

**Health Care for Immigrants in the Context of  
Economic Crisis: The Perceptions and  
Experiences of Health Professionals in Greece**

**CHARALAMPOS MILIONIS, MD**

**Faculty of Health and Medicine  
Lancaster University**

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## **Declarations**

The author declares that this thesis is his own work and has not been submitted for the award of a higher degree elsewhere.

The author declares that the word length of the thesis does not exceed the permitted maximum.

## Abstract

**Background:** Greece, alongside other European countries, is facing constant immigration inflow. Rising immigration creates unprecedented pressures on local health systems. This situation is aggravated by the current circumstances of economic recession in Greece. Health professionals are at the coal face of health care, being in constant clinical contact with immigrants. This study explored Greek health professionals' perspectives on, and experiences of, caring for the various categories of immigrants in the context of economic crisis.

**Methods:** A theoretical framework, consisting of political and economic theories about the provision of health care and concepts of culturally competent care, served as a tool to explore and interpret issues in the provision of care to immigrants from health professionals' perspective. A qualitative study was conducted based on 20 interviews with health workers of various professional identities and experiences who were practicing in public health care services in Attica and Central Greece. The participants were recruited via purposeful sampling. Interview data were analysed using thematic analysis.

**Results:** Interviewees highlighted problems relating to the social status of immigrant populations, the impact of the current economic crisis, the existing legislation regulating access to health care and the utilisation of health services by immigrants. Reported organisational difficulties were related to health system deficiencies and shortfalls in culturally competent care. The participants' accounts revealed problematic staff attitudes towards immigrants, cultural differences between staff and the immigrants they cared for, and failures in communication with immigrant patients. Measures to improve health care for immigrants are suggested.

**Conclusions:** The provision of health services to immigrants is a challenging task. Problems were found to be interrelated and their effects determine health outcomes. Managing the identified problems with appropriate health policies and practices should be prioritised in order to protect both immigrants' and non-immigrant public health.

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# Chapter 1

## Introduction

### 1.1. Background

Migration is an extensive phenomenon in today's globalised world. According to the United Nations (UN), the number of international immigrants – that is, persons living in a country other than the one in which they were born – reached 258 million in 2017 worldwide, up from 220 million in 2010 and 173 million in 2000 (UN, 2017: 4). Within the European Union (EU) member states, a total of 4.3 million people immigrated during 2016. Among them, there were an estimated 2 million citizens of non-member countries and 1.3 million people with citizenship of a different EU country from the one to which they immigrated, while the rest included returning nationals and stateless people (Eurostat, 2018).

The percentage of foreign populations in Greece – that is, persons with non-Greek citizenship – is estimated at 11.3% of the total population of the country (Hellenic Statistical Authority, 2016). In 2016, Albanian immigrants constituted approximately 35% of the immigrant population, but there were also significant numbers of people originating from other Eastern European countries (*ibid.*). More recent immigrant flows consist of Afghans, Iranians, Iraqis, Somalis and others arriving in a clandestine way mainly through Turkey. Since 2015, the arrival of refugees by sea has increased dramatically in Greece, mostly from Syria and other Middle East states. The vast majority of these people attempted to avoid war, violence and persecution in their countries of origin (United Nations Refugee Agency, 2017). More extensive data about immigration in Greece are reported in *Chapter 2*.

The presence of large numbers of immigrants in the host countries, including Greece, creates complex challenges for health professionals in delivering preventive and curative services. Inconsistencies in governmental health care policy and operational deficiencies within the health system may create a demanding working environment for health staff. This situation may be further complicated by cultural and language barriers between patients and health personnel and a lack of provision of culturally competent care among health professionals. Moreover, as explained in *Chapters 4* and *6*, the current financial crisis in Greece that started in 2009 has resulted in budget cuts in health care (Xenos, et al, 2017) and barriers to accessing health

services due to unemployment and decreased family incomes (Kyriopoulos, et al, 2014). All these problematic situations implicate the risk of suboptimal provision of health care and failure in achieving public health goals. The perspectives of health professionals on the provision of care to immigrants and the impact of economic crisis on it are a valuable source of information.

### **1.1.1. Health policy planning for immigrants' health care**

Evidence indicates that the legal provisions that regulate the delivery of care to immigrants are often multiple and complex and are not easily understood (Campbell, et al, 2010), creating ethical dilemmas for health care professionals (Campbell-Page and Shaw-Ridley, 2013). Legal restrictions regarding immigrants' access to health services vary widely across countries and impact on the type and amount of health care that immigrants can receive. For example, in some countries, immigrants without a residency permit are restricted to accessing only emergency care, while in others health care is accessible only in detention centres (Suess, et al, 2014). Apart from the legal restrictions, other barriers preventing immigrants' accessing health care include bureaucratic obstacles, such as complex paperwork and registration procedures (Hacker, et al, 2015). Health professionals' work is burdensome under these circumstances. Indeed, health workers have described feelings of distress when they are unable to provide appropriate care to immigrants due to their legal status because they have to violate professional ethical standards (Dwyer, 2004), undertake the duties of immigration control authorities (Kullgren, 2003) and make difficult distinctions between the needs for routine and emergency care (Woodward, et al, 2014). In addition, the delay in the provision of health care can result in more advanced diseases among individuals in these populations which can delay their treatment and worsen their prognosis (Rousseau, et al, 2008). In general, restrictive immigration policies are contrary to the scope of public health goals and can undermine the role of health services to provide care which is effective and responsive to the needs of the entire population (Mladovsky, et al, 2012).

The difficulties in providing care to vulnerable population groups have worsened due to the current economic crisis. In Greece, unmet health care needs, especially among the financially weak and unemployed, increased after the enactment of austerity measures (Zavras, et al, 2016). Greek health workers have witnessed a dramatic rise in their workload and expressed distress about shortages in medical supplies (Kerasidou,

et al, 2016 and Rachiotis, et al, 2014). The situation is likely to impact greatly the provision of care to immigrants. Indeed, health professionals in Spain have expressed the view that fiscal consolidation policies can exclude immigrants, especially those without residency permits, from a wide range of health services (Cervero-Liceras, et al, 2015).

### **1.1.2. Clinical practice in immigrants' care**

Evidence suggests that cultural differences between health staff and immigrant patients are often expressed through different views and expectations of health and health care and can create tensions during clinical consultations (Weerasinghe and Mitchell, 2007). Indeed, cultural differences have been highlighted by health professionals as a source of misunderstandings and a barrier to the provision of appropriate care to immigrants (Hart and Mareno, 2014). The lack of a mutually comprehensible language is a special feature of cultural diversity and can create communication difficulties leading to health disparities in the provision and utilisation of health care (Rew, et al, 2014). The cultural and verbal gaps are not easily addressed because of socio-cultural differences between health staff and interpreters, shortages in the availability of interpretation services and difficulties due to medical terminology (Nkulu Kalengayi, et al, 2015). However, the intervention of mediators has been widely observed as a potential solution among health professionals either by using professional interpreters (Bischoff, et al, 2003) or through informal pathways (MacFarlane, et al, 2008).

Furthermore, the lack of appropriately trained staff may create obstacles in caring for culturally diverse patients from vulnerable population groups (Suurmond, et al, 2010). Evidence has shown that the attitudes and cultural training of health professionals are major determinants of health outcomes from the provision of care to immigrants (Beach, et al, 2005). However, training staff may be a challenging process due to the diversity of immigrant groups, the changing patterns of immigration over time and the different prevailing social circumstances. Finally, the shortage of personnel, which is an essential source of heavy workload, can result in job dissatisfaction for health professionals and long waiting times (Nkulu Kalengayi, et al, 2015). This raises serious questions about the quality of health services.

## **1.2. The Research**

### **1.2.1. Research objectives**

According to the World Health Organization (2006b), health professionals play a critical role in improving access to, and the quality of health care for, the population. The health workforce lies at the heart of each health system: in theory, health professionals personify a health system's core values due to their role in caring for people, reducing pain and suffering, preventing disease and mitigating risk. As such, they are the human link that connects knowledge to health action (ibid.). However, not every health worker necessarily fulfils this role. A lack of professionalism on behalf of health staff can lead to poor health outcomes, patient dissatisfaction and resentment and wasteful health care delivery (Brennan, 2016).

Greek health workers in the public health care system are required to provide care to an increasing population of non-Greek patients and thus they have a unique insight into issues concerning the provision of care to immigrants, especially in the context of economic crisis. Greek health services constitute an ideal research setting because of the particular economic conditions in the country and the presence of a large number of immigrants with different legal categories and origins. Against this backdrop, the present study aimed to explore the perspectives and experiences of health staff in relation to caring for immigrants. Understanding these viewpoints can improve quality of care and can also contribute to decision-making about investment in health care within an economic context of limited financial resources.

The findings from this research may be relevant to other developed countries with large immigrant populations, as the core content of medical and nursing care is similar across countries with patient-centred health systems, although the legal framework and the socio-economic conditions may be different. The objectives of the research were to explore health professionals' views regarding: (i) issues in providing care to immigrant patients; (ii) consequences of the adverse economic conditions on immigrants' care; and (iii) measures to improve the quality of care to these populations. The findings of the research may help to address problems and promote the provision of quality care at all levels of health care (health policy, health system organisation and health staff-patient interactions).

### **1.2.2. Methods**

A qualitative approach was adopted to address the study's research questions. The goal of qualitative inquiry is to consider a phenomenon in detail and depth through understanding processes and capturing the perspectives and experiences of the participants as well as explaining their meaning (Gill, et al, 2008). Therefore, a qualitative approach was suitable for exploring the experiences and perceptions of health professionals in relation to the provision of care to immigrants. For these purposes, individual interviews with health professionals were conducted and interview data were analysed using thematic analysis (Boyatzis, 1998). A detailed description about this study's methodology is included in *Chapter 7*.

### **1.2.3. Study setting**

The study was conducted in the regions of Attica and Central Greece. The participants were health workers employed in public health care services located in the regional units of Athens (Central Section), Western Attica, Boeotia and Phthiotis. Figure 1.1 below illustrates the specific geographical locations where the participants in the study are employed. Attica is a historical region in the country of Greece that encompasses Athens, which is the capital city of the Greek state. Central Greece lies in the heart of mainland Greece. Lamia is the capital city of Central Greece. The Region of Attica is presented with the yellow colour and the Region of Central Greece is presented with the orange colour. The territories in grey colour within these Regions are the locations of the participants' health services:

Figure 1.1: The Administrative Regions of the Greek State



*The Region of Attica is presented with the yellow colour and the Region of Central Greece is presented with the orange colour. The territories in grey colour within these Regions are the locations of the participants' health services.*

### 1.3. Thesis Outline

This thesis is divided into three key parts: the first part – Chapters 2 to 4 – describes the phenomenon of immigration, analyses immigrants' rights and entitlements to health care and presents the context of immigrants' care in Greece. *Chapter 2* includes a description of the various parameters of the phenomenon of migration and explains the relevant terms used in the international literature and the present study. It also provides information about immigration trends in Europe and Greece and considers the integration of immigrants in Greek society over the last two decades. *Chapter 3* explores the association of immigration status with health and analyses immigrants' entitlement to and utilisation of health services in Europe. *Chapter 4* explores the regulation of social insurance and the operation of health services in Greece. It also explains

immigrants' entitlement to social and health care in Greece and analyses the utilisation patterns of Greek public health care services by the immigrant population.

The second part of the thesis – Chapters 5 and 6 – sheds light on what is known to date about relevant issues to the study's goals. *Chapter 5* is a critical analytical review of the existing literature about the perspectives of health professionals on immigrants' care in Europe. *Chapter 6* describes the theoretical framework that has shaped the research and constituted a directive lens through which to explore explanations for the decisions, behaviours and attitudes of health staff providing care to immigrants.

Finally, the third part of the study – Chapters 7 through to 12 – includes the methods used as well as the study's findings and their interpretation. Initially, *Chapter 7* formulates the research questions and explains the theoretical background of the research methodology. It then describes the design of the research and the process of data collection and analysis. *Chapters 8-11* report the results of the research. Finally, *Chapter 12* discusses the importance of the study in the context of the current local and global situation of immigrants and immigration.

## **Chapter 2**

### **The Phenomenon of Migration**

#### **2.1. Introduction**

Migration is an omnipresent and complex phenomenon. In order to understand its nature in the modern world, it is necessary to have a clear grasp of its constitutive elements. This chapter unpacks the issue of international migration and presents the basic principles and realities of immigration and immigration policy in Europe and Greece in particular. It also discusses concepts that are related to the social, political and legal aspects of immigrants' integration in Greece.

#### **2.2. About Migration**

The phenomenon of migration is observed globally and is a cause of social transformation in both migrant sending and receiving countries. According to the International Organization for Migration (IOM), migration is the procedure in which a person or a group of persons move from their initial place of settlement to another, either across an international border or within a state, for a certain minimum period. It is a population displacement which includes any kind of movement of people, whatever its length, cause, form or composition (IOM, 2011: 62-63). The movement of persons who leave their country of origin or the country of their habitual residence and cross an international border in order to establish themselves either permanently or temporarily for a minimum length of time in another country is called international migration (IOM, 2011: 52). Therefore, a migrant is a person who moves from one state or region to another by chance, instinct or plan. International migration can be further categorised as emigration, which is the act of departing or exiting from one state with a view to settling in another (IOM, 2011: 32), and immigration, which is the process by which non-nationals arrive in a country for the purpose of settlement (IOM, 2011: 49). The people following an emigration or immigration move are called emigrants or immigrants respectively. The types of international migration include transfers which can be legal or illegal, voluntary or forced and temporary or permanent. Voluntary migration is the displacement of persons who have decided to migrate on their own accord, although there may be also strong economic and other pressures on them to move. This category includes labour migrants, family members being reunified with

relatives and foreign students (Lundholm, et al, 2004). Forced migration refers to the movement of political refugees as well as people displaced by natural or environmental disasters, famine, smuggling, trafficking or developmental projects (Castles, 2003). Nevertheless, the multiplicity and variety of the immigration processes blur the distinction between the classically reported dyads of the phenomenon of immigration – such as legal and illegal, voluntary and forced, permanent and temporary, internal and international – making the boundaries of these polar types not clearly identifiable (King, 2002).

Throughout history, migration has existed as a way for individuals to improve their lives. International immigration depends on economic, demographic, social, political and ecological factors stimulating people to decide to move from one country to another. However, the major motivation for voluntary migration derives from economic reasons (Zimmermann, 1994) and migration flows are generally pronounced from economically less developed states to more prosperous ones. The main economic reasons include high unemployment rates, national and personal poverty and inadequate social services in migrants' home countries, which result in economic stagnation and lack of opportunities for the establishment of personal and family wealth, as well as occupational and other economic opportunities, more efficient and accessible facilities (such as health care and education) and social amenities of modern life which attract people to certain destinations (Cherunilam, 2006).

Demographic changes also play an important role in migration. Indeed, the composition of some national populations can be radically changed by high levels of migration from countries with a younger age distribution to countries where there is a low fertility rate and thus an older population. For example, this is the case in most industrialised countries, including the southern European states, where the demographic situation is characterised by fertility rates below the population's replacement level. The subsequent reduction of the young population in developed countries has been the driving force for the attraction of large numbers of young immigrants from countries with high fertility rates (Coleman, 2006).

Countries can be classified according to their typical trends regarding immigration. The following categories can be recognised among the member states of the EU (De Vito, et al, 2015 and Begg and Marlier, 2007):

- The long-standing host countries include states which have been prepared to receive substantial numbers of immigrants for a long period and are able to

continue to do so, regardless of the possible imposed limitations (such as increasing unemployment rates, potential strict immigration legislation and possible social reactions). These countries are Belgium, Denmark, Germany, France, the Netherlands, Sweden and the United Kingdom (UK);

- The new host countries include states which have recently confronted the phenomenon of immigration and have dealt with it as a means of filling potential labour shortages. These states include Ireland, Luxembourg, Finland and the Czech Republic;
- The gateway countries include states which are seen by migrants as entry points for other destinations, but also offer the prospect of extended stays. Greece, Spain and Italy are the main countries of this category, but Austria, Portugal and Slovenia could also be included;
- The transit countries include states which are points of entry only rather than a location for permanent settlement, such as Cyprus and Malta;
- The emigration countries include states where the tendency inclines towards the departure of large groups of persons for other countries, while there are limited opportunities for the arrival of migrants. Latvia, Lithuania and Poland are examples of this category; and
- The segregated minorities' countries include states where there is a substantial population of minorities, such as neighbouring countries' ethnic groups and Roma people, who have been poorly integrated within the mainstream population. Hungary, Slovakia, Estonia and Romania are the apparent countries in this regard.

The above categories are not fixed and can present dynamic changes in response to governmental policies and socio-economic conditions over long periods of time.

In general, receiving countries follow three approaches to the social acceptance of immigrants (International Labour Office, 1999):

- Countries which favour the permanent settlement of immigrants appear more likely to establish social policies aimed at supporting social integration and multiculturalism;
- Countries which allow permanent resident status after a number of years of provisional stay are more likely to focus on slow assimilation policies; and

- Countries which view immigrants as temporary employees are more likely to perceive them as short-term residents and favour their repatriation to the sending country.

Immigrant populations have different social, political and cultural features and there is a complexity of variables which influence the acceptance of immigrants by the autochthonous population and their integration into the receiving society (Bhugra and Becker, 2005). Unreceptive attitudes towards immigrants are not expressed in the same way in all host countries. In general, the acceptance and integration of immigrants depends on material factors and institutional conditions. Material factors include the local labour market situation and the general economy as well as the size and composition of the migratory inflows and the cultural diversity of the native population, whilst institutional conditions include the legislation of the receiving state and the traditional history of the local populace regarding immigration (Solé, 2004). A possible disapproval or even rejection of the immigrants' presence by the local population is based mainly on the protection of public security, cultural identity and economic stability and it is expressed either as exclusion – that is, separation of a group of people from mainstream society – or as marginalisation (that is, the relegation of certain ethnic minorities to second-class living standards). In both situations, immigrants are deprived of essential rights, liberties and opportunities (Solé, 2004). A general presumption is that immigrants who are selected according to their knowledge and skills are more likely to be successful in the host country and assimilate relatively more rapidly into the new labour environment, as compared to refugees and immigrants that follow others spontaneously without having a standard level of qualifications (Bauer, et al, 2000).

### **2.3. Classification and Definitions**

The formulation of a clear definition for the various categories of immigrants is not an easy task and is further impeded by the fact that countries use different terminology in their legislation for the classification of these populations in accordance with applied policies, political and economic goals and public attitudes. Indeed, it is common for both researchers and policy makers to refer to ethnicity, culture and race interchangeably when identifying and categorising people by background (Betancourt and Lopez, 1993). However, the distinction of the various categories is important because the degree of access to health services, as it is determined by public policy, usually depends on the legal category of each immigrant, as it is defined by the laws of

each state. Immigrants can be defined on the basis of residing legality or ethnicity and categorised according to the parameters of the duration of stay, motivation for resettling or distance of movement (Decosas and Adrien, 1997). A widely used distinction is made between documented and undocumented immigrants. On one hand, documented (or authorised) immigrants are those persons whose entry, residence and, where relevant, employment in a host or transit country has been recognised and authorised by the official state authorities (World Health Organization, 2003). On the other hand, undocumented (or unauthorised) immigrants are persons who have entered a host or transit country without legal authorisation or they have overstayed in the host or transit country, violating the terms of the authorised entry and stay (such as overstaying visitors, tourists, foreign students, temporary contract workers, immigrants with an expired residence permit and rejected asylum seekers) (ibid.).

According to the United Nations Refugee Agency, refugees are persons who reside outside the country of their nationality, or stateless people who live outside the country of their former habitual residence, due to a firmly established fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion, which makes them unable or unwilling to return to their country of origin (United Nations High Commissioner for Refugees, 1966: 14). Accordingly, asylum seekers are individuals who have crossed an international frontier into a country in which they hope to be granted refugee status, whether they are eligible for it or not, according to the accepting states' rules and international laws. According to Greek law (Law No. 4251/2014, article 1), the term 'foreigner' refers to a person who does not have Greek citizenship or even has no citizenship at all. Furthermore, a 'third country national' is an individual who has neither Greek citizenship nor the citizenship of any other member state of the EU. Under Greek law, stateless people are identified and treated by the state on equal terms with third country nationals (Law No.4251/2014, article 106).

