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Health Policy

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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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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

and challenges apparent in the provision of health care for marginalised migrants. In addition, primary care practitioners are often acutely aware of the social circumstances in which people live and the impact that wider social determinants, such as employment and housing, have on individuals [16,18].

Primary care can thus help redress inequities by acting as a gateway and co-ordinator of care to the wider health care system. This requires the provision of health services that are accessible, acceptable and appropriate – culturally and linguistically. There is a large literature on cultural competence, with guidelines and training initiatives designed to improve the cultural competence of health care professionals [28,29,36]. However, the implementation of such guidelines and training initiatives into routine care is not well understood. This was the focus of a cross-country implementation project called RESTORE – REsearch into implementation STRategies to support patients of different ORigins and language background in a variety of European primary care settings. RESTORE focussed on the implementation of guidelines and training initiatives targeting cross-cultural communication in European family practice for marginalised migrant populations (see Box 1) [28,29]. As part of the project, we also sought to understand the impact of health care systems and policy environments in supporting or preventing migrant access

to health care. In this paper, we report on the potential role of primary care in mitigating barriers to access and to identify ways in which health care policies and systems could influence the ability of primary care to meet the needs of vulnerable and marginalised migrants [28,29].

2. Materials and methods

2.1. Study design

We undertook a descriptive comparative analysis of the healthcare systems in the five RESTORE countries (Austria, Greece, Ireland, the Netherlands and the UK). It was our conjecture that the structure and funding of individual health care systems – and in particular primary care – might support or block migrants' access to care. As well as focusing on the situation of primary care within each country's overall health care system, we paid particular attention to the role of national policy in supporting migrant access and language and cultural competence in each country. We used Wendt's conceptualization of health system types to select meaningful variables to compare across systems, based on financing, service provision and access [21,37] and to provide a rigorous framework to aid comparison and interpretation of the health systems. We conducted a scoping review of the published literature on migrants' access to and use of health care, to identify barriers and facilitators to health care access.

These discrete areas of evidence were then drawn together and mapped onto Kringos's typology of primary care systems in order to identify which parts of a primary care system are more likely to facilitate migrants' access to primary care [33,38]. This is illustrated in Fig. 1.

2.2. Data sources

There is no single site or organisation which collects all of the data required to adequately describe health care systems and also migrant numbers, especially in relation to marginalised migrants. Thus, we had to draw on several sources of data (Appendix 1). However, each data source used was available at European level, ensuring comparability across the RESTORE countries for each individual variable. All data referred to 2013, the mid-point of the RESTORE project, unless otherwise stated in the tables.

Data on migrant numbers was obtained from EUROSTAT (<http://epp.eurostat.ec.europa.eu/portal/page/portal/eurostat/home/>). Data on the number of asylum applications per 1000 population, total number of asylum seekers as well as country rank in terms of asylum seeking population was obtained from UNHCR [39]. Data on undocumented migrants came from the website of the CLANDESTINO project (<http://research.icmpd.org/1244.html>; <http://irregular-migration.net/>).

Country-level data on healthcare expenditure, including government and private expenditure and per capita expenditure were obtained from the WHO World Health Statistics 2014 [40]. Medical workforce data were obtained from the OECD [41]. Mode of financing was defined according to whether the health care system is financed through general taxation, social or private insurance; entitlement

Box 1: Description of RESTORE [28,29].

RESTORE – REsearch into implementation STRategies to support patients of different ORigins and language background in a variety of European primary care settings.

RESTORE aimed to identify and support the implementation of guidelines and training initiatives designed to support cross-cultural communication in European general practice for vulnerable migrant populations: asylum seeking and refugee populations; migrants in low paid employment; and undocumented migrants. Funded by the EU Framework 7 programme, empirical work was conducted in five European primary care settings: Austria, England, Greece, Ireland and the Netherlands. A sixth partner, Scotland, focused on the extent to which the health system and policy environments supported or blocked migrant use of health care. RESTORE used a combination of participatory data collection methods – Participatory Learning and Action (PLA) – to generate rich, qualitative data. This involved a range of stakeholders including primary care practitioners, migrant service users, community interpreters and policy maker. Normalization Process Theory (NPT) – which aims to understand the work of implementing new ways of working in complex settings – was used as the underpinning theoretical framework to inform data collection and analysis. A key premise underpinning the RESTORE project was that the provision of primary care to such vulnerable populations, and the range of responses available to practitioners when dealing with these migrant populations, would be influenced by the structure, policies and financing of the primary health care system of the country. RESTORE commenced in April 2011 and was completed in March 2015.

