Principles of best and good practices in migrants' access to health services

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Abstract

Aim: This article aims at listing the principles of best and good practices in migrants' access to health services through a review of reports and studies, to identify the most relevant ones and to discuss them.

Methods: PubMed, Google Scholar and ScienceDirect were used to search for reports and studies on good and best practices on migrants' access to health services. The resulting documents were screened for their relevance.

Results: Overall, six reports and studies were found, identifying 14 principles of good and best practices.

Conclusion: Access to health services, culturally sensitive healthcare, individual quality care, respect towards migrants and efficient communication are the principles gathering the highest consensus among health professionals. But they are not easy to implement into practice as the needs greatly differ between migrants' populations and cultures and, therefore, the empowerment of migrants might be the solution. However, the current trend to fallback in Europe seriously threatens improvements and current policies aiming at bettering the access, the biggest challenge remaining the legal entitlements to access healthcare services.

Keywords: cultural sensitivity, good and best practices, migrants.

Introduction

If the general health of the populations has greatly improved after the World War II (1), inequalities in health have also grown between and within countries, but also within ethnic groups. Indeed, many studies assert the important heterogeneity existing across ethnic groups (2,3) and demonstrate that migrants and ethnic minority groups tend to have worse health status than nationals. With migration and other demographic pressures leading to a growing ethnically diverse population in many European countries (4), it is becoming crucial to investigate and monitor health inequalities as health is a factor of integration.

Health inequities have been defined as "*differences in opportunity for different population groups which result in, for example, unequal life chances, access to health services, nutritious food, adequate housing*" (5). Indeed, migrants and ethnic minority groups generally experience a lower socio-economic status than nationals, the main explaining factor for ethnic-related health inequalities (6-8). What remains poorly highlighted however are the inequalities in accessing health services, due to language, costs, location, information, and simply entitlement to receive healthcare. Therefore, suppressing health inequalities also means improving the access, the quality, and the appropriateness of health services for migrants and ethnic minority groups in Europe.

But meeting the needs of migrants and minorities is challenging. There is no agreed definitions on migrants at an European or even international level, the only definition available being the one of the United Nations: "*Migrants are people moving for various reasons to a country other than that of their usual residence, for a period of at least twelve months, so that the country of destination effectively becomes the new country of usual residence*" (9). Broadly speaking, "migrants" include first, second, and third generation migrants, undocumented migrants, asylum seekers, refugees, ethnic minorities, cultural minorities, returned nationals, and religious minorities.

Therefore the heterogeneity inside of the "migrant" category means that there is also an important heterogeneity on health determinants affecting them, healthcare services provided, utilization and needs, but overall on legal access. Indeed, the legal forms of access to health care are subject to variation across the different member states, especially concerning undocumented migrants.

Nevertheless, there is a common statement of the right of everyone to "*enjoyment of the highest attainable standard of physical and mental health*" across all member states (10).

This common statement, the growing migration flow into the European Union and the thrust towards harmonisation across the European countries is therefore a call for an assessment of the good and best practices in health services for migrants, followed by their dissemination and implementation. The aim of this paper is to gather opinions of professionals on principles of good or best practices on migrants' access to health services and to discuss the ones gathering higher consensus.

Methods

Google Scholar was first used to conduct a first-hand search, in order to find general core texts giving an insight on the health services and access issues faced by different categories of migrants in the European Union. Keywords such as "migration health", "inequalities health migration", "ethnic inequalities in health" were used.

Second, in order to find studies and reports on principles of good and best practices, Google Search, PubMed and ScienceDirect were used, with keywords such as "Undocumented migrants good practices health", "Migrants best practices health Europe", "healthcare best practices migrants", "ethnicity good practices migrants" and "Migrants Europe Best practices". In most of the cases, reports were found indirectly, through the bibliography of the studies found.

Inclusion criteria were as following: Reports and

studies considering principles of good and best practices for all or part of the 28 European countries; Reports and studies involving opinions of health care professionals and/or migrants specialists; Reports and studies in English, French, and Spanish; Reports and studies published after 2000.

Results

Six documents, studies and reports, meeting the inclusion criteria were found (Table 1).

