center offices. The provider interview was performed in the Clearwater office of the provider, jointly as part of this project and an independent project by the Center to evaluate the experiences of various providers to whom they send clients.

All interviews were conducted in person and recorded on a laptop computer with NCH Swift Sound WavePad sound recording software (with participant consent, and with pen and paper otherwise). The only exceptions to the above were the sole client and two staff members from the Miami office of the Center, whose interviews were telephonic by necessity, but recorded in the same way. What quantitative data were obtained were analyzed using descriptive statistics, as qualitative data such as were the bulk of what was recorded in the course of this project do not lend themselves well to complex statistical analyses, particularly given the small sample size.

In addition to the interviews and focus groups, time spent as a volunteer in various projects in the organization, both with and without actual firsthand contact with clients, allowed for participant observation opportunities. As discussed above, the primary investigator began volunteering with the Center in January of 2006, working primarily on site at the Center assisting with research and support activities not involving actual client contact. For obvious reasons, the Center requires extensive background checks for anyone working one-on-one with their clients, to ensure their safety and rights to privacy and confidentiality. Additionally, the primary investigator was working through the process of obtaining IRB approval for the project at the beginning of the internship, and therefore could not ethically begin recruiting participants and obtaining data until both processes were completed in late March, 2006. Events observed during and after this time period included client focus groups for other Center projects besides this one, events for refugee children, and several meetings of various personnel at the Center offices, including management, interpreters, and management with federal auditors.

Results

Table 1: Participant Demographics

Client	Gender	Age	Occupation (at interview)	Nationality	Legal Status	Length of Residency	Family Situation
1	F	66	Medically unable to work	Bosnia	(Refugee) Perm. Resident	7 years	Widowed, lives with son
2	F	58	Convenience store employee	Sierra Leone	Asylum Seeker	5 years	Married, 4 adult children
3	M	63	High school kitchen employee	Sierra Leone	Asylum Seeker	5 years	Married, 4 adult children
4	F	50	Seeking employment	Cuba	Refugee	5 years	Divorced, 2 children
5	F	46	Child care	Colombia	Asylum Seeker	6 years	Married, 3 children
6	M	51	Floor installer	Colombia	Asylee	7 years	Married, 3 children
7	F	40	Westshore Pizza cook	Colombia	Asylum Seeker	3 years	Married, 3 children

8	F	50	Teacher's aide	Colombia	Asylee	3 years	Married, with children
9	F	58	Seeking employment	Colombia	Asylum Seeker	2 years	Widowed, 2 children
Staff							
1	F	24	Interpreter	Bosnia	(Former Refugee) Citizen	9 years	Single
2	F	24	Interpreter	Bosnia	(Refugee) Perm. Resident	4 years	Single
3	F	24	Interpreter	U.S.	Citizen	All life	Single
4	F	24	Program specialist	U.S.	Citizen	All life	Single
5	M	49	Program specialist	Peru	Asylee	14 years	Remarried, 2 adult children, 1 minor
Provider							
1	F	58	Mental health worker	U.S.	Citizen	All life	Single

Table 1 (Continued)

The participants for this project ranged in age from 24 to 66 years, and were from the following countries: Bosnia-Herzegovina (two staff members and one client), Colombia (five clients), Cuba (one client), Peru (one staff member), Sierra Leone (two clients), and the United States (two staff members and one provider). It should be noted here that Client #8 on Table 1 above is not an actual registered client of the Center, but a friend of several of the members of the Colombian support group who are clients. She attends their support group regularly, and her experiences, perceptions, and feelings are much the same as any of the other Colombian participants, including and especially her willingness to participate in this project. It is thus that I include her data amongst the client participants for the purposes of this study. The foreign-born participants, both clients and staff members of the Center, included among them persons of refugee status, asylee status, seekers of asylum whose status was not yet granted at this writing, and persons who have attained full citizenship or permanent resident status after a period of being either a refugee or asylee. In addition, the three born citizens all had extensive experience with the clients and their medical needs.

Of the client participants, only two were male, one Colombian and one Sierra Leonean. All the client participants were or had been married, and all had children. Three of them, the Bosnian and Sierra Leonean clients, also had grandchildren. Five of the nine clients were in the process of seeking asylum in the United States, two had been granted asylee status, one was a refugee, and had applied for permanent residency, and one had been granted permanent resident alien status after having been classed as a refugee. Six of the nine client participants were employed at the time of their interviews, two were

seeking employment, and one was unable to work due to her medical problems. Their periods of residency in the United States ranged from 2 to 7 years, and the mean length of residency in this country for client participants was 4.78 years. The clients' ages ranged from 40 to 66 years, and the mean age of the client participants was 53.6 years.

Of the provider and staff members of the Center, only one was male, the Peruvian. The Peruvian man was also the only one of this group that was married or a parent, though he had been married twice. Three of the six members of this participant group were born citizens of the United States. Of the other half, one was an asylee, one had attained full citizenship after having been a refugee and one had attained permanent residency after having held status as a refugee. Obviously, all the members of this group were employed, though half of them (the three interpreters) were not necessarily considered full-time. Of the three members of this group who were foreign-born, their length of residency in the United States ranged from 4 to 14 years, with a mean length of residency of 9 years. The ages of the staff and provider participants ranged from 24 to 58 years, with a mean age of 33.8 years.

Research such as that which has gone into this project is not without its difficulties. As in any research, as large a sample of participants as can be gathered is always desirable, and the sample for this project is admittedly rather small. This is due not only to the completely justifiable and understandable hesitance on the part of the clients of the Center to participate in any project that deals with their health and medical issues, but also to the limitations of time and experience on the part of the primary investigator. While the primary investigator has endeavored to include as representative a

sample as possible, the willingness of clients to participate and the investigator's own ability to work out interview schedules have proven challenging in that regard. It is to be hoped that this research can become a foundation and a springboard for future projects and advocacy at the Center to determine how to better serve their clients and remove obstacles to accessing health care from their path.