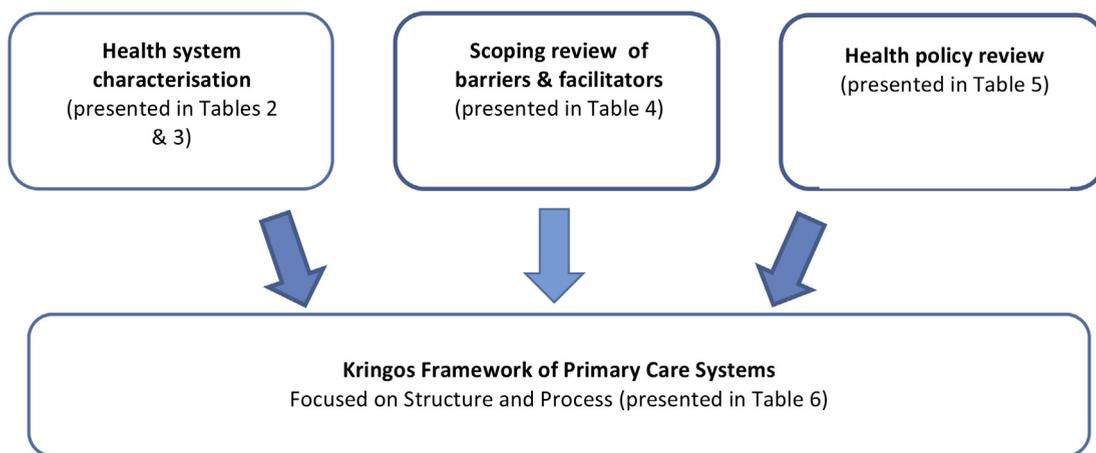


Fig. 1. Mapping barriers and facilitators to access to the Kringos dimensions of primary care.

to healthcare was characterised on the basis of citizenship, social or private insurance. These data were selected as they have been used in comparative analysis of health systems [21,42].

Features of primary care systems, including the requirement to register with a GP, choice of GP and the method of GP remuneration were again taken from Wendt [21,42]. The strength of the primary care system, from weak to strong, used the classification of Kringos et al. [38].

2.3. Identification of factors affecting access to health care for marginalised migrants, with particular reference to cross-cultural communication

We conducted a scoping review to identify recent literature concerned with the delivery of primary care to marginalised migrant groups, in particular asylum seekers, refugees and undocumented migrants. This literature was identified by the RESTORE team based on extensive prior knowledge and work in the field and by searching OVID, Web of Science and EBSCOHost using the search terms “migrant*”, “primary care” and “access” (Appendix 2). This was not intended to be an exhaustive review of the literature, but rather to provide a purposive selection of the literature addressing barriers and facilitators to migrant health care access. For that reason, we restricted our search to systematic reviews from 2000 onwards, when migrant numbers were increasing in the RESTORE countries. Key papers were sourced and reviewed by NB and COD to identify the barriers and facilitators listed in them to migrants’ access to health care.

The European database EUR-LEX (<http://eur-lex.europa.eu/homepage.html>) was searched for EU Directives; national policies concerned with health care and support for cross-cultural communication were identified by searching the websites of each country’s health system, as well as through RESTORE fieldwork [28] and a mapping process to identify guidelines and training support [36]. Documents were included if they addressed: primary care and migrant health; or language and/or cultural

competence in migrant health; or language and/or cultural competence in primary care. We conducted a thematic analysis of the identified documents to identify where language and communication featured as a facilitator to health care access for migrants.

2.4. Mapping barriers and facilitators to access to the Kringos dimensions of primary care

Kringos’s framework of primary care structure and process focuses attention on a range of dimensions: governance, economic conditions, workforce development, access, comprehensiveness, continuity and co-ordination.[32,43] The scoping review of systematic reviews identified a range of barriers and facilitators to migrants’ access to primary care, including in relation to language and communication. The characterisation of health systems in each RESTORE country and the review of national policies identified real examples of these barriers and facilitators e.g. in relation to migrant entitlement to care. We therefore mapped the results of these strands of work onto the Kringos’s framework of primary care structure and process to enable us to more clearly identify which parts of a primary care system are more important in facilitating access to care [32,43]. This process helped in our conceptualisation of the migrant sensitivity of the primary care system of each RESTORE country (Fig. 1).

3. Results

All RESTORE countries have an increasingly heterogeneous migrant population. The percentage of migrants in the population increased between 1990 and 2010 (Table 1); this was most apparent in Ireland, with a 3-fold increase over this period, and in Greece, with a 2.5-fold increase. Greece had the greatest proportion of migrants, at almost 20% of its 2010 population. All countries had an increasingly diverse migrant population, including those who are marginalised and in vulnerable situations, such as asylum seekers, and undocumented migrants. Austria and Greece

Table 1
Migration profiles across the RESTORE countries.

| | Austria | Greece | Ireland | Netherlands | UK |
|---|--|---|---|---|--|
| Country population in 2012 (million) | 8.3 | 11.3 | 4.8 | 16.7 | 61.4 |
| Migrants as a % of the population | | | | | |
| 1990 | 10.3 | 6.5 | 4.1 | 8.0 | 6.5 |
| 2000 | 12.5 | 10.1 | 6.7 | 10.0 | 8.1 |
| 2010 | 15.6 | 19.6 | 10.1 | 10.5 | 11.4 |
| Asylum seekers | | | | | |
| Number of asylum applications per 1000 population between 2008 and 2012 | 8.5 | 5.7 | 2.4 | 3.7 | 2.2 |
| Total number of asylum seekers 2008–2012 | 71,510 | 64,970 | 10,730 | 62,080 | 137,940 |
| Rank (out of 44 industrialised countries) | 9th | 10th | 18th | 13th | 20th |
| Top 5 countries of origin in 2012 | Afghanistan; Russian Federation; Pakistan; Syria; Iran | Pakistan; Georgia; Afghanistan; Iraq; Albania | Nigeria; Pakistan; Democratic Republic of Congo; China; Albania | Afghanistan; Iraq; Somalia; Iran; Eritrea | Pakistan; Iraq; Sri Lanka; Nigeria; Syria/Afghanistan (near equal numbers) |
| Undocumented migrants | | | | | |
| Estimate from CLANDESTINO project | 18,439–54,649 | 300,000+ | 30,000–62,000 | 62,320–113,912 | 417,000–863,000 |

had the largest number of asylum claims per 1000 population over the period from 2008 to 2012. The asylum seeking population can also change rapidly depending on the current international situation. For example, prior to 2012, there were very few Syrian asylum seekers. Such diversity has important implications for the provision of accessible and appropriate health care. All countries also have a substantial population of undocumented migrants, although the very nature of this population makes accurate figures hard to come by. Against this background, therefore, we examined more closely the health systems of each country and, in particular, the ability of primary care to support marginalised migrant's access to health care.