Table 1. Summary of the documents included in the study

Document	Overview of the design
"Project Report on Delphi process on best practice of health care for Immigrants" (10)	Delphi process, 16 European countries included, experts from the academic world, NGOs, policy making and health care practice, answering the question "In experts opinion, what does, at national level, constitute principles of best practices of health care for immigrants in the several European countries?"
"Good Practice In Mental Health Care For Socially Marginalized People In Europe" (11)	Semi-structured interviews with health and social care professionals with knowledge and experience of providing mental health or social care to, among others, migrants, in the capital cities of 14 European countries.
"Migration and health in the European Union" (12)	Face-to-face interviews of health practitioners from 16 European countries operating in areas with relatively high levels of migrants.
"Quality in and equality of access to health care services" (13)	Review of existing literature on barriers to access healthcare for migrants, crossed with direct interviews with health professionals in 8 European countries.
"Good practice in health care for migrants: views and experiences of care professionals in 16 European countries" (14)	Interviews with health professionals on the difficulties they experience in their service when providing care to migrants and what they consider constitutes good practice to overcome these problems or limit their negative impact on the quality of care.
"Good practices in migrant health: the European experience" (15)	Review of existing literature on barriers to access health care for migrants.

Reviewing these six documents, 14 principles of best practices were found.

Accessibility: easy and equal access to health care

Migrants should have the same access as the local population, whether it is insurance-based or free, and for all care, not only primary care. Access also means that service hours should be adapted to the usual long working hours of most of the migrants' jobs. This result was found in 5 documents.

Empowerment of migrants

Health literacy is fundamental. Migrants should be informed about their rights, prevention, illnesses, and the functioning of the healthcare and social system,

in their own language. But not only the health care sector is concerned: the access to work as well as work and living condition should be improved, language courses of the host country should be provided, and migrants should be involved in NGOs dealing with migrants' rights. This result was found in 5 documents.

Culturally sensitive health care

Health care providers should receive specific training on cultural competencies and communication skills, or cultural mediators or health care providers of migrant descent should be hired. Health education and health promotion messages should take into account cultural diversity. This result was found in 5 documents.

Quality of individual care

The patient is an individual who should not be stereotyped with the characteristics of the cultural group they are perceived to belong to, and his medical and social background should be taken into account. Time to listen to the patient, seeking truly informed consent, establishing trust, guaranteeing continuity of care and adapt the care to the person are also very important factors. This result was found in 3 documents.

Patient-health care provider communication

Accessibility to high quality interpreter services, and services should take into account varying levels of both health literacy and mastery of the local language. This result was found in 5 documents.

Respect towards migrants

Practitioners should show respect, create trust, be interested and address patients without prejudice and with an open mind. Health care services should be delivered without any sign of racism. Health care providers should be motivated to deliver care for migrants with attention to their specific needs and priorities. This result was found in 4 documents.

Networking and inter-disciplinarity

Within health care services, inter-disciplinarity is essential. Therefore, there should be a networking within healthcare services and between health and social services, to help migrants in developing their social network for example. A good coordination is also important between primary care services and refugee-specific health care services. This result was found in 4 documents.

Targeted outreach activities

Some migrant groups are difficult to reach, therefore outreach activities in health education, screening, prevention and promotion should be planned. This result was found in 1 document.

Availability of data and knowledge

Services should have access to knowledge on health and risk factors about the populations they are dealing with, but also to health registries monitoring migrant health with full respect of human rights. Availability of knowledge also means to focus on migrant health in education and research. This result was found in 2 documents.

Special attention paid to vulnerable groups (women, children, elderly)

Some groups are more vulnerable than others, and special programmes should be implemented such as maternal care, family planning, new born and infant care. Interventions that target these groups allow for more health gains because impact on the future generations. Older people are also a vulnerable group as they tend to be isolated and lacking social contacts. This result was found in 1 document.

International cooperation among countries

Cooperation between countries of origin and destination of big flows of migrants and between European countries is primordial, not only for the management of health workforce but also to

improve the knowledge on the practices. This result was found in 1 document.