Perspectives of Client Participants

The client participants all described a number of barriers that they have experienced while seeking health care here in the United States, which fell into five primary categories: language, bureaucracy and hassles of a general nature, transportation, difficulties with providers, and the costs of healthcare.

Language

The majority of the clients were non-English speakers, or at least not sufficiently proficient with English as to be able to interview without a translator. Only the two clients from Sierra Leone, where English is spoken as a national language due to its status as a former British colony, had any real command of the English language. Naturally then, linguistic difficulties were specifically mentioned by all seven of the other clients as a barrier to gaining effective healthcare that they have experienced. These clients expressed the feeling that they were not able to effectively communicate their problems to medical personnel, nor understand their responses, particularly when ad hoc interpreters (that is, non-professional interpreters) were employed.

In one example given during the focus group interview, a 40 year old female client from Colombia related how the hospital at which she was seeking services called

over a member of their cleaning staff who was bilingual to interpret for them. This client said that her concerns were inadequately represented to the doctors because the cleaning staff member was “busy, and in a hurry,” and unable to effectively relate her problems to the doctors, or the doctors’ terminology-laden responses. Another Colombian client told of how a ruptured appendix put her nephew in a local Hillsborough County hospital where the doctor and nurses made no attempt whatsoever to offer translation services of any kind to her family during his 18-day stay, despite their obligation under federal Department of Health and Human Services (DHHS) standards and Florida state law to do so when working with patients of limited English proficiency. Finally, the male Colombian client remarked that lack of proficiency in English often “makes understanding bills a big challenge.” This is perfectly conceivable given that it is oftentimes challenging to understand medical billing even with a native grasp of the English language! Indeed, “researchers have documented lower rates of satisfaction among LEP [limited English proficiency] patients, even when compared with patients of the same ethnicity who have good English skills” (Brach & Fraserirector 2000: 190).

With people of minority ethnic status “expected to comprise more than 40 percent of the U.S. population by 2035 and 47 percent by 2050, addressing their health needs has become an increasingly visible policy goal,” (Brach & Fraserirector 2000: 181). Increasingly evident also is the need to address the negative consequences that can result from a lack of familiarity with the cultural beliefs and practices of a given group, especially those with limited English proficiency. Indeed, “one study of why Vietnamese

refugees in the United States do not optimally use health care suggests that the sheer presence of interpreters could have a positive impact” (Brach & Fraserirector 2000: 192).

Bureaucracy/Hassle in Obtaining Services

Another commonly mentioned barrier to accessing health care was the hassle involved in scheduling and showing up for medical appointments. Difficulties in accessing care falling under this category were mentioned by all nine client participants. As most of the clients of the Center are either uninsured or on Medicaid, depending on their immigration status and whether or not they have a family, their options are limited from the outset with regard to where they can go to seek health care services. Eight out of the nine clients I spoke with rely primarily on local free clinics, and/or emergency rooms as needed, for the majority of their care, while the other client saw a regular family doctor. While this is generally either a less expensive or more immediately available option than scheduling with private practice physicians, it nevertheless costs the clients in time spent away from work. By comparison, at least two of the clients come from countries that have or had socialized or universal access medical systems, or resided in such countries while on their way to the United States, for example Bosnia-Herzegovina, Cuba, and Germany. As a result, the sheer magnitude of red tape in the United States’ system of health care often comes as a shock to them.

The male client from Sierra Leone, who resides in Pinellas County, gave an example of the hassle involved in his efforts to seek health care at a local free clinic in St. Petersburg. Doing so firstly required a two-hour bus trip, both ways, because the public transportation routes were sufficiently convoluted in his area as to require him to switch

buses en route to the clinic. Then the time spent in the waiting room, treatment room, and going to the pharmacy for any prescribed medications must also be taken into account.

After all that, he said, “a whole day is lost just going to the clinic for health care.”

The situation of the Colombian clients, who reside in Hillsborough County, proved to be even worse. The local free clinic they attend is apparently so understaffed, inefficient, and busy that it requires them to get up at four in the morning to stand in line all day just to make an appointment for later in the week, and then come back, losing a second day of work, in order to keep the appointment. One female Colombian client made the comment that “you can’t afford to get sick because you lose too much work!”

According to its own literature, the clinic in question has only three full-time employees (an executive director, night clinic coordinator, and receptionist) and five part-time employees (two staff assistants, an administrative assistant, a dental assistant, and a pharmacist). All other medical personnel at this clinic are volunteering their time, and the clinic provides free treatment and medication to patients with incomes between 100% and 250% of the federal poverty line. As they claim to handle over 26,000 patient visits a year, it is easy to believe that such convoluted appointment procedures may be necessary. It is an unfortunate truism of the U.S.-style health-as-commodity system that “uninsured individuals who do not qualify for Medicaid,” as asylum seekers do not, “are expected to pay out of pocket or receive ‘charity’ in one form or another in hospital emergency rooms, physician offices, and private or public clinics” (Lasseby et al. 1997: 60).

Another female Colombian client related an experience she had had with her child, whom she took to the emergency room at a local Hillsborough County hospital

with a high fever. After a two hour wait to be seen, the doctors ordered “multitudinous tests” in order to diagnose the client’s child with a viral infection, tests which took time and ended up being billed to the client in the amount of “approximately \$5000, when a doctor in Colombia could diagnose him without all this fancy technology, in rapid order, using his knowledge and experience.”

Eight of the nine clients specifically mentioned large numbers of tests they perceived as unnecessary to be one of the major deterrents from seeking healthcare, especially since doctors are typically loath to begin any sort of treatment for a problem without the results of such tests to back up their diagnosis. In the words of my Cuban participant, “Months can pass here [in the United States] between diagnosis and treatment, and a person can get worse.” She said this very situation has been particularly frustrating in the case of her chronically disabled mother.