3.1. Health care systems across the RESTORE countries

Traditionally health care funding has relied on taxation or social insurance. However, healthcare systems are adopting increasingly diverse methods of funding, management and entitlement [42,44]. This was apparent in the RESTORE countries. Entitlement on the basis of citizenship/payment of taxes exists in two RESTORE countries – Ireland and the UK (Table 2), although Ireland also has a significant private health insurance sector. In Austria and the Netherlands, funding of healthcare is traditionally based around social insurance. Recently, however, the Netherlands has moved from social insurance to a private insurance system, regulated by the government. Finally, in Greece, the basis of entitlement is a mix of tax, social insurance, private and out-of-pocket payments.

The total expenditure on health, as a percentage of GDP, was similar across the countries, although slightly higher in the Netherlands (Table 2). The proportion of health spend

coming from national Government varied markedly, from 66% in Greece to 84% in the UK; this had a corresponding impact on the private sector share of all expenditure on health. Individuals contributed to this private spend through out-of-pocket payments, e.g. paying for medications or to see a doctor. The impact of such payments on individuals was greatest in Greece, Austria and Ireland. In Greece, 91% of private expenditure on health care was attributed to patient out-of-pocket payments. Health systems in Ireland and the Netherlands also have a substantial market for private prepaid plans for health care; these were not a feature of the Greek or UK systems. The per capita expenditure on health care also varied markedly, both overall and from the Government; per capita funding in Greece was far lower than in the other countries and below that of the WHO European region as a whole.

The structure of the health care system and, in particular the strength of primary care, also varied. Both Starfield and Kringos have conceptualised primary care systems along a spectrum from strong to weak [31,32]. Within the RESTORE countries, there was a clear divergence between those with a strong primary healthcare system and those which instead place emphasis on specialist, hospital-based care (Table 3). UK and the Netherlands have strong primary care systems, whereas Greece, Austria and Ireland have relatively weaker primary care systems. 'Strength' is not solely a reflection of the number of GPs per head of population but related to a number of factors coming together within a system, including the strength of the hospital-based sector and how patients' access to care is managed. So, for example in the Netherlands and the UK patients must be registered on a practice list in order to see a GP and access to hospital care is generally by GP referral. In Greece, however, there

Table 2
Health care system financing in each RESTORE countries in 2013.

| Country | Total expenditure on health as % of GDP ^a | General government expenditure on health as a % of total expenditure on health ^a | Private expenditure on health as a % of total expenditure on health ^a | Out of pocket expenditure as a % of private expenditure on health ^a | Private prepaid plans as a % of private expenditure on health ^a | Per capita total expenditure on health (converted to US\$) ^b | Per capita government expenditure on health (converted to US\$) ^b | Funding base ^b | Entitlement healthcare ^b |
|---------------------|--|---|--|--|--|---|--|--|-------------------------------------|
| Austria | 11.3 | 75.3 | 24.7 | 62.2 | 16.4 | 5643 | 4251 | Social insurance | Social insurance |
| Greece | 9.0 | 66.1 | 33.9 | 91.3 | 8.4 | 2304 | 1522 | Tax, social insurance | Citizenship |
| Ireland | 8.8 | 67.0 | 33.0 | 42.2 | 38.0 | 4306 | 2883 | Tax | Citizenship |
| Netherlands | 11.9 | 79.5 | 13.4 | 41.4 | 38.7 | 5997 | 4769 | Social insurance; increasing private insurance | Social insurance |
| UK | 9.4 | 82.8 | 17.2 | 56.8 | 6.0 | 3659 | 3031 | Tax | Citizenship |
| WHO European Region | 9.0 | 73.9 | 25.8 | 68.8 | 20.9 | 2370 | 1782 | Tax | – |

^a From [40].

^b From [21,42].

is no such system [45]. GP remuneration also varies, with capitation-based systems in Ireland, the Netherlands and the UK, but a fee-for-service system in Austria and Greece [32,43].

3.2. Barriers and facilitators to health care access reported in the literature

Our scoping review identified six systematic reviews which addressed barriers and facilitators to health care access for migrant groups [46–51]. Most of the reviews focussed on barriers to access (Table 4). These were often reported at the level of patients/individuals; providers; and the health care system. Key barriers, reported across multiple reviews, included: language and communication; access to interpreters; inability to access care due to migrant status (e.g. an asylum seeker or undocumented migrant); lack of access to health insurance. Provider level barriers focussed on health care practitioners, in particular hospital doctors and family doctors/general practitioners. Barriers here included lack of ability to communicate; poor cultural awareness and competence. Provider-level barriers also operated at the structural level, with access to primary care appointments, waiting times and referral systems described as provider-level barriers. System level barriers included a lack of interpreter services and national policies in relation to rights and entitlements for different migrant groups. One study also suggested that countries with weaker primary care systems – in particular the US – might lead to under-use of services by migrant groups [47]. Facilitators to access at the individual level included: speaking the language of the host country; good social support networks. At the provider and system level, facilitators included: access to professional interpreters or bi-lingual staff; flexible payment systems; low cost services; and doctors willing to accept lower fees.

