Migrants' healthcare experience: a meta-ethnography review of the literature.

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Running head: **Migrants' healthcare experience**

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Abstract

Purpose. Worldwide, more than 214 million people have left their country of origin. This unprecedented mass migration impacts on healthcare in host countries. This paper explores and synthesizes literature on the healthcare experiences of migrants.

Design. A meta- ethnography study of qualitative studies was conducted.

Methods. Eight databases (MEDLINE, CINAHL, PsychInfo, EMBASE, Web of Science, Migration Observatory, National Health Service Scotland Knowledge Network, and ASSIA) were searched for relevant full text articles in English, published between January 2006 and June 2016. Articles were screened against inclusion criteria for eligibility. Included articles were assessed for quality and analysed using Noblit and Hare's seven step meta ethnography process.

Findings. Twenty-seven studies were included in the review. Five key contextualization dimensions were identified: Personal Factors, The Healthcare System, Accessing Healthcare, The Encounter and Healthcare Experiences. These five areas all underlined the uniqueness of each individual migrant emphasizing the need to treat a person rather than a population. Within a true person-centred approach, the individual's cultural background is fundamental to effective care.

Conclusion. From the findings, a model has been designed using the five dimensions and grounded in a person-centred care approach. This may help healthcare providers to identify weak points, improve the organisation and healthcare professionals to provide person-centred care to migrant patients.

Clinical relevance. The proposed model facilitates identification of points of weakness in the care for migrant patients. Employing a person-centred care approach may contribute to improve health outcomes for migrant patients.

Introduction

The International Organisation for Migration (IOM) (2017) defines a migrant as*:"any person who is moving or has moved across an international border or within a state away from his/her habitual place of residence, regardless of the person's legal status, voluntary or involuntary, causes, and the length of the stay*". It furthermore defines refugees and asylum seekers as migrants who left their home country due to fear of persecution or to the threat to their lives. Refugees and asylum seekers have their specific health profiles due to their experiences and exposure in their home countries and during their migration to the host countries. Traumatic injuries, psychological problems and infectious diseases are prevalent. (Müller, Khamis, Srivastava, Exadaktylos, & Pfortmueller, 2018).With the number of international migrants escalating (United Nations, 2016), migrant healthcare becomes an urgent global public health issue as migrants face numerous barriers to access an appropriate level of high quality healthcare (World Health Organization, 2008). These include, amongst others, cultural, information and language barriers, as well as migrant's lack of knowledge about the host country's healthcare system (Hakonsen, Lees, & Toverud, 2014; Kalich, Heinemann, & Ghahari, 2016; Suphanchaimat, Kantamaturapoj, Putthasri, & Prakongsai, 2015). Furthermore, while some countries such as the Netherlands have paid systematic attention to migrant healthcare for almost two decades, many countries do not include migrant

health in their policy targets, others do not provide universal health coverage leaving migrant patients excluded from accessing healthcare in the first place. Exclusion of migrant patients

from care thus affects the individual patient but is also a threat to public health as untreated infectious disease might spread if patients lack access to care (World Health Organization, 2008). The migrants patients' perspective provides insight into health disparities and the associated barriers to care in this specific patient group (Tilburt, 2010). Although migrant health has received a fair amount of attention in research, the evidence on migrant patient experience has not been synthesized systematically. This review aims to address this gap in knowledge by synthesizing published literature related to adult migrant patients' experiences of healthcare and their healthcare seeking behaviours. The objective is to obtain a comprehensive overview of barriers at various stages of the patient journey.

Metaethnography

was chosen to synthesize the studies because it enables the interpretation of the findings from the individual studies into a larger, whole picture that provides deeper understanding of an issue (Noblit & Hare 1988). In order to provide a comprehensive, illustrative overview of the barriers along the patient journey, the results were collated in a comprehensive framework. The population included in this review were adult migrant patients, articles pertaining to paediatric or maternity care in migrant patients were excluded.