Transportation

Transportation itself proved to be another common difficulty, mentioned by eight of the nine client participants I spoke with. The male Sierra Leonean client considered this the primary barrier he has experienced in his time here in the U.S. Few clients of the Center own their own vehicles, and those that do generally have only one per family, and as such they must oftentimes rely on the public transportation system to get where they need to go. In the Tampa Bay area, both the Pinellas Suncoast Transit Authority (PSTA) and the Hillsborough Area Regional Transit (HARTline) are notoriously inefficient busing companies. Additionally, their schedules do not extend very far into the night, usually ending by 9:00 or 9:30 pm, depending on the route. Needless to say this makes

travel after that time extremely problematic for those without a vehicle of their own, or the means to afford frequent taxicab rides. In the Miami-Dade area, there are a number of overlapping systems (Metrobus, Metrorail, and Metromover), which become so convoluted it can “take several hours just to go a few miles,” according to my Cuban participant, the sole client participant from the Miami area, particularly if one is unfamiliar with the routes.

Seven participants from both areas specifically mentioned the problems caused by the frequent lateness of buses, which often has the frustrating result of causing the clients to miss a connecting bus later in their route. This causes them to be late to appointments, and even to work in some cases. Also the routes themselves oftentimes seem unnecessarily circuitous to the participants I spoke with, sometimes requiring excessive amounts of time to go relatively short distances as the crow flies. Route maps of the three areas can be found in Appendix C, below.

The Sierra Leonean client mentioned above has since found a free clinic within fifteen minutes’ walk of his home, which was helpful since he and his wife had no working vehicle at the time of his interview. Nevertheless, when the scope of their medical problems lies beyond the abilities of the providers at the free clinic and a specialist is needed, then they are back at square one, having to rely on the buses to get where they need to go for their healthcare.

Problems with Providers

The efficiency, expertise, interpersonal skills and bedside manners of medical personnel, as perceived by the participants, was another issue frequently commented

upon, in this case by two thirds of the client participants. As an example, most free clinics have few actual MDs available at any given moment, since those who do work there are typically volunteering their time. Therefore such clinics, including rural health clinics and migrant worker clinics, are forced to rely heavily on mid-level practitioners such as physician's assistants, nurse-practitioners, and certified nurse-midwives who "obviously do not have all the knowledge or skills of physicians but are prepared to function as independent practitioners in circumstances where they can be supervised by physicians while providing otherwise unavailable services" (Lassey et al. 1997: 43). As a result, most clients with problems beyond the abilities of such mid-level practitioners must pay out for hospital fees, and/or specialists, or simply deal with their problems without professional care, such as with home remedies, as four of the nine clients mentioned that they do, typically for minor illnesses.

The attitude of many medical practitioners of all levels, and indeed many of the social services employees with whom my participants have had contact, also impressed six of the nine client participants as a challenge to work with. Medical and social services personnel interacting with clients (particularly those of limited English proficiency) frequently have come off as cold, indifferent, sometimes even downright rude or even hostile. The comments such clients made to me expressed their disbelief and dismay at the apparent lack of compassion of people whose job it is help others.

Additionally, a third of the client participants remarked on the seeming inability of medical personnel at different levels of care to effectively communicate with one another regarding the treatment of their patients. If a specialist is needed for a particular

ailment, for example, they often repeat tests and procedures done by referring practitioners because they were unaware that they had already been done. Even when they are aware, according to my female Sierra Leonean participant, their tendency is to “repeat the tests anyway rather than trust that they were done correctly” by the referring practitioner. All of the female Colombian client participants in particular compared the diagnostic abilities of American physicians unfavorably with their counterparts in the participants’ country of origin.

Apparently, the technological advancement of health care in America can be just as much a hindrance as a help to my participants in gaining quality health care in some circumstances. The Colombian and Cuban clients I spoke with especially expressed their frustration that American doctors seem to rely so heavily on technology and tests that their counterparts in the clients’ home countries seem to manage to do without. The literature on refugee health care terms it “ironic that advances, breakthroughs, and technological improvements often create additional barriers to patient care,” and I agree, but this certainly proved to be the perception of my participants (Burgess 2004: 3).

Two of my female Colombian client participants, both mothers, who said they had had problems with getting prompt and compassionate care for their children, made comments such as: “the doctors here [in the United States] don’t look at patients, only test results,” or “doctors in Colombia can diagnose your illness and tell you right away, using their knowledge and experience,” to explain the level of aggravation caused by a large number of tests which are frequently expensive and often unnecessary (at least in the eyes of the clients), especially since they often have to wait for treatment of any kind

until the results are in. The 58-year-old female Colombian client even claimed that she was not given access to the results of several tests done on her by doctors at the above-mentioned free clinic in Hillsborough County, despite their legal obligation to make that information available and understandable to her.

Additionally, my Cuban client participant asserted that “the weakness of the American doctors is their fear to make a diagnosis without support from technology, and fear to act with treatment because of the possibility of malpractice suits,” which are evidently not a problem in Cuba, where such suits are not allowed. The literature actually bears out these perspectives to a degree, in that the situation that arises from physicians and hospitals practicing “‘defensive medicine’ in part to avoid the possibility of malpractice litigation... leads to a large number of medically unnecessary tests and procedures, estimated at 15 to 30 percent of all such activities” (Lasseby et al. 1997: 54-55).

Healthcare Costs

Finally, there was the issue of the cost of quality health care in the United States. The clients of the Center almost always exist in a lower socio-economic stratum than they did before having to flee their home countries, sometimes significantly lower. Indeed, “the majority of refugees come to countries of second asylum with nothing but clothes and perhaps one or two mementos of their former life” (Kemp & Rasbridge 2004: 39). Although refugees and asylees with families can apply for Medicaid, and elderly clients for Medicare as well, those asylum seekers whose status has not yet been granted, and even those with granted status but without families, have no such access. Even those with

Medicaid frequently find that “because physician and hospital reimbursement rates under Medicaid are relatively low (often 50 percent or less of usual charges), many providers refuse to accept Medicaid” (Lassey et al., 1997: 58). It is therefore no surprise that the costs of health care in the United States were mentioned by every single client participant, without exception, as a barrier to accessing good quality care, and by several at length.