3.3. Migrants' access to primary care in the RESTORE countries

The literature indicated the importance of supporting language and communication for marginalised migrant groups, particularly in relation to the provision of interpreting services to facilitate inter-cultural communication. We thus explored the degree to which each RESTORE country had policies which supported migrant access to primary care generally, and to communication support in particular (Table 5). All five RESTORE countries had policies which acknowledged the rights of migrants to access health care or the importance of supporting language and communication in practice. However, the RESTORE researchers conducting fieldwork with health care practitioners reported that practitioners “on the ground” had poor knowledge of such policies.

Primary care's ability to deliver care to migrant populations is driven in part by the legal entitlements of diverse migrant populations to access health care. While asylum seekers and migrants with permission to be in the host country all had a legal entitlement to access health care, the situation was very different for undocumented migrants, as previously described [20,52]. Only the Netherlands and the

Table 3
Health systems (primary care in relation to hospital care) across the RESTORE countries in 2013.

| Country | Number per 10,000 population ^a | | | Hospital beds per 10,000 population ^b | Features of the primary care system | | | |
|-------------|---|--|------------------------------------|--|---|---------------------------|---------------------------------------|---------------------------------|
| | Specialist medical practitioners ^c | General medical practitioners ^d | General practitioners ^e | | Registration with GP ^f | Choice of GP ^f | GP remuneration ^f | Strength of system ^g |
| Austria | 24.2 | 15.9 | 7.8 | 76 | Free | Limited | Fee for service | Weak |
| Greece | 36.3 | 3.0 | 3.0 | 48 | Free | Free | Fee for service | Weak |
| Ireland | 13.8 | 27.3 | 7.2 | 29 | Obligatory (medical card holders) Free | Free | Capitation | Weak |
| Netherlands | 17.4 | 14.0 | 7.3 | 47 | Required | Free | Capitation | Strong |
| UK | 19.4 | 8.1 | 8.1 | 29 | Required | Limited | Capitation + some pay-for-performance | Strong |

^a From [41].

^b From [40].

^c Includes: Medical and surgical specialists; obstetricians and gynaecologists; paediatricians; psychiatrists.

^d Includes hospital-based medical specialists; family doctors; general practitioners.

^e Includes district medical doctors; family doctors; general practitioners.

^f From [21,42].

^g From [32].

UK allowed undocumented migrants access to primary care and, even then this was restricted to “medically necessary” treatment.

Requirements for migrants to make out-of-pocket payments, register with a GP and have a choice of GP mirrored that of the wider primary care system of the country. Thus, countries which make their indigenous population register with a GP (the Netherlands and the UK) applied this requirement to migrant populations as well. Countries with a reliance on private expenditure and out-of-pocket payments (Austria, Greece and Ireland) require at least some migrant groups to make such payments too. Finally, although almost all countries had policies which acknowledged the importance of language and communication, only the UK readily provided interpreter services. Austerity measures and changing political landscapes impacted on provision in the other countries. In Ireland, there was some provision of interpreters but this was patchy; the Netherlands had provided interpreting services but withdrew funding for such services in 2012, shifting the onus of paying for interpreters to practices or patients [53].

3.4. Mapping of identified barriers, facilitators and health system characteristics to Kringos's framework of a primary care system

We mapped the features of health care systems, barriers and facilitators in the literature and the policy review to the Kringos framework, as illustrated in Fig. 1. This highlighted how such barriers and facilitators exist within both the structural and process dimensions of a primary care system (Table 6). This exercise clearly demonstrated that the structural configuration of health systems impact on migrants' access to health care, over and above the day-to-day routine configuration of services such as practice

appointment systems, or issues of communication within the consultation.

For example, an absence of clear policies on entitlement to care and legal restrictions on health care access for marginalised migrants, in particular undocumented migrants or refused asylum seekers, present structural barriers to health care access for these groups. The economic conditions of a primary care system are also crucial; barriers identified in the literature included a lack of financial support for interpreters and a lack of mainstreaming for migrant health projects. As a result, many projects targeting migrant access and health care are short-term and rely on specific project funding, which can be withdrawn at any time. Some studies found that doctors could be reluctant to accept lower fees for caring for migrants.

Workforce development was another key feature which could inhibit or promote migrant use and access to primary care, including professional knowledge of the rights of migrants to health care, a lack of training in the use of interpreters, and little professional recognition for interpreters. Conversely, high levels of professional knowledge, good training and recognition of the need for and respect of professional interpreters were facilitators of migrant access to appropriate primary care.

Within the process dimension, out-of-pocket payments, which are generally required upfront, impact on migrants' ability to access primary care. Navigating health care systems can also be complex. Registration procedures, appointment systems and the need to negotiate access with reception staff all add to the burden of accessing care for migrants. Referral systems and waiting times are often perceived as not only a barrier but as discriminatory. Finally, language barriers and expectations based on experiences of health care systems from home countries all impact on a migrants' experience of accessing health care in a new country.