Aim

To synthesize published, qualitative literature on adult migrant patients' experience of healthcare and healthcare seeking behaviours

Methods

Design

A meta-ethnography of qualitative studies was undertaken on studies published between January 2000–June 2016. The studies were analysed according to the seven phases of meta-ethnography: (1) determining a qualitative research question; (2) study selection & quality assessment; (3) repeated reading of studies, data extraction & identification of themes; (4) comparison of themes & finding relationships; (5) bringing together related themes into new common themes; (6) reassessing original themes & new interpretation; (7) illustration of findings (Noblit & Hare, 1988).

Literature search

A literature search using the search engines MEDLINE, CINAHL, PsychInfo, EMBASE, Web of Science, Migration Observatory (United Kingdom, UK), National Health Service (NHS) Scotland Knowledge Network and ASSIA was performed. Search terms used included 'migrant', 'migrant patient' 'immigrants', 'quality of care', 'nursing care', 'satisfaction with nursing care', 'experiences of care', 'expectations'. The above search terms were used in several combinations using the Boolean operators 'AND' and 'OR'. The investigators also checked for spelling variations and synonyms. A further search was conducted on Google and Google Scholar to identify studies not published in indexed journals. In addition, the citations from the reference lists of previously gathered articles were scrutinized to identify unpublished studies and grey literature.

Inclusion and exclusion criteria

Any peer-reviewed, qualitative research study in English, published between January 2000-June 2016 and exploring migrant patients' experiences of healthcare was considered. Studies that involved migrant patients as a subgroup were also included. Studies involving children and maternity care were not included. Studies with non-qualitative research designs, systematic reviews, case reports, case series, scholarly or theoretical papers, editorials, and commentaries were excluded.

Study Selection

The initial search identified 326 potentially relevant articles and removal of duplicates brought this number down to 264 (see Figure 1). All authors were involved in screening titles against the inclusion, which criteria reduced the sample to 62 articles. A further review of the titles and abstracts resulted in the selection of 49 potential papers. The full text was retrieved for all 49 articles and assessed according to the inclusion criteria by the two first authors (MLL and BH). Eleven articles reporting quantitative studies and three reporting mixed methods studies were excluded. Eight more articles were removed as they did not explore patients' experience or pertained to maternity care. In the case of disagreement, both reviewers read and discussed the paper to reach a consensus. The final sample comprised 27 articles.

Quality review and data extraction

Study quality was assessed using the qualitative critical appraisal tool of the Critical Appraisal Skills Programme (CASP) Oxford (Critical Appraisal Skills Programme, 2013). The CASP tool facilitates the assessment of trustworthiness and relevance of studies. A data

extraction template was used to record relevant study characteristics such as purpose, research

design, sampling method, sampling and sample, etc. and to record the quality scores. Two authors (MLL and BH) independently scored the articles and classified them as of low or high

score (CASP score 0 to 5 and 6 to 10 respectively); 92.8 % of the articles were classified identically by the two authors (Cohen's kappa coefficient 0.67).

Findings

The research team included 27 qualitative studies in the analysis. The majority of these (n= 19) originated from Europe, specifically the Nordic countries Sweden (n=7), Denmark (n=2) and Norway (n=2). The remaining European studies came from the UK (n=5), the Netherlands (n=2) and Poland (n=1). Further studies (n=8) were from Australia (n=4), South Africa (n=2), Canada (=1) and China (n=1). More than half the studies reported on the results of semi-structured interviews (n=16), whereas about a third of the studies combined focus groups and individual interviews (n=7). The remaining studies presented the results of focus groups (n=2), individual interviews and observations (n=1), or just observations (n=1). The majority of studies were of high quality (n=26) as per CASP criteria (Critical Appraisal Skills Programme, 2013).