Time and organizational resources

In some countries, administrative matters can be really complicated especially when practitioners have to deal with undocumented migrants. Simplifying the procedures or providing resources to deal with them could greatly improve the efficiency of health professionals to meet the needs of the migrants. This result was found in 2 documents.

Sustainability of change

Several attempts on implementing good practices failed or were suppressed after a few years due to lack of funding, absence of political will, and absence of obvious direct short-term results, while they were beneficial to the migrant population. This result was found in 1 document.

Reducing hurdle in obtaining documents

Undocumented and documented migrants face a lot of difficulties in accessing health care services due to the complexity or even absence on obtaining documents to access care. This result was found in 1 document.

Discussion

It is not easy to find a definition of what a good or best practices are, neither to find a theoretical framework or common elements that they should have. In most documents, practices are categorized as good or best without any understanding of what does it really means, the authors assuming that the adjectives good and best are self-defined. The absence of any definition or framework for good practices is also noticeable in the documents found, as only one defines them. Indeed, the Project Report on Delphi process on best practice of health care for immigrants poorly defines the best practices as "*the factors contributing most efficiently and effectively to an optimal health care delivery to migrants and ethnic minority groups*" (10).

Even if the purpose of the reports was the principles of good or best practices and not the practices themselves, it seems essential to define the guidelines, framework, the outcomes or the criteria that a practice, based on the principles, has to meet to be considered as good or best.

The UNESCO developed a framework that can be used to assess good and best practices in migrants' health, the UNESCO framework for best practices in immigration planning. Following the UNESCO definition (17):

- Best Practices are innovative. A Best Practice has developed new and creative solutions to common problems.
- Best Practices make a difference. A Best Practice constitutes a positive and tangible impact on the living conditions, quality of life or environment of the individuals, groups or communities concerned.
- Best Practices have a sustainable effect. A Best Practice contributes to sustained eradication of problems.
- Best Practices have the potential for replication. A Best Practice serves as a model for generating policies and initiatives elsewhere.

Additionally, the adjectives "good" and "best" seem to be randomly used and it seems to be no criteria for labelling a practice as "good" or "best" in the different documents. In the context of principles of practices for migrants health, it seems however more adequate to talk about good practices rather than best. Indeed, "best" implies that there is a hierarchy and that there are other approaches but that the selected one is better, an assumption that would definitively never be valid as there is a great range of different situations, contexts, migrant groups, and overall different views on the question depending the culture of the countries, something that has to be respected. Then, when a framework is used, it is common that a practice does not meet all the criteria, especially the replicability, while

having positive outcomes and therefore it would not be appropriated to name it "best".

Among the main issues identified by health practitioners in the delivery of healthcare to migrants are the communication problems, mainly due to the language barrier. Indeed, a level of language proficiency sufficient to get by in everyday life may be insufficient in the health services framework, requiring clear communication and understanding about non-everyday matters and potentially accompanied by considerable stress (12). If no numbers could be found for Europe, the Institute for Healthcare Advancement (IHA, 2003) estimates that 73 billion of US dollars are wasted annually in the United States due to communication problems in health care, many of which originate in language differences. Indeed, this waste is partly attributed to wrong diagnoses, lack of compliance with therapies, lower patient safety and lower treatment satisfaction on both sides. (12). Struggle in the diagnosis and misunderstanding between staff and patients also leads to a strained relationship between patient and health professionals.

The problem of the language barrier is often overcome by the use of official or unofficial interpreters. In the everyday practice and emergency situations, unofficial interpreters are mainly used. They can be members of staff, family, friends, or even a cleaner. Many problems arise when the translation is done by a friend, a family member, or even a child of the patient: The patients are not always willing to tell the full information due to privacy issues, pressures, and embarrassment, and the interpreter may interfere and interpret freely the words of the patient. Reliance on family members, especially children, destroys the confidentiality of the encounter and may be emotionally challenging for those involved (18).

The use of official interpreters is therefore perceived a high quality service as it allows more anonymity, but is also more difficult to obtain, due to financial means or waiting list. Also, there are a few drawbacks. It requires planning in advance, and therefore this method is mostly used in case of planned appointments, for example follow-ups of diabetes or mental issues (19). Generally, not all the languages are provided, and when a rare language is available it is most likely to happen that the interpreters and the patients are from the same community, a situation that can potentially introduce a bias.

