Health Policy 120 (2016) 495–508

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Review

Reducing the health care burden for marginalised migrants: The potential role for primary care in Europe

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ARTICLE INFO

Article history:
Received 6 July 2015
Received in revised form 12 February 2016
Accepted 24 March 2016

Keywords:
Migrant access
Primary care
Health care policy
Entitlement
Equity

ABSTRACT

There is a growing interest in the health of migrants worldwide. Migrants, particularly those in marginalised situations, face significant barriers and inequities in entitlement and access to high quality health care. This study aimed to explore the potential role of primary care in mitigating such barriers and identify ways in which health care policies and systems can influence the ability of primary care to meet the needs of vulnerable and marginalised migrants. The study compared routinely available country-level data on health system structure and financing, policy support for language and communication, and barriers and facilitators to health care access reported in the published literature. These were then mapped to a framework of primary care systems to identify where the key features mitigating or amplifying barriers to access lay. Reflecting on the data generated, we argue that culturally-sensitive primary care can play a key role in delivering accessible, high-quality care to migrants in vulnerable situations. Policymakers and practitioners need to appreciate that both individual patient capacity, and the way health care systems are configured and funded, can constrain access to care and have a negative impact on the quality of care that practitioners can provide to such populations. Strategies to address these issues, from the level of policy through to practice, are urgently needed.

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http://dx.doi.org/10.1016/j.healthpol.2016.03.012

1. Introduction

Migrants comprise a substantial minority population in the European Union (EU). On 1st January 2014, there were 33.5 million people born out with the EU living in the 28 countries of the EU, 6.6% of the EU population. Of these, 19.6 million were still citizens of countries outside the EU, while 14.3 million were citizens of one EU country, but living in another [1]. Migrants are a heterogeneous population and include students, those migrating for work and for family reunification. Our particular interest in this paper is migrants who we would consider to be in marginalised situations; this group includes asylum seekers, refugees, undocumented migrants, victims of trafficking and economic migrants in unskilled, low paid employment. Such groups are, of course, growing greatly in number in and on the borders of the EU, due in particular to the on-going conflict in Syria.

Accurate estimates of the number of marginalised migrants in the EU28 are hard to find. The European Council on Refugees and Exiles estimated that there are approximately 1.5 million recognised refugees in the EU (http://www.ecre.org/refugees/refugees/refugees-in-the-eu.html). In 2014, there were 625,920 applications for asylum in the EU28, an increase from 431,090 in the previous year [2]. Of these, 19.5% came from Syria with a further 6.6% from Afghanistan. Finally, there are undisclosed numbers of both undocumented migrants (estimated at 1–4% of the European population (http://www.nowhereland.info/)) and victims of trafficking. What is beyond doubt is that such migrants are a substantial minority population in today's Europe.

Relatively little data is available on the health status of marginalised migrants [3]. Country of origin, reasons for migration, socio-economic status, age and gender are all factors that influence their health [4]. Many come from low and middle income countries which are also experiencing an increase in non-communicable diseases, such as diabetes, cardiovascular disease, depression and anxiety disorders [5]. Once in a new country, multiple factors influence migrants' ability to access health care. These include legal entitlement; knowledge and awareness of the health system in a new country [6]; previous experience of health care [7]; language and cultural barriers [8]; health beliefs and attitudes [9]; and, importantly, how the new country's health system is itself configured.

The World Health Organisation has drawn attention to the role these factors – including entitlement to health care, organisation and quality of services – play in promoting or reducing health care access for marginalised migrant groups [3,10]. Primary care is often the first point of contact that individuals have with health care [11,12]. This study aimed to explore the potential role of primary care in mitigating such barriers and identify ways in which health care policies and systems can influence the ability of primary care to meet the needs of vulnerable and marginalised migrants. In doing so, we hope that this will stimulate and continue the debate on the role of primary care to care for marginalised migrant groups, as outlined by the WHO and others [11–14].

Before describing our methods, we will briefly summarise the literature about health care systems as a potential social determinant and the role of primary care in caring for marginalised migrants.

1.1. Health care systems as a potential social determinant

There has been a growing call by researchers to consider how determinants such as ethnicity or migrant status may impact on individual and group health and wellbeing and on wider population-level inequities [15,16]. It is our contention, however, that health care systems themselves can also be considered a social determinant of health, interacting with migrant status to perpetuate inequities in health care access. This view is also promulgated by other researchers and organisations, including the World Health Organisation [17,18], with Marmot writing in 2008 that "The health-care system is itself a social determinant of health, influenced by and influencing the effect of other social determinants" [19].

Everyone has a fundamental right to health and to access health care, legally enshrined in both international and European instruments, such as the European Charter of Fundamental Rights [3]. However, while such rights may be set down in legal documents, in practice the picture is very different, particularly for migrants in vulnerable situations. For example, depending on migration status, migrants may have limited entitlements to health care due to national laws and policies [20]. The structure and organisation of health systems, as determined by government policy, can have a profound influence on the ability of particular groups to access health care. Availability of services, the need for health care insurance, the extent of health care coverage and out-of-pocket payments can all impact on populations' and individuals' ability to access health care [21,22]. Such issues have been identified as sources of "treatment burden" for patients and their caregivers, placing increased demands on them and contributing to adverse outcomes [23–26]. This is particularly true for individuals with low health literacy, different cultural backgrounds, or language barriers which will lessen their capacity to cope with such demands [27–29]. Thus, a health care system can amplify or mitigate the impact of inequities caused by the social determinants of health [19]. This makes the comparison of different health care systems, and their influence on the capacity of primary care to meet the health needs of marginalised groups, increasingly important.

1.2. Primary care as a support for marginalised migrants

There is increasing evidence that strong primary care systems are associated with improved health system outcomes in the general population such as lower rates of mortality and hospital admissions for ambulatory care-sensitive conditions [30–33]. This is attributed to several unique characteristics of primary care. It is a first point of access to wider health care provision, and provides person-centred, continuous, co-ordinated and comprehensive care [34,35]. With a focus on preventive care and health promotion, primary care is ideally placed to address the inequities