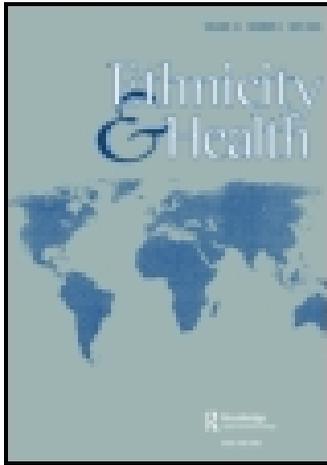


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### Is health a right for all? An umbrella review of the barriers to health care access faced by migrants

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## Is health a right for all? An umbrella review of the barriers to health care access faced by migrants

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**Objective.** To synthesise the scientific evidence concerning barriers to health care access faced by migrants. We sought to critically analyse this evidence with a view to guiding policies.

**Design.** A systematic review methodology was used to identify systematic and scoping reviews which quantitatively or qualitatively analysed data from primary studies. The main variables analysed were structural and contextual barriers (health system organisation) as well as individual (patients and providers). The quality of evidence from the systematic reviews was critically appraised. From 2674 reviews, 79 were retained for further scrutiny, and finally 9 met the inclusion criteria.

**Results.** The structural barriers identified were the lack of health insurance and the high cost of drugs (non-universal health system) and organisational aspects of health system (social insurance system and national health system). The individual barriers were linguistic and cultural. None of the reviews provided a quality appraisal of the studies.

**Conclusions.** Barriers to health care for migrants range from *entitlement* in non-universal health systems to *accessibility* in universal ones, and determinants of access to the respective health services should be analysed within the corresponding national context. Generate social and institutional changes that eliminate barriers to access to health services is essential to ensure *health for all*.

**Keywords:** migrants; health services; access; barriers; review

### Introduction

Ever since the United Nations declaration of human rights in 1948, health has been considered to be an intrinsic human right for all regardless of socio-economic status, gender, religion, sexuality, nationality or ethnic origin; in short, there is acclamation of *health for all* (United Nations 1948). However, it is well known that poor health is disproportionately experienced by those on the margins of society and living in disadvantaged socio-economic conditions, and migrants are highly represented in these

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groups (Ahonen, Benavides, and Benach 2007). Although the newly established settlers in the host country show better health indicators than people in their countries of origin (Abraido-Lanza et al. 1999; Newbold 2005), the physical, mental and social health of migrants is progressively affected over time mainly due to adverse living and working conditions in the new country (Krieger 1999; Harding et al. 2008; Grulich et al. 1992; Weber, Hiebl, and Storr 2008; Taloyan, Sundquist, and Al-Windi 2008).

It has been argued that discrimination and racism in society contribute to the breach of the right to health and health care in migrants and ethnic minorities (Williams and Mohammed 2009). These groups are subject to more diffuse forms of social exclusion rooted in discrimination which are not solely manifested as individual experiences. As a collective, they are also subject to forces that influence the economic and social structure and which may lead to diminished socio-economic opportunities; this disadvantaged position can result in a poorer health status, a lower quality of life and curtailed access to social and health services (Agudelo-Suárez et al. 2009). Different groups of migrants are often dealt with separately by researchers and policy-makers. In most countries, there is partial overlap between these groups and they can face problems similar to social exclusion. At the same time, however, it must be borne in mind that the composition of these groups is very diverse. There is substantial evidence of inequities in the state of health of these groups and in the accessibility and quality of the health services available to them. However, differences from the majority population vary according to the specific group being studied, the health problems or services involved and the country concerned (WHO 2010).

The *right to health* means that governments must generate conditions which allow everyone to be as healthy as possible. Such conditions range from ensuring availability of health services, healthy and safe working conditions, a healthy environment, adequate housing and nutritious food (WHO 2007a). Health services are an important social determinant of health and inequalities in health (WHO 2007b). This is particularly so in relation to how social stratifications are reflected in the provision of, and access to, health care services. Systems of coverage vary between countries and are often highly complex. The extent to which migrants, in particular, can benefit from these systems may be hard to define, as the degree of entitlement often depends on their migration status and the health services involved (Gelormino et al. 2011).

Thus, the social and political values which underlie society also constitute the foundations of the welfare state and health care system. Therefore, health services may also exacerbate health inequalities if provision and access are also unequal. The identification of groups which are potentially vulnerable to different risks for their health and which may not have access to or use health services sufficiently is a fundamental issue in terms of tackling health inequalities. A theoretical approach based on deprived and vulnerable groups in society has revealed that population groups with high health needs do not always receive adequate health care provision (Tudor Hart 1971; Frohlich and Potvin 2008). Other theoretical approaches related to health care provision (Andersen and Newman 1973; Aday and Andersen 1974) have analysed the perspective of health policy objectives, the characteristics of the health system and the results obtained (output) from care provided to populations at risk (input). Moreover, the model identifies the influence of both structural and contextual barriers (health system organisation, also physical, political, social or economic environment) and individual barriers (behaviour of patients and providers) in shaping health care access.