#### **2.4. Immigration in the EU**

Eurostat data show that immigrant populations in the EU have been growing significantly (Eurostat, 2018). This trend is creating a new demographic, social and economic reality in host countries. In 2016, there were 38.2 million immigrants in the EU, corresponding to 7.5% of the total population of the 28 member states (ibid). The majority of them, 21.4 million, were third country nationals, namely citizens of non-EU

countries, while the remaining 16.8 million were citizens of another EU member state (ibid.). Table 2.1 below presents the size of the foreign population in the EU member states. The number of immigrants depends not only on international migration, but also on demographic factors, such as births and deaths within this population. Furthermore, it is affected by the number of citizenship acquisitions since those who acquire citizenship in an EU member state are no longer counted as immigrants in the particular country (ibid.):

Table 2.1: Immigrants in the European Union by Citizenship Type in 2017

Country	Immigrants					
	Total		Citizens of another EU member state		Non-EU citizens and stateless people	
	thousands	% of the population	thousands	% of the population	thousands	% of the population
<b>EU-28</b>	<b>38,247.1</b>	<b>7.5</b>	<b>16,841.3</b>	<b>3.3</b>	<b>21,405.8</b>	<b>4.2</b>
Belgium	1,346.4	11.9	890.4	7.8	456.0	4.0
Bulgaria	79.4	1.1	13.5	0.2	66.0	0.9
Czech Republic	510.8	4.8	208.3	2.0	302.6	2.9
Denmark	484.9	8.4	202.4	3.5	282.6	4.9
Germany	9,220.0	11.2	3,985.2	4.8	5,234.8	6.3
Estonia	196.3	14.9	16.5	1.3	179.9	13.7
Ireland	564.9	11.8	426.5	8.9	138.4	2.9
Greece	810.0	7.5	205.2	1.9	604.8	5.6
Spain	4,419.6	9.5	1,932.8	4.2	2,486.8	5.3
France	4,638.6	6.9	1,587.7	2.4	3,050.9	4.6
Croatia	46.0	1.1	15.1	0.4	30.9	0.7
Italy	5,047.0	8.3	1,537.2	2.5	3,509.8	5.8
Cyprus	140.4	16.4	110.6	12.9	29.7	3.5
Latvia	279.4	14.3	5.9	0.3	273.5	14.0
Lithuania	20.1	0.7	5.5	0.2	14.6	0.5
Luxembourg	281.2	47.6	240.3	40.7	41.0	6.9
Hungary	150.9	1.5	79.3	0.8	71.5	0.7
Malta	54.3	11.8	30.2	6.6	24.1	5.2
Netherlands	915.0	5.4	489.1	2.9	425.9	2.5
Austria	1,333.2	15.2	655.5	7.5	677.7	7.8
Poland	45.5	0.1	14.8	0.0	30.7	0.1
Portugal	210.3	0.6	29.4	0.1	180.8	0.5
Romania	114.5	0.6	53.5	0.3	60.9	0.3
Slovenia	114.4	5.5	18.7	0.9	95.7	4.6
Slovakia	69.7	1.3	53.5	1.0	16.2	0.3
Finland	242.0	4.4	97.2	1.8	144.8	2.6
Sweden	841.2	8.4	310.5	3.1	530.6	5.4
UK	6,071.1	9.2	3,626.5	5.5	2,444.6	3.7
<b>EEA countries</b>						
Iceland	30.3	8.9	25.2	7.4	5.1	1.5
Liechtenstein	12.8	33.8	6.7	17.8	6.1	16.0
Norway	559.1	10.6	348.5	6.6	210.5	4.0
Switzerland	2,099.3	24.9	1,382.9	16.4	716.5	8.5

Source: Eurostat, 2018

At member state level, there are significant differences regarding the origin of the foreign population. Some common factors affecting the choice of the country of destination include: employment opportunities; language; geographical proximity; historical and political links; and established networks and opportunities for mobility. Citizens of Turkey, Romania, Morocco, Poland, Italy and Albania are the most numerous amongst the immigrants in the EU countries.

## **2.5. Immigration in Southern Europe**

The southern member states have been transformed from exporters of labour force to destination places because of internal and international socio-economic developments during the last two to three decades. Indeed, the phenomenon of immigration has become a common and increasing feature in southern European countries. Greece, Italy, Spain and Portugal present similar, though not identical, immigration patterns (King, 2000). Traditionally speaking, these countries were all emigrating states from the 19th century until relatively recently. Greece, Italy and Spain acquired immigration identity in the early 1970s and Portugal followed shortly after. The transformation from migrant-sending to migrant-receiving states was sudden and the countries were partly unprepared for the management of large amounts of immigrants (Cavounidis, 2004 and Baldwin-Edwards, 2002). Consequently, they exhibited certain difficulties in confronting the new reality at the policy level. Initially, the typical response was the characterisation of the arrived immigrants as illegal and, later, on the application of a series of efforts for their legalisation, the main response was the administration of short-term residency and work permits (Baldwin-Edwards, 2002). Consequently, unauthorised immigrants turned to informal employment. In addition, the regularisation of immigrants by these programmes across the southern European countries was usually followed by lapses back into illegality (Hatziprokopiou, 2004 and Baldwin-Edwards, 2002). Immigrants in southern European countries are predominantly younger people. They work mostly in the industrial, agricultural and serving sectors where there are vacancies that cannot be filled by national workers either because of insufficiency or due to the unwillingness of the indigenous population, and so immigrant employees are occupied in positions with minimum recruiting competition (Solé, 2004).

However, there are also notable differences between the situation in Greece and the experience in other southern European states (Rovolis and Tragaki, 2006 and Cavounidis, 2002). Firstly, in the cases of Spain and Portugal, the immigration inflows derive largely from their former colonies in Latin America and Africa, while in the case of Italy, the immigrants' origins present great geographical variation. Balkan and the Eastern European countries are the main source of immigrants for Greece. Secondly, the immigrants in Greece largely derive from countries which are geographically proximal to the Greek borders. This phenomenon does not occur in Portugal and is only observed partly in Spain due to immigration from Morocco and in Italy because of immigration flows from Albania (Rovolis and Tragaki, 2006 and Cavounidis, 2002). It

is worth noting that public officials, non-governmental organisations (NGOs) representatives and trade unionists in Spain and Italy identify immigrants with non-EU citizens, whilst in Greece the distinction is primarily made between the Greek and non-Greek population rather than Europeans and non-Europeans (Triantafyllidou, 2000).

## **2.6. Immigration in Greece**

Until the early 1970s, Greece was considered to be an emigration country. Most of the emigrating outflows occurred after the Second World War and were motivated mainly by economic circumstances. The main countries of destination at the time included the United States, Canada, Australia, South Africa and the developed countries of Northern and Western Europe (Kasimis and Kassimi, 2004). The year of 1974 was the first one in which the number of immigrants became greater than the number of emigrants in Greece (Tsoupakis and Tziafetas, 1983) and by the 1980s Greece had been transformed from an emigration to an immigration country with the arrival of immigrants mainly from Africa and Asia (Sarris and Zografakis, 1999). This immigration trend was limited in scope and legal in character. It was only in the 1990s that Greece started receiving large inflows of immigrants from Central and Eastern Europe. Much of that movement was by those entering the country in an illegal, clandestine way (Cavounidis, 2004; Lianos, 2001; and Lianos, et al, 1996). The first immigrants came from Poland, Bulgaria and Romania and large numbers of Albanians followed after a while. During that decade, Greece had the highest proportion of immigrants in relation to its labour force in the EU (Kasimis and Kassimi, 2004). The contributing factors included Greece's geographical location, porous borders, improved economic situation, the large size of its informal economy and the seasonal nature of many of its employment sectors (such as tourism, construction and agriculture) (Cavounidis, 2002).

Since the early 1990s immigration to Greece has intensified into what Kasimis (2012) describes as a massive and almost uncontrollable phenomenon. Since then, Greece has been established as a place of reception and settlement for a considerably large number of immigrants (and their dependents) as shown in the national censuses (see Table 2.2 below). In 1981, foreign citizens amounted to 1.85% of the total population (National Statistical Service of Greece, 1984) but by the most recent census in 2011, foreign citizens had increased to 8.43% of the overall population in Greece (Hellenic Statistical Authority, 2013):

Table 2.2: Population of Greek and Foreign Citizens by Gender in Greece According to 1981, 1991, 2001 and 2011 Censuses

	1981 census			1991 census		
	Both sexes	Male	Female	Both sexes	Male	Female
<b>Total population</b>	9,739,589	4,779,571	4,960,018	10,259,900	5,055,408	5,204,492
<b>Greek citizens</b>	9,558,994	4,687,549	4,871,445	10,092,624	4,965,792	5,126,832
<b>Foreign citizens</b>	176,119	89,497	86,622	166,031	88,897	77,134
<b>No/unclear citizenship</b>	4,476	2,525	1,951	1,245	719	526
	2001 census			2011 census		
	Both sexes	Male	Female	Both sexes	Male	Female
<b>Total population</b>	10,934,077	5,413,426	5,520,671	10,815,197	5,302,703	5,512,494
<b>Greek citizens</b>	10,171,906	4,997,874	5,174,032	9,903,268	4,835,789	5,067,479
<b>Foreign citizens</b>	761,813	415,368	346,445	905,224	463,510	441,714
<b>No/unclear citizenship</b>	378	184	194	6,705	3,404	3,301

Source: National Statistical Service of Greece, 1984; National Statistical Service of Greece, 1998; National Statistical Service of Greece, 2007; and Hellenic Statistical Authority, 2013.

It should be noted that there are a lot of immigrants who are not officially declared because of the illegal status of their presence in the country. This means that the actual scale of immigration in Greece is not exactly known and the overall number of immigrants settled in the country can be much larger. Undocumented immigrants are very likely to remain undetected by the censuses or any other form of enrolment because they often evade enumeration in order to avoid the attention of authorities and they do not frequently reside in typical dwellings. Nevertheless, Lianos and colleagues (2008) estimated the number of illegal immigrants to be between 81,000 and 275,500 persons. The wide range of this estimate is due to the variety of assessment methods and the different reference periods used in these data sources. Furthermore, the census figures about the size of immigrant populations ignore ethnic Greek immigrants from Albania and the former Soviet states who have been naturalised by the Greek state (Fakiolas, 2003).

There are several factors that explain Greece's growing immigration inflows over the last few decades. The collapse and fragmentation of the Soviet Union, as well as the fall of the political regimes in many Eastern European countries, created social and financial instability for many habitants of these states who emigrated to Greece and

other countries in search of employment and social safety (Cavounidis, 2004; Iosifides and King, 1996; and Lazaridis, 1996). The economic and social differences between the sending and receiving countries are also responsible for the rise in the number of immigrants in southern Europe. Since the 1990s, political agitations, unemployment and harsh living conditions in several European, Asian and African countries (Lazaridis, 1996) have led to the displacement of large groups of people to wealthier countries – such as Greece – where unskilled labour was needed. The immigrants offered their labour mainly in the working sectors of construction, domestic employment, agriculture, fishing and tourism where employment is frequently informal and seasonal. Despite the existing unemployment, there is, indeed, a large number of low-skilled jobs which are not filled by Greek employees whose working aspirations are now much higher due to the advanced educational and living standards of the population over recent years. In fact, evidence shows that a high proportion of jobs requiring low qualifications (such as household helpers) are filled by immigrants (Social Insurance Institute, 2016) who are often forced by their circumstances to accept posts inferior to their skills. More than half of the immigrants present in Greece at the point of the 2001 census had settled in the country for employment reasons and this percentage is higher among males (National Statistical Service of Greece, 2007). The demography of the southern European region is also of interest. Greece and other developed southern European countries have aging populations and thus attract immigrants from countries with a younger work force (Kasimis, 2012). Finally, it is worth noting that Greece is the geographical gate of Europe in the south-eastern territory. The country's extended coastline and numerous islands cannot be guarded thoroughly and consequently some immigrants try to enter the EU illegally through Greece and many of them stay in the country (*ibid.*).

A recent European immigration crisis began in 2015 when a rising number of refugees and migrants made the journey towards Europe in order to seek asylum, travelling across the Mediterranean Sea or through southeast Europe. They originated mainly from western and south Asia, but also from Africa and the western Balkans. According to the United Nations High Commissioner for Refugees (2016), the top three nationalities of the over one million Mediterranean Sea arrivals between January 2015 and March 2016 were Syrian (46.7%), Afghan (20.9%) and Iraqi (9.4%) citizens. These people were fleeing ongoing conflicts in several Asian and African countries. Greece has been the main gateway point for the flow of asylum seekers who arrived via the

Greek islands through Turkey. As of March 2016, 151,452 immigrants had arrived in Greece during 2016 in addition to the 856,723 who had arrived during 2015 including mainly asylum seekers from Syria, Iraq and Afghanistan (United Nations High Commissioner for Refugees, 2016). Due to border controls established by many European states, a large portion of this immigrant population is currently residing all over the territory of Greece (ibid.).

## **2.7. Integration of Immigrants in Greece**

Integration is the process by which immigrants become accepted into the host society, both as individuals and as groups (Pennix, 2003). Integration also refers to immigrants' perceptions of their 'belongingness' in the structure of the host society (Amit and Bar-Lev, 2015). After the settlement of immigrants in the receiving country, the concept of integration becomes particularly important especially if there is a cultural distance between the home and the host society. There are two parties involved in the procedure of integration: (1) the immigrants, with their characteristics and efforts to adapt; and (2) the receiving society, with its institutions, habits and attitudes towards the newcomers. It is the interaction between these two sides that determines the direction and outcome of the integration process. As a result, the ways in which immigrants adapt to the differences between the cultures of the original and the receiving country and the degree of acceptance by the local society are of great interest as factors for individual well-being and social cohesion (Fuente and Herrero, 2012; Heckmann and Schnapper, 2003; and Pennix, 2003). The integration of repatriating ethnic nationals or even related ethnic groups in the host society is normally easier than that of immigrants with a foreign ethnic identity and the repatriating or related populations are usually treated in a more favourable way by both the state and the host population compared with other newcomers. For example, in Greece, both the Greek state and the local population treat the repatriating ethnic Greeks in a more advantageous way in comparison with foreign immigrants in public policy and administration issues (Voutira, 2004). Likewise, in Spain, Latin Americans are integrated easier into Spanish society and have better access to the labour market than other immigrants because of their ethnic affinity with the Spaniards (Triantafyllidou, 2000).

The undocumented status of some immigrants is the greatest obstacle against their integration in the host societies and the differentiation between legal and illegal immigrants is often a source for discriminatory practices (Baldwin-Edwards, 2002). In

Greece, Baldwin-Edwards and Safilios-Rothschild (1999) argue that increased personal contact with immigrants leads to more positive evaluations which can transform the social stereotyping, despite an initial dislike or even fear towards undocumented immigrants. Drydakis (2013), using data from the Greek Migration Study to explore the integration of immigrants from countries of the former Eastern Bloc, found that young and male immigrants and immigrants who have lived longer in Greece are better integrated. Moreover, Christians are more easily integrated and less marginalised compared with people of other religions, while health impairments have a negative effect on integration. Other factors which favour integration include higher educational levels, capability for work and being employed (ibid.). In an earlier study, Drydakis (2010) found that Albanians face greater barriers to the rental housing market in Athens than Greeks. Indeed, they have lower access to newer, above-ground and repaired apartments and have to pay higher rents than Greeks. Of further importance is the finding that Albanians have higher access to housing in areas closer to the city centre, suggesting the role of landlords in creating residential ethnic segregation (Drydakis, 2010).

Legalising the presence of immigrants in the host country is a basic prerequisite for their integration because their illegal status does not allow them to attain any civil or working rights and forces them to work within the informal economy under unpropitious working conditions and without social insurance (Tsoukala, 2001). Nevertheless, legalisation has some costs, because immigrant workers become more expensive for the employer to pay and thus they may face difficulties in finding or retaining jobs (Glytsos, 2005). Legalisation does not always entail legal employment because some legal immigrants prefer to relapse back into informal work in order to avoid unemployment (ibid.).

The integration of immigrants is important for securing social cohesion. From this perspective, Wiesbrock (2011) suggests that the objectives of every host state may include efforts for the establishment of equal rights, responsibilities and opportunities for all within the boundaries of a democratic society, irrespective of ethnic and cultural background. Protection with social insurance and access to health care are significant elements for supporting the general wellbeing of immigrants and their ability to participate both in the labour market and community life and thus they are an essential part of any programme of integration at a national level (Craig, 2015).

## **2.8. Conclusions**

Over the last two to three decades, immigrants have become an important part of Greek society, contributing positively both to the economy and the cultural diversity of the country. The presence of large numbers of immigrants, however, puts the issue of health protection and health care coverage of these populations to the forefront of policy-making. The next chapter explores the effects of immigration on immigrants' health status based on a review of the current research in Europe. It also describes the concept and the legal parameters of the human right to health. Furthermore, it reveals factors that limit immigrants' access to social insurance and health care and investigates utilisation patterns of health services by immigrant populations.

## **Chapter 3**

### **Immigrants' Health, Rights and Entitlement to Health Care**

#### **3.1. Introduction**

The extended scale of human displacement has turned the issue of the provision of health care to immigrants into a public health priority in the European context and worldwide (Rafnsson and Bhopal, 2008). One of the greatest challenges facing health systems across the world is how they manage immigrants' health needs (Gushulak, et al, 2009). Immigrants are considered to be a vulnerable group because their population is often at increased risk of poor physical, psychological and social health outcomes and they have inadequate health care (Flaskerud and Winslow, 1998). The facilitation of immigrants' access to health services is therefore important for the protection of public health and the establishment of immigrants' human right to health, especially in the present conditions of economic crisis where the needs of the poor and marginalised persons are compromised (United Nations Department of Economic and Social Affairs, 2009).

This chapter firstly explores the impact of immigration on various aspects of population health through reviewing a number of European studies. Secondly, it provides some insights into the meaning of the right to health and health care and its promotion by various international organisations and national governments. The promotion of immigrants' rights to health and health care is explored since existing national regulations often diminish the importance of these rights on the basis of legal or financial reasons, although the protection of people's health status transcends issues of citizenship or economic status (Rousseau, et al, 2008). Thirdly, the chapter describes the general legal principles that regulate immigrants' access to health services in Europe. Finally, it provides evidence from a review of European studies about patterns of utilisation of the various types of health services by immigrants.

#### **3.2. Migration and Health Status**

Immigrant populations and undocumented persons in particular have potentially special health issues due to a variety of direct and indirect reasons (Norredam, et al, 2010; Bhopal, 2009; and Maffla, 2008). Firstly, immigrants may present different rates of incidence and prevalence for various diseases compared with the indigenous population

because of variations in these rates in their country of origin. Secondly, some immigrants are exposed to a number of risks before, during and after migration that can impact their health status. Thirdly, barriers to health services in the receiving countries may hamper some immigrants' access to appropriate care. Finally, certain social, economic, cultural and educational features as well as distinct demographic and biological characteristics of some immigrant populations can lead potentially to a series of differences in both care-seeking behaviour and health condition. Therefore, immigrants may be at risk of poorer health. These issues are discussed in more depth below.

Davies and colleagues (2010) and Kristiansen and colleagues (2007) have described several factors that may have an impact on immigrants' health before, during and after their departure from their countries of origin. Before the journey, immigrants may experience war, torture, imprisonment, loss of relatives and socio-economic hardship which may affect their health status. They may also be exposed to various unsanitary circumstances during the migrating move, especially when they travel in a clandestine manner: here, journey conditions often include extended periods of time during which large numbers of immigrants are hidden in a small space of a truck or a boat. Undocumented immigrants who fall ill during transit usually do not have access to medical services. The detrimental effects on their health status may remain long-term, particularly if the diseases remain undetected or untreated during the migrating journey (see Davies, et al, 2010; Kristiansen, et al, 2007; and Gushulak and MacPherson, 2000). Nonetheless, some immigrants' health status continues to be more susceptible to health risks even after their arrival in the destination location. Non-privileged immigrant populations are often affected by poverty, discrimination and social exclusion in the receiving countries and thus their opportunities to make healthy choices may be limited (Castañeda, et al, 2015). These immigrants often live in poor housing conditions which can have a negative impact upon their health status (Novoa, et al, 2015). Furthermore, their working environments may have a higher risk for work-related injuries and long-term occupational diseases (Takala, et al, 2009). In addition, the separation from familiar social norms and friends and families may cause mental illnesses, such as depression and anxiety disorders (Davies, et al, 2010; Magalhaes, et al, 2010; and Kristiansen, et al, 2007). In 2015, 40.2% of the non-EU-born population residing in the EU was assessed to be at risk of poverty or social exclusion compared with 21.7% of native-born persons (Eurostat, 2017).

Immediately after their arrival, immigrant populations may have a high incidence of infectious diseases if these are common in their countries of origin (Castelli and Sulis, 2017). Over time, the frequency of communicable diseases declines and there is an inevitable exposure to risk factors for non-communicable diseases, such as ischaemic heart disease, cancer, diabetes, stroke and asthma, in the receiving environment of a developed country (Lopez-Gonzalez, et al, 2005 and Stronks, 2003). This reduction in differences between newcomers and natives may occur because immigrants tend to become progressively similar to the receiving population in their socio-economic status and health-related behaviours (ibid.). Nevertheless, first generation immigrants may initially have a lower crude mortality rate – that is, the number of deaths in a specified population over a stated period of time – than the host population. This ‘healthy immigrant’ phenomenon can be attributed to the fact that the healthiest individuals among the sending population are selected by employers or are self-selected for migration (Fennelly, 2007). Moreover, it has been argued that immigrants may return to the country of origin when they are elderly or critically ill (Domnich, et al, 2012). The different health status of the immigrant populations may also result from different genetic and biological identities (Williams, et al, 2010). All the aforementioned factors are compounded by possible socio-economic and cultural differences in dietary habits, sanitary knowledge, housing conditions, care-seeking behaviour and psychological orientations (Solé-Auró and Crimmins, 2008 and Thomas and Thomas, 2004). It should be noted that morbidity patterns vary across space, time, age, gender, type of disease, country of origin and form of immigration (Mladovsky, 2007). Against this backdrop, a brief analysis of some of the main health problems of immigrants in the EU vis-à-vis the local populations is adduced.