But the ambivalence introduced by the presence of a third party also happens with professional interpreters. It is always a potential barrier to a good communication and relationship between the patient and the health professional as it can, in a conscious or unconscious way, interfere with the therapeutical relationship. Bilingual professionals seems to be therefore a better solution as it avoids those drawbacks. However, the proficiency in the language needs to be high, and the range of languages spoken is not likely to cover all the languages needed. Nevertheless, having practitioners speaking also Spanish in the United-States or Russian in the eastern countries can be a great improvement due to their prevalence as second language.

A rather new but seen as the most effective service is the use of cultural mediators. Cultural mediators are health workers not only providing interpreting services but also mediating actively between health practitioners and services users. Their role is pretty extensive, involving helping health professionals and patients to understand their respecting point of view and advising on how to solve the problems encountered.

France is one of the countries, among Belgium, the UK, Ireland, and Spain that have implemented those cultural mediators (16). The public health mediators' programme is an experience of training and follow-up of mediators in public health, aimed at facilitating access to prevention and healthcare for underprivileged populations. If migrants are not the only target, they represent a big part of it. The programme has a community health approach as it is based on the hypothesis that the intervention of health mediators recognized and close to those usually excluded from prevention and early treatments policies will help in reducing the social and cultural distance between

health care workers and patients and improving the access to healthcare.

A direct effect of the intervention of the mediator has been observed after one month, on the average of 30 people per mediator. Among others, it has been observed that the programme allows a better access to healthcare, facilitate the response of the professionals and the institutions, encourage screening and prevention, and help people to take into consideration the social determinants of health (16). Indirectly, there was also a positive effect on the health system through collecting information on the expectations, representations and behaviours of specific populations and reporting it to the institutions. In fact, the use of cultural mediators potentially gather a lot of the principles of good practices found by the experts, as the respect towards migrants, quality of individual care, targeted outreach activities, empowerment and cultural competences. Indeed, they are not only concerned with overcoming language barriers but also cultural and social barriers (12).

Culture is a relatively important matter when regarding healthcare and migrants, but it does not have to be seen as some sort of mental luggage that migrants bring with them from their birth country and that the label could be assumed to tell to the health practitioners what they can expect to find inside (12). Stereotyping the culture might increase the gap rather than closing it. Instead, acknowledging that culture is not-fixed and subjected to change and being aware of one's own preconceptions and deconstructing them is the best way to make health services culturally adapted (20). Having culturally competent services through the use of cultural mediators can make the interactions between people from different background way easier, over the language. Indeed, the culture difference express itself in many different ways the cultural mediator would be able to "translate": explaining factors of an illness, representations of the health, healing, bodily processes, transcultural validity of the diagnosis (21). However, certain studies claim that a practitioner or a cultural mediator of the same culture is not always the best option for cultural, political and historical reasons (12), as the practitioner and the patient can come from two different conflictual ethnic groups, or have different views of the common values that can offend the other.

A complementary approach to the cultural mediators could be the empowerment on cultural matters of the health professionals. But to what extend should health professionals adapt to the culture of the patient? This is a raised question which found an answer in a Belgian study, concluding that health professionals do not consider that it is their responsibility to adapt to the culture but, instead, it is the responsibility of the patient (22). Therefore, if they do not feel a responsibility to adapt, they are less likely to be involved in a culturally competent health care even if paradoxically it is viewed as a good practice principle. Improving access to health care and surpassing cultural and social barriers can only be achieved through empowerment and especially through increasing the level of health literacy. In Germany, the project "Health promotion for Migrant Women" aims at improving knowledge on sexual diseases, genital mutilation and unwanted pregnancy, in order to support positive and self-determined sexuality. A close cooperation with organisations working in the multicultural context ensures that a maximum of women and girls are reached. The general objective is to strengthen women and girls having no access to services and information by improving their knowledge and self-determined action on their sexuality, to enable them to communicate about health without the need of an interpreter (16).