In fact, studies from different countries have shown how migrants' access to health services affects their health care (Hernández-Quevedo and Jiménez-Rubio 2009; Nandi et al. 2008). Compared with native populations, migrants made greater use of emergency services at the expense of primary and specialist care (Carrasco-Garrido et al. 2009). Similar patterns of health service use have been identified amongst ethnic minority groups, and studies have also looked at the role of racial discrimination in restricting access to certain types of services such as preventative health care (Trivedi and Ayanian 2006).

A great deal of information is available about migrant access to health services that focuses on different countries and social contexts. This information has been examined in a number of heterogeneous review studies, ranging from the theoretical to the systematic. Thus, the aim of this study was to synthesise the existing scientific evidence related to barriers to health care access faced by migrants. We sought to critically analyse the reviews in terms of assessing the procedures used and their analysis of original papers in order to identify the best evidence which would provide useful policy guidance for health care services and other public institutions.

### **New contribution**

Although the migratory processes are heterogeneous, migration aimed at seeking work and improving their social conditions has predominated. To date, the range of review studies focused on migrant access to health services is extremely diverse. A vast majority of reviews and research studies do not differentiate in the results, the specific barriers in minority ethnic groups and those experimented for other type of migrants. A synthesis of the existing scientific evidence concerning barriers to health care access faced by migrants could be useful to guide future policies. The reviews analysed show that barriers to health care for migrants range from entitlement in non-universal health systems to accessibility in universal ones. Our results suggest that other barriers were linguistic and cultural.

### **Methods**

#### ***Design, search strategy and period***

The methodology used was the 'umbrella review,' which is an overview of other reviews aimed at identifying, appraising and synthesising evidence from systematic reviews (Bambra et al. 2010; Becker and Oxman 2008). Although by definition this methodology is mainly related to an analysis of the effects of interventions, in the present study it was adapted in order to synthesise and analyse the evidence generated concerning the kind of barriers to health services access that affect the migrant population.

We searched three electronic databases that cover life sciences, health sciences, physical sciences and social science and humanities: medline (1950–2011), Scopus (1960–2011) and EMBASE (1980–2011). Furthermore, the Cochrane Database of Systematic Reviews was searched. Finally, in order to explore all possible sources of information, we also searched the reference section of the studies included. To identify the largest amount of information possible, we searched studies from all countries and selected those in English, Portuguese, French or Spanish. Our search strategy is outlined in [Box 1](#).

Box 1. Search strategy used in umbrella review of studies on barriers to access to health services by migrants.

We searched Medline, Scopus, EMBASE, and Cochrane Database.

We used combinations of text words and thesaurus terms that includes access to health care [Mesh Term] access to health care [Title/Abstract], accessibility, health services [Title/Abstract], availability of health services [Title/Abstract], health services availability [Title/Abstract], accessibility of health services [Title/Abstract], programme accessibility [Title/Abstract], health services misuse [Title/Abstract], health services needs [Title/Abstract], health services demand [Title/Abstract], migrant [Thesaurus Term], migrant [Title/Abstract], migrants [Title/Abstract], transient [Title/Abstract], transients [Title/Abstract], emigrant [Title/Abstract], emigrants [Title/Abstract], immigrant [Title/Abstract], immigrants [Title/Abstract], alien [Title/Abstract] and aliens [Title/Abstract]. For databases lacking a thesaurus system we used free text searches using similar search terms. Below is an example of the search syntax we used for Medline.

Examples of EMBASE search syntax used:

[accessibility of health care (Mesh) AND transient (Mesh)] AND [(English (lang)) OR (French (lang)) OR (Spanish (lang)) OR (Portuguese (lang))]

Example of Medline search syntax used:

[access to health care [Mesh Term] OR access to health care [Title/Abstract] OR accessibility, health services [Title/Abstract] OR availability of health services [Title/Abstract] OR health services availability [Title/Abstract] OR accessibility of health services [Title/Abstract] OR programme accessibility [Title/Abstract] OR health services misuse [Title/Abstract] OR health services needs [Title/Abstract] OR health services demand [Title/Abstract]] AND [migrant [Thesaurus Term] OR migrant [Title/Abstract] OR migrants [Title/Abstract] OR transient [Title/Abstract] OR transients [Title/Abstract] OR emigrant [Title/Abstract] OR emigrants [Title/Abstract] OR immigrant [Title/Abstract] OR immigrants [Title/Abstract] OR alien [Title/Abstract] OR aliens [Title/Abstract]]

### ***Inclusion and exclusion criteria***

We sought to identify systematic reviews which quantitatively or qualitatively analysed data from primary studies concerning the barriers migrants face to health service access.