What was surprising, at least to me, was that not every client’s home country was favorably compared to the United States with regard to the costs of health care. Indeed, those to whom I spoke that hailed from countries with an ideology of healthcare-as-commodity similar to that of the United States, such as Sierra Leone, indicated that quality health care was even more expensive there, relatively speaking, for the end product. In Sierra Leone, for example, “the centrally organized national health service reaches only 35 percent of the population. Among the poor in urban areas, and in most rural areas, the majority of health care comes from self-treatment or the traditional sector” (Jambai & MacCormack, 1996: 273). Even the Sierra Leonean clients acknowledged, however, that the costs of good quality health care in the U.S. without insurance, which is “one of the first things they ask for at hospitals and pharmacies” by the female client’s reckoning, are far out of their economic reach.

While the Colombian health care system may not necessarily be classified by experts as one of universal access, my client participants described certain aspects that do fit in such a system. For example, the Colombian clients claimed that in Colombia individuals pay one quarter of their insurance premiums, and the rest is covered either by

one's employer, the government, or both. Additionally, according to the clients, while access to basic primary health care is mandated by law to all citizens, one can also purchase prepaid medicine programs above and beyond what employers and/or the government provide, at reasonable prices.

Here in the United States, on the other hand, "Medicaid is the only option for many families, and it is limiting," for reasons indicated above. My male Colombian participant, who is fortunate enough to have insurance through his employer, made the statement that "it is too easy to get referrals for surgeries. Doctors don't want to treat. They want to do surgeries. The better your insurance coverage, the more surgeries they want to perform." A female Colombian client claimed that "healthcare in Colombia" is treated as "a universal human right, but here [in the United States] you have to pay out big" if you want quality treatment. Indeed, "the major contrast of the U.S. system with the more universal and comprehensive systems of other advanced countries" is that "both uninsured and underinsured must depend on the willingness of health care providers and government agencies to serve their needs, often without compensation," which unfortunately results in the frequent failure of their needs to be fully met (Lassey et al. 1997: 60).

A universalized national health and insurance system, with a UN-style ideology of care, was favored by every client participant I spoke with, regardless of experience with a working one in another country, over the current healthcare-as-commodity system in place in the United States today. Even so, the financial aspect of health care in the United States was nothing short of astounding to those participants who did have experience

dealing with socialized or universal medical systems. My Cuban participant, for example, strongly felt that the American system would be much improved when “the patient stops being a commercial transaction and becomes a personal interaction,” the way it is in Cuba. She also expressed dismay that doctors with whom she has dealt seem “more concerned with money than with treating people,” and that the needs of patients are subordinated to managed care organizations and profit margins.

Perhaps the saddest example of how inferior the American-style health-as-commodity system is to the UN-style health-as-human-right system would be the case of my Bosnian client participant. A retirement-aged woman, she had, at the time she was interviewed for this project, been granted refugee status in the United States for seven years. What this meant for her was that, since she was unable to pass the citizenship test, she had just lost access to public assistance programs such as SSI, Medicaid, Medicare, food stamps, etc., that refugees are granted by law for the first seven years of their residency. Her husband had passed away only a few months prior, and though while he lived his income was sufficiently high that the two of them did not qualify for Medicaid, without him, and without the ability to work or speak English herself, “life [has become] strange, uncertain, and difficult” for her. At the time she was interviewed, she was living with her son and daughter-in-law and their two children, but gave me to understand that things were strained for her there because of her ailments (“pain in legs and head, and occasionally forgetting things”) and inability to provide income for the household, while her needs (medical and otherwise) cost money.

She sung the praises of the Center and her case manager, who was working on helping her with the above-mentioned N648 form waiving the citizenship test requirement for social services after seven years of residency, although she expressed concern that it would not help. She also praised the system of healthcare in Bosnia before the war, especially in comparison to that of the United States. “It was better healthcare, and more universally available,” she said. Indeed, “with regard to benefits, the health SIZ [an acronym for “self-managing communities of interest”] provided comprehensive and universal coverage,” although they did tend to favor the white-collar working class (Saric & Rodwin 1993: 225).

It is certainly also worth mentioning that, like many people forced to flee their country of origin, she and her family lived at a significantly higher socioeconomic status prior to seeking refuge here in the United States from the horrors of the wars that began ripping former Yugoslavia apart in 1991. Indeed, prior to the incidences of torture that caused the various clients to have to flee their home countries, this was the case for every single one of my client participants. Were the Bosnian client and her family able to draw on more of their old resources, perhaps the seven-year limit on social services to refugees/asylees would not be so problematic. If the United States had a UN-style ideology for its health care delivery system, it certainly would not be, since the determinant of her access to health care would be her medical needs, rather than her ability pay for services.

Despite the enormous expenditures on health care in the United States, we remain the sole developed nation in the world without a universal national health insurance. The

costs of health care continue to grow without any recourse to direct intervention by the government, and the restructuring of the health care financing system remains in the hands of employers and insurance companies whose sole motivation is to increase profits. Since the easiest way to do so is to limit or deny coverage, especially to those with higher risk of filing a claim, those persons end up with minimal or no insurance and thus face much greater difficulty obtaining quality health care. Indeed, “there is a significant correlation between lack of insurance and less access to care” (Harvard Law Review, 1995: 1325-6).

Perspectives of Staff and Provider Participants

The staff members of the Center, and the community mental health provider to whom the Center sends a number of clients, also discussed several primary categories of barriers to care that they have observed the clients with whom they work to have experienced. There was, unsurprisingly, a great deal of overlap with the responses of the client participant group, including healthcare costs, language, transportation, bureaucratic and other hassles, and problems with individual providers. Indeed, all five of the staff members asserted that clients typically do not bother even trying to enter the professional sector of health care unless their problem is serious, due to such barriers, in spite of the fact that, according to the Peruvian participant, “the services you can get here are a luxury compared to what is available in Peru, or Mexico,” where he also spent time on his way to this country. This is consistent with the literature on refugee health-seeking behavior, in that only after their “most basic needs have been met, do refugees and immigrants tend to seek health care. Seeking health care may also be delayed by concern

that immigration status might be negatively affected by health problems, or in the case of illegal immigrants, that health providers may report them” to INS, neither of which, unfortunately, are altogether unfounded fears (Kemp & Rasbridge 2004: 26). Even those with Medicaid, private insurance through an employer, or a managed care organization rarely are able to afford quality health care because, in the words of the American-born interpreter, a graduate student of public health, “the ‘benefits’ they offer are a form of rationed care. People suffer because the U.S. is too focused on curative medicine and not enough on preventative.”