### **3.2.1. Infectious diseases**

The frequency of tuberculosis among immigrants is high in southern Europe (Baussano, et al, 2013; Alcaide Megías, et al, 2004; Alonso Moreno, et al, 2004; and Rifes and Villar, 2003) as well as in other European countries (Anderson, et al, 2007; Laifer, et al, 2007; Farah, et al, 2005; Diel, et al, 2002; and Lillebaek, et al, 2002). Tuberculosis is essentially a disease of poverty and thrives in contexts with poor nutrition, overcrowding and poor health care. A large number of immigrants come from endemic areas in countries with poor hygienic conditions and insufficient provision of health care. In addition, the poor working and living conditions of some immigrant populations

in the host country may create further risk factors for them to contract the disease, whilst social exclusion, language barriers and attitudes towards seeking health care often render the biomedical risks even greater (Pittalis, et al, 2017). For instance, immigrants may not be eligible for national health insurance or they simply may not have sufficient knowledge about the utilisation of services, as explained later in this chapter. The drug-resistant form of this disease is being increasingly reported in Europe (Fattorini, et al, 2012) and may constitute a real public health threat in the future. Immigration from countries with high endemicity is a major contributing factor. Much the same can be said about hepatitis A which is also a disease advanced by poverty and poor hygienic conditions. Exposure to the hepatitis A virus because of the living conditions in some host countries is possible due to the risky situations that immigrants face (Whelan, et al, 2013).

The link between immigration and sexually transmitted diseases is more complex. Some immigrant populations have a high prevalence of HIV infection (Kaoutar, et al, 2012 and Llenas-García, et al, 2012). The situation may reflect the origin of many immigrants from countries where the disease is prevalent (Elam, et al, 2006). Additionally, the conditions and the length of the migrating journey, the intermediate stopovers and immigrants' lifestyle, socio-economic status and education in the host countries seem to also be implicated in their vulnerability to HIV infection (ibid.). For example, male immigrants who are moving alone may have a higher tendency for unsafe sexual behaviour (Kuznetsov, et al, 2013). In the case of women, the situation can be aggravated by rape, sexual abuse, exploitation and occupation in commercial sex (Platform for International Cooperation on Undocumented Immigrants, 2010).

Regarding tropical infections in the EU, malaria is the most important public health issue. Over recent years, an increasing number of imported cases have been identified in the Mediterranean region (Ramírez-Olivencia, et al, 2012; Espinosa-Vega, et al, 2011; and Spinazzola, et al, 2007) and they are largely associated with the influx of immigrants from endemic countries in tropical and subtropical areas and the temporary movement of already settled immigrants to their country of origin for holidays (Monge-Maillo and López-Vélez, 2012 and Odolini, et al, 2012). Other tropical infections among immigrants include filariasis, helminthiasis, infections with intestinal protozoa, hepatitis C, other non-parasitic infections and other sexually transmitted diseases (López-Vélez, et al, 2003).

### **3.2.2. Reproductive health**

In general, the reproductive health of immigrants, especially of women, seems to be affected by changes in socio-economic conditions, access to health care and changes in sexual behaviour. Premature births, low birth weight, stillbirths and perinatal mortality are higher among immigrants in the EU (Castelló, et al, 2012; Ekéus, et al, 2011; and Mortensen, et al, 2011). Moreover, immigrant women face more delivery complications and pregnancy-related illnesses and, additionally, unwanted pregnancies, abortions, insufficient antenatal care and poor knowledge about contraception are common problems among immigrant women (Carballo and Nerukar, 2001).

### **3.2.3. Occupational health and safety**

Immigrants tend to take jobs that are temporary, require few skills and are largely unattractive to local labour forces (Benach, et al, 2011). Many jobs that are available, such as those in construction, agriculture, manufacturing industry and mining, often involve poor environmental conditions and a lack of safety measures (ibid.). Moreover, language obstacles, poor communication, a lack of familiarity with some of the technology used, insufficient training and different attitudes to occupational safety all contribute to work-related risks (Solé, et al, 2013; Mastrangelo, et al, 2008; and Carballo and Nerukar, 2001). The result is that the number of labour accidents and work-related diseases is higher among immigrant workers (Johansson, et al, 2012; Mosconi and Riva, 2011; and Ahonen and Benavides, 2006).

### **3.2.4. Immigrants' health status in Greece**

Studies which have investigated the health status of immigrants in Greece are limited to the field of infectious diseases. Cases of tuberculosis among immigrants have increased in the country recently, especially among persons originating from regions with a high prevalence of the disease; the incidence of the disease among the Greek population has actually decreased (Papaventsis, et al, 2010). The medical community in Greece is also worried about the rising prevalence of the resistance of the *Mycobacterium tuberculosis* to isoniazid and rifampicin which is attributed, inter alia, to immigration (Kanavaki, et al, 2006).

Nikolopoulos and colleagues (2005) found an increasing trend of HIV-seropositive immigrants among various immigrant groups in the country. According to this study, the main mode of transmission amongst the Greek population is homosexual

contact between males, while heterosexual transmission prevails among immigrants. Other research (Paraskevis, et al, 2011) has highlighted the potential role of immigrant intravenous drug-users in the initiation of a recent outbreak of HIV-1 infection in Greece due to the introduction of cases originating from diverse places outside the country. Indeed, a broad HIV-1 genotypic diversity has been found in Greece that can be partly attributed to population movements, such as immigration (see Paraskevis, et al, 2007 and Nasioulas, et al, 1998).

The immigration of populations from countries of high endemicity in hepatitis B is an important public health issue in Greece, especially in areas bearing a high proportion of immigrants (Pantazis, et al, 2008). Refugees living in Greece are characterised by a high prevalence of the hepatitis B virus (HBV). The seroprevalence of HBV markers is higher among refugees from Albania and Asia (Roussos, et al, 2003 and Skliros, et al, 2001). This finding indicates the origin of the specific population from countries with a high endemicity but could also be attributed to the poor living conditions of refugees. Moreover, pregnant immigrant women in Greece, especially those from Albania, present with high rates of chronic HBV infection and low vaccination-induced immunity rates in comparison with Greek women (Elefsiniotis, et al, 2009). Furthermore, immigrant women have been found to have a greater prevalence of genital infection with herpes simplex virus than Greek females and this finding may indicate a less protected sexual behaviour within immigrant networks (Kyriakis, et al, 2003). Finally, cases of malaria have been reported in Greece and are either imported from countries to which malaria is endemic (Vakali, et al, 2012) or are domestically acquired, mainly among immigrant populations, in the agricultural areas of Evrotas, Laconia and, sporadically, in some other regions (Danis, et al, 2013).

### **3.2.5. Implications for public health**

The sheer scale of human displacement has turned immigrants' health into a priority health policy issue. Ethical obligations, public health consequences and the long-term costs of the morbidity associated with access to health care are important factors to consider for the protection of immigrants' right to health and the facilitation of their access to health care, especially during periods of economic hardship (Reyes-Uruena, et al, 2014). There are economic and social costs associated with the inadequate treatment of medical conditions (Lu, et al, 2000 and Kuiper, et al, 1999) and the violation of ethical principles in health care (Parsi and Hossa, 2012).

### 3.3. The Right to Health and Health Care

Prior to the analysis of immigrants' access to health care in the EU member states, it is necessary to elaborate on the international human rights standards which concern the human right to health. The concept of human rights applies to everyone, regardless of race, ethnicity, gender, sexuality, religion, political opinion, social origin, economic background or any other status (Beitz, 2009). The right to health is an essential parameter of life because it secures the necessary conditions that enable persons to exist and personalities to develop fully and thus it is indispensable for the exercise of many other human rights (International Forum for the Defence of the Health of People, 2002 and Toebe, 1999). The human right to health is recognised as a fundamental human right by several international conventions and declarations (see Table 3.1 below):

*Table 3.1: International Conventions Defining and Protecting the Right to Health*

<b>Institution</b>	<b>Convention</b>	<b>Year of issuance</b>
UN	Universal Declaration of Human Rights	1948
UN	United Nations' International Covenant on Economic, Social and Cultural Rights	1966
UN	International Convention on the Elimination of All Forms of Racial Discrimination	1965
UN	Convention on the Rights of the Child	1989
UN	Convention on the Elimination of All Forms of Discrimination against Women	1979
UN	International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families	1990
UNESCO	Universal Declaration on Bioethics and Human Rights	2005
WHO	Constitution of the World Health Organization	1946
WHO and UNICEF	Declaration of Alma Ata	1978
WHO	World Health Declaration	1998

*UN: United Nations, UNESCO: United Nations Educational Scientific and Cultural Organization, WHO: World Health Organization, UNICEF: United Nations International Children's Emergency Fund.*

It is noted that conventions are legally binding formal agreements between states (Kinney, 2001), while declarations are not legally binding, although they may have political weight (Druzin, 2017). Many countries have adopted the binding and/or non-binding obligations which derive from these conventions and declarations in their national legislation. Nevertheless, the concept and purpose of a human right to health

has been the subject of ongoing debate amongst academics and researchers across the globe.

The right to health includes the right to health care as well as the right to the underlying preconditions for health, also known as the social determinants of health such as sanitation, sufficient food and safe water, appropriate housing, adequate education and favourable working conditions (see Gruskin, et al, 2007; Hunt, 2006; and Marmot, 2005). Pace (2010) recognises a variety of instruments that secure immigrants' right to health, either as binding agreements of an international, regional or sub-regional scope or as guidelines and authoritative interpretations which create moral obligations. Currently, the right to health has also been formally recognised by several states in national constitutional and statutory provisions (Backman, et al, 2008 and Kinney and Clark, 2004) either due to motivation by international conventions or because of independent volition.

Although most of the above health instruments have direct and indirect legal implications for countries, the realisation of the right to health occurs ultimately at the national level. Therefore, it depends mainly on governments to make efforts to embody the relevant imperatives into their domestic health policies. It has been argued that the right to the highest attainable standard of health is the cornerstone of any consideration of health and human rights and is valid in an operational, systematic and sustained aspect of health care provision (Hunt and Backman, 2008). This requirement necessarily demands comprehensive health coverage which is accessible to all, regardless of their authorised or unauthorised residence in the country. However, as explained later in this chapter, the current reality in most European countries falls short from the moral and legal obligations of a universal access to health care.

Because of the sensitivity and importance of the right to health, it is vitally important that effective monitoring and accountability are in place to ensure that the interests of disadvantaged persons are met (Hunt and Backman, 2008). Accountability means that countries, organisations and bodies are obliged to answer for their acts or omissions in cases of potential violations of the right to health. If there are no controlling mechanisms, the right to health will be largely meaningless or ineffective. Several different types of accountability mechanisms can be distinguished and include judicial, quasi-judicial, administrative, political and social controls (Riedel, 2009).

### 3.3.1. Immigrants' right to health

Despite the extended international focus on the right to health, the enjoyment of this right by immigrants is often limited because of legal prohibitions as well as other social, political and economic reasons (such as discrimination, language difficulties, cultural barriers and economic hardship, as further explored in *Chapters 5 and 6*). Many countries have adopted exclusionary policies which are discordant to the international documents for the protection of the right to health (Aginam, 2002 and Fidler, 1996). Indeed, many countries have explicitly declared that they cannot or do not wish to provide the same level of protection to immigrants as to their own citizens. Accordingly, they have defined their health obligations towards non-citizens in terms of “essential” or “emergency” care only (United Nations High Commissioner for Human Rights and World Health Organization, 2008). Since these concepts have a different content in the various countries, their interpretation is often left to individual health workers and thus the daily practice can often be unpredictable (*ibid.*). Finally, immigrants' right to health depends largely on their working and living conditions rather than solely on their access to care. Therefore, it is necessary for governments to take measures towards the realisation of the appropriate political, living and labour parameters which, among other things, include legal residence, official access to health services, adequate housing, safe and sanitary working environments, sufficient food and water and personal security. Table 3.2 below presents the major difficulties for immigrants – undocumented persons in particular – with respect to the enjoyment of their right to health:

*Table 3.2: Major Difficulties Faced by Immigrants Regarding the Enjoyment of their Right to Health*

They are generally inadequately covered by the public health systems, are often unable to afford health insurance and usually have limited access to social services.
They face difficulties in accessing information on health matters and available services.
They often do not use health services because of the fear that health professionals may denounce them to immigration authorities.
They often work in unsafe and unhealthy conditions.
The housing conditions are often unsanitary.
They may be more prone to risky sexual behaviour due to their vulnerable situation, far away from their families, and their exclusion from major prevention and care programmes.
Trafficked individuals are subject to physical violence and abuse.

*Source: United Nations High Commissioner for Human Rights and World Health Organization (2008: 19).*

Although the right to health has a general scope and meaning, adequate access to health services and products is a necessary component. The existence of an effective health system by providing medical care and setting the health of individuals, communities and populations as a primary goal is an essential parameter of the right to the highest attainable standard of health (Beauchamp and Faden, 1979). A conceptual consideration for the establishment of a basic minimum of accessible health care is a necessary duty for every state and society regardless of the scarcity of existing resources (Menzel, 2011). Inequalities in the application of the right to health can be observed either internationally (Malmusi, 2015) or between different populations living in the same place, such as between immigrants and the indigenous population (Gotsens, et al, 2015).

Regarding access to health care, the right to health is compromised by well-documented barriers to health services and products (Llop-Gironés, et al, 2014). With respect to immigrants, a study by Cuadra (2012) revealed that both the indigenous population and legal immigrants have (varying degrees of) access to existing care facilities because they receive political recognition from the public governing and administrative bodies. On the other hand, undocumented immigrants often have no legal access to health care or they are provided with lower standards of care due to the illegality of their presence in the country and thus the right to health is not applied equally for them. The interruption of this inequality is particularly important both as an ethical issue, in the attempt to extend the right to health globally, and in practice for a better organisation of health systems and the protection of public health generally (Kingston, et al, 2010).

#### **3.4. Immigrants' Entitlement to Health Care in Europe**

Although entitlement to health care is regarded as a fundamental human right, there is a resistance by states to the necessity for recognition and application of this right to immigrants, particularly the undocumented population (Zuckerman, et al, 2011 and Van Krieken, 2000). Health policies in most European countries provide for no more than emergency services for immigrants with unauthorised presence (Gray and van Ginneken, 2012). In certain exceptions a wider range of services is provided in accordance with three different strategies: (1) only segments of populations are covered, such as children or pregnant women; (2) only specific types of services are provided, such as emergency services or treatment of infectious diseases; and (3) financial

requirements are demanded, like allowing undocumented immigrants to purchase insurance, services or products (Gray and van Ginneken, 2012).

The decision of policy-makers not to grant full health care access to undocumented immigrants is justified by them on a basis of economic, political and administrative factors (Romero-Ortuño, 2004). Provision of full health care to undocumented immigrants compromises the need for restricting public expenditure, especially in the current economic financial crisis where this imperative has even curtailed the entitlements of the official population (*ibid.*). Furthermore, there is a political cost if people who are not paying taxes to the state or contributing to insurance funds are enjoying the same access to health services and products with those who do 'pay their way'. In addition, an increase in the number of health services users has a direct impact on the functionality of the health system, since it affects the allocation of resources, increases staff workload and lengthens waiting lists (Romero-Ortuño, 2004). However, other authors (Mladovsky, et al, 2012 and Fallek, 1997) suggest that the provision of sufficient health care in the host country cannot be considered as a major pull factor and the deficiency of health services and products in the home country is not a crucial push factor for migrants.

With respect to the regulation of undocumented immigrants' entitlement to health care, EU member states have relatively different policies. An important point of reference concerning access to health care is provided by the Council of Europe which has addressed the issue of undocumented immigrants' entitlement to care in a resolution of the Parliamentary Assembly which clearly defined emergency health care as a minimum right that should be available to all undocumented immigrants (Council of Europe, 2006). In comparison with these minimum standards set by the Council of Europe, the European states' policies can be indicatively classified into three categories according to the level of the adult undocumented immigrants' entitlement to health care (see Cuadra, 2012). The first category includes countries where the provided authorisation is limited to a narrow range that makes even emergency care legally inaccessible or financially unaffordable or the appropriate health care is offered only within detention centres. In the second category, undocumented immigrants are only entitled to immediate or urgent care. Greece is included in this category. Finally, the third category includes countries which offer health services beyond solely emergency care. Table 3.3 below presents the categorisation of the EU states based on information about undocumented immigrants' entitlement to health care:

*Table 3.3: Undocumented Immigrants' Entitlement to Health Care in EU Member States in Comparison with the Minimum Rights to Health Care According to the Standards of the Council of Europe*

<b>Grade of Access</b>	<b>Member States</b>
<b>1. Less than minimum rights for health care</b>	
Access to emergency care with a payment of the full cost	Austria, Croatia, Czech Republic, Finland, Hungary, Luxemburg, Latvia
Access to emergency care with a payment of a low fee	Sweden
Free of charge access to emergency care only in special ambulatory settings	Bulgaria, Poland
<b>2. Minimum rights for health care</b>	
Access to emergency care for an unclear cost (usually free of charge in daily practice)	Cyprus, Greece, Malta
Free of charge access to emergency care, access to primary and secondary care with payment for the full cost	Denmark, Estonia, Germany, Ireland, Lithuania, Romania, Slovenia, Slovakia, Spain
<b>3. More than minimum rights for health care</b>	
Access to health care free of charge or with a moderate fee	Belgium, France, Italy, Netherlands, Portugal, United Kingdom

*Source: European Union Agency for Fundamental Rights (2015) (information updated as of 31 December 2015).*

Of course, the situation in many countries is not static because the existing policies governing entitlement are amenable to potential reforms or are not implemented in day-to-day practice (Platform for International Cooperation on Undocumented Immigrants, 2007). However, it is clear that there are wide differences in the entitlements to health care for undocumented migrants across the EU. According to the above classification, and at the time of writing, in 10 member states the right of access to health care is less than the minimum rights' standard outlined by the Council of Europe, while in 12 member states an appropriate access to emergency care is permitted for undocumented immigrants (thus meeting the specific minimum requirement). However, according to the Human Rights Committees and the International Organisations, the access to emergency care falls far short from the full scope of the right to health (Cuadra, 2012). Therefore, there are several countries whose policies do not effectively confer the human right to health.

Another observation is that the existing variations in the level of health care for undocumented immigrants do not seem to be associated with the type of health system's funding: that is, whether it is tax-based or insurance-based. Intuitively, it would be expected that firmly established social welfare states would grant wider entitlements to undocumented immigrants. However, it is observed, for example, that the Nordic

countries provide limited health services to undocumented immigrants compared to other countries with a lesser welfare tradition. Cuadra (2012) notes that member states which offer an open access to health care for undocumented immigrants have either high (Italy, Spain and Portugal) or moderate (France and the Netherlands) proportions of undocumented immigrants from a European comparative perspective. Hence, the volume of unauthorised immigration can constitute a potential predictor for the formation of policies governing access to health care for undocumented immigrants. Further, the type of immigrants' illegality of residency could contribute to these types of policies since, as Cuadra (2012) again notes, those countries with open access to health services mainly harbour undocumented immigrants employed in the illegal (informal) working market, while countries in which undocumented immigrants derive mostly from failed asylum seekers tend to present more restrictive policies.

### **3.5. Immigrants' Utilisation of Health Services**

Because of the growing phenomenon of immigration, European health systems are currently under pressure to adapt to the needs of a multicultural population and to provide care to people who are not legally entitled to it. As previously discussed, immigrants' official entitlement to health care is determined by the existing legislation in each country. Nevertheless, their utilisation of health services depends not only on law but also on medical, social and economic factors. Therefore, granting access to health services is not enough; a guarantee that this access becomes a reality is also necessary. In other words, the concept of 'access' should include the combination of entitlement and affordability to receive health care (Gold, 1998).

Equity in access to health care is important for the fulfilment of the moral principal which declares that immigrants should have the possibility to attain the same physical and mental health with the host population. Equity in access to health services is defined as equality in the right to use and equality in the actual utilisation of health services when the health needs of the various individuals or groups are equal (see Whitehead, 1992). Therefore, equity in health care means that there are no systematic disparities in access between the various social groups by virtue of their underlying social status (Braveman and Gruskin, 2003). Access should be exclusively determined by the medical needs which emerge from the health status of the individuals or groups regardless of ethnicity, income and insurance availability (Rosenbach, et al, 1995). Equitable health care also requires that the process of resource allocation is determined

mainly by the medical and social needs of the population regardless of factors such as ethnicity or immigration status (Oliver and Mossialos, 2004). Equity in access to health care is crucial to ensure that immigrants have at least the possibility of attaining the same state of mental and physical well-being as host populations. However, immigrants may present different utilisation of health services vis-à-vis non-immigrants because both immigrants' needs and access are affected by a series of factors and this is especially true for first-generation immigrants (Norredam, et al, 2010).

The actual utilisation of health services depends on a combination of determinants which can be divided into structural barriers and factual medical causes. Unfortunately, the differentiation of these two terms is not often specified in the published literature, although it is particularly important for health research and policy. The structural barriers refer to any modifiable obstacle which disturbs immigrants' access to health services and goods in comparison with the indigenous population's access and they can be further categorised into formal and informal obstacles (O'Donnell, et al, 2016). The formal barriers include deficiencies in the operation of the health and social insurance system and legal prohibitions regarding the provision of care to immigrants, while the informal barriers include deficiencies due to social, economic, cultural and practical difficulties and diversities (Norredam, et al, 2007a). Certain informal barriers have been reported in the international literature concerning the lower use of health services by immigrants and undocumented immigrants in particular. These factors include extended waiting times, professionals' prejudiced attitudes, high costs, linguistic differences, deficient integration and lack of awareness of the system (see Saurina, et al, 2010). Furthermore, there are medical factors which can also generate differences in the utilisation of health services between immigrants and the native population and these depend on immigrants' demographic and biological characteristics (Scheppers, et al, 2006).