As far as possible, these systematic reviews had to comply with one of the two mandatory criteria of the database of abstracts of reviews of effects (Centre for Reviews and Dissemination 2012), namely: (1) that there is a defined review question and/or (2) that the search strategy include at least one named database, in conjunction with either reference checking, manual searching, citation searching or contact with authors in the field.

Moreover, in order to retrieve valuable information about the subject under study, it was also decided to include ‘scoping reviews,’ a type of review study that uses a systematic method of searching for information with the aim of accumulating as much evidence as possible and mapping the results (Armstrong 2011). As stated by experts in this methodology, systematic reviews are aimed at locating the ‘best available evidence,’ and therefore the hierarchy of evidence needs to be applied pragmatically (Bambra 2011). Theoretical reviews were excluded for the purpose of this study.

Studies which focused on any type of health system, such as national health service, social insurance health system (mixed) and non-universal health system, were included.

Studies related with health issues but not health services were excluded. For the purposes of the umbrella review, we examined articles which targeted migrant populations, analysing studies which primarily considered economic migrants, defined as:

A person leaving his/her habitual place of residence to settle outside his/her country of origin in order to improve his/her quality of life. This term may be used to distinguish from refugees fleeing persecution, and is also used to refer to persons attempting to enter a country without legal permission *and/or* by using asylum procedures without *bona fide* cause. (Perruchoud and Redpath-Cross 2011)

Studies which included temporary residents, refugee claimants and irregular migrants were also considered, provided that economic migrants still made up the bulk of the population studied. Studies focusing on other populations were excluded.

### **Data extraction**

Two reviewers (DG/MC) independently screened all titles and abstracts identified in the literature search for relevance. After removing duplicate papers, we obtained 2674 records. No systematic reviews in this topic were found in the Cochrane Database of Systematic Reviews. Subsequently, 79 full papers of any titles/abstracts that were considered relevant by either reviewer were set aside for further scrutiny and independently assessed for inclusion. Any discrepancies were resolved by consensus and, if necessary, a third and fourth reviewer (CV/AA) were consulted. Only systematic and scoping reviews meeting all the inclusion criteria underwent data extraction ( $n = 9$ ; Figure 1).

Of the nine reviews included, we extracted information such as the author and year of publication, objective(s) of study, number of papers included in the review, type of study (systematic or scoping review), sociodemographic characteristics of the study population, (quantitative or qualitative data, age, regions of origin, host country, population and type of health care system), type of barrier analysed (Andersen model) and main results.

### **Data analysis and critical appraisal**

We took into account the Andersen model classification (Andersen and Newman 1973; Aday and Andersen 1974) to analyse barriers regarding access to health services in the studies.

#### *Structural and contextual barriers*

Structural and contextual barriers are concerned with how the health service might be funded, structured and delivered, and the physical, political, social or economic environment to which the health system belongs.

#### *Individual barriers*

Providers' barriers are barriers related to the beliefs, attitudes and training of health professionals. Patients' barriers are barriers related to the beliefs, language and education of the individual as well as the acceptability of services.