More than half of the studies explored migrants' overall experience with the healthcare services in the host country (n=16). The remainder (n=11) focussed on more specific parts of the healthcare system: care and support or community services (n=3), general hospital care

(n=2), cancer care (n=2), psychiatric care (n=1), primary care (n=1), end of life care (n=1), and diabetes care (n=1). Various migrant groups were included; undocumented migrants or refugees of uncertain legal status (n=2) migrants with legal residency permit who tend to stay in host country for economic or safety reasons (n= 23) and retirees with the choice to stay in the host country or return to their home country (n=2). Generally, the definitions of the term migrant varied considerably across the studies. Table 1 provides a detailed summary of the characteristics of the studies.

The research team identified 116 first and second order constructs across the studies, which were condensed and interpreted into 15 third order constructs. These third order constructs identified by the synthesis team (BH and MLL) were contextualised into the following dimensions: (1) personal factors; (2) healthcare system; (3) access to healthcare; (4)

the encounter; and (5) healthcare experience. In the following, a description of the factors and their respective third order constructs are presented. Quotes from the original studies have been included to illustrate the findings.

Personal factors, such as legal status, enculturation, society of origin and the associated religious or value systems influence health-seeking behaviours. In addition, individual life experiences, particularly traumatic ones of war and displacement, are powerful:

'*I did not want to live because of what is gone. I was eating, sleeping only […] I tried to forget it but I can't. My history, my life is stamped into my heart.' (*Fang, M., Sixsmith, J.,

Lawthom, R., Mountian, I., & Shahrin, A., 2015, *p.5)*. Advice from trusted people within a migrant's personal network influences health-seeking behaviour, as does the willingness to integrate within the host country (Alzubaidi, Mc Namara, Browning, & Marriott, 2015; *Fang et al.*; Main, 2016; Munyewende, Rispel, Harris & Chersich, 2011)).

In sum, personal factors determine a person's overall life context (Biswas, Kristiansen, Krasnik, & Norredam, 2011; Krupic, Sadic, & Fatahi, 2016; Main, 2016; Seffo, Krupic, Grbic, & Fatahi, 2014). For some migrants, such as expatriats who migrate voluntarily in search of a better quality of life the context is characterized by positive experiences when seeking healthcare (Legido-Quigley & McKee, 2014; Legido-Quigley, Nolte, Green, la Parra, & McKee, 2012). For others, such as undocumented migrants, the life context is extremely precarious: *'You don't even have your identity. You've lost your home, you've lost your relatives, you've lost your mother tongue, you've lost your culture and friends [...]' (Biswas et al. 2014, p.4*).

Healthcare system. A country's legal framework and healthcare system determines citizens' and migrants' entitlement to care and the overall service provision (Biswas et al., 2011; Legido-Quigley & McKee, 2014; Legido-Quigley et al., 2012). Some countries provide universal healthcare cover for citizens and migrants alike, others require healthcare insurance. Undocumented migrants are generally excluded from accessing healthcare services, even in countries that provide universal healthcare (Biswas et al., 2011).

As service provision between countries may differ (Legido-Quigley & McKee, 2014; Lin et al., 2015; Main, 2016; Seffo et al., 2014), there may be a mismatch between migrants'

expectations and care provision in the host country: *'It is not easy for a foreigner to cure our diseases. The Chinese … when they go to school, they don't teach them about African sicknesses. […]' (Lin et al. 2015, p.7).*

Access to healthcare. A migrant's socio-economic and legal status is crucial for accessing healthcare. While documented migrants and particularly expats often have access to