The patterns of utilisation of health services by immigrants in European states have been investigated by a number of studies – mainly in the Nordic countries, the United Kingdom, the Netherlands, central Europe and southern Europe – by measuring differences in utilisation rates between immigrants and the native-born population. This literature varies considerably in relation to the immigrants' characteristics and the type of health service studied (additionally, there are methodological differences between these studies which make direct comparisons difficult). Nevertheless, they constitute a

primary tool for the exploration of differences between immigrants and the indigenous populations in care-seeking behaviour. This literature is discussed below.

### **3.5.1. Immigrants' utilisation of emergency care services**

In general, the majority of literature shows that immigrants demonstrate higher utilisation of emergency medical services compared with the indigenous populations' rates in the southern European region (Bonvicini, et al, 2011; Dias, et al, 2008; and Rué, et al, 2008) as well as in the rest of Europe, particularly in EU member states (Nielsen, et al, 2012 and Norredam, et al, 2004). Immigrant populations tend to use hospital emergency departments more frequently, even for non-urgent care, because of the legal barriers to their access to primary care services (ibid.). Another reason for the inappropriate use of emergency services is the lack of knowledge about the structure and operation of the local health system as immigrants may come from countries with different health systems or few health care facilities (Cots, et al, 2007 and Norredam, et al, 2007b). In addition, there are particular medical conditions – such as infectious diseases and occupational accidents – which increase the needs for emergency care of immigrants in comparison with the native population (Junyent, et al, 2006 and Farchi, et al, 2005). That said, some research does suggest that immigrant status is not a factor for inappropriate use of emergency care (David, et al, 2006) or, even, that utilisation of acute care services is lower among the foreign-born residents (Sandvik, et al, 2012 and Buron, et al, 2008).

### **3.5.2. Immigrants' utilisation of routine care services**

The determination of a pattern in the use of primary care is a more difficult task because the observed differences are related to less clear factors. The various studies do not agree on the existence, degree or even direction of the observed differences in health services utilisation, while there are also various interpretations about these differences. In general, no overall consistent pattern can be distinguished with respect to the utilisation of primary care services by immigrant groups (Uiters, et al, 2009). Indicatively, there are European studies which have shown that immigrants receive a higher (Lanting, et al, 2008 and Uiters, et al, 2006), similar (Calderón-Larrañaga, et al, 2011; Hargreaves, et al, 2006; Livingston, et al, 2002; and Smaje and Le Grand, 1997) and lower (Dias, et al, 2011a; Regidor, et al, 2009; Vall-Llosera Casanovas, et al, 2009; Stronks, et al, 2001; and Cooper, et al, 1998) quantity or quality of routine care services,

while there are also studies with mixed results (Fassaert, et al, 2009; López Nicolás and Ramos Parreño, 2009; and Dyhr, et al, 2007). In general, the significance of differences varies across host countries, ethnic immigrant groups and health systems. Moreover, the utilisation of routine care services depends on certain factors, beyond medical necessity, which influence care-seeking behaviour, such as demographic characteristics, educational level, socio-economic conditions, insurance coverage, health status and self-perceived health condition (Berchet, 2013 and Reijneveld, 1998).

### **3.5.3. Immigrants' utilisation of preventive care services**

With respect to preventive health care, lower rates of vaccination coverage among immigrants compared to the indigenous population in Europe have been reported (Borràs, et al, 2007). Additionally, important research has been conducted in the field of routine medical screening among women against certain types of cancer. Regarding breast cancer screening, there is evidence which shows that immigrants are more likely to fail to comply with a regular mammography programme compared to the native population in southern Europe (Martín-López, et al, 2013; Pons-Vigués, et al, 2011; and Pravettoni, et al, 1993) and other European states (Vermeer and Van den Muijsenbergh, 2010; Fontana and Bischoff, 2008; Visser, et al, 2005; Remennick, 2003; and Lagerlund, et al, 2002). Furthermore, participation in cervical screening programmes has been found to be lower among immigrants compared to non-immigrants in European countries (van Leeuwen, et al, 2005 and Webb, et al, 2004). Moreover, reported higher rates of unintended pregnancies (Wolff, et al, 2005) and induced abortions (Rasch, et al, 2008 and Helström, et al, 2003) among immigrant women suggest disparities in the utilisation of preventive medical services. There is also evidence which suggests that immigrant women have decreased odds of being diagnosed with cancer at an early stage (Norredam, et al, 2008).

### **3.5.4. Immigrants' rates of hospitalisation**

Regarding hospitalisation differences between immigrants and the indigenous population, the existing literature shows contrasting results probably due to the variety of factors which determine clinical admission and duration of stay in a hospital. Several studies in Europe have demonstrated higher hospitalisation rates among immigrants compared to the non-immigrant population (Muñoz-de Bustillo and Antón Pérez, 2010; Danielsson, et al, 2003; and Robertson, et al, 2003). However, other studies show a

similar (Baglio, et al, 2010 and Balarajan, et al, 1991) or even a lower (Cacciani, et al, 2006) hospitalisation rate for immigrants compared to the indigenous European population. The findings of these studies may suggest that hospitalisation rates are related to the nature and epidemiology of the diagnosed diseases, the health status of each population group, working and living conditions, relevant legislation, the type of admissions (emergency and non-emergency) and other social, administrative and cultural parameters.

### **3.6. Conclusions**

Health professionals work in an increasingly multicultural clinical setting as it is shaped by contact with people from various cultural backgrounds. The richness of this diversity can create special and challenging conditions in the provision of health care to immigrants. The immigrant population is not a homogeneous group of people in terms of cultural identity, socio-economic status, residency status, documentation, duration of presence in the host country, migrating journey conditions, country of origin and ethnicity (Rechel, et al, 2013). While there are special needs to address for every individual patient, there are also common difficulties when providing care for immigrant groups.

While there are numerous international conventions and declarations promoting the universal right to health care, the reality demonstrates a clear distinction between the rights granted to residents in a regular situation (indigenous population and authorised immigrants) and the rights permitted to undocumented immigrants in most European countries. The relevant restrictive policies are based on concerns about the financial and administrative burden as well as the public's reaction regarding the implementation of open access health care. It is undeniable that universal health care coverage carries major financial costs, especially for countries in a difficult financial situation. Nevertheless, the moral obligation to protect vulnerable population groups from social exclusion and the medical need to effectively manage public health problems underlines the importance of establishing open access to health care for all in a sustainable and long-term manner.

Following the discussion of the specificities and special demands of immigrants' care, it is necessary to focus on the current conditions in Greece in order to understand the research setting. For this reason, the next chapter describes the operation of the Greek health system within the context of the prevailing economic crisis. Furthermore,

it provides information on the employment status and social insurance of immigrants in Greece. It also reports and comments on the legal framework that regulates immigrants' access to Greek health services. Finally, it offers evidence about immigrants' utilisation of the Greek public health care services through reviewing relevant studies.

## **Chapter 4**

### **Immigrants and Health Care in Greece**

#### **4.1. Introduction**

Most countries with organised health systems have formulated criteria for defining pathways for citizens to receive health care (Rutten and van Busschbach, 2001). Under the operation of a national health system, access to public health care services is full and universal and the financing of a health system comes from the state budget. In the presence of a social insurance system, as in Greece, a security fund is responsible for covering health care costs for insured members (Lameire, et al, 1999). This fund is a non-for-profit organisation whose premiums come from contributions by both employers and employees (Saltman, 2004). The regulations governing funding of, and access to, the health system depend on each state's health policy and aim to protect individuals and households from unbearable payments for health care (Xu, et al, 2003). Therefore, in social security-based systems, the operating conditions of the health system and the circumstances determining the acquisition of social insurance through employment are of great significance for the provision of care to the population, including immigrants. In view of the above, this chapter discusses the organisation and operation of the Greek health system and the social security of immigrants. It then refers to the eligibility of immigrants to the different types of health services as well as the actual use of these services by the immigrant population in Greece.

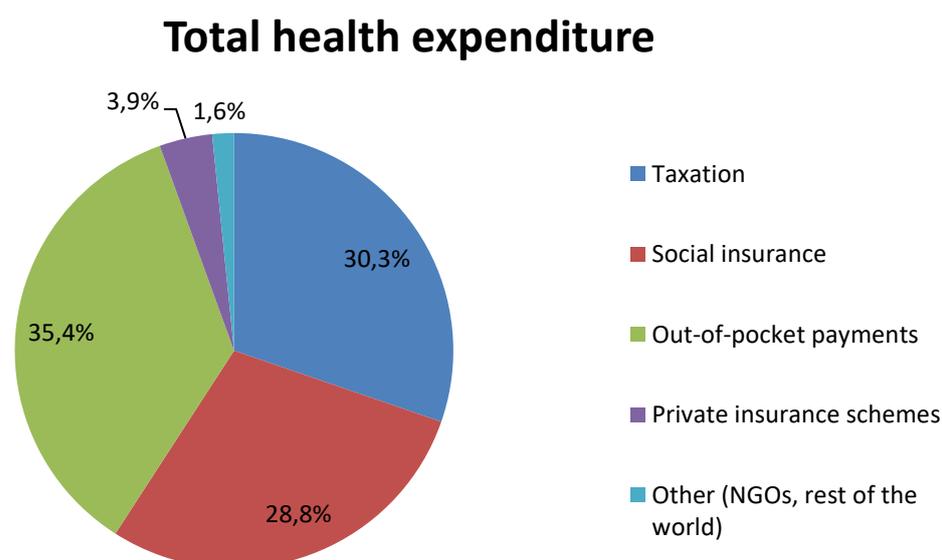
#### **4.2. The Greek Health System**

##### **4.2.1. Overview of financing**

The Greek health system is considered to be a 'mixed' system in terms of funding (Economou, et al, 2017). The state finances the operation of a national health system, while social insurance organisations cover the medical expenses of insured employees. However, citizens in Greece can use health services provided by the state or private institutions as private customers with their own expenses or by making contracts with private insurance companies (ibid.). Health services in Greece are divided into open (primary) care and hospital (secondary or tertiary) care services. The suppliers of health services include both the public sector (state hospitals, health centres, provincial

surgeries, polyclinics and municipal dispensaries) and private initiatives (private hospitals and clinics, diagnostic laboratories and self-employed doctors). Within the Greek health system, primary care services are provided through health centres and provincial surgeries in rural areas, while the outpatient departments of regional and district hospitals, polyclinics and private doctors offer primary care services in urban areas. Secondary care is provided by public hospitals and private for-profit hospitals and clinics (ibid.). Funding for health services and products comes primarily from the state budget and social insurance funds (59.1%) and secondly from private costs (40.9%) (World Health Organization, 2018). Figure 4.1 below presents the distribution of the total expenditure on health in Greece by source of revenue. The total health expenditure accounts for 9.1% of the total state budget (ibid.):

*Figure 4.1: Total Expenditure on Health by Source of Revenue in Greece*



*Source: World Health Organization, 2018.*

Health care expenditure in Greece has increased substantially over the last three decades in both absolute monetary units and in relative terms. However, the trend is currently being reversed due to the measures taken by the most recent Greek governments to curb the country's mounting public sector debts. Health expenditure in US\$ per capita and as a share of GDP has been decreasing since 2008 and 2009 respectively (World Health Organization, 2018). Furthermore, the reduction of disposable personal incomes due to the restraints in wages and unemployment seems to

have resulted in a containment of the personal expenses for health care (Diamantopoulos and Niakas, 2017). Nevertheless, Greece continues to be above average among the Organisation for Economic Co-operation and Development (OECD) countries in health care spending (Dervenis, et al, 2013).

#### **4.2.2. Provision of medical services**

Public hospitals in Greece are responsible for the delivery of a wide range of medical services. Firstly, they provide primary care through their outpatient departments, although almost the entire medical personnel consist of specialists. The same outpatient departments are responsible for the provision of ambulatory regular care and specialist consultations. They operate during morning hours, consultations are free and the visits are scheduled on an appointment basis (Economou, et al, 2017). In recent years, hospital outpatient departments and their staff have also offered medical services during afternoon hours on private, appointment-only, grounds for which they are paid on a fee-for-service basis. This arrangement seems to achieve patients' satisfaction while, at the same time, attracts private funds to the public health system (Niakas, et al, 2005). Secondly, public hospitals are responsible for the provision of emergency care forming a network of urgent services which operate on a 24-hour basis. As a referral mechanism is not compulsory in the Greek health system, patients can directly visit the hospital emergency departments or seek specialist care according to their own personal estimations, bypassing the primary care contact points and without any geographical restrictions (Mossialos, et al, 2005). Finally, secondary and tertiary in-patient care is provided by public hospitals according to their capacity.

There are two main factors which define entitlement to the Greek health system: (1) citizenship regulates access to the public outpatient services; and (2) social insurance obtained from occupational status provides access to services financed by social insurance organisations (Mossialos, et al, 2005). Entitlement on the basis of citizenship involves two types of health care settings which include health centres, polyclinics and provincial surgeries for primary care and hospital outpatient departments for ambulatory and emergency care. In this case, Greek citizens, EU citizens and immigrants with a residency permit can receive services at any of these clinical settings. Entitlement on the basis of social insurance applies when accessing in-patient care and services provided by private practitioners, diagnostic centres and hospitals contracted through social security funds and covers the insured members and their families

(Economou, et al, 2017). The uninsured are covered by central government and are entitled to free access to public health care services (under law No. 4368/2016, article 33). Besides citizenship and social insurance, the ability and willingness to pay is a separate factor of access to health services. A person, whether covered by a social organisation or not, is free to choose a public or a private health provider or make a contract with a private health insurance if he/she is able and willing to pay the emerging cost (Economou, et al, 2017).

In Greece, coverage for health services by the social insurance organisations and the national health system is full and universal as long as the aforementioned prerequisites of social insurance and citizenship are satisfied. As such, access to health services and products is free and equal and patients pay no official fees at the point of use, with the exception of small user charges for the cost of medication and tests in private laboratories (Economou, et al, 2017). However, a significant characteristic of the mixed public-private financial resources of the Greek health system is that private spending is exceptionally high and remains increased even in the context of the modern financial crisis (Souliotis, et al, 2016). In part, this can be explained by the undersupply of biomedical technology in the public sector, especially outside the large cities of the country, the understaffed and disorganised primary care facilities and the limited coverage of dental care (Siantou, et al, 2009). These deficiencies oblige patients to use external private personnel and facilities at significant cost. Moreover, the problem of high private spending is aggravated by the existence of informal payments in the public hospital sector. These unofficial, and also illegal, transactions concern the provision of hospital services and include payments to physicians – primarily surgeons – so that patients can get quicker access (such as bypassing waiting lists) or ensure a better quality of care (Liaropoulos, et al, 2008). This unfortunate phenomenon extends across socio-economic classes (ibid.).

#### **4.2.3. The Greek health system and the current financial crisis**

The current financial crisis in Greece has been highlighted extensively by the international media. Since May 2010, the Greek economy and the public administration have been kept under surveillance by the International Monetary Fund, the European Commission, the European Central Bank and more recently the European Stability Mechanism, due to the rapidly increasing annual deficits and total public debt which have led to a crisis in the state's credit competency. In 2017, the general government

debt amounted approximately to €317 billion, which is around 180% of the GDP (Hellenic Statistical Authority, 2018). Table 4.1 below presents the time series of GDP and government deficit and debt. The direct result of these circumstances is a significant reduction in personal and family income due to heavier taxation and a more general market downturn. At the same time, the demand for publicly-funded health services has increased because there has been a decline in disposable personal and family earnings. This has increased pressure on the public health system thus compromising its efficiency and effectiveness. In addition, the deficits of public hospitals and social insurance institutions continue to rise, while private health care providers find their income reduced as people turn increasingly to state services for their health care needs (Kentikelenis and Papanicolas, 2012; and Kentikelenis, et al, 2011):

*Table 4.1: GDP, Government Deficit and Debt, 2014-2017*

		<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>
<b>Gross Domestic Product (GDP)</b>	(million euro)	178,656	176,312	174,199	177,735
<b>General government balance (deficit/surplus)</b>	(million euro) (% of GDP)	-6,460 -3.6	-9,990 -2.1	1,094 0.6	1,454 0.8
<b>General government debt</b>	(million euro) (% of GDP)	319,629 178.9	311,724 176.8	315,009 180.8	317,407 178.6

*Source: Hellenic Statistical Authority, 2018.*

Greece's current economic situation is contributing to an increasing pressure upon health care resources. Apart from the economic difficulties because of the excessive national deficit, Rovithis (2006) identified four additional factors which compromise the financial survival of the Greek health system: (1) the country has an elderly population that is growing more rapidly than that of most other countries and may place an additional strain on the relevant budgets due to the likely higher prevalence of age-related diseases; (2) the higher ratio of retired to working age people within the population and increasing unemployment also diminish the insurance contributions; (3) the immigration waves from neighbouring countries constitute a major burden to the health system; and (4) the introduction of sophisticated medical technology increases health care expenses.

Since the onset of the current economic crisis, successive Greek governments have planned and applied a range of structural adjustments as measures to tackle excessive expenditure and achieve greater efficiency. The most drastic reforms

included: the merging of almost all social health insurance funds and public health service providers; the collection of detailed data on hospital expenditures; the retrenchment of health care personnel's salaries; limited recruitment of health staff; and a reduction of pharmaceutical costs through electronic prescribing and promotion of generic drugs (Hudetz, 2014). However, Kentikelenis (2017) supports that these structural reforms had a negative impact on the operation of Greek public health care services and their outcomes through direct and indirect mechanisms. Direct actions included cuts to hospital operating costs, restrictions to social insurance funds, limitations to public health care services, reduction of benefits and increases in prescriptions' participation rates, while indirect effects were linked to stringent austerity measures applied across the public sector, limiting the number and remuneration of public employees, implementing additional taxation and hardening employment conditions (ibid.). The present research attempted to provide new insights into the provision of health care to immigrants from the health professionals' point of view. Therefore, it is important to understand that the deterioration in overall service quality in the public health care system is likely to have influenced the perceptions of health professionals of the process and outcomes of caring for immigrants.

#### **4.3. Employment and Social Insurance of Immigrants in Greece**

The vast majority of legal immigrants in Greece work as employees – manual workers in particular – in the private sector and they are socially insured by the *Social Insurance Institute – Unified Insurance Fund for Employees (IKA-ETAM)* (Social Insurance Institute, 2016). Table 4.2 below presents the distribution of insured employees by nationality in the private sector in March 2016 (ibid.):

Table 4.2: Number of Insured Employees by Citizenship and Gender in the Private Sector (March 2016)

Country of citizenship	Total insured population			
	Males	Females	Total	(%)
Greece	855,134	758,164	1,613,298	90.37
Albania	61,234	31,964	93,198	5.22
Other immigrants	47,008	31,784	78,792	4.41
<b>Total immigrants</b>	<b>108,242</b>	<b>63,748</b>	<b>171,990</b>	<b>9.63</b>
<b>Total</b>	<b>963,376</b>	<b>821,912</b>	<b>1,785,288</b>	<b>100.00</b>

Source: Social Insurance Institute, 2016.

There was a rapid increase in the national unemployment rate after the onset of the economic recession in 2010, but it has declined since 2014 (Hellenic Statistical Authority, 2016a). In 2016, 28.2% of people with foreign nationality were unemployed compared to 22.7% of those with Greek nationality (Hellenic Statistical Authority, 2016b). In contrast, the percentage of economically active people amongst the foreign population was 72.7%, much higher than the corresponding percentage (51.1%) for those with Greek nationality (ibid.) because of the younger age distribution of the immigrant population. However, the actual unemployment rate among immigrants is unclear due to the illegal status of many immigrants in Greece and the atypical illegal and therefore uninsured employment of a large proportion amongst them. Mitrakos (2013) reported that some documented immigrants in the country work illegally, although they fulfil the prerequisites for official employment. The reasons include the unwillingness of some employers to formalise the work relationship with their foreign employees and pay the required social security contributions and the desire of some immigrants to work informally and earn greater amounts of income (ibid.).

Regarding job seeking, Drydakos and Vlassis (2010) found that Albanian applicants are less likely to receive an invitation for a job interview and be hired – while the offered monthly wage and insurance coverage is lower, too – in comparison to Greek applicants with similar qualifications across a large spectrum of low-skilled positions in offices, industries, cafés, restaurant services and shop sales. Nonetheless, the Greek labour market has allowed Albanian and other immigrant workers to be employed in large numbers in manual low-skilled jobs where they are frequently uninsured or underinsured and often work under illegal or precarious conditions (Psimmenos and Kassimati, 2004). Immigrants in Greece have opportunities to work full-time in manual

jobs where they are even absorbed more easily than Greeks, at least in those sectors where immigrant workers are concentrated. The main observed problems are institutional in nature and are associated particularly with the terms and conditions of employment. It has also been suggested that immigrants do not face extended discrimination in the working environment in Greece (Marvakis, et al, 2004).

In general, competence in the host country's language and its culture generates better employment opportunities, an increase in productivity and easier access to social networks and information which are required for success in the receiving society, while inadequate adaptation to local norms and customs and separation from the host society may result in less labour opportunities and wage losses (Battu and Zenou, 2010; Casey and Dustmann, 2010; Izquierdo, et al, 2009; and Constant and Zimmermann, 2008). In Greece, immigrants who have greater identification with Greek culture and society have easier access to the labour market, while separated and marginalised immigrants face disadvantages in seeking employment (Drydakis, 2013). In addition, according to the Greek Migration Study, integration – as expressed through language, cultural elements, self-identification, societal interaction and future citizenship plans on the part of immigrants – is positively associated with higher wages, while alienation has the opposite effect (Drydakis, 2012).