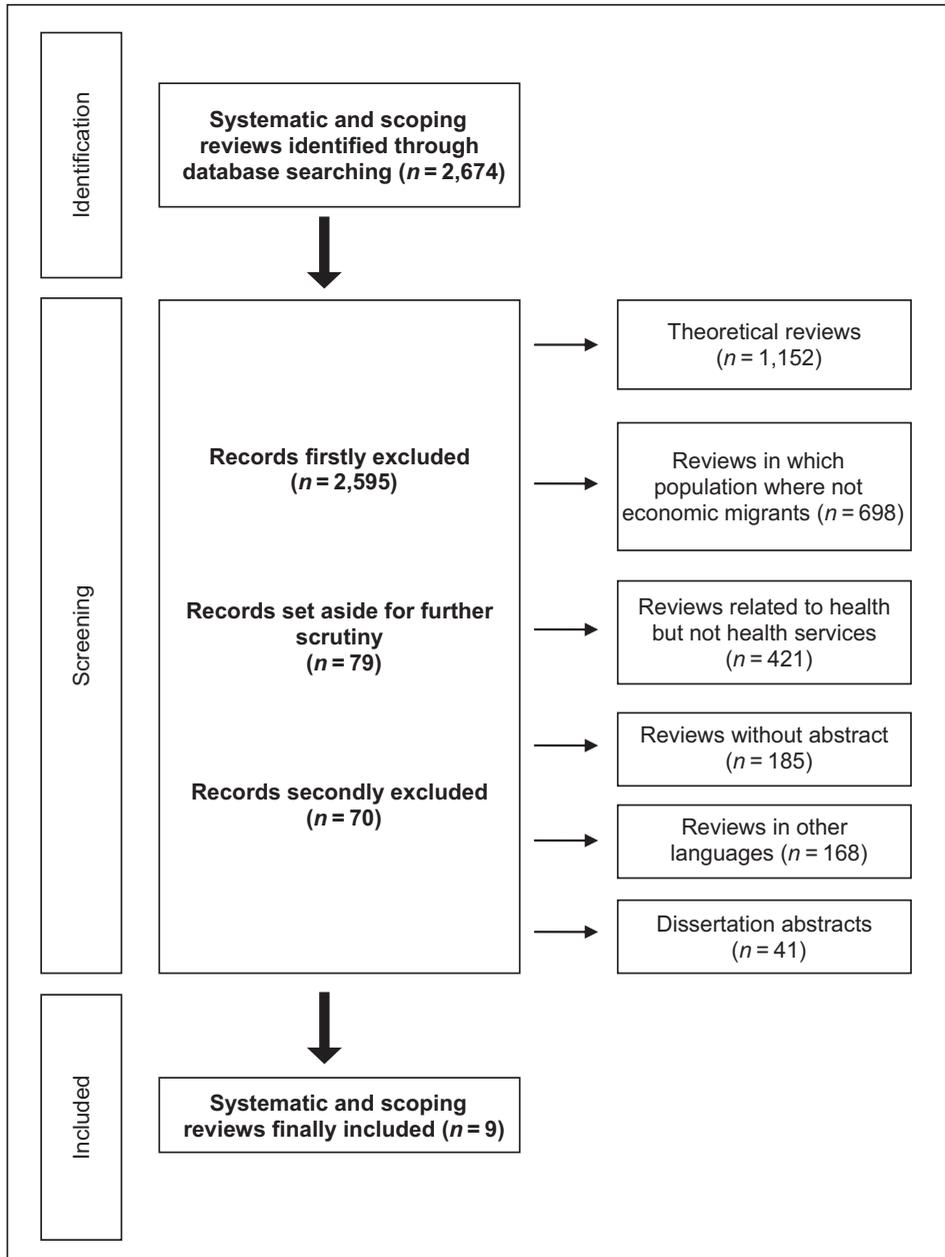


Figure 1. Flow diagram showing the selection process in the umbrella review.

The quality of evidence from the systematic and scoping reviews was critically appraised using a checklist adapted and applied by experts in this methodology (Bambra et al. 2009). Two researchers (DG, MC) independently analysed the quality of each review included in this umbrella review, obtaining a high level of concordance when comparing the results of the questions included in the critical appraisal. We appraised the

Table 1. Critical appraisal criteria.

1. Is there a well-defined question?	The question should define at least the participants, the intervention, the outcomes and the study designs.
2. Is there a defined search strategy?	The search strategy should include at least one named database combined with reference checking, hand searching, citation follow-up or expert contact.
3. Are inclusion/exclusion criteria stated?	The review should state the grounds for study inclusion and exclusion transparent in terms of participants, intervention, outcomes and study design.
4. Are the primary study designs and number of studies clearly stated?	The review should outline the designs of included studies and make it clear which and how many studies are in the final synthesis.
5. Have the primary studies been quality assessed?	The review should clearly describe the quality assessment process, which quality appraisal tool is used, and the relative quality of each included study.
6. Have the studies been appropriately synthesised?	The review should use meta-analysis or narrative synthesis, whichever is most suitable given the heterogeneity of studies and their methodological quality. If studies are very heterogeneous, narrative synthesis is appropriate.
7. Has more than one author been involved at each stage of the review process?	To minimise bias, the review should have at least two reviewers involved in each stage (study selection, data extraction, quality appraisal and synthesis) of the review.

Source: Bamba et al. (2009).

systematic and scoping reviews included according to these criteria, which were used for descriptive purposes only and to highlight variations in their quality. No quality score was calculated and studies were not excluded on the basis of their quality (Table 1).

## Results

Five systematic reviews were included in this umbrella review (Gushulak et al. 2011; Norredam, Nielsen, and Krasnik 2009; Pitkin Derose et al. 2009; Shpilko 2006; Claassen et al. 2005), as well as four other scoping reviews which provided information on the methodology and added relevant data regarding barriers to health care system access mainly faced by migrants (Magalhaes, Carrasco, and Gastaldo 2010; Nandi, Loue, and Galea 2009; Coughlin and Wilson 2002; Bodo and Gibson 1999; Table 2). The reviews analysed show that barriers to health care for migrants range from entitlement in non-universal health systems to accessibility in universal ones. The results suggest that other barriers were linguistic and cultural.