The staff/provider participant group perceived an important additional category of barrier production, namely the allocation of funds for healthcare by local, state, and federal agencies responsible for ensuring access to care. Rather than lapse into redundancy regarding the barriers to care that the client participant group mentioned, I will focus on this aspect of their responses, as it was a facet of access to healthcare that all six members of this participant group mentioned, and two at some length.

One of the Bosnian interpreters stated that “allocation of resources [for health care] needs reprioritization along more compassionate lines,” because “too many people are allowed to suffer because they don’t have money, or insurance, to pay for services. People shouldn’t have life or death decided by red tape.” It is certainly true that “there are shortages in the United States because of limited funding for certain services,” which leads to “considerably poorer outcomes than in Europe and Japan” (Lasse et al 1997: 330). Indeed, the American female program specialist and Peruvian male, both based out of the Miami office, asserted that “doctors frequently don’t give a full physical” to low-

income or immigrant patients, but simply “treat them on a case-by-case basis,” without thought to preventative care, which, to be fair, it is unlikely such patients to afford to begin with.

Even the mental health practitioner acknowledged the inadequacies of the community mental healthcare system in which she is forced to work to try and help her clients, both those referred from the Center and otherwise. According to her, “community mental health care is better for short-term counseling,” due to the high volume of patients she sees, but unfortunately, the “long-term mental health counseling is what [Center] clients typically need due to lack of community support and involvement, and that sort of thing is generally more than [she] can realistically give” in the community health care environment. While she praised the Center for working to create communities of and for its clients, she suggested that government relocation policy would enormously benefit the mental and emotional health of the clients if it could be altered to help create enclaves of people who have all fled from the same areas, allowing the recreation of a familiar societal format in miniature.

One positive aspect of allocation of funds noted by the staff/provider group came from the Miami office, where a local health center with satellites all over the area provides free health care for refugees and asylees (though not asylum seekers) for five years from the granting of their status. This provides a great option for low-income people new to the country to seek health care they would otherwise most likely not be able to afford. However, even this health center suffers from staffing difficulties in the face of a deluge of clients similar to the above-mentioned Hillsborough County clinic

frequented by my Colombian participants. Additionally, its policy still doesn't help those asylum seekers whose status is not yet determined by INS, nor does it help any patients who are undocumented. Both the Miami staff members said they "would like to see the government provide more health options for undocumented people, improved efficiency [in both health centers and the legal processes that determine asylee cases], and greater manpower and resources to serve the huge low-income population" in their area.

All five staff members of the Center specifically mentioned health insurance as a factor in giving equitable access to care. Those who were born citizens opined that "lowering the cost of health insurance, even that offered by employers, is needed to grant more access to low-income people, especially those without families who aren't eligible for Medicaid." The two Bosnian interpreters both held the view that the government should subsidize a national health insurance system, similar to the ones they experienced in Bosnia before they fled and in Germany afterward. The Peruvian program specialist had experience only with the American-style ideological systems that exist in Peru and Mexico (although Mexico does provide a good deal of federal funding for health, especially for upper and middle class healthcare, and particularly in urban centers) (Lassey et al. 1997: 314). Nevertheless he was saddened to see similar health burdens on the lowest-income people in this nation as exist in Mexico and his native Peru (Lassey et al. 1997, Glass-Coffin 1998, Joralemon 1999).

Conclusions

No system of health care delivery is without its problems. There is always room for improvement in some areas, even for nations who embrace the UN-style ideology of health as a human right to which all people are entitled. “Each type of health care system is perceived by consumers to have deficiencies,” but “satisfaction level are considerably higher in Western Europe, Canada, and Japan than in the United States” (Lassey et al. 1997: 327). Clearly, the health care system of the United States leaves much to be desired. Equally clear is the fact that the ideology of health as a commodity to be sold and profited from is at the root of this prodigious gap between the ideal and the actual outcomes of our system of health care.

The barriers that primarily affect the ability of the clients of the Center to gain total and effective health care appear to be systemic rather than localized. The language barrier for those of limited English proficiency, the inefficiencies of medical administration and bureaucracy, the inadequacies of public transportation, the failure or inability of the political establishment to create a more humane national health insurance system, and the often staggering costs of the fee-for-service system of healthcare itself are all issues that do not necessarily lend themselves to a quick fix. Nevertheless, I believe that the key to helping the clients of the Center overcome the barriers that have come up in my research lies in garnering enough social and political influence for the

idea that systemic fixes that benefit the clients would also significantly benefit American citizens who face similar difficulties.

As an example, it is certainly not necessary to have fled here from another country to understand problems caused by the inefficiency of the public transportation system in the areas that the Center serves. It makes sense that working to streamline the system in the Tampa Bay and Miami-Dade areas would benefit all of the millions of people who live there, not just the clients of the Center. Likewise, making sure that free clinics and other low-cost medical care venues are adequately staffed with fully trained and compassionate caregivers would be helpful to all of those who patronize such establishments, many of whom are lower- and middle-class American citizens who, unlike the refugees and asylees that make up the bulk of the Center's clientele, have the power to exercise their vote in such a direction.

The data I gathered from my interviews, and all the events and services of the Center that I have borne witness to during this project, indicate to me that there is much potential for applied anthropological work in connection with the Center and its goals, particularly since the Center personnel with whom I have interacted over the course of this project have indicated the desire to expand their research activities. Although it is important to distinguish between advocacy and anthropological research applied to the purpose demonstrating the needs of the population that the Center serves to those with the authority to make a difference, in this case that line is a particularly thin one. No researcher could long remain unmoved when confronted with the reality of the Center clients' experiences, and as a result it is difficult to maintain any semblance of

professional detachment or objectivity when interacting with them. Nevertheless, I have endeavored to do so in the collection and presentation of the data gathered in this project to the fullest extent of my ability, as those with the authority to make the policy changes that are clearly necessary are more likely to pay heed to arguments backed by precisely the sort of qualitative data that professional anthropologists excel at gathering. I can imagine no more worthy application of the anthropological work I have herein undertaken.