This question on whose responsibility to adapt can be raised at the political level. Indeed, at the political level, cultural competence and language services are sensitive topics, linked to the immigration and integration debates, and therefore are not systematically viewed as good practices everywhere. As a matter of example, the current debate in Austria is not about adapting the healthcare system to migrants, but rather about their integration and assimilation and their financial contribution, and in Denmark, translated material is being removed and mediator services

suppressed as well as free interpreter services for migrants living in the country for more than seven years (10).

If those examples could be used to argue about the relativity of what can be considered as good practices depending on the views of the country, this is found irrelevant as the outcome considered here is a better access to health services by migrant populations, and there are serious doubts about the usefulness of those policies on a public health perspective. Moreover, making healthcare inaccessible in order to motivate migrants to learn the language and adapt themselves is a rather counterproductive policy, as health is itself a factor of integration (23). Additionally, if the costs of such services are most often mentioned, the cost of not providing these services is generally overlooked: If it is not likely that they reach the level estimated for the US, the human and financial costs of mistakes, misunderstandings and ineffective health care delivery in Europe might be important (12).

To go further on this issue, equal access to healthcare, or, in other words, legal entitlement to access healthcare services is also subject to vivid discussions in Europe because linked to the immigration debate, even if unanimously recognized as a good practice by professionals. Indeed, the legal entitlements to access the different levels of the health care system vary greatly depending on the country and the category of migrants. In many countries, undocumented migrants are only allowed to access emergency services, while in others they have no rights at all. Under this trend is the fear of attracting more migrants if they were entitled access to healthcare. This assumption goes against many evidences from studies showing that a quest for healthcare benefits is not a motivation for migrating and that extended healthcare coverage will not attract significant numbers of migrants to Europe (15,24). Moreover, restricting access to emergency care is a waste of resources as the costs of identifying and charging undocumented migrants outweigh possible savings due to the small number of concerned people. Nevertheless, good practices still exist despite this trend to fallback. A report from *Médecins du Monde* on healthcare provisions for undocumented migrants in 11 European countries showed that in France, Italy, the Netherlands, Belgium, Spain and Portugal, the health system may cover part or all the costs for undocumented migrants unable to pay (25). However, this does not show the condition accompanying the delivery of healthcare (obligation to report to the police) and therefore shadows other potential obstacles. Indeed, the same report highlights that 50% of the undocumented migrants interviewed in Belgium cited administrative problems as a barrier to healthcare, and that 98% of them could theoretically benefit of healthcare but that 25% of them were not aware of their rights. In Belgium, undocumented migrants have the right to "Urgent medical help", following the law. However, this term does not mean that only emergency cases are considered, but encompasses a great range of care provision: Medical examination, operation, childbirth, physiotherapy, medication, test and exams, and even "*the assistance that it is necessary to avoid a health situation that is dangerous for a person or his/her circle*" (16). If the procedure is a long way and therefore not ideal, many undocumented migrants and asylum seekers can actually benefit free healthcare.

Effective communication and cultural competences, linked to equal respect and quality of care provided, as well as empowerment of migrants are crucial practices to implement in order to improve the access to healthcare services by migrant populations. But those principles are subjected to great difficulties in their implementation into practices as culture is a sensitive and inconsistent matter. Also, practices are produced by their environment, circumstances and reality, and can have positive outcome to some groups somewhere while having none or little effect in another context. The empowerment of migrants and their active participation might be then the best practice to implement, regarding all perspectives. Indeed, migrants are the true experts on their needs, and enabling them to be proactive and to make decisions based on true knowledge avoids the bias

introduced by having third parties involved in the delivery of healthcare.

But, if professionals succeed in identifying effective principles of good practices, and that examples of good practices based on those principles can be found in Europe, the debate on integration has not only the potential to impact on the provision of culturally adapted services and language support, but also simply on the provision of healthcare to migrants. Indeed, there is a big gap between migrants' needs and the trends of policies due to misconceptions on immigration and potential costs, and the biggest challenge in order to improve access to healthcare services and to remove inequalities remains the legal entitlement to access healthcare services on the same basis as nationals.

Conflicts of interest: None declared.

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