### *Quality appraisal*

The methodological quality of all the reviews was analysed using critical appraisal criteria (Bamba et al. 2009; Table 2). None of the reviews included a quality assessment of the primary studies. Only one review contained a well-defined question (Norredam, Nielsen, and Krasnik 2009), and two reviews involved more than one author at each stage of the review process (Gushulak et al. 2011; Magalhaes, Carrasco, and Gastaldo 2010).

Table 2. Main characteristics of the systematic and scoping reviews about barriers to access to health services by migrants.

Author/year	Objective(s) of study	Number of studies included	Type of study Sociodemographic characteristics of study population	Type of barrier (Andersen model)	Main results	Quality appraisal outcomes
Gushulak et al. (2011)	To identify demographics, health status reports, access to health care and health system implications of migrant populations in Canada	20	Type of study: systematic review Data: quantitative Age: no data Sex: men and women Regions of origin: Asia, Europe, America Host country: Canada Population: permanent residents (economic migrant, family reunification, humanitarian class), temporary residents (migrant workers, international students, refugee claimants and others), other migrants (irregular, visitors) Type of health system: national health system	Structural Patient	(1) Linguistic and cultural needs of migrants and cultural tools in health system	Defined search strategy Inclusion/exclusion criteria stated Primary study designs and number of studies clearly stated More than one author been involved at each stage of the review process
Magalhaes, Carrasco, and Gastaldo (2010)	To summarise and disseminate current academic and community-based findings on the health and service access in undocumented migrant in Canada through a scoping review of peer-reviewed and grey literature between 2002 and 2008	24	Type of study: scoping review Data: Qualitative Age: no data Sex: men and women Regions of origin: Latin America, Africa Host country: Canada Population: economic migrants, transients, undocumented, uninsured	Structural	(1) Delayed care resulting from community health centres' (CHCs) long wait lists (2) Denied care at emergency rooms in hospitals or CHCs which lack the space, resources or policies to provide care	Defined search strategy Inclusion/exclusion criteria stated The studies been appropriately synthesised More than one author been

Table 2 (Continued)

Author/year	Objective(s) of study	Number of studies included	Type of study Sociodemographic characteristics of study population	Type of barrier (Andersen model)	Main results	Quality appraisal outcomes
Norredam, Nielsen, and Krasnik (2009)	To review the European literature on utilisation of somatic health care services related to screening, general practitioner, specialist, emergency room and hospital by adult first-generation migrants	21	Type of health system: national health system  Type of study: systematic review Data: quantitative Age: 15–74 years Sex: men and women Regions of origin: Latin America, Asia, Africa Host country: European Union countries Population: labour migrants, refugees, asylum seekers Type of health system: social insurance mixed system and national health system	Structural Patient	(3) Lack of financial resources to pay for emergency hospital fees or doctors visits  (1) Legal restrictions on access for certain groups such as asylum seekers and undocumented migrants  (2) User payment which may affect migrant populations because they overall tend to have lower socio-economic status compared to non-migrants  (3) Barriers related to organisation and lack of referral between services: Language, communication, sociocultural factors and ‘newness’ may lead to informal barriers	involved at each stage of the review process Defined question Defined search strategy Inclusion/exclusion criteria stated Primary study designs and number of studies clearly stated The studies been appropriately synthesised
Nandi, Loue, and	To perform a critical review concerning the health status and	15	Type of study: Scoping review Data: Quantitative	Structural	(1) Lack of health insurance	The studies been

Table 2 (Continued)

Author/year	Objective(s) of study	Number of studies included	Type of study Sociodemographic characteristics of study population	Type of barrier (Andersen model)	Main results	Quality appraisal outcomes
Galea (2009)	access to health services among immigrant populations in the USA		Age: no data Sex: men and women Regions of origin: Latin America Host country: USA Population: undocumented migrants Type of health system: non-universal system			appropriately synthesised Inclusion/exclusion criteria stated
Pitkin Derose et al. (2009)	To gain an overall understanding of immigrants' health care experiences as well as inform policy and research related to the care of immigrants	67	Type of study: Systematic review Data: Quantitative Age: no data Sex: men and women Regions of origin: Latin America, Western Europe, Asia Host country: USA Population: migrants, years in the USA, citizenship status, limited English proficient (LEP), non-English language preference Type of health system: non-universal system	Structural Service provider	(1) Lack of health insurance and a regular source of care (2) The foreign-born or non-English speakers were less satisfied and reported lower ratings and more discrimination	Defined search strategy Inclusion/exclusion criteria stated Primary study designs and number of studies clearly stated The studies been appropriately synthesised
Shpilko (2006)	To provide US health care practitioners with additional information on specific diseases and disorders common among Russian-speaking patients and	18	Type of study: systematic review Data: quantitative and qualitative Age: no data	Structural Service provider	(1) Russian women do not receive the same 'push' interest from their current providers	Defined search strategy Inclusion/exclusion criteria stated