My research has also made it evident to me that the Center does well within the system as it stands, but there are always means by which it might do better. The “center without walls” concept is both novel and effective in meeting the various needs of Center clients by connecting them to various providers of services, who are given training and information by the Center on how to effectively work with their clients. The best way I can see to improve this system is to take it one step further. Since “refugees and asylees often struggle for years with language and cultural barriers, family reunification issues, and legal status problems in addition to health problems,” it makes sense to treat their problems in an integrated fashion (Moreno et al. 2001: 1215). In other words, rather than simply acting as the hub of a network of providers that each deal with their individual piece of the total problems that clients face, the Center might go one step further and work to create multidisciplinary teams of providers who, working together through the Center’s mediation, can deal with all facets of a given client and his or her needs at once, in an integrated, holistic way. As an example, “clinicians working with asylum seekers can play a valuable role in preparing them psychologically to fill out their asylum

application, and in testifying in their asylum interview or in immigration court” (Quiroga & Berthold 2004: 6). Such a clinician already working in tandem with the immigration attorney of his patient on that patient’s case would be that much more effective.

For the Center to be able to truly reach its goal of supporting the healing of torture survivors and their families, however, I see the need for a visionary change in the ideology of the American healthcare system itself; a change from health as a commodity to be bought and sold to health as an inalienable human right. Examples of just how effective such a paradigm of health care can be are easily found in the experiences of those Center clients who are from or have resided in countries where the UN-style ideology of healthcare as a human right exists; in particular former Yugoslavia, Germany, and Cuba.

While a detailed description and analysis of the system in place before the wars that split the Yugoslavian republics apart is beyond the scope of this paper, the truth of the pre-war Bosnian health system is that “despite social ownership, the way the system was financed and organized was not much different from that of countries having a national health service” (Saric & Rodwin 1993: 220). A payroll tax of “some 8 percent of each employee’s wage was deducted, and together with the employer’s contribution... was allocated to the local unit of the health care SIZ” (Saric & Rodwin 1993: 225). The SIZ was, at least in theory, an autonomous organization with regard to the allocation of funding for the health care of people within its geographic area of concern. In practice, however, the “republican and federal governments” regulated the “rate of contribution to the fund from both employees and employers,” as well as other aspects of how individual

SIZs distributed their resources so as to meet the focus on providing primary care to all citizens (Saric & Rodwin 1993: 226).

The Bosnian participants I spoke with stated that what they remembered of the health care system in their home country worked very well, involving “virtually universal entitlement to basic health services” (Saric & Rodwin 1993: 220). Indeed, each of the six republics of the former Yugoslavia “stipulated the entitlements of its citizens to health care services at no out-of-pocket cost. Most beneficiaries were entitled to receive health education, basic outpatient medical services, basic reproductive health services, and hospital care” (Saric & Rodwin 1993: 226). In this case, Saric and Rodwin’s statement is consistent with the statements made by the Bosnian participants. Though they paint a somewhat less glowing picture of the realities of the Yugoslavian health delivery system than my participants did, theirs is also an etic and impersonal perspective, as opposed to the emic, experiential perspective of my participants, all of whom admittedly were in the most advantaged pre-war Yugoslavian socio-economic group as far as healthcare was concerned (e.g., urban white collar workers).

On the surface, the German system is not dissimilar to the pre-war Bosnian system described above. However, the ability of the Bosnian system to “reconcile its promise to cover virtually all of its population with extensive health care benefits, and its financial, organizational, and managerial capacity to deliver on this promise” do not compare favorably with that of Germany (Saric & Rodwin 1993: 231). At least two of the three Bosnian participants mentioned spending some time in Germany while waiting for

their refugee status to be granted by the United States. Those who spoke to me of the German system were effusive in their praise for its efficiency and simplicity of use.

As much as 81 percent of all German health care financing comes from various local, state, federal, and especially payroll taxes, which contribute to “sickness funds” that “significantly redistribute income from the better-paid to the less well-paid” to help cover everyone’s medical costs (Lassey et al, 1997: 141). These funds are responsible for paying the physicians for their services, either on a salaried basis for hospital physicians, or to ambulatory care physician associations which then reimburse their members for their services. In fact, “patients pay nothing directly to the physician, and in most instances, do not learn what their treatment actually costs” (Lassey et al, 1997: 144)! Once again, my participants’ experiences were consistent with what has been written in the literature about the health care delivery system of Germany.

In contrast to First and Second World countries such as Germany and pre-war Bosnia, respectively, Cuba does not have the same level of resources available to provide health services to its population. Despite Cuba’s status as a “developing, Third World country,” however, health indicators such as life expectancy, infant mortality, and maternal mortality were nearly comparable to those of North America for the closing years of the twentieth century (Gilpin, 1991: 83-4). This is because the government of Cuba has demonstrated an uncompromising dedication to the idea that health and health services are rights to which its people are entitled. “Time and again the [Cuban healthcare] system creatively responds to problems, not with bandages but with the

application of macro-level systems thinking leading to massive structural changes” (Gilpin, 1991: 100).

My one Cuban participant indicated strongly that the healthcare system was one of the few things she missed about her home country, precisely because the Cuban system has already responded to and eliminated all of the barriers mentioned above (with the possible exception of language, which admittedly is not such a difficulty there) in the course of its development, at least at the level of the individual user. One can only speculate what the Cuban health care system might be able to accomplish for its people if it had the resources of the American system, or alternatively, what the American system could accomplish for its people with the Cuban mindset on healthcare as a human right, and similar willingness to make the necessary macro-structural changes to make it a reality.