#### **4.4. Immigrants' Legal Entitlement to Health Care in Greece**

According to Aristotelian philosophy and Christian beliefs, which are widely prevalent in Greece (Leone, 2012), and also in accordance with the relevant international conventions mentioned in *Chapter 3*, every citizen should be treated equally and thus health services should be oriented in a way to offer equitable access to all social subgroups. In Greece, immigrants' access to the free-of-charge services of the public health care system depends on their employment status and the legality of their presence in the country.

##### **4.4.1. Documented immigrants' entitlement to health care**

According to Greek law, third country nationals legally residing and working in Greece are covered by social insurance organisations and have officially the same rights as Greek citizens in respect to health care and social security (Law No. 4251/2014, article 21). Accordingly, documented immigrants with employment and registered with a social security organisation can enjoy access to health services and products for free or

by paying only a percentage of the incurred costs. The social protection covers the individual immigrant employee and their dependent family members. The benefits emerging for the insured immigrants are the same as those of Greek citizens and include medical and pharmaceutical care, hospital care, sickness and accident benefits, maternity allowances and pension rights. The insurance agency which covers most of the immigrants is the *Social Insurance Institution – Unified Insurance Fund for Employees (IKA-ETAM)*, but also a significant number of immigrants are registered with the *Agricultural Insurances Organisation (ΟΓΑ)*.

#### **4.4.2. Undocumented immigrants' entitlement to health care**

The existing Greek legislative framework does not allow public services, public entities, local authorities, public utility agencies and social insurance organisations to provide their services to third country citizens who do not have a passport or any other travel document recognised by the international conventions, a visa or a residence permit and generally are not able to prove that they have entered and reside legally in Greece (Law No. 4251/2014, article 26). However, the law exempts hospitals, nursing homes and clinics from this prohibition, but only in cases of treating individuals with medical emergencies and minors. Furthermore, the public officials who violate these provisions can be prosecuted and punished for disciplinary misconduct (Law No. 4251/2014, article 26). Consequently, foreigners who are unable to prove they are legally resident in Greece – such as undocumented immigrants – are not entitled to non-emergency health care. They can be treated only in case of medical emergencies and only until their situation has been stabilised (Ministry of Health and Social Solidarity, 2005). These immigrants can thus be treated only in a hospital context and for a limited amount of time. The medical emergencies include pregnancy-related complications and delivery, but not prenatal care unless the pregnant woman is a minor. In cases where people have HIV/AIDS and/or other infectious diseases, the appropriate treatment is provided free of charge and a temporary stay permit is granted for the duration of the treatment (Law No. 2955/2001, article 11).

#### **4.4.3. Refugees and asylum seekers' entitlement to health care**

According to international and Greek national law (Legislative Decree No. 3989/1959), the Greek state is obliged to offer full access to public health care to lawfully-residing refugees and asylum seekers provided that they are uninsured and financially weak and

fall into one of the following categories (Presidential Decree No. 266/1999, article 15): (1) they are recognised by the competent authorities as refugees; (2) they have applied for refugee status recognition and their application is under examination by the Ministry of Citizen Protection; or (3) their stay permit has been approved for humanitarian reasons or a deadline has been defined and has not yet expired. However, this health care provision is different from the one which is offered to Greek citizens and other documented immigrants, since refugees and asylum seekers can enjoy access to health care only within the services of the National Health System (public hospitals, health centres and provincial surgeries) (Presidential Decree No. 266/1999, article 16). The Presidential Decree 266/1999 in conjunction with further legislative acts (Presidential Decrees 220/2007, 96/2008 and 114/2010) obviously recognised the vulnerability of refugees, asylum seekers and beneficiaries of international protection in general and provided for free medical and hospital care. This provision favours primarily the economically disadvantaged. However, in practice, no economic preconditions are imposed (Ministry of Health and Social Solidarity, 2012).

#### **4.4.4. Deficiencies in immigrants' right to health in Greece**

As argued above, the Greek state's policy regarding immigrants' entitlement to health care depends mainly on the legal status of immigrants. The main characteristic of this policy is that there is open access for all legal immigrants, including refugees and asylum seekers, as well as for minors regardless of documentation, while the undocumented adult immigrants are entitled only to emergency health care. Therefore, undocumented immigrants have unequal rights to health care access compared to the rest of the population. The strict existing legislation excludes illegal immigrants from health care facilities with possible detrimental consequences for both the health condition of these populations and wider, societal public health, especially in cases of communicable diseases.

The Greek Constitution includes two critical provisions on the right to health: the first one states that 'everyone has the right to the protection of his/her health and genetic identity' (Hellenic Parliament, 2010a: 22) and guarantees the individual right to health, and the second one secures the social right to health and provides that 'the State shall care for the health of citizens' (Hellenic Parliament, 2010b: 36). While, according to the interpretation of this provision, Greek citizens are the beneficiaries of the social right to health, the validity of this demand could be extended in order to include the

foreign population living in Greece (Dagtoglou, 2011). The current immigration law (Law No. 2910/2001, article 54) abolished a previously standing provision which obliged the directors of clinics and hospitals to inform the police or the immigration authorities as to the arrival and departure of illegal immigrants. The Hellenic Data Protection Authority had already opined that this provision was contrary to the Greek Constitution (Hellenic Data Protection Authority, 2001) because it violated the universal right to health and breached medical confidentiality.

The protection of the individual and public health by the state is a necessary condition for the realisation of the scope and the principle of respect for human beings (Papakonstantinou, 2005). Accordingly, the right to appropriate health care is one of the most important components of this principle and should not exclude immigrant patients whether they are legal or not. Restricted access to medical and pharmaceutical services and products on a regular basis can lead to the deterioration of health to such an extent that the case is considered as an emergency and justifies urgent treatment. This practice is not consistent with the obligation of the state to protect human dignity.

In a more general provision, the Greek Constitution states that ‘the respect and protection of the value of the human being constitute the primary obligations of the State’ (Hellenic Parliament, 2010c: 6). Therefore, foreigners residing illegally in the Greek territory cannot be excluded from the provision of necessary health care because this exclusion is opposed to the concept of human dignity which directly depends on the protection of one’s health. Therefore, if we consider that the Greek Constitution refers to the entirety of the population in the country – regardless of the legality or not of their presence – a conflict between Greek immigration law and the Greek constitution emerges. The fundamental social rights, particularly those related to health, have a direct impact on a persons’ quality of life regardless of the legality of their presence in the country (Katrougalos, 2008). Furthermore, according to Greek law for medical ethics ‘the physician must promote equal access to health services and...avoid discrimination which arises from educational, legal, economic, social and geographical differences’ (Law No. 3418/2005, article 11). Therefore, the obligation of medical doctors to deny care to undocumented immigrants is against their code of conduct.

The absence of preventive care, screening and early diagnosis can have detrimental effects on an individual’s health condition (see, for example, May, et al, 2011; Chadborn, et al, 2006; Virnig, et al, 2009; Sesso and Belasco, 1996; Arvanitakis, et al, 1992; and Farley and Flannery, 1989). In the case of the immigrant population in

Greece, the progress of a disease can lead to the mandatory regularisation of the seriously ill. This may burden the health system's operation because health services have to manage more serious cases than they would otherwise face if the health problems of immigrants were treated in an earlier, non-emergency way. Setting a higher threshold for the level of health care provision to illegal immigrants has been argued to be necessary because the economic and public health consequences from their exclusion can be detrimental (Sanchez, et al, 2011).

An additional problem caused by the existing legal framework derives from the fact that both the emergency health care and the stabilisation of a patient's health condition are concepts that cannot be clearly defined from a medical point of view. As such, the cases covered by the specific provision cannot be accurately determined, leading health professionals to address undocumented immigrant patients in an inconsistent way in practice (Greek National Commission for Human Rights, 2007a). A practical definition of emergency care is health care which is provided after the appearance of new or the worsening of already existing symptoms and includes: (1) immediate care which is necessary within a few hours in order to avoid severe consequences for the patient's health; and (2) care which requires a chronologically proximate use of the technical equipment of a hospital for diagnostic or therapeutic purposes (Lang, et al, 1996). The level of health care which is necessary for the stabilisation of a patient's health could include the provision of the necessary medical treatment in order to assure, within reasonable medical probability, that no material deterioration of the patient's condition is likely to appear in the near future (Black, 2006). However, the clinical factors that determine the potential for a severe risk for health condition and the progress of health recovery may be unclear and difficult to predict without reasonable medical doubt.

An important objection to the provisions of immigration law was expressed by the Greek National Commission for Human Rights (2007b). The Commission proposed the modification of the legislation which concerns the change of eligibility for access to health services of undocumented immigrants on the basis of the Greek Constitution's provisions and the internationally declared documents on human rights. Firstly, the Commission proposed the removal of the law's section which forbids the provision of routine non-emergency health services to immigrants without legal documents. Secondly, it argued that the provision of emergency medical care to undocumented immigrants should be extended to cover treatment after the stabilisation of the condition

of one's health until the most attainable rehabilitation. Thirdly, the Commission suggested that access by immigrants to health care should be widened to include preventive medical procedures and underlined that pregnant women should be fully covered during pregnancy, childbirth and the postpartum period (Greek National Commission for Human Rights, 2007b). However, the role of the National Commission for Human Rights is only advisory and its recommendations are not binding on the state. As of 2018, the Greek state has still not adopted these proposals.

#### **4.5. Immigrants Utilisation of Health Services in Greece**

The utilisation of health services by immigrants in Greece has not been sufficiently examined and the relevant literature is scarce. In a study by Galanis and colleagues (2013), the majority of participants (self-declared documented immigrants) reported that they had great difficulties in accessing health services and consequently had unmet needs for care. The most important reasons included the high costs of health care, long waiting times in hospitals, lack of free time, difficulties in verbal communication with health professionals and the system's complexity. Moreover, most of the respondents reported that they were dissatisfied with the services they did receive.

There is some evidence indicating that the indigenous population seems to be more likely to visit the public primary care services, while Albanians, the largest group of immigrants in the country, are more likely to visit the hospitals' emergency departments (Lahana, et al, 2011). There may be various explanations for this: it is possible that immigrants prefer to attend hospitals' emergency departments because of their lack of social insurance, which makes it difficult to access primary care (ibid.). In addition, as already noted, undocumented immigrants are not entitled to use routine medical care services for non-emergency situations (ibid.). Furthermore, there may be a lack of knowledge about the structure and operation of the national health system among immigrants, especially the newly arrived, and this could lead to a disproportionate preference for emergency care services (ibid.). Another proposed explanation was that these populations belong to younger age groups and thus they are less likely to use health services due to chronic illnesses, while they may visit hospital services mainly when faced with emergency incidents (ibid.). In addition, immigrants in Greece are mostly employed in manual occupations, which can be rather hazardous and thus they are more prone to accidents and subsequent submissions to hospital emergency departments (ibid.).

These conclusions are supported by Tsitsakis and colleagues (2017) who found that the hospitalisation rate of immigrant patients due to chronic medical conditions is significantly lower compared to non-immigrant patients. The authors attributed this finding mainly to the younger age distribution of the immigrant population. However, the opposite was found to be true regarding accident-related cases. The difference in these admissions was largely explained by injuries in the workplace due to the hazardous nature of work entrusted to immigrants and the inadequate safety measures taken by their employers. Higher hospitalisation rates among immigrants were also found for infectious diseases and medical conditions pertaining to depression and alcohol abuse (ibid.). The comparisons of the average length of stay showed no overall differences between immigrants and non-immigrants and the authors considered this finding to be indicative of equal access to health care (ibid.).

With respect to the utilisation of preventive care services, immigrant women in Greece were found by Simou and colleagues (2011) to be less likely to use breast and cervical cancer preventive services – such as the performance of Pap smear tests and mammography – either ever or on a recommended timeframe compared to Greek women. The limited access by immigrants to medical care because of their low socio-economic status or the lack of health insurance was suggested by authors as possible reasons for this. A further provided explanation may be the inability of some immigrant women to communicate properly with health care providers or to navigate in the Greek health system because of language barriers (ibid.). Moreover, research suggests that pregnant women of non-Greek nationality are more likely to have inadequate knowledge about prenatal diagnostic procedures compared to Greeks (Kitsiou-Tzeli, et al, 2010).

#### **4.6. Conclusions**

The provision of broad social insurance and health care to the population, including immigrants, is widely recognised to be an essential feature of a democratic society because it promotes health equity, thus protecting social groups from disease and disability and enabling individuals to participate in all aspects of social life (Daniels, 2001). As previously explained in *Chapter 3*, undocumented, unemployed and/or poor immigrants constitute a vulnerable group in society. Facilitating access to social support, including social insurance and health care, for immigrants is compromised due to a variety of systemic factors, such as social marginalisation of these populations,

political imposition of funding cuts and the limited capacity of the host society (Simich, et al, 2005). There is a strong relationship between employment and health care access in countries with social insurance-based systems. Therefore, adequate health care coverage for immigrants can be achieved by strengthening health services and by creating occupational opportunities for the immigrant population.

Due to the current economic crisis and the political instability in Europe's neighbouring countries, the issue of immigrants' health care is becoming increasingly topical, especially in immigrant-receiving countries such as Greece. In many countries, immigrants tend to face obstacles in using the available health services. Nevertheless, some immigrant groups are potentially more vulnerable to accidents, ill health and diseases, mainly due to their socio-economic disadvantaged status, their limited access to health care and the lack of knowledge about access to appropriate services. Health professionals can play an important role in improving access to needed health care for socially marginalised immigrants by helping society understand the importance and widespread benefit of universal health care coverage and advocating for health policies and programmes that serve vulnerable populations (American College of Obstetricians and Gynecologists, 2015). For this reason, the next chapter explores the existing research on the views of providing care to immigrant groups amongst health professionals in Europe.

## Chapter 5

### Health Professionals' Perspectives on the Provision of Health Care to Immigrants: A Literature Review

#### 5.1. Introduction

As explained in the previous chapters, in recent years immigration has risen markedly in the EU and the southern European countries in particular. The increasing numbers of immigrants in health services creates unprecedented occupational conditions for health workers. Health professionals across Europe face the challenge of providing the best possible care to a large population of immigrant patients on a daily basis against the backdrop of reducing public expenditure in health care. Nevertheless, the investigation of this situation from the health professionals' point of view is currently quite limited on an international scale. This chapter includes a review of the emerging literature which has explored the views and experiences of health professionals on caring for immigrants in Europe and looks at the challenges and barriers that health personnel may face in clinical practice with immigrants.

In this thesis, the findings (presented in *Chapters 8-11* and discussed in *Chapter 12*) need also to be compared with existing literature which is related to the research topic. A literature review provides the readers with an overview of the currently established knowledge in the relevant field. This chapter does not simply summarize prior research but critically evaluates the relevant studies and then identifies the gaps in knowledge which then frames the basis for this study. It should be noted that the conclusions from the literature review contributed to the formation of the topic guide that was used in the interviews.

The literature reviewed was retrieved from a systematic search of *Medline*, *Web of Science* and *Google Scholar* using the terms 'health professionals', 'health care', 'immigrants' and 'migrants' (see Table 5.1 below):

*Table 5.1: Use of Terms for the Systematic Literature Search*

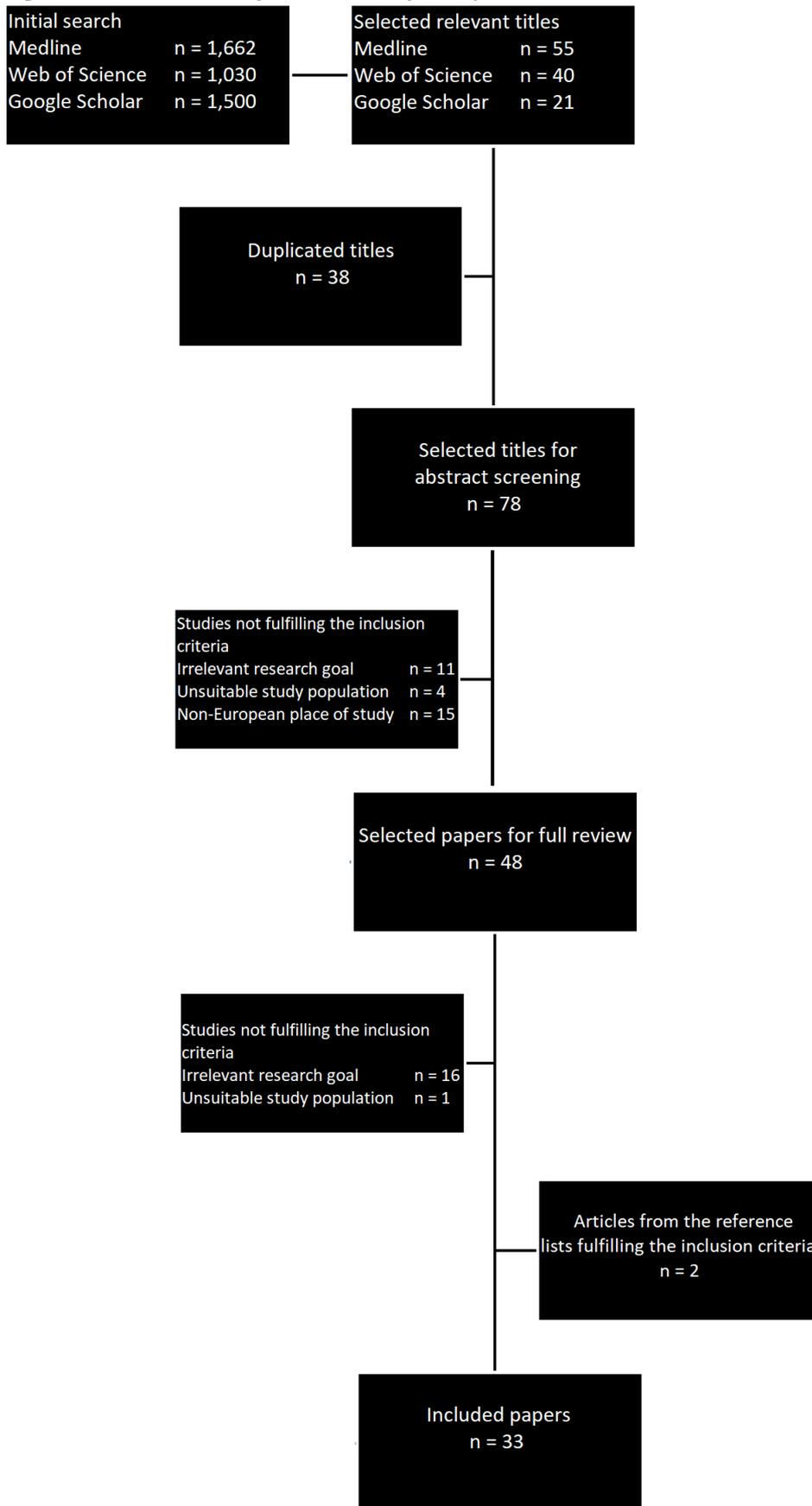
<b>MEDLINE</b>
((("health personnel"[MeSH Terms] OR ("health"[All Fields] AND "personnel"[All Fields]) OR "health personnel"[All Fields] OR ("health"[All Fields] AND "professionals"[All Fields]) OR "health professionals"[All Fields]) AND ("delivery of health care"[MeSH Terms] OR ("delivery"[All Fields] AND "health"[All Fields] AND "care"[All Fields]) OR "delivery of health care"[All Fields] OR ("health"[All Fields] AND "care"[All Fields]) OR "health care"[All Fields])) AND (("emigrants and immigrants"[MeSH Terms] OR ("emigrants"[All Fields] AND "immigrants"[All Fields]) OR "emigrants and immigrants"[All Fields] OR "immigrants"[All Fields]) OR ("transients and migrants"[MeSH Terms] OR ("transients"[All Fields] AND "migrants"[All Fields]) OR "transients and migrants"[All Fields] OR "migrants"[All Fields]))
<b>Database:</b> PubMed
<b>WEB OF SCIENCE</b>
<b>TOPIC:</b> (health professionals) AND <b>TOPIC:</b> (health care) AND <b>TOPIC:</b> (immigrants OR migrants)
<b>Indexes:</b> SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, ESCI.
<b>GOOGLE SCHOLAR</b>
health professionals health care immigrants OR migrants

The titles of the retrieved records were checked for duplication and their abstracts were reviewed. After the relevant abstracts were selected, and judged according to the inclusion criteria below, the respective full articles were examined. The same procedure was followed for the articles in the reference lists of every included article. The inclusion criteria were as follows: (1) authors' aim to investigate experiences and views of delivering care to immigrants without suggesting predefined issues or problems to address; (2) health professionals as the study population; (3) adult international immigrants, regardless of their legal status, ethnic identity and country of origin, as the recipients of care; (4) studies conducted in Europe; and (5) publication up to 2017 (no studies published before 2001 were discovered which indicates that this is a recently developed field of research). For operational purposes, 'health professionals' were defined as persons engaging in direct provision of health care to patients in organised health services, such as hospitals, primary care units and community clinics (Suphanchaimat, et al, 2015).