Table 2 (Continued)

Author/year	Objective(s) of study	Number of studies included	Type of study Sociodemographic characteristics of study population	Type of barrier (Andersen model)	Main results	Quality appraisal outcomes
	explain their past medical practices as well as their current outlook on health care		Sex: men and women Regions of origin: Russia Host country: USA Search categories: Russian-speaking migrants Type of health system: non-universal system		in the USA than in their country of origin (2) High cost of drugs prescribed by physicians in the United States, language barrier, and a lack of relevant health information	
Claassen et al. (2005)	To identify the extent and nature of research on mental disorders and their care in immigrant populations in three major European countries (Germany, Italy and UK) with high levels of immigration	157	Type of study: systematic review Data: quantitative Age: no data Sex: men and women Regions of origin: Europe, Africa, Latin America, Asia Host country: Germany, Italy and UK Population: migrants, ethnic minorities, refugees, asylum seekers Type of health system: social insurance mixed system and national health system	Structural Patient	(1) Barriers related to organisation of health system (2) Cultural and language barriers	Defined search strategy Inclusion/exclusion criteria stated Primary study designs and number of studies clearly stated The studies been appropriately synthesised
Coughlin and Wilson (2002)	To review published studies of breast and cervical cancer screening among women who are migrant and seasonal farm workers	11	Type of study: scoping review Data: quantitative and qualitative Age: no data Sex: men and women	Patient Structural	(1) Cultural beliefs (2) Cost or lack of health insurance, lack of transportation and childcare difficulties	Inclusion/exclusion criteria stated Primary study

Table 2 (Continued)

Author/year	Objective(s) of study	Number of studies included	Type of study Sociodemographic characteristics of study population	Type of barrier (Andersen model)	Main results	Quality appraisal outcomes
Bodo and Gibson (1999)	To examine and understand how differences in the cultural backgrounds of Canadian physicians and their Vietnamese patients can affect the quality and efficacy of prenatal and post-natal treatment	8	<p>Regions of origin: Latin America                      Host country: USA                      Population group: migrants, transients                      Type of health system: non-universal system</p> <p>Type of study: scoping review                      Data: qualitative                      Age: no data                      Sex: men and women                      Regions of origin: Asia                      Host country: Canada                      Population: Vietnamese migrants                      Type of health system: national health system</p>	Patient Service provider	(1) Cultural beliefs	<p>designs and number of studies clearly stated</p> <p>The studies been appropriately synthesised                      Inclusion/exclusion criteria stated</p>

Five reviews clearly stated the primary study number (Gushulak et al. 2011; Norredam, Nielsen, and Krasnik 2009; Pitkin Derose et al. 2009; Claassen et al. 2005; Coughlin and Wilson 2002). Six reviews performed an appropriate synthesis of primary studies (Magalhaes, Carrasco, and Gastaldo 2010; Norredam, Nielsen, and Krasnik 2009; Nandi, Loue, and Galea 2009; Pitkin Derose et al. 2009; Claassen et al. 2005; Coughlin and Wilson 2002). Six reviews adequately defined the search strategy (Gushulak et al. 2011; Magalhaes, Carrasco, and Gastaldo 2010; Norredam, Nielsen, and Krasnik 2009; Pitkin Derose et al. 2009; Shpilko 2006; Claassen et al. 2005). Lastly, nine reviews stated the inclusion and exclusion criteria (Gushulak et al. 2011; Magalhaes, Carrasco, and Gastaldo 2010; Nandi, Loue, and Galea 2009; Norredam, Nielsen, and Krasnik 2009; Pitkin Derose et al. 2009; Shpilko 2006; Claassen et al. 2005; Coughlin and Wilson 2002; Bodo and Gibson 1999).