Macro-structural change is always difficult, particularly when powerful stakeholders such as pharmaceutical companies, for-profit hospitals, the American Medical Association, and other entrenched facets of the medical establishment stand to lose from such change. However, there are instances in which principle must be placed over profit, and the access to good quality health care is such an instance. To do otherwise, to deny people the right to be healthy based on their individual socioeconomic circumstances, is to deny the humanity of those people and reduce them to mere account numbers. In a nation which prizes the freedoms and rights of the individual above all other things, it is unconscionable to allow such an ideology to continue to flourish.

List of References

- Brach, Cindy, and Irene Fraserirector
2000 *Can Cultural Competency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model*. *Medical Care Research and Review* 57(Supplement 1): 181-217.
- Burgess, Ariel
2004 *Health Challenges for Refugees and Immigrants*. *Refugee Reports* 25(2): 1-3.
- Centers for Disease Control and Prevention (CDC)
2006 *Frequently Asked Questions: Domestic Refugee Health Program*.
Electronic document, <http://www.cdc.gov/ncidod/dq/refugee/faq/faq.htm>,
accessed 4/1/07.
- Gilpin, Margaret
1991 *Update: Cuba: On the Road to a Family Medicine Nation*. *Journal of Public Health Policy* 12(1): 83-103.
- Glass-Coffin, Bonnie
1998 *The Gift of Life: Female Spirituality and Healing in Northern Peru*.
University of New Mexico Press, Albuquerque, NM.
- Harvard Law Review
1995 *Universal Access to Health Care*. *Harvard Law Review* 108(6): 1323-1340.
- Hofrichter, Richard, ed.
2003 *Health and Social Justice: Politics, Ideology, and Inequity in the Distribution of Disease*. John Wiley & Sons, Inc., San Francisco, CA.
- Jambai, Amara, and Carol MacCormack
1996 *Maternal Health, War, and Religious Tradition: Authoritative Knowledge in Pujehun District, Sierra Leone*. *Medical Anthropology Quarterly* 10(2): 270-286.
- Joralemon, Donald
1999 *Exploring Medical Anthropology*. Allyn & Bacon, Inc., Needham Heights, MA.

- Kemp, Charles, and Lance A. Rasbridge
2004 *Refugee and Immigrant Health: A Handbook for Health Professionals*.
Cambridge University Press.
- Lassey, Marie L., William R. Lassey, and Martin J. Jinks
1997 *Health Care Systems Around the World: Characteristics, Issues, Reforms*.
Prentice Hall, Inc., Upper Saddle River, NJ.
- Moreno, Alejandro, Linda Piwowarczyk, and Michael A. Grodin
2001 *Human Rights Violations and Refugee Health*. *Journal of the American
Medical Association* 285(9): 1215.
- Ohnuki-Tierney, Emiko
1984 *Illness and Culture in Contemporary Japan: An Anthropological View*.
Cambridge University Press. New York, NY.
- Quiroga, Jose, and S. Megan Berthold
2004 *Torture Survivors: Unique Health and Mental Health Issues*. *Refugee
Reports* 25(2): 5-8.
- Saric, Muhamed, and Victor G. Rodwin
1993 *The Once and Future Health System in the Former Yugoslavia: Myths and
Realities*. *Journal of Public Health Policy* 14(2): 220-237.
- Tilson, Hugh H.
1989 *Health Care in the United States: A Course for Refugee Health Workers*.
American Journal of Public Health 79(8): 1051-1052.
- United Nations General Assembly
1948 *Universal Declaration of Human Rights*. Electronic document,
<http://www.un.org/Overview/rights.html>, accessed 3/28/07.
- United States Citizenship and Immigration Services
2006 *Immigration and Nationality Act*. Electronic document,
<http://www.uscis.gov/graphics/lawsregs/ina.htm>, accessed 10/3/06.
- United States Code
2006 *United States Code, Title 18- Crimes and Criminal Procedure*. Electronic
document,
http://www4.law.cornell.edu/uscode/search/display.html?terms=torture&url=/usc/ode/html/uscode18/usc_sec_18_00002340----000-.html, accessed 3/28/07.

Bibliography

- Baer, Hans A., Merrill Singer, and Ida Susser
1997 *Medical Anthropology and the World System: A Critical Perspective*.
Bergin & Garvey. Westport, CT.
- Brown, Peter J.
1998 *Understanding and Applying Medical Anthropology*. Mayfield Publishing
Company. Mountain View, CA.
- Good, Byron J.
1994 *Medicine, Rationality, and Experience: An Anthropological Perspective*.
Cambridge University Press. New York, NY.
- Johannessen, Helle, and Imre Lazar, eds.
2006 *Multiple Medical Realities: Patients and Healers in Biomedical,
Alternative, and Traditional Medicine*. Berghahn Books. New York, NY.
- Kleinman, Arthur
1995 *Writing at the Margin: Discourse Between Anthropology and Medicine*.
University of California Press. Berkeley, CA.
- Romanucci-Ross, Lola, Daniel E. Moerman, and Laurence R. Tancredi, eds.
1997 *The Anthropology of Medicine: From Culture to Method, 3rd edition*.
Bergin & Garvey. Westport, CT.
- Sargent, Carolyn F., and Thomas M. Johnson, eds.
1996 *Medical Anthropology: Contemporary Theory and Method, revised edition*.
Praeger Publishers. Westport, CT.
- Sokolovsky, Jay, ed.
1997 *The Cultural Context of Aging: Worldwide Perspectives, 2nd edition*.
Bergin & Garvey. Westport, CT.
- United Nations General Assembly
1984 *Convention against Torture and Other Cruel, Inhuman, or Degrading
Treatment or Punishment*. Electronic document,
<http://www.un.org/documents/ga/res/39/a39r046.htm>, accessed 10/3/06.