This review focused on studies conducted in European countries for several reasons. Firstly, most of the European countries have non-profit health systems which are funded from taxation or social insurance in contrast with privately-funded health systems. They aim to provide a patient-centred standard of practice demonstrating a respect for the patient's needs and preferences and considering his/hers circumstances and potentials in decision-making without prioritizing the gain of economic benefit from the provision of care (Rogers, et al, 2005 and Ponte, et al, 2003). In addition, as these systems are publicly funded, they are more likely to be the services that immigrants will try to access. Therefore, the findings of European studies are more feasibly transferable within European health services. Secondly, the geographical and political context of Europe relates to special immigration moves and trends. The collapse of communist regimes and the opening of borders across Eastern Europe led to inflows of immigrants into Western European countries. Furthermore, the unification of the European market eased intra-EU movements (Van Mol and de Valk, 2016 and Salt and Almeida, 2006). In addition, rising numbers of immigrants have arrived in Europe from the relatively proximal areas of the Middle East and Africa over the last few years because of civil wars and economic stagnation (Marozzi, 2016). These factors create an additional context for research. Finally, this review did not examine studies that referred to the paediatric population. The aim of the review was to investigate views and experiences deriving from health workers' direct interaction with patients. Often in paediatric care, these interactions are mediated through patients' parents (Cahill and Papageorgiou, 2007). As such, it was considered that the exploration of the provision of health care to immigrant children was beyond the scope of this particular review.

The initial search retrieved 1,662 titles from *Medline* and 1,030 titles from *Web of Science*, whereas only the first 1,500 titles from *Google Scholar* were examined (the relevance of the titles had already diverged significantly by that point anyway). A total of 116 titles – 55 from *Medline*, 40 from *Web of Science* and 21 from *Google Scholar* – were selected from the initial large pool based on assessment of relevance from titles. After dropping 38 duplicated titles, 78 abstracts were reviewed. Another 30 articles were excluded either for not meeting the inclusion criteria listed above. A total of 48 papers were fully reviewed. Of these, 31 studies were found to be relevant. An additional two papers retrieved from the reference lists of the selected articles were also judged as fulfilling the inclusion criteria. In sum, 33 papers were included in the review. Figure 5.1 below shows the flow chart of the systematic review process:

Figure 5.1: Flow Chart of the Process of the Systematic Literature Search



The retrieved published material included a variety of studies in terms of the applied methods, populations of reference, social context and study area. Firstly, the research methods consisted of quantitative or qualitative approaches with various numbers of participants and response rates. An overview of the methods used in the reviewed studies for data collection is presented below in Table 5.2. Secondly, the assessed articles referred to various study populations consisting of a wide range of health professionals, while the immigrant population of reference was often different (for example, immigrants in general, immigrants from specific regions of the world, undocumented immigrants, refugees and asylum seekers). Thirdly, the research was conducted across different kinds of health systems, types of health care, legal aspects of entitlement and immigration policies. For those reasons, the findings deriving from these studies are not directly comparable. Nevertheless, they can provide some insights into the types of difficulties that health professionals face in providing care to immigrant patients:

*Table 5.2: Type of Research Method Used in the Reviewed Studies for Data Collection about Health Professionals' Perspectives and Experiences in Relation to the Provision of Health Care to Immigrants in Europe*

<b>Method of data collection</b>	<b>Number</b>
Qualitative	
Individual interviews	15
Focus groups	5
Mixed qualitative	
Individual interviews and focus groups	6
Individual interviews and observation	1
Quantitative	
Questionnaire	5
Mixed qualitative/quantitative	
Questionnaire and focus groups	1

Unsurprisingly given the research topic, the reviewed papers mainly consisted of qualitative studies. A detailed presentation of the reviewed articles – authors, study time period, method, study population, clinical setting and geographical region – is provided in the *Appendix* (see Tables A.1-A.7). For the purpose of this review, a thematic analysis of the findings from the qualitative studies was conducted (see Table 5.3 below). After

repetitive reading of the articles, a series of concepts were captured and coded to construct a framework of descriptive themes. Afterwards, relations between initial themes were investigated and higher-level analytical themes were produced. Finally, the synthesised themes were formed and reported (Thomas and Harden, 2008). The conclusions of the quantitative studies are also discussed:

*Table 5.3: Steps Followed for Reviewing the Selected Qualitative Studies*

<b>Step 1:</b> Repetitive reading of the articles
<b>Step 2:</b> Identification of concepts and themes
<b>Step 3:</b> Exploration and determination of relations between themes
<b>Step 4:</b> Synthesis of themes
<b>Step 5:</b> Report of the outcome

Most of the reviewed studies were qualitative and exploratory in focus aiming to gain an understanding of the underlying reasons, motivations and explanations for the difficulties in providing health care to immigrants experienced by health professionals. There were a smaller number of studies that aimed to describe and quantify attitudes, views and behaviours of health professionals providing care to immigrants. Qualitative and quantitative studies were reviewed separately. This review was interested in looking at both – quantitative and qualitative – methodological ways of exploring the field. The quantitative approach has the potential to reveal what type of attitudes exist and how common they are in each context, while qualitative approaches have the potential to identify what is known about the meanings and the aetiology of the phenomena. It is for this reason that the two bodies of work were analysed and reported separately. In addition, it was decided that the separate synthesis of qualitative or quantitative would better facilitate the process of drawing conclusions due to common epistemological foundations (Dixon-Woods, et al, 2005). The findings of the qualitative and quantitative studies are brought together in the final section of this chapter.

## **5.2. Quality Appraisal of the Reviewed Studies**

The expression of some views by research participants towards immigration issues is a sensitive topic from a political and social perspective. This may affect research quality in several ways. Firstly, participants' responses to this issue may be influenced by social desirability bias, whereby respondents answer questions in a manner that is considered

acceptable (Janus, 2010). Secondly, professionals with more negative perspectives towards immigrants may be more likely to avoid participation. On the other hand, those with strongly negative feelings may wish to express their frustration and therefore be more likely to agree to participate in research. In other words, selection bias may have operated in diverse ways in the reviewed studies, especially in the ones using qualitative research approaches because of the personal interaction between researchers and participants.

The health professionals included in the reviewed studies were mostly selected from areas with high proportions of immigrant populations. Therefore, they are likely to have been exposed to frequent clinical contacts with immigrant patients. This situation has a possible dual impact on how health workers viewed the provision of services to these population groups. On one hand, frequent exposure to a vulnerable group of patients with serious needs may have led to stronger feelings of sympathy, reduced stereotypes and conflicts and promoted understanding and cooperative relations. But on the other, constant contact with immigrant patients under severe stressful circumstances may have also sparked negative feelings and increased tension. Hudelson and colleagues (2010) suggested that because of the inherent difficulties in providing health care, it seems unlikely that frequent contact with immigrant patients alone is enough to encourage positive attitudes. Unfortunately, it was not possible to identify such processes operating in individual studies during the review and, as such, this was not explored in the synthesis of the reviewed findings.

This review sought a broad description of the perceptions, attitudes and experiences of health professionals in relation to the provision of care for international immigrants. A qualitative research approach is the most appropriate design for understanding such issues in the context of health care (Pope, et al, 2002) because it generates knowledge about issues that matter from an individual's perspective (Morse, 2015 and Pope and Mays, 2009). However, quantitative studies can be important in this field because they provide an element of objectivity by quantifying the social conditions of the issues that matter (Yilmaz, 2013).

Even though qualitative research is not a unified field regarding its methodological approach, its conduct should be guided by certain essential principles (Kneebone and Fry, 2010). Indeed, it should be ethical, be of importance, have a clear and coherent articulation and use appropriate and rigorous methods (Cohen and Crabtree, 2008). Research is considered important when its results are pragmatically

and/or theoretically useful and advance current knowledge. The clarity and coherence of the research report are achieved through a clear description of the research question, the contextual conditions, the study design and the emerging findings. Finally, the description of the data should not be exaggerated and the relationship between results and conclusions should be understandable (Cohen and Crabtree, 2008).

Qualitative studies handle non-numerical information and phenomenological interpretations which are inextricably connected to human senses and subjectivity. However, they should be in a position to be submitted to a procedure of scrutiny which could assure their methodological rigour. Dixon-Woods and colleagues (2004) suggest that the process of evaluation for qualitative research can be best formulated as prompts which can sensitise appraisers to the various dimensions of the studies. These prompts avoid commitments to particular methodological approaches and have distinguished aspects between reporting, study design and execution (see Table 5.4 below):

*Table 5.4: Prompts for Appraising Qualitative Research*

Are the research questions clear?
Are the research questions suited to qualitative inquiry?
Are the following clearly described? – sampling – data collection – analysis
Are the following appropriate to the research question? – sampling – data collection – analysis
Are the claims made supported by sufficient evidence?
Are the data, interpretations and conclusions clearly integrated?
Does the paper make a useful contribution?

*Source: Dixon-Woods, et al, 2004.*

Popay (2003) argues that there is a set of ‘technical’ criteria for assessing quality, which are common to all research whether qualitative or quantitative (see Table 5.5 below), but more importantly she identifies a primary epistemological marker tailored to the collection, analysis and interpretation of data which ascertains whether the research has illuminated or not the investigated meanings, actions and contexts.

Although the contents of the above suggestions cannot have a solid and universal application to qualitative studies, they were used by the researcher to appraise the reviewed studies:

*Table 5.5: Common Technical Criteria for Assessing Quality*

Method appropriate to research question
An explicit link to theory
Clearly stated aims and objectives
A clear description of context
A clear description of sample
A clear description of fieldwork methods
Some validation of data analysis
Inclusion of sufficient data to support interpretation

*Source: Popay (2003)*

The quality of the reviewed articles was assessed using the aforementioned criteria. It should be noted that the quality assessment did not aim to eliminate articles. Instead, it was used to evaluate the methods and findings and thus the value of each study. The appraisal found that the selected studies varied substantially. Although all the qualitative studies clearly specified the research aims and the methods used, only half of them (14 out of 28) were judged to have justified why such research designs were employed. All the studies described the sampling strategy but usually did not provide sufficient rationale for participants' selection. Furthermore, the extent of information on respondents' personal characteristics – except their professional role – was limited (only in 8 studies). The data collection method was stated in all studies, but only a few (6 of them) were considered to have given justification for that selection.

Most importantly, the assessed articles appeared to suffer from a lack of engagement with underlying theory associated with the research topic. Most of the reviewed qualitative studies presented description-focused depictions of their findings without a rigorous critical analysis. Indeed, the emerging categories were usually not linked to social theory which demotes the usefulness of their evidence. Although all the qualitative research articles included some kind of data analysis, the majority of them were found not to visibly employ any theoretical framework with regard to research background and the interpretation of data. Only three studies – Papadakaki, et al (2017), Nkulu Kalengayi, et al (2012) and Hultsjö and Hjelm (2005) – were clearly engaged

with theory, describing an underlying conceptual framework and linking its results with it. Another two studies – Akhavan (2012) and Høye and Severinsson (2008) – mentioned the existence of relevant theory but failed to incorporate it in the discussion of their findings. The rest of the studies were limited to the description of views and experiences among certain groups of health professionals concerning a specific topic about immigrants' care. Their results were reported as emerging themes, the produced data were related to existing literature and further implications were mentioned. However, a lack of rigor with regard to the interpretation of findings was obvious and was caused by the absence of a thorough theoretical framework which could serve as a basis for the development of new knowledge.

Another common quality issue of the reviewed studies was the failure to consider the issue of reflexivity at any stage of the research process (at either the formulation of research question, sampling, and/or data collection and analysis) and to critically examine the extent of potential bias or influence on the findings from the role and experience of the researchers. As researchers were engaged in studies on sensitive and politicised issues about immigration, a polarising effect may have appeared. The nature of the topic can lead both researchers and participants to take sides and, in such cases, it has been suggested that the relationship between, and influence of, the researcher and participants should be made explicit (Jootun, et al, 2009). However, only five studies raised issues of reflexivity and how these were managed during the research process (Akhavan, 2012; Boerleider, et al, 2013; Flye Sainte Marie, et al, 2015; Nkulu Kalengayi, et al, 2012; and Wachtler, et al, 2006).

Regarding the quantitative studies, their findings vary widely regarding health professionals' attitude towards immigrants for many reasons. The positive attitudes towards immigrant patients may be partially attributed to national policy efforts for the promotion of immigrants' integration. On the other hand, the neutral responses of health workers are possibly due to the hesitation in answering questions on issues about immigration policy and prevention of discrimination because these are currently major political and social concerns. The negative views may be a reflection of the negative attitudes of the general population towards immigrants. Therefore, there is a possibility that social desirability biased participants' responses, although the anonymity of the informants seemed to be preserved.

### **5.3. Health Professionals' Views of Providing Care to Immigrants: Qualitative Studies**

The two main themes identified in the analysis of the reviewed qualitative studies were: (1) health professionals' perceptions of the difficulties in their provision of care to immigrants; and (2) measures proposed by health staff to improve immigrants' care.

#### **5.3.1. Professionals' perceived difficulties in providing care to immigrants**

Caring for immigrants was a common duty in daily clinical practice for the study populations in the reviewed papers. The provision of services to immigrant populations was found to pose a series of problems for health personnel. These difficulties can be categorised into four main themes: (i) barriers in communication between health professionals and immigrants; (ii) problems deriving from immigrants' characteristics and their use of services; (iii) the health system's operational and structural failures; and (iv) health personnel's subjective concerns and misconceptions. The reported importance of each problematic situation was different across the various studies. The four themes and their sub-themes are presented below in Table 5.6. Most problems were common across the European countries, were raised by staff in all types of services (primary, in-patient and emergency care) and were not necessarily linked to the origin of immigrants. However, professionals in primary care services more often mentioned difficulties in arranging further care, health workers in community mental health services put more emphasis on the social stresses for immigrants and staff in acute and emergency departments focused mainly on problems arising from different cultural norms:

Table 5.6: Problems Regarding the Provision of Care to Immigrants According to Health Professionals in European Studies

<b>Problematic area</b>
<b>i. Communication barriers between health professionals and immigrants</b>
<b>ii. Immigrants' characteristics</b>
iia. Lack of entitlement to health coverage for undocumented immigrants
iib. Health professionals' responses to distinct cultural features of immigrant groups
iic. Social and economic disadvantages of immigrants
iid. Perceptions of inappropriate use of health services by immigrants
iie. Difficulty in monitoring and contacting immigrant patients
<b>iii. Failures in the health system's operation and structure</b>
iiia. Deficiencies in health services' operation
iiib. Inadequate training of health professionals
<b>iv. Health professionals' personal concerns and misconceptions</b>

*(i) Communication barriers between professionals and immigrants:* Communication problems in clinical encounters were a common issue identified in the reviewed studies for both health professionals and immigrants themselves. The greatest barrier was the lack of sufficient knowledge of the spoken language(s) in the host country by immigrant patients (Jirwe, et al, 2010, and Hultsjö and Hjelm, 2005), especially among newly arrived persons (Lindenmeyer, et al, 2016, and Terraza-Núñez, et al, 2011). Health professionals stated that they often tried to fill the language gap with sign, body language and facial expressions (Lyberg, et al, 2012, and Hultsjö and Hjelm, 2005). It was suggested that even when staff and immigrant patients speak the same language, misunderstandings are possible because of dissimilarities in verbal and non-verbal behaviours or because the level of the language fluency of immigrants may not allow them to fully understand the provided information (Høye and Severinsson, 2008). Interestingly, Lindenmeyer and colleagues (2016) found that a shared language was also perceived as problematic, blurring boundaries and perhaps enabling stronger demands to be made, because of an assumed social bond between patients and staff.

Furthermore, health professionals reported that low educational levels and high illiteracy rates among some immigrants can limit their ability to use written materials, such as letters and leaflets, and distant technology, such as telephone calls, e-mails and e-health information (Boerleider, et al, 2013; Nkulu Kalengayi, et al, 2012; and Terraza-Núñez, et al, 2011). Communication was also reported to be influenced by health

workers' ability to understand the health values, beliefs and behaviours of immigrant patients. In Wachtler and colleagues' study (2006), doctors felt that the level of mutual understanding can be affected by discrepancies between the expectations of the two parties, differences in understanding the problem and communication obstacles due to variations in cultural identity, educational level, gender, age, social class and urban or rural upbringing. In Meeuwesen and colleagues' study (2006), doctors invested more in trying to understand immigrant patients, while in the case of non-migrant patients they showed more involvement and empathy. In a later study (Jirwe, et al, 2010), nurses believed that normal social interactions with immigrant patients were missing and, as a result, the provision of care becomes mechanistic and impersonal.

In some studies, health professionals felt that clinical practice was complicated by miscommunication leading to misunderstandings between the health staff and patients which could result in incorrect assessments, misdiagnoses, inappropriate treatment and poor compliance (Priebe, et al, 2011; Jensen, et al, 2011; Jirwe, et al, 2010; and Walchter, et al, 2006). In Dauvrin and colleagues' study (2012), acute care staff emphasised language barriers in the process of reaching a diagnosis, whilst primary care and mental health professionals reported broader communication difficulties. In the study by Tesfaye and Day (2015), respondents claimed that the lack of printed information in immigrants' languages can impede the promotion of healthy lifestyles. Extensive physical examinations and an excessive number of diagnostic tests were reported to be required to compensate for deficient verbal communication, while administrative procedures were also reported as prolonged and more complicated elsewhere (Priebe, et al, 2011). However, participants in Akhavan' study (2012) felt that the available time for a meeting was often very limited and health professionals were unable to achieve an effective consultation in the specified slot.

The verbal gap can be potentially covered with the mediation of professional interpreters. However, health professionals suggested that the limited use of official translation services often results from pragmatic reasons, such as the lack of interpreters with proficiency in a particular language, demand for an interpreter of a certain gender or ethnicity, financial restrictions in hiring translating personnel and organisational difficulties in the availability of interpreters and access to the interpretation services (Dauvrin, et al, 2012; Jirwe, et al, 2010; Kurth, et al, 2010; and Hultsjö and Hjelm, 2005). In Jirwe and colleagues' study (2010), nurses stressed that doctors have easier access to accredited interpreters compared to them. The call for interpreters at short

notice is seen by some health staff as impossible (Worth, et al, 2009), while Kurth and colleagues (2010) found that interpreters were often not available even in pre-booked follow-up appointments.

Some health professionals felt that the mediation of a professional interpreter is not an optimal solution to communication difficulties because it compromises the patient-practitioner relationship and has a possible impact on confidentiality in sensitive cases, especially when the interpreter is from the patient's own community (Priebe, et al, 2011). In fact, some immigrants reportedly refused the mediation of an interpreter (especially when he/she is known to them through their community) and may prefer a family member or friend to translate (Tesfaye and Day, 2015). The caregivers were also concerned about inaccurate translations, patient discomfort, unprofessional interpreters and an inability to prevent friends and relatives from interpreting (Nkulu Kalengayi, et al, 2012). Because of civil conflicts in many of the immigrants' countries of origin, the ethnicity of both the patient and the interpreter was also reported as an issue in obtaining suitable interpreters (Drennan and Joseph, 2005). Particularly for psychiatric diagnosis, health professionals noted that indirect communication with the patient through an interpreter made the severity of symptoms difficult to judge (Sandhu, et al, 2013).

According to health professionals, the absence of, or the restrictions in, the official interpretation services may result in the use of a patient's relative, friend or neighbour, especially when a quick solution is needed. Although health professionals may positively judge this solution (Jirwe, et al, 2010), it can be especially problematic in some cases because respondents felt that family members and friends often tend to be selective in translation, or summarise or censor the communication (Priebe, et al, 2011; Høye and Severinsson, 2008; and Hultsjö and Hjelm, 2005), mainly because they do not want to cause distress to their relative in case of a grave prognosis or therapy or they may find the message embarrassing, particularly if it is related to personal aspects of care. Furthermore, although relatives may be able to converse in normal social situations, they may not have sufficient grasp of the local language to translate complex medical concepts according to health professionals (Jirwe, et al, 2010). In Nkulu Kalengayi and colleagues' study (2012), participants suggested that the mediation of a friend or relative may result in the accidental disclosure of stigmatisable conditions, such as a positive HIV status. Moreover, some patients may not wish their relative to know the full details of their condition according to informants in the study by Jirwe and colleagues (2010). In Hawthorne and colleagues' study (2003), most informants

agreed that using third persons to communicate is mostly acceptable for administrative tasks, but it is often also applied for passing on clinical information because of the lack of alternative solutions.

Other practical solutions used to facilitate communication include the intervention of a bilingual employee, the use of non-verbal communication and the reliance on tapes, pictures or artefacts (Jensen, et al, 2011; Jirwe, et al, 2010; Høye and Severinsson, 2008; Hawthorne, et al, 2003; and Cioffi, 2003). Communication was reported to be a complex process that consisted of more than just a linguistic component to also require the interpretation of speech, tone, facial expressions, body language, gestures and assumptions shared between those involved about the context and purpose of the exchange (Jirwe, et al, 2010). Language barriers were reported to create uncertainty among health professionals and exacerbate their feelings of stress, anger and helplessness (Hawthorne, et al, 2003) and to cause emotions of compromise and/or failure in clinical practice (Boerleider, et al, 2013; Terraza-Núñez, et al, 2011; Fuertes Goñi, et al, 2010; and Wachtler, et al, 2006).

**(iia) Lack of entitlement to health coverage for undocumented immigrants:** Another common theme in the reviewed studies was associated with the provision of care to patients with no legal entitlements to non-emergency health services. In a Spanish study (Ramos, et al, 2001), health professionals noted that care of immigrants in health services is not uniform in practice. Some centres voluntarily provided care to all immigrant patients regardless of their legal status, while in other centres the provision of care to undocumented persons was denied as the law demands. In a Danish study (Jensen, et al, 2011), doctors from emergency departments expressed the view that the medical treatment offered to undocumented immigrants is not different from the provision of care to any other person, although doctors of non-emergency care reported that undocumented immigrants often face administrative barriers accessing primary care because of a lack of health insurance. In a more international study by Priebe and colleagues (2011), respondents reported that they would first treat patients and then – possibly – consider issues of entitlement and insurance.