Table 4

Barriers and facilitators experienced by migrants in primary care as identified from the scoping review.

| Paper | Aim and description of review | Barriers identified | Facilitators identified |
|-----------------------------|--|--|--|
| Scheppers et al. 2006 [46]. | Aim: To present an overview of the potential barriers and factors which may restrict minority ethnic patients from using health services. 54 studies included from 12 countries; published between 1990 and 2003. Population focus: migrants and ethnic minorities. Health system: primary and secondary care. | Barriers identified at three levels: patient, provider and system levels. Patient level barriers included: being younger, male, unmarried, of lower socioeconomic position, lack of family and social support, insecure living conditions. Lack of language skills in new country; lack of trust in interpreter. Health beliefs and attitudes; lack of knowledge in health care system. Lack of money; inability to access health insurance. Lack of correct visa/work permits. Provider level barriers included: Application of medical procedures and practices without due consideration to cultural norms of the patient. Lack of holistic approach on part of the practitioner; lack of cultural awareness and knowledge. Poor communication skills in inter-cultural consultation. Lack of awareness when communicating through an interpreter. System level barriers included: Appointment systems, waiting times and referral systems. Short consultation times. Lack of appropriately translated materials. Medical paradigm used in Westernised medicine. | This paper focused on identifying potential barriers. |
| Uiters et al. 2009 [47]. | Aim: To provide a systematic overview of the existing research on differences in primary care utilisation between immigrant groups and the majority population. 37 studies included from 7 countries; published between 1982 and 2004. Population focus: migrants, defined by ethnicity or country of birth. Health system: primary care. | Lower use of primary care services by migrants observed in studies set in the US. Authors postulate that country and strength of primary care system may be a stronger predictor of difference in primary care use than the migrant group using care. | Higher or similar levels of primary care use found amongst migrant groups for 64% of the outcome measures reviewed. Studies adjusting for cultural and language differences in their data collection methods were more likely to report similar or lower use of primary care services; authors suggest importance of addressing cultural and language barriers, both in research and in service provision. |
| Norredam et al. 2009 [48]. | Aim: To review the European literature on utilisation of somatic healthcare services related to screening, general practitioner, specialist, emergency room and hospital by adult first-generation migrants. 21 studies included from 6 countries; published between 1998 and 2008. Population focus: migrants, defined by country of birth; some studies included labour migrants and asylum seekers/refugees. Health system: primary and secondary care. | Migrants less likely to access cervical screening and mammography services. Authors identified formal and informal barriers to health care use. Formal barriers included: Organisation of the health care system; legal restrictions to access dependent on status (e.g. asylum seekers); user payments; lack of referral between services. Lack of skilled interpreters identified as a major barrier. Informal barriers included: Language barriers leading to communication difficulties; lack of knowledge about the services available; difficulties in making appointments, especially with GPs. | Appeared to be higher use of primary care and emergency room services by migrants; Speaking language of the country of residence appeared to facilitate greater use of primary care |

Table 4 (Continued)

| Paper | Aim and description of review | Barriers identified | Facilitators identified |
|----------------------------------|---|---|---|
| Agudelo-Suarez et al. 2012 [49]. | <p>Aim: To describe the views of migrants regarding barriers and determinants of access to health services in the international literature.</p> <p>28 studies included from 7 countries; published between 1997 and 2011.</p> <p>Population focus: migrants, defined by country of birth or by ethnicity.</p> <p>Health system: Primary care, mental health services and unspecified.</p> | <p>Barriers identified at patient and system level.</p> <p>Patient-level barriers included: Lack of knowledge of health care system in host country; own beliefs and knowledge of health. Ability to communicate in host country's language.</p> <p>Provider-level barriers: Attitude of health care professionals; communication ability. Cultural competence of staff.</p> <p>System-level barriers: Cost of health services; need to have health insurance. Documented status and its impact on ability to access health care.</p> <p>Political/structural barriers. Discrimination and fear of discrimination, operating at both individual and system-level. Lack of clarity in immigration legislation around access to health care.</p> | <p>Support networks and social networks can play important role in facilitating and improving knowledge and confidence, thus increasing likelihood of access health care.</p> <p>Health care professionals who are bi-lingual valued.</p> <p>Flexible payment systems.</p> |
| Joshi et al. 2013 [50]. | <p>Aim: To identify components of primary health care service delivery models for refugees which have been effective in improving access, quality and co-ordination of care.</p> <p>25 studies included from 5 countries; published between 1990 and 2011.</p> <p>Population focus: refugees in resettlement countries.</p> <p>Health system: primary and secondary care, including mental health services.</p> | <p>Lack of interpreters in some languages; unmet health needs.</p> <p>Lack of doctors willing to accept fees limited to government insurance levels.</p> <p>Some patients continued to experience persistent cultural and language barriers.</p> <p>Transitioning from refugee-specific service to ongoing mainstream services can be hampered by lack of knowledge, language barriers, fear, distrust, negative experiences, political, economic and administrative constraints on health systems</p> | <p>Approaches which facilitated access to care included: Multidisciplinary staff teams including non-health workers improved co-ordination and access across services. Use of interpreters and bilingual staff; gender-sensitive providers of care. No-cost or low cost services for refugees; minimising fees to ensure they were covered by government health insurance. Outreach services and services in refugees' homes; free transport for appointments; longer consultation hours. Patient advocacy; staff advocating for refugees to other services e.g. housing. Training providers in culturally sensitive care; appropriate use of interpreters and bilingual staff led to improved patient satisfaction, improved referrals and increased access to care.</p> |
| Woodward et al. 2014 [51]. | <p>Aim: To identify the extent, nature and distribution of existing primary research exploring health and access to care for undocumented migrants in the EU.</p> <p>54 studies included from 27 countries, including published papers, reports, theses and meeting abstracts; published between 2005 and 2012.</p> <p>Population focus: undocumented migrants.</p> <p>Health system: primary and secondary care.</p> | <p>Poor access to primary, secondary and tertiary care, especially to secondary and tertiary care; access to primary care often delayed.</p> <p>Access to mental health services and to dental care also problematic.</p> <p>Lack of awareness of legal entitlements found amongst both undocumented migrants and health care professionals; health professionals uncertain as to when undocumented migrants have right to access health care.</p> <p>Fear of being reported to authorities a barrier for migrants.</p> <p>Financial costs of access care and paying for medications.</p> <p>Reimbursement systems increased workload for health care professionals.</p> <p>Cultural and language barriers impact on migrants' ability to negotiate services.</p> <p>Some evidence of within-country differences in implementation of rights operating at regional and local level.</p> | <p>Patient-held records may improve continuity of care and empowerment amongst undocumented women.</p> <p>Use of voluntary health organisations improved access, by linking migrants to primary and secondary care, by providing outreach clinics and acting as advocates.</p> |

