Contemporary Themes

Health care for travellers: one year's experience

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The health service has a duty to try to provide equal access to health care for all. After a study of travellers in Kent showed that this was not so the Medway Health Authority appointed a clinical medical officer in 1985 to look into the provision of health care for travellers in the district. The first year's work is described below.

Traveller population

There are no accurate figures of the number of travellers living in England and Wales. The Department of the Environment issues figures twice a year of the number of caravans, counted by local councils, parked in each district, but not all councils return figures. The figures that are returned are of limited use, as they are a count of caravans, not people. On average these figures show that there are about 10 000 caravans in England and Wales, of which about 700 are in Kent,¹ though the number is often higher in summer owing to seasonal movements.

In 1984-5 a survey of the health of travellers in Kent found a high prevalence of stillbirths in women aged under 30 and a low uptake of antenatal care, family planning facilities, developmental screening, and immunisation.² It also found that many sites were hazardous for children and often lacked sanitation, electricity, and water. This is despite the fact that local councils have a statutory duty "to provide sufficient adequately resourced sites for travellers residing in and resorting to the area."³

On the large temporary council site within Medway district identified by the study as a particular cause for concern the only facilities available after eight years were two taps and irregular rubbish collection. The travellers dug pit latrines, and rats were a persistent problem, as the site was built on a rubbish tip. In September 1985 there were 107 people living on the selected site, of whom 14 were aged 0-5, 17 were aged 6-11, 19 were aged 12-16, and 57 were aged over 16. Thus 47% of the population was aged 16 or under. The figures released by the Department of the Environment regularly showed 80-110 caravans in this part of the district. In July

1986 an alternative count to that of the local council was undertaken, and the figure subsequently reported was rather higher than that of the past two years (table I). A large proportion of the caravans were illegally sited.

Planning the project

In other parts of the country health care for travellers has been provided by named health visitors, either as a result of concern expressed by individual health visitors or doctors or after attention has been called by the voluntary sector to the gap in the provision of services.^{4,5} This may be the first time that a programme of health care for travellers has been set up and monitored by a health authority.

The aim of the proposed service was to provide access to health care, encouraging the use of services that were already available if possible, combined with offering specific preventive services on site. As access to health care was thought to be the problem we assumed that the services offered would be accepted. Initially, regular visits were made to the site with a teacher to meet

travellers and to discuss with them the idea of setting up a clinic. A local education project was also started, and a request for a female doctor to visit the site was made. Support was also received from an interagency group, comprising representatives from the Departments of Education, Health, and Social Services and other people working with the travellers, which had been set up to monitor conditions on the site, encourage liaison among agencies, and review the development of future sites in the district.

Provision in practice

Two health visitors were given responsibility for the site, and they, together with the clinical medical officer, started visiting the site in late November 1985, using a multipurpose mobile bought by the local education project as a base from which to work. Liaison with the teachers already working on the site helped the project to be accepted by the travellers. During the year the site was visited formally at least twice a month, each visit generating further informal visits. Additional visits were also made when particular problems arose. Visits were gradually extended to include illegal encampments nearby.

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The initial target group was families with young children. Immunisation, developmental screening, advice on feeding, weighing, and family planning services were specifically offered, though any problem that was presented was dealt with. Women known to be pregnant were encouraged to book early and attend the antenatal clinic.

Later we extended our help to travellers of all ages and both sexes, as it had been claimed that men and older adults did not always have access to health services. As well as providing preventive services on the site information about local services was provided, and readily accepted, including the names of local general practitioners who were willing to accept travellers on their lists. Service appointments—for example, visits to the dentist and chiropodist—were made if requested or agreed to, and health visitors accompanied the travellers on these visits to provide moral support. Welfare claims were dealt with as they arose, and health education was provided when an interest was shown. Cards used locally by the child health clinic and for immunisation records were given to the travellers to provide continuity of care should they move away from the district and also to encourage interest in health care. We had few problems with cards being lost.

TABLE I—Official count of number of caravans in Swale Borough (number legally sited in parentheses)

	1984	1985	1986
January		80 (36)	72 (31)
July	106 (37)	94 (33)	116 (30)

The travellers themselves did request help with various problems. Their first priorities were daily needs such as clothing, welfare, and problems with eviction, but once these had been resolved other matters relating to health care were raised. It became apparent that there were several reasons for travellers' difficulty with access to health care, some of which we had not anticipated. We realised that it was important to be aware of and sensitive to these matters if our project was to succeed.