In England (Tesfaye and Day, 2015), participants reported that the lack of documentation can be an obstacle even for registration in primary care services. In Dauvrin and colleagues' international study (2012), although professionals in acute and emergency departments stated that they provided the same treatment pathways for the

official population and undocumented immigrants, primary care and mental health personnel experienced more difficulties in performing further diagnostic and therapeutic interventions due to the legally restricted access of undocumented patients to health services. In the same study, some professionals – especially in primary care – reported transferring patients between services or delaying treatment until legal issues were resolved. In addition, some professionals reported referring undocumented immigrants to other health services with better human or material resources, while others suggested that they would consider transferring patients, even if they were allowed to care for them or had the required funds to do so, to avoid the burden of illegal immigrants in their environment. Non-governmental organisations were quoted as potential referral agencies (Dauvrin, et al, 2012).

Some health professionals stated that significant problems arise from their limited knowledge of the legal guidelines, difficulties in interpreting immigration law in regard to health care and the restricted access for undocumented immigrants to laboratory tests, referrals to specialists and prescribed medication (Dauvrin, et al, 2012 and Ramos, et al, 2001). Some professionals reported attempting to circumnavigate the official barriers by submitting samples in their own name, prescribing cheaper medication, personally contacting specialists or registering the patient in an alternative way (such as providing fake social security numbers) (Priebe, et al, 2011 and Jensen, et al, 2011). In many cases, the provision of necessary services to undocumented immigrants was reported to be feasible only after the intervention of non-governmental organisations or the mediation of social workers (Ramos, et al, 2001). In some studies, health practitioners believed that undocumented immigrants have to settle for less than would be the case of a native-born patient and that treatment to some extent is based on assumptions due to diagnostic uncertainty deriving from the lack of access to laboratory tests and specialised care (Priebe, et al, 2011 and Jensen, et al, 2011). Regarding the financial aspects of the provision of care, Jensen and colleagues (2011) discovered that primary care doctors stated that they usually provide their services to undocumented immigrants free of charge but also suggested that problems arise when finances outside their own practice are involved, such as the use of external diagnostic facilities or the payment of prescriptions.

In that study (*ibid.*), considerable frustration was reported by health professionals who were continuously obliged to work around the system in order to provide care to immigrants with no entitlement rights, while in Kurth and colleagues' study (2010) in

Switzerland, informants stated that caring for immigrants within the limits of the law may conflict with ethical principles to treat all patients equally. In both studies of Dauvrin and colleagues (2012) and Jensen and colleagues (2011), most respondents stated that they would not report an undocumented immigrant patient to the police or other authorities as they expressed the belief that health care is independent from the legal status of the patient. However, some doctors mentioned special circumstances in which they would consider calling the police, such as the involvement of a patient in a crime, the presence of danger for himself/herself or other people's lives and the need for identification of a patient (ibid.). A Swedish study (Hultsjö and Hjelm, 2005) found that informants perceived problems related to asylum seekers, especially when they are refused a residency permit or they receive a deportation order. In this study, some health professionals working in emergency care suggested that a malingering behaviour or deliberate efforts to damage their own health (for example, medication overdose) was taken in order to obtain a favourable decision regarding their legal status. Kurth and colleagues (2010) described a psychologically-stressful triple role for doctors due to potential conflicts deriving from the requirement for them to: (1) provide patient care; (2) provide valid health certificates for the immigration authorities; and (3) properly secure and allocate funding resources.

It is reasonable to assume that difficulties in treating undocumented immigrants depend on the type of health system in the host country and the permissible access of these patients to health services. However, the limited number of reviewed studies does not allow for clear conclusions about the existence of patterns of difficulties among the various European countries.

***(iib) Health professionals' responses to distinct cultural features of immigrant groups:*** Certain difficulties in delivering health care to immigrants were reported by health staff to be associated with the perceived distinct cultural characteristics of specific immigrant populations. Some health professionals felt that views of the causes and treatment of various illnesses may differ between cultures and thus can cause differences in the utilisation of health services and in treatment expectations (Hjelm, et al, 2009 and Høye and Severinsson, 2008). Terraza-Núñez and colleagues (2011) found that immigrants were perceived by health workers to be less adherent to medical advice, which in turn was felt to lead to a low uptake of preventive care, a high prevalence of folk medicine, unhealthy habits and a limited adoption of hygienic behaviours.

Additionally, some health professionals suggested that differences in cultural norms, religious practices and customs often complicate examination and treatment, increase the sense of overload and create practical problems, such as inappropriate appointment attendance patterns (Priebe, et al, 2011 and Fuertes Goñi, et al, 2010). Limited knowledge about different cultures sometimes causes difficulties for health staff when being confronted with diverse cultural traditions and ceremonies, as suggested by some informants in the study by Hultsjö and Hjelm (2005). Other work revealed that the influence of cultural differences extends beyond the clinician-patient relationship to interactions with the patient's family members (Sandhu, et al, 2013; Wachtler, et al, 2006; and Hawthorne, et al, 2003). Jirwe and colleagues (2010) found that anxiety among health professionals is greatest when encountering a completely unknown situation, such as meeting a patient from a country they have not come across before or facing behaviours they have not previously observed. In the study by Worth and colleagues (2009), practitioners seemed anxious about being culturally inappropriate, causing affront or appearing culturally insensitive.

According to some informants, specific gender roles among immigrants can be problematic as they impede direct contact with female patients (without the presence of the father or husband) or demand the provision of care by staff members of the same gender (Dauvrin, et al, 2012 and Hultsjö and Hjelm, 2005). In the study by Høye and Severinsson (2008), female staff perceived the dominating role of some male immigrants as a threat to their identity and a lack of respect. In the same study, nurses expressed uncertainty regarding asking female patients to expose parts of their body. Health professionals reported that the patriarchal cultural practices on the part of some immigrant groups impose the role of fathers/men as the primary authorities for giving and receiving medical information about the other family members (Nkulu Kalengayi, et al, 2012 and Hawthorne, et al, 2003) and making the decision on care issues (Otero-Garcia, et al, 2013 and Lyberg, et al, 2012). Furthermore, some health professionals noted that immigrants present a lack of trust towards staff (Nkulu Kalengayi, et al, 2012) or authorities (Sandhu, et al, 2013), mainly for political or religious reasons and for fear of discrimination. In certain cases, it was reported that some immigrant patients requested to see another member of the staff or to withhold information on these grounds (Priebe, et al, 2011).

Some health workers suggested that occasionally there was a hierarchical relationship between immigrant patients and health professionals in which the patient

only trusts and accepts doctors as the principal clinical authority (Boerleider, et al, 2013). Nurses in some studies found this situation frustrating and irritating because it made them feel inferior to doctors (Høye and Severinsson, 2008 and Hultsjö and Hjelm, 2005). In addition, some health workers believed that immigrant patients tend to have a more intensive mode of communication, both verbal and non-verbal (Hultsjö and Hjelm, 2005), and be excessively demanding, requiring immediate care or often unnecessary prescriptions (Nkulu Kalengayi, et al, 2012 and Hultsjö and Hjelm, 2005). In the study by Hultsjö and Hjelm (2005), intense behaviours by patients or relatives were noticed in emergency care and sometimes resulted in difficulties in assessing the seriousness of illness. For example, in the study by Høye and Severinsson (2008), nurses noted that immigrant families often express their emotions loudly when experiencing pain and grief. Those working in the ambulance service and the emergency ward also described difficulties in managing a crowd of people around the patient (Hultsjö and Hjelm, 2005). It was acknowledged that immigrant families can extend beyond the immediate relatives and also include aunts, uncles, cousins and close friends and that can often produce stressful situations, such as rooms crowded with family members, a greater number of visitors and disrespect for visiting hours, which was felt to hinder nursing procedures in the patient's room and oblige nurses to restrict the number of visitors in order to maintain clinical routines (Høye and Severinsson, 2008).

**(iic) Social and economic disadvantages of immigrants:** Health professionals reported in some studies that the precarious working conditions of immigrant employees are a significant cause of labour accidents and that the strict employment environment is related to absences or delays in outpatients' appointments, losses in continuity of care and doctor-patient conflicts regarding sick leave and visits at inappropriate hours (Terraza-Núñez, et al, 2011 and Hawthorne, et al, 2003). Moreover, poor living conditions, such as overcrowding and unsanitary housing, were reported to be related to the prevalence of infectious diseases (Terraza-Núñez, et al, 2011). Overcrowding and poor maintenance of accommodation is also an obstacle to well-being according to the health staff in the study by Tesfaye and Day (2015). Other reported problems included: social marginalisation; poor social and financial background; lack of familiarity with the health system; and traumatising past experiences, especially among recently arrived immigrants (Boerleider, et al, 2013; Lyberg, et al, 2012; Priebe, et al, 2011; Kurth, et al, 2010; and Hultsjö and Hjelm, 2005). Financial difficulties were given as a reason for

the lack of significance given to health in personal and family spending (Flye Sainte Marie, et al, 2015). In addition, health professionals in Fuertes Goñi and colleagues' study (2010) stated that in some cases the priority for immigrant patients is not the preservation of their health, but the fulfilment of their occupational obligations.

In cases of psychiatric pathology specifically, Sandhu and colleagues (2013) found that mental health professionals were concerned that immigrant patients were more prone to becoming marginalised than non-immigrants with similar conditions. The combination of living with mental health disorders and adjusting to a new, unfamiliar environment with few supportive social contacts and limited economic resources could potentially hinder progress and engagement with health services according to participants in this study (ibid.). In regard to the expression of emotional difficulties by immigrants, health professionals mentioned that previous traumatic experiences may be recalled and intensified (Høye and Severinsson, 2008). Immigrant patients' previous negative experiences of torture, oppression and ethnic conflicts may also induce negative responses to the way that care is delivered in the host country (Sandhu, et al, 2013). In the study by Fuertes Goñi and colleagues (2010), informants suggested that immigrant patients present a diffuse range of pathology, including an increased incidence of unusual conditions (such as stab wounds), tropical and other serious infectious diseases (such as tuberculosis and malaria) and somatisation symptoms.

***(i) Professionals' perceptions of inappropriate use of health services by immigrants:***

In Terraza-Núñez and colleagues' study (2011), health professionals attributed their perception about immigrants' inappropriate utilisation of health services to a series of factors, including: misconceptions among immigrant groups about the health services' operation and the role of health care; immigrants' low level of knowledge regarding the local health system; language barriers; fear and distrust due to undocumented immigrants' illegal status; and immigrants' demands for an immediate response to their health problems. In Tesfaye and Day (2015), health professionals identified a wide range of factors associated with the assessed immigrants' inappropriate use of emergency services, including: their lack of documentation and entitlements to care; limited awareness of the health system's operation; dissatisfaction with the clinical interaction with the general practitioner; language barriers; low education; and the need for transport to the general practitioner for out-of-hours services. Health visitors in the

study by Burchill and Pevalin (2012) reported difficulties referring refugees and asylum seekers to a general practitioner because sometimes the relevant surgery would refuse to register them. Furthermore, they identified an inappropriate use of more sophisticated services (such as emergency services) by immigrants for treatment of minor illnesses due to the lack of access to routine care, the limited knowledge on the health system's operation and the gate-keeping system of primary care (ibid.). In fact, in Llosada Gistau and colleagues' study (2012), participants suggested that the hospital's emergency department was the main gateway to health care for most immigrant groups. It was noted that some studies highlighted concerns among health professionals that inappropriate use of health services by immigrant groups – especially refugees, asylum seekers and immigrants with unclear residence statuses – may create additional burdens on the resources available to support health services and on health care providers (Lindenmeyer, et al, 2016; Burchill and Pevalin, 2012; and Llosada Gistau, et al, 2012). Moreover, Hawthorne and colleagues (2013) found that even in cases of the unlawful use of health services by immigrants, health professionals may decide not to deny the provision of services out of fear of being accused of exhibiting racism or discrimination.

Participants mentioned that undocumented immigrants often delay seeking treatment and hence they are in a more advanced disease state before the initiation of treatment (Jensen, et al, 2011). The delay in seeking health care also occurs with documented immigrants and this has been explained by the perceived immigrants' dedication to traditional medicine and their lack of economic resources (Llosada Gistau, et al, 2012). Health professionals estimated that some immigrants lack skills in accessing educational and self-care material, booking or cancelling appointments and communicating with caregivers through the telephone, websites, or e-mails. Consequently, they were perceived to seek care as drop-in patients and it was felt that it was difficult to convince them that they needed an appointment (Nkulu Kalengayi, et al, 2012).

*(iie) Difficulties in monitoring and contacting immigrant patients:* An important problem identified by some health professionals was the lack of monitoring of immigrant patients. They attributed this phenomenon to legal issues, such as immigrants' unauthorised presence in the host country, but also to the mobility of immigrant populations for occupational reasons and their attitudes towards follow-up care (Llosada Gistau, et al, 2012 and Ramos, et al, 2001). Rapid address changes make

contact details difficult to update according to informants in the study by Drennan and Joseph (2005). Some health professionals expressed concern about not being able to contact an immigrant patient in cases of abnormal test results and having to confront patients with fake identification or false papers (Priebe, et al, 2011). The lack of contact details for patients' relatives was seen as particularly important by doctors in emergency departments where a fatal outcome was a real possibility (Jensen, et al, 2011). Health professionals were also concerned that the lack of contact details often made decisions regarding consent and next of kin issues problematic (Priebe, et al, 2011).

The lack of access to a medical history was also reported as a significant issue, especially for undocumented immigrants (Priebe, et al, 2011 and Jensen, et al, 2011). Even if such information was available, clinicians stated that it was usually in a foreign language (Lindenmeyer, et al, 2016). The reported direct complications of this lack of medical history were a lack of awareness about possible allergies, previous vaccinations and underlying health problems (Priebe, et al, 2011). Their frequent change of accommodation was suggested to be a challenge for health professionals when tracing immigrants (Tesfaye and Day, 2015). In addition, some health professionals believed that immigrants hesitated to disclose their medical histories because they feared immigration authorities (Akhavan, 2012). The lack of knowledge regarding medical history was reported to attach uncertainty to the relationship between health professionals and patients and to compromise the dynamic process of consultation by creating doubt and suspicion during the investigation of potential existing pathology (Fuertes Goñi, et al, 2010).

**(iia) Deficiencies in health services' operation:** At the provider level, organisational problems were also identified and included inaccessible primary care opening times for immigrant workers, limited internal and external coordination between various services and scarce managerial support to health personnel's needs and initiatives (Terraza-Núñez, et al, 2011). In the study by Drennan and Joseph (2005), respondents complained that the health visiting schedule was excessively full of consultations and the concomitant administrative support was limited due to a lack of resources. Health professionals attributed the inadequacy of resources to insufficient funding, the absence of a suitable planning and regulation by health authorities, the rapid increase in the immigrants' population size and immigrants' particular special needs (Terraza-Núñez, et al, 2011). However, there were cases where the existing resources and services were

reported to be underused because of the limited familiarity of the newly arrived immigrants with the health system (Priebe, et al, 2011). The limited knowledge of the health system of the host country by immigrants was noted as an important issue for health staff in other studies too (Tesfaye and Day, 2015; Llosada Gistau, et al, 2012; and Hultsjö and Hjelm, 2005). Furthermore, doctors in Flye Sainte Marie and colleagues' study (2015) mentioned that they often did not refer immigrants to social services due to limited knowledge of and bonding with the social care network amongst medical personnel. Finally, health systems were sometimes perceived by health staff to be inflexible and therefore unable to meet immigrants' special health care needs (Worth, et al, 2009 and Hawthorne, et al, 2003).

**(iiib) *Inadequate training of health professionals:*** Primary care doctors and nurses underlined their limited training and skills for working in cross-cultural consultations (Papadakaki, et al, 2017). Moreover, nurses raised the need for more knowledge about diverse cultures (Høye and Severinsson, 2008), while midwives noted that training in caring for multicultural patients could enable staff to provide equal and beneficial services (Akhavan, 2012). Health professionals suggested that the lack of training in clinical suspicion and diagnosis of tropical diseases creates difficulties in clinical encounters with immigrant patients from countries where these diseases are prevalent (Ramos, et al, 2001). In Worth and colleagues' study (2009), some participants stated that they were unaware of any available training in cultural competence, while others claimed that existing programmes were ineffective.

**(iv) *Health professionals' personal concerns and misconceptions:*** The perspectives of health professionals on immigrants and immigration were found to be formed in part by the daily experience of interacting with immigrant patients. Many health professionals perceived the phenomenon of immigration as a dynamic process due to the rapid increase in the number of immigrants and the continuous change of the demographic characteristics of this population (Terraza-Núñez, et al, 2011). Ramos and colleagues (2001) concluded that there was a consensus amongst health professionals in Spain that there had been an increase in the amount and diversity of economic immigration, which was perceived as a 'massive arrival'. Immigrant groups were usually not viewed by health professionals as a homogeneous category of people but as a diverse mixture in terms of origin, duration of residence in the host society, legal or illegal presence in the

country, social status, linguistic ability, religious identity and cultural proximity (Nkulu Kalengayi, et al, 2012 and Fuertes Goñi, et al, 2010).

Constant contact with immigrant patients may influence the ideas and attitudes held by health professionals in either a positive or a negative way. According to some informants, the initial response from health professionals towards the presence of immigrants in health services was sometimes negative due to reticence, but there was a subsequent change in health personnel's attitudes towards immigrants and a decrease in their prior worries regarding the consultation with immigrant patients in some cases after more experience in caring for them was gained (Terraza-Núñez, et al, 2011). In contrast, it was also reported that some health workers, mostly from primary care, experienced the provision of care to immigrants as a laborious and emotionally demanding professional challenge which intensified as time progressed (Lindenmeyer, et al, 2016; Terraza-Núñez, et al, 2011; and Kurth, et al, 2010). Terraza-Núñez and colleagues (2011) attributed the negative change in staff's attitudes over the years to stereotypes and misconceptions, increased workload, the perceived immigrants' lack of interest in adopting the host country's culture, rules and language differences and a lack of competence in providing care to immigrant populations. In that study, the attitudes and perspectives of health professionals that worked in areas with a greater presence of immigrants might differ from those working in areas where the immigrant population is less present (*ibid.*).

The process of providing care to immigrants may be perceived differently across the various categories of health professionals. Fuertes Goñi and colleagues (2010) found that doctors supported the need for a better distribution of workloads and a greater involvement of nurses in patient consultation involving immigrants, while social workers wanted an augmented role. Furthermore, Boerleider and colleagues (2013) found that midwives perceived professional interaction with immigrant women as a fascinating and interesting task because of the very difficulties that have to be overcome in dealing with patients from different cultural backgrounds. Hawthorne and colleagues (2003) found that health visitors reported a more sensitive approach to ethnic minority groups compared with other professionals. In addition, Nkulu Kalengayi and colleagues (2012) found that doctors and nurses appeared to focus mainly on medical treating, while social workers showed more empathy and understanding about immigrants' difficulty in adapting to their new environment.

Some respondents reported that immigrants attached an excessive, emotional dimension to health which influenced the attitudes of health staff and hindered the establishment of relations with immigrant patients (Fuertes Goñi, et al, 2010). Caregivers expressed frustration over immigrants’ perceived overreaction to negative information about their medical conditions, especially if this concerned life-threatening or debilitating diseases (Nkulu Kalengayi, et al, 2012). The situation may lead to a feeling of deficiency and a stereotypical view of immigrants (Høye and Severinsson, 2008).

### 5.3.2. Proposed measures for improving immigrants’ care

The second theme emerging from the reviewed qualitative studies concerned health professionals’ suggestions on how to improve the delivery of health care to immigrants. The needs expressed by informants as to the provision of appropriate health care to the immigrant population covered three key areas (see Table 5.7 below):

*Table 5.7: Proposed Measures for the Improvement of the Provision of Care to Immigrants According to Health Professionals in European Studies*

<b>Proposed interventions</b>
i. Communication and information support
ii. Education and training of health professionals
iii. Changes in health systems’ operation

*(i) Communication and information support:* The need to enhance the relationship between immigrant patients and care professionals through better communication between these two parties emerged as a strong theme across many of the studies (Devillé, et al, 2011; Priebe, et al, 2011; Fuertes Goñi, et al, 2010; and Vázquez Navarrete, et al, 2009). Suggestions to improve communication included: providing material in various languages; translation services and; to a lesser extent, cultural mediators. Translated material could include information about the health system’s operation, administrative documents (informed consent forms, test preparation sheets, for example) and educational brochures in the languages of the immigrant groups with the largest presence in the territory (Priebe, et al, 2011 and Vázquez Navarrete, et al, 2009). However, some professionals believed that immigrants may still need assistance to be guided to leaflets and, especially where illiteracy was an issue, personal assistance

was required rather than just pieces of translated written material (Priebe, et al, 2011). Participants suggested that high quality interpretation services – both in person and by telephone – should be easily accessible and should also take into account varying levels of both health literacy and mastery of the local language (Devillé, et al, 2011). Respondents argued that improving immigrants’ command of the local language through the establishment of language training centres and courses could facilitate their integration into the host country (and consequently their access to health care) and is the best long-term answer to reducing language barriers (Devillé, et al, 2011 and Priebe, et al, 2011).