Table 5
Primary care and migrant access in the RESTORE countries, identified from national policy and health system characteristics.

| | Austria | Ireland | Greece | Netherlands | UK |
|--|--------------------|----------|---------|--|----------|
| Number of relevant policies identified | 4 | 3 | 2 | 2 | 7 |
| Structure | | | | | |
| Policy guidance on migrant health | Yes | Yes | Unclear | Yes | Yes |
| Policy acknowledgement of language and communication | Yes | Yes | No | Yes, but policy retraction | Yes |
| Knowledge of policy guidance at practitioner level | Unknown | Poor | Poor | Poor | Poor |
| Funding for migrant sensitive services | Yes | Cut | Cut | Cut | Yes |
| Legal entitlement to primary care for selected migrant populations | | | | | |
| Asylum seekers | Yes | Yes | Yes | Yes | Yes |
| Undocumented migrants | No, highly limited | No | No | Only for medically necessary treatment | Partial |
| Authorised residents | Yes | Yes | Yes | Yes | Yes |
| Process | | | | | |
| Out-of-pocket payments required | Partial | Yes | Yes | No | No |
| GP registration required | No | Required | No | Required | Required |
| Choice of GP | Limited | Free | Free | Free | Limited |
| Interpreting services available | No | Yes | No | No | Yes |

4. Discussion

Our comparative analysis of health care systems, and primary care in particular, has provided a basis upon which to consider the ability of primary care systems in five European countries to provide health care for marginalised migrant groups. This has highlighted wider social and political influences on primary care and the way in which macro-level health care systems and policies operating at national level may amplify or mitigate barriers to primary health care. The published literature used here identified well-recognised barriers and facilitators to access, including language and communication barriers and issues around inter-cultural competence and understanding. Drawing this knowledge together with a comparison of the health systems has highlighted where national policy and health system organisation may intersect with provider and migrant patient characteristics, to influence access to care.

4.1. Strengths and limitations

We used two conceptual frameworks to help us identify key variables in health system organisation and funding and to identify key components of primary care. This approach helped overcome a key limitation, namely the lack of a single source of data which adequately covers all aspects of health system organisation, funding, entitlement and workforce. Recognising that data comparability across countries would be problematic, we chose to use key international datasets from WHO Health Statistics, OECD Health Statistics and Eurostat data. The data available were aggregated at country level, limiting our data presentation to high level descriptive comparison.

Wendt's conceptualisation of health systems was used as it has been used previously to characterise health care systems, particularly European health care systems, and offered a structured way to identify key variables which influence a health care system, including mode of funding, basis of entitlement to care, workforce and access [21,37]. Kringos's typology develops the well-recognised work of Barbara Starfield [30] and is, to our knowledge, the only

current typology of primary care which seeks to characterise primary care systems across the key dimensions of structure, process and outcome [43]. While we were able to identify and use data on the structural and process dimensions of primary care systems, a limitation of our work was the lack of data on health care outcome for migrants. This has been discussed by others [3,15] and is a clear limitation of work in this area, as we are currently unable to draw conclusions about variation in primary care systems in relation to patient outcomes in primary care.

Kringos's typology describes primary care systems along a spectrum from "strong" gatekeeper-led systems with universal coverage to "weak" systems with little or no gate-keeping function and a lack of registered populations with family doctors [32]. This is, however, a fluid situation and changes in political will and policy can quickly move a country across the spectrum, in either direction.

4.1.1. Final discussion and implications

Previous good practice in national policy towards health care for migrants has been highlighted, with particular mention made of the intercultural policies developed in Ireland and the Netherlands [54,55]. The use of Kringos's framework of primary care has allowed us to clearly conceptualise where in a primary care system policy has impact and traction and, importantly, highlights not only barriers to equitable primary care, but facilitators as well.

Our work suggests that national level system and political decisions, which limit rights to entitlement and access and lead to a reliance on out-of-pocket payments, reduce the capacity of migrants to access primary care and – importantly – hamper professionals' ability to respond to such patients. For example, in the Netherlands, a change in government has resulted in a policy retraction from migrant health, including the dissolution of paid interpreting services [56]. These dimensions of governance and economic conditions have serious repercussion for migrant care. Wider austerity measures and an increasingly hostile political climate at the supra-national levels, for example across EU countries, also impact on care [57,58]. However, the removal of legal restriction to entitlement could potentially improve the ability of primary care to care for such

Table 6

Mapping of the key facilitators of primary care identified in the literature, policy and health system data to Kringos's framework of primary care systems.