Problems with access to health care for travellers

There seem to be two groups of travellers: those who depend on social security, such as the old, the disabled, and the ill, who tend to remain on permanent sites, and younger families who respond to seasonal work. This second group may be highly mobile and often illegally parked and may have greater difficulty in obtaining adequate health care, though both groups have similar general problems.

Firstly, many travellers have poor levels of literacy, making it difficult for them to find out where to go for health services. When combined with the fact that many share the same surname and that the post office refuses to deliver letters to temporary or illegal sites, this makes attendance at hospital clinics unlikely even if travellers remain settled in one area, as they often do during the winter. The inability to read also makes health education, which is important in overcoming travellers' rejection of some preventive services, difficult.

Secondly, misunderstandings also arise because of health workers' lack of knowledge about travellers' cultural beliefs and outlook on life.⁶ Travellers see things outside their bodies and trailers as dirty and polluting, while things entering their bodies—for example,

food—and the inside of their trailers must be kept very clean. Separate bowls must be used for washing their bodies (dirty) and preparing food (clean). If an outsider uses a “clean” bowl to wash “dirty” hands pollution occurs. Similarly, immunisation is seen as putting something dirty from outside into the clean body. Considerable tact and explanation may be needed to overcome fears about pollution. Complaints about “dirty gypsies” from people who have not seen the travellers' way of life or the inside of their trailers also arise from this misunderstanding.

Thirdly, health visitors will normally make contact with pregnant travellers only after they have booked for delivery and been seen by midwives. Often this will be after delivery rather than during early pregnancy; it is crucial that mothers are encouraged to take up adequate antenatal care at an early stage of pregnancy.

Finally, until general practitioners provide a patch based service people living in the area but not registered with them are not their concern. Travellers are often not accepted on to practitioners' lists even when they do seek to register. Many travellers use accident centres for most of their health care; this may be an inappropriate use of services but they find it easier as access is not restricted.

Results

The services offered were quickly seen to be fulfilling a need: we received referrals from the school nurse, general practitioners, teachers, a young physically handicapped team, and the environmental health officer. Liaison with the different agencies providing services to the travellers, particularly the education service, helped to make the health services more acceptable and sensitive to the needs of the local traveller population. It also helped to overcome problems such as cases of travellers travelling up to 50 miles to reach services that were easily available locally.

During the year many health problems other than those presented by the travellers were observed. Intermarriage among travellers is quite common, and in one family observed this resulted in two cases of ataxia telangiectasia. Requests for welfare allowances and access to services were also dealt with (table II); table III shows the numbers and types of consultations held throughout the year. Some preventive services (developmental screening and hearing and vision testing) were taken up, but the uptake of immunisation was not as high as had been hoped for initially, which concerned us, as travellers have been found to be a source of non-Sabin like isolates of poliovirus.⁷ The uptake has improved recently as the team has been accepted. The women did use the family planning facilities available, and we were successful in encouraging both men and women to make appointments for dental, chiropody, and physiotherapy treatment. Welfare issues were dealt with if direct medical

support was needed; otherwise they were referred to the social services. Not included here are the results of work done by health visitors on their own, general discussions and advice given, and chronic problems that were presented but were already being adequately managed.

TABLE II—Access to welfare benefits and services provided

Welfare benefits	Services		
Attendance allowance	Dentist	Practice nurse	
Mobility allowance	Chiropodist	General practitioners	
Single payments (special diet, heating)	Family planning	Ear, nose, and throat	
Maternity grant	Community psychiatric nurse	Psychiatrist	
	Occupational therapy	Social worker	
	Special needs education provision	Welfare rights officer	
		Environmental health officer	

TABLE III—Number of consultations October 1985 to September 1986 by age, sex, and type of consultation

	Children (0-16 years)			Adults (17-59 years)			Elderly (>60 years)		
	M	F	Total	M	F	Total	M	F	Total
General medical problems:									
Acute	20	11	31	3	9	12	1	3	4
Chronic	1	2	3	3	5	8	1	1	2
First aid (for example, burns)	1	3	4						
Service appointments	2	2	4	14	8	22			
Welfare (only cases in which doctor was able to help)	4	2	6	3	8	11	1	1	
Family planning, gynaecology					22	22			
Immunisation	21	21	42	2		2			
Developmental screening	10	3	13						
Vision, hearing, ear, nose, and throat	6	4	10		1	1			
Positive action (for example, giving up smoking)		2	2	2	2	4			
Total			115			82			7

Running the van caused some problems, but these could have been overcome by sharing the cost of maintenance with other outreach programmes or districts with regional funding, as in East Anglia (K Sampson, personal communication).