### ***Reviews of barriers to health care access faced by migrants***

The number of papers included in these reviews varies between 8 and 157 (Bodo and Gibson 1999; Claassen et al. 2005). In these reviews, populations of migrant men and women were defined by the following features and characteristics: labour migrants, undocumented, uninsured, permanent and temporary residents (Gushulak et al. 2011; Magalhaes, Carrasco, and Gastaldo 2010; Norredam, Nielsen, and Krasnik 2009; Nandi, Loue, and Galea 2009; Pitkin Derose et al. 2009; Shpilko 2006; Coughlin and Wilson 2002; Bodo and Gibson 1999), ethnic groups (Claassen et al. 2005) and refugees (Gushulak et al. 2011; Norredam, Nielsen, and Krasnik 2009; Claassen et al. 2005). Only one review mentioned the age of the population (15–74; Norredam, Nielsen, and Krasnik 2009). The host countries where the studies took place were USA (Nandi, Loue, and Galea 2009; Pitkin Derose et al. 2009; Shpilko 2006; Coughlin and Wilson 2002), Canada (Gushulak et al. 2011; Magalhaes, Carrasco, and Gastaldo 2010; Bodo and Gibson 1999) and European countries (Denmark, Germany, the Netherlands, Spain, Sweden, UK, Italy) (Norredam, Nielsen, and Krasnik 2009; Claassen et al. 2005). The regions/continents of origin of migrants were North America (Gushulak et al. 2011), Latin America (Magalhaes, Carrasco, and Gastaldo 2010; Norredam, Nielsen, and Krasnik 2009; Nandi, Loue, and Galea 2009; Pitkin Derose et al. 2009; Claassen et al. 2005; Coughlin and Wilson 2002), Western Europe (Gushulak et al. 2011; Pitkin Derose et al. 2009; Shpilko 2006), all European regions (Gushulak et al. 2011; Claassen et al. 2005), Asia (Gushulak et al. 2011; Norredam, Nielsen, and Krasnik 2009; Pitkin Derose et al. 2009; Claassen et al. 2005; Bodo and Gibson 1999) and Africa (Magalhaes, Carrasco, and Gastaldo 2010; Norredam, Nielsen, and Krasnik 2009; Claassen et al. 2005).

As regards the type of barriers (Andersen model), structural barriers were analysed in eight reviews (Gushulak et al. 2011; Magalhaes, Carrasco, and Gastaldo 2010; Norredam, Nielsen, and Krasnik 2009; Nandi, Loue, and Galea 2009; Pitkin Derose et al. 2009; Shpilko 2006; Claassen et al. 2005; Coughlin and Wilson 2002), provider barriers were identified in three reviews (Pitkin Derose et al. 2009; Shpilko 2006; Bodo and Gibson 1999) and patient barriers were examined in five reviews (Gushulak et al. 2011; Norredam, Nielsen, and Krasnik 2009; Claassen et al. 2005; Coughlin and Wilson 2002; Bodo and Gibson 1999).

The main results of the reviews show that structural barriers significantly affect migrants' access to health services (Magalhaes, Carrasco, and Gastaldo 2010; Norredam, Nielsen, and Krasnik 2009; Nandi, Loue, and Galea 2009; Pitkin Derose et al. 2009; Coughlin and Wilson 2002). In countries with a non-universal health system, the lack of health insurance (Nandi, Loue, and Galea 2009; Pitkin Derose et al. 2009; Coughlin and Wilson 2002) and the high cost of medication (Shpilko 2006) were identified as extremely significant structural barriers. In countries with mixed or universal health care systems, the structural barriers identified involved factors associated with organisational aspects of the health care system (Norredam, Nielsen, and Krasnik 2009), which included legal restrictions on access for certain groups such as asylum seekers and undocumented migrants, as well as user payment rules. The structural barriers identified in these countries also included other organisational barriers such as a lack of referral and cohesion between service tiers.

The influence of the barriers generated by health care providers is analysed in three reviews (Pitkin Derose et al. 2009; Shpilko 2006; Bodo and Gibson 1999). In the USA, the foreign-born or those with linguistic problems were less satisfied and reported more discrimination when they received health care (Pitkin Derose et al. 2009). The cultural differences between patients and providers contributed to mutual misunderstandings which were seen to affect the quality and efficacy of the health care provided (Bodo and Gibson 1999). Migrants felt that they did not attract the same level of interest from health care professionals in the host country as in their country of origin (Shpilko 2006; Bodo and Gibson 1999). The lack of relevant health information provided was also identified as a significant barrier (Shpilko 2006).

Some reviews showed that poor linguistic communication between users and professionals was a patient and provider barrier (Gushulak et al. 2011; Norredam, Nielsen, and Krasnik 2009; Pitkin Derose et al. 2009; Shpilko 2006) which resulted in migrants using fewer health services than the native population, hence incurring lower costs (Pitkin Derose et al. 2009; Shpilko 2006; Claassen et al. 2005; Coughlin and Wilson 2002). Some studies show higher emergency department costs for migrant children (Pitkin Derose et al. 2009) and a higher rate of hospital admissions among Afro-Caribbean patients in the UK (Claassen et al. 2005). Undocumented migrants, who are subject to legal restrictions on access to health care and lack of financial resources for user payment, have been shown to be disadvantaged in terms of the treatment and follow-up they receive and also present increased morbidity (Magalhaes, Carrasco, and Gastaldo 2010).

## **Discussion**

Barriers to access to health services as defined in Andersen's model have identified both structural/contextual and individual barriers. Those barriers involving a lack of health insurance or user payment, legal restrictions on access for certain vulnerable groups and problems in the organisational model of the health system have been identified as structural. Cultural and linguistic factors, and the lack of relevant health information provided, have been characterised both as a consequence of service provision and of patient and provider beliefs. It should be stressed that this umbrella review examines a diverse range of reviews from different countries based on heterogeneous populations;

this implies that the barriers and determinants of access to the respective health services should be analysed within the corresponding national context.