| Key dimensions of a primary care system according to Kringos et al. ^a | Evidence from health systems, literature and policy | Potential outcomes |
|---|--|---|
| Structural dimensions of a primary care system | | |
| 1. Governance | | |
| Primary care governance includes: Clear policies relating to the health care system and its goals Clear policies relating to equity in access (De)centralisation of management and services, allowing regional and local management Quality management Patient advocacy | Literature review highlighted different policies and rules to health care entitlement across different migrant groups (e.g. asylum seekers, undocumented migrants) (Table 4). Legal restrictions on health care use by some migrant groups, e.g. undocumented migrants, failed asylum seekers, hinders access and reduces equity of provision (Tables 4 and 5). Increased move towards private insurance systems for health care services can hinder access e.g. through restrictions on use or charges to access care (Tables 2 and 4). There was no evidence of patient advocacy in relation to marginalised migrant groups. | Clear policies and guidance on migrants' rights to access health care could promote consideration of equity in service provision. Removal of legal restrictions could facilitate primary care's ability to provide preventive and reactive health care to all migrant groups. |
| 2. Economic conditions | | |
| Economic conditions includes: The health care funding system The total expenditure on health care and on primary care Primary care coverage Employment status of the workforce, for example self-employed, salaried Remuneration system, for example pay-for-service, capitation, pay-for-performance Income of workers | There was variation in the amount of funding given to primary care across the RESTORE countries (Table 2). The amount of funding given to primary care will influence the extent to which it can invest in services for particular patient groups. Some RESTORE countries had a much greater reliance on out-of-pocket payments, private expenditure on health care and social or private insurance (Tables 2 and 5). Literature identified that migrants in lower socioeconomic groups or with less income less likely to access health care (Table 4). Some systems encourage registration with a general practitioner/family doctor for all patients – regardless of migrant status (Tables 3 and 5). Several RESTORE countries have seen significant disinvestment in funding for migrant sensitive services (Table 5). Literature suggests that some GPs are unwilling to accept lower fee payments from government insurance schemes when caring for migrant patients (Table 4). | Systems which rely on personal contributions to health care will further marginalise migrants with little or no economic resources. Support for translation services, professional interpreters and cultural competence training for staff requires additional resources and funding and may be harder to achieve in countries with low levels of investment in primary care. Systems which encourage everyone to register with a primary care doctor will enhance migrants' access to health care. GPs may be more likely to accept migrants as patients if their remuneration is based on capitation, rather than fee-for-service, and if costs for interpreters are met. Health care systems need to invest in skilling up their workforce to work effectively in inter-cultural consultations. Interpreting services could play a key role in providing effective care. Workforce development should include professional interpreters working in primary care. Improving the knowledge of both clinical and non-clinical primary staff to migrants rights and entitlements could improve their access primary care. |
| 3. Workforce development | | |
| Workforce development includes: Profile of workforce in primary care Professional status of the workforce Recognition and responsibilities of different professional groups Academic status of the primary care workforce Professional associations | Literature identified a clear need for a workforce skilled in inter-cultural communication, able to work with interpreters and – where possible – bilingual (Table 4). Some literature showed that multidisciplinary teams were effective in enabling access to care for migrants; this included non-health professionals and use of voluntary groups as advocates (Table 4). Health care professionals "on the ground" had little knowledge of migrants rights to access primary care (Table 5). There was no acknowledgement in either the literature or in policy of the professional status of interpreters working in primary care. | Health care systems need to invest in skilling up their workforce to work effectively in inter-cultural consultations. Interpreting services could play a key role in providing effective care. Workforce development should include professional interpreters working in primary care. Improving the knowledge of both clinical and non-clinical primary staff to migrants rights and entitlements could improve their access primary care. |
| Process dimensions of a primary care system | | |
| 1. Access | | |
| Access includes: Density and availability of primary care services Geographic availability of primary care services Affordability of primary care services Patient satisfaction Equality in access | Several RESTORE countries had systems with weaker primary care, particularly in Greece where the number of family doctors per head of population is extremely low (Table 3). Literature showed that accessibility of services for migrants, in terms of geographical proximity, can improve access (Table 4). Literature suggests that transitioning from migrant-specific services to mainstream services can be a barrier (Table 4). Entitlement to health care based on the ability to pay (e.g. through social or private insurance) is a major barrier (Tables 2, 4 and 5). Several RESTORE countries had health care systems which required substantial out-of-pocket payments, limiting affordability for migrant patients (Table 2). While health systems generally had the same access rights for migrant and non-migrant patients (e.g. requirements to register with a GP or to pay fees), systems which rely on private expenditure present barriers to migrant access (Tables 2, 4 and 5). Use of health care may be predicated on ability to obtain health insurance; this is a substantial barrier for many migrants (Table 4). | Locally available accessible services are important to migrants, especially for those who may have little or no income. Health care systems which base entitlement to health care on citizenship, rather than ability to pay, could promote access for marginalised groups. The abolition, or reduction, of out-of-pocket payments to visit practitioners and for medications would greatly promote access and use of primary care. Health systems which promote full universal coverage, regardless of legal status, promote equity and equality of access. |