Appendices

Appendix A

Sample Questions for Client/Center Staff Participants

1. How long have you been in the United States?
2. Are you classed as a citizen, refugee, asylee, or asylum seeker right now?
3. How much experience have you/your clients had with the American health care system?
4. How does the American health care system compare to that of your home country, or any other in which you resided?
5. Do you/your clients have any problems navigating the American health care system? If so, what kind?
6. Do you/your clients use home remedies or any other sorts of non-biomedical therapy? If so, what kind and why? If not, why not?
7. Do you think the American health care system could be improved? If so, how? If not, why not?

Appendix B

Sample Questionnaire for Provider Participant(s)

Relating to self:

1. How did you become involved with the center?
2. Can you describe your background and training as a Provider with the center?
3. What are your general experiences of being a Provider for the center's clients?
4. How many clients have you had or do you currently have, and how many are the center's clients?
5. What are some of the most significant factors that have shaped your development as a Provider working with the center's clients?

Relating to the client:

For confidentiality purposes, please think of an individual you have worked with from the center in the last 3 years (if applicable). Don't tell me the name.

- a. Is this person male or female?
 - b. What is this person's country of origin?
1. How did you begin working with the client?
 2. What services did the client receive?

Appendix B (Continued)

3. Give me a timeline of services provided to the client.
4. Did services diverge from the original identified need(s)?
5. In your opinion, did the client actively utilize your services?
6. What is your perception of what worked with the client?
7. What is your perception of what didn't work with the client?
8. What challenges did you encounter when faced with these issues?
9. What changes were made to address these issues?
10. In your opinion, what did the client consider as strengths of the program?
11. In your opinion, what complaints did the client have?
12. Please describe the communication between you and the center Staff regarding this client.
13. What did you learn from your experience with this client?

Relating to the program:

1. If you had to describe the center's program to community member who knew nothing about the program, how would you describe it?
2. Please describe your program. In your opinion, what are strengths of your program? In your opinion, what are weaknesses of your program?
3. Can you describe how your program relates to the center's program?

Appendix B (Continued)

4. How would you describe your communication with the center's program and Staff?
5. What recommendations do you think are needed for improvement of the program?
6. Looking back at your experiences, how would you describe its influence on your work as a [*Name specific occupation*] ?

Appendix C

Public Transit System Route Maps



Figure 1. Miami-Dade Integrated Transit Route Map

Appendix C (Continued)

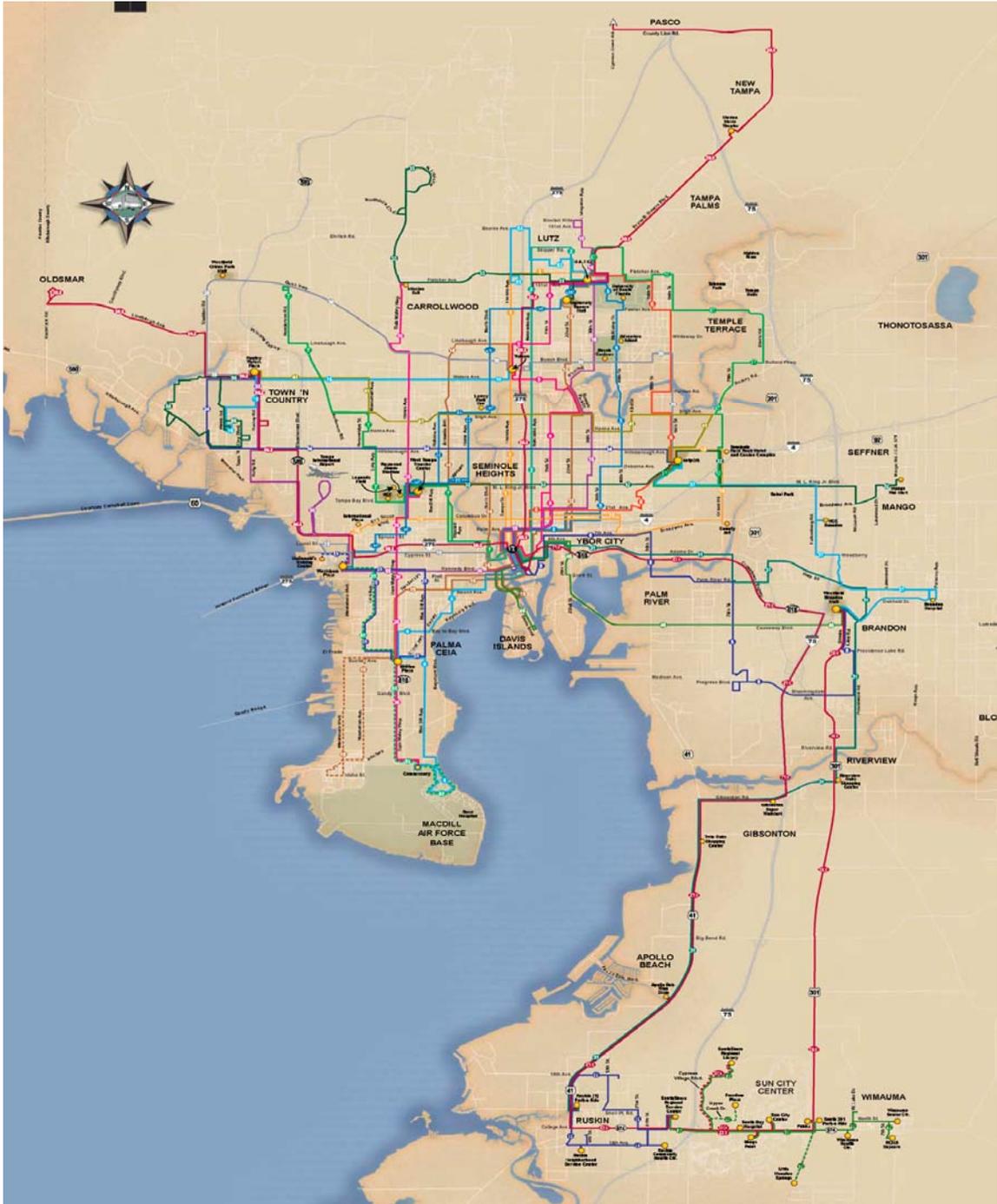


Figure 3. HARTline Bus Route Map