Conclusions

As all health authorities should aim to provide equal access to health care for everyone according to their need,⁸ we recommend that they should take the following actions:

(a) Regularly monitor the number and health of travellers in their district, including illegally camped groups, as well as the environmental conditions in which they are living. The lack of basic facilities, even on a council site, was similar to that seen in Third World countries and caused us great concern.

(b) Name particular health visitors to have responsibility for the health care of travellers within a district. This would reduce the time spent liaising and make the provision of health care more efficient and acceptable. An established network of health visitors round the country would improve the continuity of care considerably.

(c) Ensure that the health visitor reaches travellers of all ages and both sexes (including pregnant women) and shows respect for the travellers' cultural values. An outreach approach is necessary as young families may be highly mobile. Mobile clinics could be useful here, but their design and maintenance should be considered carefully.

(d) Consider using health cards that travellers can present each time that they visit a doctor, clinic, or hospital. These cards should summarise their medical history, investigations, and treatment and

indicate a contact address for further information. The Sheffield mobile clinic committee has designed and used such a card.

(e) Ensure that all agencies liaise so that they are working towards the same clearly defined goals, thus maximising any help provided.

(f) Play an active part in health education and promotion among the travellers. Health and education departments should cooperate to produce health education projects, particularly material, such as videos, suitable for adults with minimal literary skills. Subjects covered should include preventive health care and inherited disease resulting from intermarriage between members of close family.

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MATERIA NON MEDICA

Bribery and corruption

Just after the second world war I was asked to be external examiner in surgery at the National University of Ireland with the examination starting in Cork. No coal being available, the trains were travelling on peat, wood, in fact any combustible material. It took one day from Belfast to Dublin and another from Dublin to Cork, with many stops.

On the way to Dublin, while talking to a friend, I told him I was catching the 9 am train the next day to Cork. He said, "That is what you think; it is the only train in the day and it is full from 7 am so you will find no seats available. But I can tell you what to do. You must ask for Johnnie MacLaughlin with a £1 note—just visible in your hand—and he will help you."

Being a man opposed, in theory, to bribery and corruption, I decided that I would be at the station myself at 7 am. This I did and found a very crowded platform. I went forward to the sharp end of the train and then back to the blunt end and indeed saw that all the carriages were entirely full. Pocketing my pride and my morals, I hailed a junior porter—I would say a young man of house surgeon or junior registrar status—and asked him if he could possibly find Mr Johnnie MacLaughlin, who I assumed was the consultant railway porter in charge. Johnnie appeared in due course. I explained that I had been told that he could get me a seat. I made the £1 a little more obvious but not ostentatiously so. He said, "Hold your ground" and proceeded to go forward to the front end of the train and then to the back. He then reported to me that the train was full. This from my own "recce" I already knew. He thought for a moment and then said, "Could you have a limp?"

I had never been asked that before, but I said I could try; so he proceeded to walk very slowly up the platform to the front of the train carrying my bag, and I walked slowly behind him with a minor limp. I still, after 40 years, feel very ashamed. At the second carriage from the front there was a "RED CROSS" on the window and a notice which said, "For the wounded." He opened the door, lifted my bag carefully on to the rack, helped me in, and after the £1 note had changed hands he quietly closed the door and departed.

After a short time I recovered and in a truly professional manner leant over to my colleague on the opposite seat. I said, "My good chap, what happened to you?" To which he replied, "Exactly the same as happened to you." This made my conscience somewhat easier—at least for the time being. I found later that all the occupants had had the same experience. I am astonished that no intelligent chap noticed that these same unfortunate limpers left the platform in Cork with a brisk and manly step.—IAN FRASER, Belfast.