Table 6 (Continued)

| Key dimensions of a primary care system according to Kringos et al. ^a | Evidence from health systems, literature and policy | Potential outcomes |
|--|--|--|
| <p>2. Comprehensiveness of primary care Comprehensiveness includes: First contact care for common health problems Treatment and follow-up Preventive health care Health promotion Medical equipment</p> | <p>Health systems generally had the same registration systems for migrant and non-migrant patients (e.g. requirements to register with a GP) (Tables 3 and 5). Literature showed that a lack of knowledge about the health system of the host country was often a barrier to migrant access and use of care (Table 4). Literature identified appointment systems and waiting times as a barrier for migrants (Table 4). Medical procedures and approaches often seen as discriminatory and lacking holism (Table 4). It is often unclear whether preventive care is covered by a migrants' entitlement to access care, not whether it is financially covered by the health system (Table 4).</p> | <p>Systems which require registration with a general practitioner/family doctor may be a deterrent to migrants, unless they are supported to access such systems. Primary care could do more to promote knowledge and awareness amongst migrants of the organisation of the system, with particular focus on appointments and waiting times. Preventive care for migrants could be given a greater priority in primary care systems. Sensitive design of services, recognizing migrants' needs and understanding of health care systems in a new country, could increase uptake and awareness.</p> |
| <p>3. Continuity of care Continuity of care includes: Long term relationship with a primary care practitioner Shared access to medical record across health system Quality of long-term relationship between patient and practitioner</p> | <p>Literature shows that language barriers can impede the development of an on-going relationship with a practitioner; access to high quality interpreting can overcome this (Table 4). Access to professional interpreters can enhance the quality of the consultation (Table 4). Migrants' expectations of care are often shaped by their experience of health care in their home country (Table 4). Patient-held or shared medical records may improve continuity of care (Table 4).</p> | <p>Expectations from the consultation are often based on previous health system knowledge e.g. expectations of a referral to a hospital-specialist or a prescription for antibiotics. Practitioner awareness of this, improved provision of translators and information on health care systems could mitigate some of these barriers.</p> |
| <p>4. Co-ordination of care Co-ordination of care includes: Gatekeeping system Skill mix of primary care team Integration of care across primary and secondary care</p> | <p>Systems which operate a gatekeeping and referral system to specialists often not well understood by new migrants. Appointment systems in particular are viewed as a barrier (Table 4). Advocacy groups, social support and local education targeted at migrant communities about accessing and using primary care appear to mitigate some of these barriers (Table 4). Multidisciplinary teams, including non-clinical staff, and integration with community and voluntary organisations promote awareness and knowledge of health care systems (Table 4).</p> | <p>Greater links between primary care and community organisations involved with migrants could promote understanding of services and improve access. All staff, not just clinical staff, need to be trained in issues affecting migrants e.g. legal status, financial situation, cultural expectations.</p> |

^a From [32,43].

patients and, importantly, provide the opportunity for primary care to provide preventive as well as reactive care [56–58].

Migrants are often at the 'sharp end' of debates around health care costs, with changes to health care systems having a greater impact on them and bringing into relief the inequalities and inequities faced by many groups in health care systems. Primary care professionals are well placed to understand the challenges faced by migrants and to assume an advocacy role. Such a role has, for example, recently been seen in Greece, when general practitioners publically raised their concerns about the provision of care for migrants [59]. In the UK, the Royal College of General Practitioners challenged the UK government's consultation which proposed to extend charging for primary care services to migrants [60]. We suggest that practitioners working in primary care are in a good position to raise these issues and their consequent detrimental effects on the care of migrant patients.

At the individual level, communication difficulties, low health literacy, lack of social support and other forms of socioeconomic problems adversely affect the *capacity*

of migrants to successfully navigate complex and changing health and social care systems. This is compounded by problems of discontinuity and poor or absent care coordination, which increases the work migrants have to undertake to effectively access and navigate primary care. In addition, migrants often have to "work" harder than others to make coherent diagnoses and make sense of the implications of health care problems because of language barriers and deficiencies in information provision in a form that is easily accessible. Similar to other groups, such as those with multimorbidity, migrants' may therefore experience an imbalance of heavy treatment burden while at the same time often having limited capacity to cope with such burdens [24,25]. It has been hypothesised that such a situation is likely to lead to poor health care outcomes and impact on patient safety [26,27,61].

In conclusion, we believe that primary care is well suited to provide accessible and appropriate health care for marginalised migrants, even in times of austerity. Policymakers need to appreciate that both individual patient capacity, and the way health care systems are configured,

shapes access to care and impacts on the quality of care that practitioners can provide to such populations. For primary care to realise its potential in relation to accessible and appropriate health care for marginalised migrants requires wider macro-level system policies to support the ideals of primary care, namely the provision of care that is universal, free at the point of need, co-ordinated, continuous and patient-centred coupled to recognition of the importance of inter-cultural communication. If primary care can be developed to provide that for some of the most vulnerable in society, it can provide it for all.

Authors' contributions

COD, FM, CD and AMcF conceived the original idea as part of the RESTORE project. NB and COD designed the analysis, which NB conducted with COD and FM. NB wrote the first draft; COD and FM wrote the substantive re-drafts, with substantive editing from CC and CD. COD and NB wrote the revised version of the original submission. All authors contributed to the development of the ideas in this paper and subsequently commented on and revised drafts. All authors have seen and approved the final paper.

Conflicts of interest

There are no conflicts of interest.

Funding source

This work is funded by European Union's FP7 Health Programme, contract number 257258. The funder has not contributed to the views expressed in this paper.

Ethical approval

The desk based-policy analysis and literature searching did not require ethical approval. Data generated as part of fieldwork in the RESTORE countries has been approved by the relevant local research Ethics Committee.

Acknowledgements

We acknowledge the wider RESTORE team for discussion of the ideas and for the fieldwork which has contributed to this paper. We also thank Dr. Victor Montori for helpful comments on an earlier draft. We also thank the two anonymous reviewers for their very helpful comments which strengthened and improved our paper.

Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at <http://dx.doi.org/10.1016/j.healthpol.2016.03.012>.

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