The systematic and scoping reviews analysed reflected two types of situations that can be distinguished in the definition of the types of access barriers to health services faced by migrants. On the one hand, there are structural barriers conditioned by law and regulatory restrictions established according to the type of health care model in force in each country and limiting the entitlement of the most vulnerable groups among which migrants are included. And, on the other hand, there are barriers related to the limited capacity of the health services and providers to meet the specific needs of migrants, hence limiting their accessibility (WHO Regional Office for Europe 2008). While *entitlement* relates to financing and stewardship (which mostly affects the non-universal health system model), *accessibility* relates to characteristics of service provision (which is more related to the National Health System model). To distinguish between these issues, it is important first to pinpoint the obstacles present at the various institutional levels of health care, second to gauge the weight of the social context of each country and third to identify priority areas for tracking inequalities in health access in each case.

In each specific health care setting, barriers arise when the health system does not grant providers with the necessary tools to increase their cultural competence. Furthermore, barriers also arise when the professional is unable to appreciate, explore and accept social and cultural differences between him- or herself and his or her patient. This concept of culture is not considered as static and determinative of actions of individual, but as dynamic processes (Kleinman and Benson 2006). In this regard, it is important to promote health care for migrants which consider cultural elements from an anthropological perspective. In a qualitative study, carried out in Catalonia, Spain, health service managers and providers indicated the need for the provision of multilingual materials and translation services, in order to overcome communication and information barriers. In addition, with the aim of attending patients from different cultures, health providers considered that they required practical training that focused more on cultural aspects, such as migrants' perception of the disease or health care, than on imported infectious pathologies (Vázquez Navarrete et al. 2009).

Despite these recommendations, few studies evaluated intervention programmes regarding barriers faced by migrants to health care access, although they provided useful knowledge on how to remove these barriers (Beach et al. 2006). In a recent umbrella review of interventions based on the wider social determinants of health, four reviews focused on interventions aimed at improving cultural and geographic access (Bambra et al. 2010). Nevertheless, the evidence from these reviews was generally inconclusive. Although some interventions seemed to improve health care access for populations, none of the reviews reported whether impacts of interventions differed between different groups in the population studied. Another review on interventions to improve cultural competence in health care systems was unable to determine the effectiveness of any of the interventions carried out (Anderson et al. 2003). The authors claim that additional research is needed to determine whether or not these interventions are effective in improving client satisfaction with care received, improving client health and reducing inappropriate racial or ethnic differences in the use of health services or in the received or recommended treatment.

It seems that it is vital to devise mechanisms to achieve migrants' participation in health systems, with the support of professionals and communities (Laroche 2000).

Moreover, given the lack of communication and the cultural differences observed between patients and caregivers, experts also recommend improving the health education of patients and the skills of health professionals (Hjern et al. 2001). According to public health professionals, public or private health systems (structure, organisation and professionals) are an important health determinant that affect access and use of health care by the population in question, and hence its health status. In this sense, generate social and institutional changes that eliminate barriers to access to health services is essential to ensure *health for all*.

### Limitations and strengths

The strength of this umbrella review is that the main life sciences, health sciences, physical sciences and social science and humanities databases were consulted. Furthermore, broader terms were applied to identify studies of interest in the field of *health services* and *migration* and enhance the thoroughness of the literature search. Search terms such as *barriers* were not used as they did not capture sufficient information. In addition, the search included a specific source: the Cochrane Database of Systematic Reviews. Nevertheless, grey literature findings were not included in this umbrella review. An important limitation related to the nature of umbrella reviews is the risk that bias is transmitted upwards from primary studies to the reviews and then to the umbrella review.

In addition, the systematic and scoping reviews included in this umbrella review showed significant methodological deficiencies. None of them carried out a quality appraisal of the studies included. The two mandatory criteria indicated by the database of abstracts of reviews of effects were only partially fulfilled by the systematic reviews included. Admittedly, this may hinder knowledge of the quality and relevance of the scientific evidence generated on the subject studied and its usefulness in guiding policies. Furthermore, this implies that ideally more in-depth consultation of the primary studies is required (Bambra et al. 2009).

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### Key messages

- (1) Despite the heterogeneous nature of migratory processes, migration aimed at seeking work and improving the social conditions of the migrant population, and their families has predominated.
- (2) To date, reviews focusing on migrant access to health services are scarce, extremely diverse, of poor quality and show considerable deficiencies concerning the factors which influence barriers to health care for migrants in host countries.

- (3) Barriers to health care for migrants range from *entitlement* in non-universal health systems to *accessibility* in universal ones.
- (4) Current scientific evidence concerning barriers to health care access by migrants could be useful to guide future policies.

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