care (Biswas et al., 2011; Legido-Quigley & McKee, 2014; Lin et al., 2015), care-seeking can be outright dangerous for undocumented persons: *"If I go to the doctor and the doctor is a very good Danish person, a good citizen, then maybe he will call the police. And then I would be handed over to the police and then I would have a great problem. Then my life is risky." (Biswas et al. 2011, p.5).* Importantly, migrants require knowledge about their entitlement to care (Suurmond, Rosenmoller, El-Mesbahi, Lamkaddem, & Essink-Bot, 2016; Worth et al., 2009), yet they are often ill-informed due to lack of language skills: '*I remember that I got a letter probably informing me about how to register to a fastlege (GP). I am not very sure about it because I didn't understand the language' (Czapka & Sagbakken, 2016, p. 5).* Furthermore, healthcare staff can act as gatekeepers to services (Crush & Tawodzera, 2014; Munyewende et al., 2011; Suurmond et al., 2016). In extreme cases, they may deny care: *'The moment you speak in English, you are in trouble. The nurses pretend they do not understand what you are saying and they leave you and go to treat the next person who speaks their language.' (Crush & Tawodzera, 2014, p.11).* If healthcare is not accessible, alternative health-seeking strategies are used (Biswas et al., 2011; Czapka & Sagbakken,

2016; Lin et al., 2015; Main, 2016). '*When I am not feeling well, I will call my doctor in my home country. He will ask about my symptoms and tell me what medicine to get over the phone' (Lin et al., 2015, p. 6).*

The encounter. The encounter between healthcare professional and migrant determines the healthcare experience. Language barriers and mutual insecurity about how to behave in a culturally appropriately are a challenge (Biswas et al., 2011; Shaw et al., 2016; Worth et al., 2009): *'Well they did tell but I could not understand, it is another language you know. Something you understand something you don't. […]* (Shaw et al., 2016) Furthermore, unawareness of discrepancies in fundamental societal ideas (collectivism versus individualism) or healthcare paradigms (biomedical thinking versus holistic thinking), can be a source for mutual misunderstanding (Czapka & Sagbakken, 2016; Lin et al., 2015; Main, 2016; Razavi, Falk, Bjorn, & Wilhelmsson, 2011): '*In Poland, people go to the doctor more often. Pregnancy is the best example. In Poland, your pregnancy is over-medicalized. You are*

constantly under medical surveillance, constantly tested. Here it is the opposite […] pregnancy is not an illness; you don't need to be on sick leave all these months […]' (Main, 2016, p.8). Cultural awareness, language skills and mutual appreciation foster positive relationships between healthcare providers and migrant care seekers (Legido-Quigley et al., 2012; Main, 2016).

The healthcare experience. The overall positive or negative evaluation depends on whether a patient's needs and expectations are met or not. The healthcare system of their

home country provides the frame of reference for comparison and evaluation (Krupic et al., 2016; Seffo et al., 2014). However, with a higher degree of integration, language proficiency and acceptance of the host culture, the comparison of healthcare systems becomes more astute

and potentially more favourable of the host country (Legido-Quigley & McKee, 2014; Legido-Quigley et al., 2012; Main, 2016): '*I wouldn't go to the [British] NHS. My experience of medical care is good [in Spain] ... The biggest difference about Spain and England is that people care about nursing and the people in England they are more worried about targets*.' (Legido Quigley & McKee, 2014, p.12).

Line of argument

As per interpretation of the research team, four dimensions describe factors which determine the migrants' healthcare experience. The fifth dimension displays the evaluation of the experience. A migrant patient's healthcare experience is shaped by: 1) personal factors; 2) characteristics of the host country's healthcare system; 3) the ease or difficulty of gaining access to care; and 4) the encounter with a healthcare professional, which is thereafter evaluated as meeting or not meeting needs and expectations. Often, migrant patients make a comparison by using their home country healthcare system as a frame of reference. Personal factors (1) and characteristics of the host country's healthcare system (2) determine whether access to care (3) is achieved. During the encounter (4) language barriers or cultural misunderstandings are a challenge for establishing a relationship between healthcare professional and patient. Figure 2 shows the cohesive model of the different dimensions.

Discussion

Migration is a growing global phenomenon due to a number of reasons including warfare, natural disasters and economic hardship. The research team set out to explore migrants´ experiences of healthcare, because despite a plethora of literature on migrant health,

to date there is no review compiling the evidence on migrant patient experience in a comprehensive framework.

Generally, The research team found that despite the availability of international definitions the terms ‘migrant’ and ‘immigrant’ were often used interchangeably and poorly defined in a number of the studies included in this review. The findings also show that the issue of migrant health has been most intensively studied in Europe, which for historical and geographical reasons has long been a major destination for global migrants. Most European countries, which provide political sanctuary, also recognise the moral obligation to ensure the good health of everyone within their borders, without discrimination.

The review uncovered a host of influencing factors, which were collated in a comprehensive model, a flow diagram that illustrates the antecedents and succedents of the migrants' healthcare experience. This model may help healthcare providers to identify and address antecedents to poor quality migrant healthcare as well as areas of improvement. For the nurse in her encounter with a migrant the flow diagram shows the personal factors and healthcare system factors that ante cede and shape the encounter. It also shows the factors of the encounter itself which matter and the factors which determine how the migrant

experiences the encounter subsequently.

The model highlights that language difficulties and differences with migrants' experience in the home countries are important factors in all stages of a patients' journey through the health system. This finding implies that the mere provision of linguistically congruent information might not serve all migrants' needs, as it is generally aimed at people who already understand the workings of a healthcare system. However, migrant patients may lack this basic understanding. Information should therefore be adapted to the different needs of 'migrants' (for example refugees and illegal immigrants). This would include providing a basic explanation of access to and routes through the healthcare system. In addition, understanding of the host cultures, how patients relate to healthcare professionals and which behaviours are acceptable, or not, should be explained. However, within the economic constraints that all health systems face, there are certainly limits to the extent of language support that can be provided. Healthcare professionals cannot be expected to cover the whole range of languages that may be required and, in some systems such as the UK, NHS staff are not encouraged to make use of any linguistic skill they possess (Ali & Johnson, 2017). A stronger focus on eliciting patients' needs in an encounter may thus improve encounters between healthcare professionals and migrants. Studies show that healthcare professionals often perceived migrants as 'others', as being different from 'them'. 'Othering' precludes an open-minded encounter and healthcare professionals need to be mindful of potential prejudice. Migrants, like every individual, are individuals who are shaped by their culture of origin as well as their life experience and they have thus diverse needs. Migrants'

backgrounds may be alien to healthcare professionals and difficult to understand. Awareness of ones' own preconceived ideas can enable healthcare professionals to approach migrants as the unique individuals they are; people with specific health needs that need special attention, just as any other patient (Grove & Zwi, 2006). Using a model of Person Centred Care (PCC) could be helpful in this respect. PCC aims to improve interaction between the patient and the healthcare professional, to improve shared decision-making and setting goals (McCance, Slater, & McCormack, 2009; Ekman et al., 2011). A PCC approach may prevent healthcare professionals from taking a prescriptive approach. Exploring a migrant patient's needs and expectations, their priorities and preferences through skilful elicitation should ensure more adequate care provision.

Conclusion and Implications

Rather than being ‘othered’ and disconnected from society, migrants need to have a fair chance to improve their physical and social status, thus being able to integrate and contribute to society and become a valued member of their new home country. Yet, migrant patients' experience of healthcare in their host country is often unsatisfactory due to culture and language barriers, which may cause misunderstandings between patients and healthcare professionals. Healthcare professionals and especially nurses, who are often the first point of contact, need to develop the appropriate skills and knowledge to better address the healthcare needs of migrants. An education and research agenda should focus on developing awareness of cultural diversity, foster reflection on how healthcare professionals' own conceptions influence the encounters with migrant patients and promote PCC routines and documentation.

Healthcare professionals, and nurses in particular, can contribute to reinforce co-creation of care between healthcare professionals and patients. In this way, they can create the optimal conditions to improve migrants' healthcare experiences, their sense of coherence and ultimately their involvement in society as a whole.

Clinical resources

• United Nations on International migration:

http://www.un.org/en/development/desa/population/migration/publications/migrationreport/docs/MigrationReport2015.pdf

• Person Centred Care NHS perspective: https://hee.nhs.uk/our-work/person-centredcare

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