Health professionals noted that good translation services can be achieved through well-trained professional interpreters and improved access to interpretation services (Sandhu, et al, 2013). The availability of staff for translation is considered necessary by professionals for territories with high proportions of immigrants and also having those translators work extended hours, especially in hospitals’ emergency departments (Priebe, et al, 2011 and Vázquez Navarrete, et al, 2009). Furthermore, respondents supported the existence of a service budgeted by the state for the translation of patients’ clinical documentation (for example, medical reports or vaccination cards) with interpreters at the reception point and facilities for multiple languages (ibid.). Nevertheless, the presence of cultural mediators and interpreters generates divergent views amongst health staff. On the one hand, some participants questioned their usefulness for solving problems because of inadequate training such actors may have received and conflicts around medical confidentiality. On the other, some health professionals believed that they could reduce the cultural gap between health personnel and immigrant patients (ibid.). Some participants believed that the use of interpreters within their work can secure their professional responsibility by ensuring the transmission of clear health messages and guiding the disclosure of sensitive information (Tesfaye and Day, 2015), while others recognised the existence of language barriers, but they did not prioritise the incorporation of translators into the health system (Ramos, et al, 2001). Regarding translation over the telephone, participants suggested that the use of a telephone interpreter is of some value because it protects the patient’s anonymity, although it lacks proximity (Lyberg, et al, 2012).

Due to the complexities and dilemmas generated by the interpreters’ presence in the health care setting, some health professionals concluded that certain prerequisites should be fulfilled for the optimisation of their effectiveness (Devillé, et al, 2011). It

was suggested that the interpreter should be used not only for communication assistance but also as a practical and informative guide for immigrants in the health system specifically. Health professionals regarded it important to consider the type (trained professional interpreter, family member or bilingual health staff) and mode (face-to-face or via telephone) of interpretation. Moreover, they assessed the interpreter's ethnic origin, religious background, gender, language or dialect, social group, appearance and attitude as important shapers of the interaction. Finally, the employment of cultural mediators and health staff of immigrant descent was also considered as a potential solution (Devillé, et al, 2011).

**(ii) Education and training of health professionals:** Training in multicultural aspects, religious customs and communication skills that would assist health professionals to provide care to patients with diverse cultural features was perceived by health staff to be a core issue for the delivery of satisfactory and respectful care to immigrants and the relief of self-perceived feelings of work overload (Devillé, et al, 2011; Priebe, et al, 2011; and Fuertes Goñi, et al, 2010). In addition, respondents suggested that information on cultural differences can lead to improvements in understanding and communication and the reduction of cultural reticence on the part of some professionals (Vázquez Navarrete, et al, 2009 and Ramos, et al, 2001). The participants suggested training topics that were targeted at daily contact, without getting lost in technical medical descriptions, as well as educating on medical issues specific to immigrant populations, especially for primary medical care (such as epidemiologic and demographic characteristics of immigrants, travel medicine and tropical diseases) (Vázquez Navarrete, et al, 2009 and Ramos, et al, 2001). According to some informants' views, competent knowledge on cultural issues and health problems of immigrants can lead to more accurate diagnoses and suitable treatments, while meeting patients' needs for health care with better cultural understanding (Priebe, et al, 2011). Moreover, it was suggested that the training of health personnel is also needed for managing the stressful occupational challenges that emanate from immigrants' psychosocial problems (Kurth, et al, 2010). Jirwe and colleagues (2010) concluded that cultural knowledge acquired during a nursing study course equipped nurses with an understanding of cultural diversity that could facilitate their interactions with patients from different ethnic backgrounds. However, they still lacked skills and confidence in applying this

knowledge in practice when assessing patients' needs and were anxious about causing offence through their line of questioning (ibid.).

Some participants wanted training programmes to include the development of strategies to prevent negative attitudes and stereotyping. Many felt that improving health workers' interaction with immigrant patients would contribute to the delivery of better health care (Devillé, et al, 2011). Health professionals suggested that the relevant training could be applied to physicians from all specialties, from the first cycle of medical studies, during specialisation but also beyond (Flye Sainte Marie, et al, 2015). The presence of immigrant staff was also raised by health workers as an important matter for the acceptance of immigrants, and a better understanding of their health needs, within the health system (Priebe, et al, 2011).

**(iii) Changes in the health system's operation:** Informants in Devillé and colleagues' study (2011) believed that health services should be easily accessible to immigrants on equal terms with the general population: so in tax-based health systems, the same entitlement should be also applied to immigrant populations, while in insurance-based health systems, immigrants should have the right to be insured. Health professionals also believed that the health system of the host country should grant adequate resources to cater for the needs of immigrant patients and follow targeted strategies to improve the medical management of the immigrant population (Vázquez Navarrete, et al, 2009). Additionally, it was suggested that staff could be employed to manage social and administrative issues, thus freeing more time for practitioners to devote time to patients' medical care (Priebe, et al, 2011). Moreover, according to some health practitioners, primary care centres should extend their opening hours to reduce access difficulties that arise from the working conditions immigrants tend to exist in and correct their inappropriate utilisation of emergency departments (Devillé, et al, 2011 and Vázquez Navarrete, et al, 2009). Informants believed that patients could also be referred to clinics specialising in providing care to immigrants, offering cheap or free medication or giving private prescriptions, especially for those who were illegally present in the country (Priebe, et al, 2011). The creation of special units of tropical medicine could also be helpful according to participants (Ramos, et al, 2001). Furthermore, some professionals suggested the need for clearer information and guidelines on what type of care different immigrant groups are entitled to (Devillé, et al, 2011 and Priebe, et al, 2011).

Across several studies, health professionals believed that improvements in intra-sectoral and inter-sectoral coordination of health services and collaboration with social services as well as regular staff meetings were important for jointly addressing any perceived problems (Flye Sainte Marie, et al, 2015; Sandhu, et al, 2013; Devillé, et al, 2011; Priebe, et al, 2011; Fuertes Goñi, et al, 2010; and Vázquez Navarrete, et al, 2009). Health workers also noted the importance of a flexible and individualised approach for immigrant patients within mainstream care, with more walk-in sessions, open appointment slots and advocacy services (Priebe, et al, 2011). It was proposed that the health system of the host country should create structures, services and procedures adapted to the pathology, working conditions, cultural particularities and social conditions of immigrants (Fuertes Goñi, et al, 2010). Policies to prevent discrimination in health care facilities should also be implemented (Deville, et al, 2011).

#### **5.4. Health Professionals' Views of Immigrants' Care: Quantitative Studies**

The quantitative part of the reviewed data derived from a limited amount of studies (five quantitative studies and one mixed qualitative/quantitative study). These studies focused mainly on health professionals' attitudes towards immigrant patients and health professionals' views of the utilisation of health services by immigrants.

*(i) Health professionals' attitudes towards immigrant patients:* Hudelson and colleagues (2010) found that personal interest in the provision of care to immigrants is higher amongst medical students, professionals with frequent contacts with immigrant patients, non-native professionals and professionals with relevant training in working with immigrants than among doctors, staff with limited contact with immigrants, indigenous personnel and those who had not received training in cultural competence. However, the findings of this study are limited by a relatively low response rate and the possibility of a higher participation of respondents with greater interest in cross-cultural medicine. Furthermore, it is unclear whether respondents' training leads to more positive attitudes or respondents with greater interest in caring for immigrant patients are simply more likely to attend cultural competence training activities. Therefore, the results may not be fully representative of the health professionals' population.

Hudelson and colleagues (2010) also found that women seemed to present more positive attitudes towards immigrant patients than men. Indeed, Roter and Hall (2004) found that female clinicians tended to engage in a more patient-centred communication.

Moreover, Michaelsen and colleagues (2004) reported that doctors and nurses show more positive attitudes towards immigrants, while assistant nurses show more negative ones. Dias and colleagues (2012) took this wider and found that doctors and nurses show more positive attitudes towards immigrants compared to office workers in health care settings, attributing this finding to the lower educational level and the responsibility for managing administrative issues of the latter. A higher educational level is linked to greater tolerance and understanding of human rights, a resistance to stereotypical beliefs and propaganda, a lack of competition with immigrants and an ability to reduce conflicts and aggressive situations (Jenssen and Engesbak, 1994).

Michaelsen and colleagues (2004) found that older doctors had more positive attitudes towards immigrants than younger doctors because of longer experience and greater psychological and intellectual maturity which resulted in better management and more realistic expectations. However, there may be other explanations for these findings. For example, immigrants may behave more respectfully to senior doctors. Additionally, junior staff's duties may include more problematic contacts with immigrants and thus a greater frustration. In contrast, Dias and colleagues (2012) found that older doctors reported less positive attitudes than younger ones. A suggested interpretation of this finding was that older generations tend to be less tolerant and have stronger negative feelings towards immigrants due to a higher adhesion to conservative values, whilst younger people tend to follow more tolerant social norms, showing more openness to diversity and positive attitudes towards immigration. Hudelson and colleagues (2010) found that medical students and younger respondents generally had more positive attitudes and perspectives regarding the care of immigrant patients and this could be a sign that curriculum changes that included cultural competence topics early in training can have a positive impact.

Dias and colleagues (2012) also found that health workers with less daily contact with immigrants revealed more positive attitudes (although Michaelsen and colleagues (2004) drew the opposite conclusion). Dias and colleagues (2012) also found that health professionals evaluated their knowledge and competencies to work with immigrants as moderate or low and considered that receiving specific training about immigrants' health was important for improving their professional performance. This aspect was more common amongst administrative officers and nurses rather than amongst doctors.

*(ii) Views on the utilisation of health services by immigrants:* In Michaelsen and colleagues' study (2004), the majority of health professionals considered immigrants to be a special group of patients who used health services inappropriately. In Dias and colleagues' study (2011b), health professionals recognised two categories of factors that influenced the utilisation of health services by immigrants: (1) factors which derived from the immigrant population's characteristics; and (2) factors caused by the health system's operation. Most health professionals in this study agreed that immigrants' frequent change of residence, lack of economic resources, special cultural and religious beliefs and traditions, fear of detection by authorities, ignorance about the right to access health services and language differences may affect access and use of health services by immigrants. The largest proportion of participants in this study also considered the limited social and cultural awareness of health staff, the complex bureaucratic procedures, the financial cost and the lack of interpreters in the health system as barriers to health care (ibid.). Health professionals in Esteva and colleagues' research (2006) emphasised the view that the increased geographical mobility of immigrants in search of better life opportunities may hinder the provision of primary care to immigrants.

### **5.5. Current Status of Knowledge and Challenges for the Present Research**

This review of previous research has highlighted a range of problems perceived by health professionals to impede the provision of care to immigrant populations. These included the socio-economic disadvantage of immigrants, communication barriers, difficulties in the continuity of care due to lack of official contact details and deficiencies in the medical history of patients, workforce limitations and other funding shortages. Concepts of health, disease and health care may be perceived differently by people of different cultural backgrounds and health professionals often lacked understanding of these differences. In addition, differences in cultural values – such as gender roles, social norms and religious adherence – were also found to compromise the quality of clinical contact. Professionals reported ethical dilemmas and substantial uncertainty concerning how to respond when providing care to undocumented immigrants in particular. At the same time, previous research also suggests that health professionals may feel that immigrants use health services inappropriately, particularly undocumented migrants. These difficulties were reported to add to the workload of professionals and cause stress. Previous research has also reported that health professionals can perceive immigrants to be using health services inappropriately,

particularly undocumented migrants. Some negative attitudes towards immigrants have also been reported amongst health staff.

Earlier research has also highlighted ways in which health service provision for immigrants could be improved. Health professionals were generally positive about the use of well-trained professional interpreters (although there were concerns about the costs involved and the additional time required). Professionals also highlighted the need for specific training and guidance on interacting with multicultural patients, managing tropical diseases, acknowledging legal and administrative issues and coping with occupational stress associated with the delivery of care to immigrants.

Most of the European research reviewed has been conducted in countries with a long tradition in the reception of immigrants – such as the UK, the Nordic states and the Netherlands – while among the southern European states the great majority of the reviewed studies have been conducted in the Iberian countries, especially in Spain. There is, however, a limited extent of research on the experience of health professionals in Greece where immigration on a significant scale is a recent phenomenon. Additionally, while the research review has identified a range of important factors that health professionals perceived to be influencing the provision of health services for migrants, the findings are not consistent across studies and do not reveal causal pathways of phenomena. Consequently, they cannot meet accurately the needs of health care policy or be the springboard for further health services research in countries with recent and large-scale immigration, like Greece. The present study attempted to fill this gap by providing a health workers' perspective which may be relevant to other tax-based or social security-based health systems and health services with multi-cultural patients.

Nowadays, immigration in the developed countries has created social contexts where there is large diversity in ethnicity, birthplace, upbringing, education, language and religion. This situation poses demanding challenges in tackling the health care needs of increasingly multicultural populations by health systems (Torres-Cantero, et al, 2007) and achieving a mutual understanding between health professionals of the host country and immigrants (Daniels and Swartz, 2007 and McBride, 2005). Health services and professionals need to learn about the existing cultural and social variations, adapt accordingly and deliver high-quality services. Fuertes Goñi and colleagues (2010) suggested that immigration puts care services into a crisis which, on one hand, creates an overload to the system and the personnel, while on the other hand can lay the

foundations for improvement. However, many of the reviewed studies were driven mainly by exploring and solving practical problems without addressing the fundamental causes and associations of care issues in relation to policy, service operation and personal interaction. The present study aimed to reveal the complexity of issues in immigrants' care from health professionals' perspective deriving from interrelations within the fields of health policy, health systems operation and interpersonal contact.

The liberation of sufficient resources for the recruitment of personnel, the establishment of interpretation services and staff's training was suggested by health professionals in many studies. However, the implementation of such measures is most likely to be influenced by political priorities in the modern context of financial crisis, especially in Greece which is managing a large public debt. In high-income countries, health systems and professionals could be better resourced to meet the complex needs of caring for immigrants. In contrast, the economic crisis has spread rapidly in Greece along with its effects on the state and people. The financial measures afflict the potential of the public health care system to maintain a satisfactory quality of care. Greek health professionals working in the public services are at the centre of a tug-of-war that comprises of the challenges to care for immigrant patients and the restrictions due to the economic crisis. This situation is likely to influence their views and experiences in caring for immigrants.

However, health care efficiency does not always depend on the availability of resources and may be partly achieved through appropriate policies and clinical protocols. For example, some of the most challenging aspects include the stimulation of health professionals' interest in treating immigrants as well as the integration of different ethnic groups in the host society. In general, the views of health professionals may apply not only to immigrants, but also to wider groups of patients in difficult socio-economic situations. Greece has been facing an incessant influx of immigrants of multiple origins and identities and therefore the public health care system is exposed to newcomers with a variety of needs. Therefore, it is a context for topical research that could be useful for designing health policies and elaborate research in countries that have or will enter similar circumstances.

In order to underpin the research goal and questions and produce new evidence, the next chapter describes in detail theories that seek to illuminate factors and processes in relation to the provision of care to immigrants from the health professionals' point of view. These theories were used for various reasons. Firstly, they served as a framework

for the formation and support of the research inquiries. Secondly, they constituted an organisational scheme for the presentation and interpretation of data. Thirdly, they were used as a starting point for the production of new knowledge from the research evidence. Lastly, they were destined to be a sensitising concept to inform the reader about the important aspects of the research.

## **Chapter 6**

### **The Theoretical Framework for the Research**

#### **6.1. Introduction**

The previous chapter included a selective review of the literature about health professionals' perceptions of various aspects of caring for immigrants in Europe. Despite the value of the findings of the reviewed studies and their importance for health policy planning and clinical practice, a limited application of theory-driven research was demonstrated by the authors. Nevertheless, reflecting on existing theory is an essential part of the process through which the scientific community gets familiar with the objectives, results and implications of the study (Andersen and Kragh, 2010). This chapter presents the theories that were chosen as the framework for understanding and explaining the findings of this qualitative study and, in turn, for challenging and expanding existing knowledge.

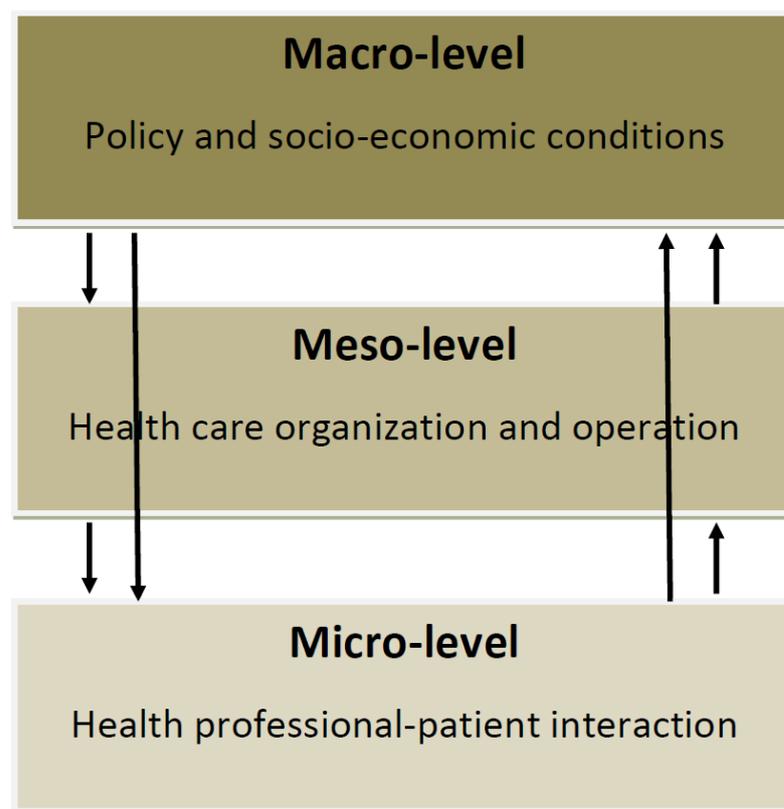
The selection of an appropriate theoretical framework to support a qualitative study is a challenging task because the role and position of existing theories in the interpretation of a subject are usually not straightforward (Tavallaei and Abu Talib, 2010). In the present study, theories were selected to offer a framework for the presentation and interpretation of data and to serve as a scheme for explaining the implications of the findings (Bradbury-Jones, et al, 2014). Although alternative theories could also provide explanations, the selection of the specific theoretical framework is in accordance with Sandelowski's (1993a) notion that theory derives from the researcher's general perspectives, assumptions and disciplines. The theories were selected in order to correspond to the research objectives. As explained in the next chapter, the present study explores the provision of health care to population groups with distinct cultural features and entitlements to health care in the context of harsh societal economic conditions. Therefore, the theoretical framework was chosen to offer greatest analytical leverage and an interpretational lens for issues associated with equity in health, economic austerity and intercultural clinical encounters.

#### **6.2. Overall Theoretical Framework**

The World Health Organization (WHO) has suggested a specific strategy to organise thinking about health systems in which health care is divided into levels (WHO, 2002).

Macro-, meso- and micro-levels refer to the wider political context and socio-economic conditions that determine or influence the provision of health care (macro-level), the organisation and operation of the health system and services (meso-level) and the individual interaction among health professionals and patients (micro-level). Each of the three levels interacts with the others and their combination dynamically influences the provision of health care (ibid.). When events and actions within macro-, meso- and micro-levels function successfully, health care is argued to be efficient and effective. Health professionals work under ideal circumstances and patients receive optimal services. Dysfunction within and amongst levels is believed to create difficulties in caring. Figure 6.1 below represents schematically the classification and interrelation of macro-, meso- and micro-levels in health care:

*Figure 6.1: Macro-, Meso- and Micro-Levels in Health Care*



*Source: WHO, 2002 (modified).*

The theories used in this study focus on processes that impact upon the provision of health care to immigrant populations operating at these three different levels. Three main fields of theory were selected in order to correspond to the formation of explanations regarding events and situations within the political/socio-economic,

organisational/operational and interpersonal context of immigrants' care: (1) political theory about equity in health care; (2) economic theories about the impact of financial crisis; and (3) culturally competent care theories (including theory about the significance of and factors influencing verbal communication).

Firstly, political theory about equity in health care provides explanatory links between governmental policies on health care and population health (Culyer, 2001) and thus it is important within the macro-context. Secondly, theories about the importance of the social determinants of health and perceptions of the mechanisms by which economic crisis affects health care, systems and services can provide an analytical lens for socio-economic interpretations of the impact of austerity on health. Therefore, these political and economic theories provide a framework for explanations mainly in macro- and meso-levels of health care. Finally, theories about culturally competent care can offer interpretations about the appropriate ways to care for immigrants with sensitivity to their needs and cultural features as well as ways to understand factors that impact health professionals' experiences and clinical encounters with immigrants (Leininger, 2002). Therefore, these theories are suitable for interpretations of phenomena mainly in the micro- and meso-level. All the aforementioned theories are discussed in more detail below. Although political theories on equity in health, economic theories about the impact of austerity in health and culturally competent care theories can be applied independently to interpret actions and situations in the context of health care, they can also synergistically explain and predict phenomena in all three levels of health care (macro-, meso- and micro-level), as discussed later in this chapter.

### **6.3. Political Theories about Equity in Health Care**

Achieving universal health coverage is defined by the WHO as “ensuring that all people can access the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship” (WHO, 2017). The provision of universal health coverage is based on the protection of the human right to health which was explored in detail earlier in *Chapter 3*. The process of approaching the protection of health as a human right integrates three distinct concepts: (1) universality; (2) equity; and (3) comprehensiveness (De Negri Filho, 2008). This means that the acceptance of the right to health entails an ethical position that disapproves of societies in which health systems fail to provide comprehensive and equal access to

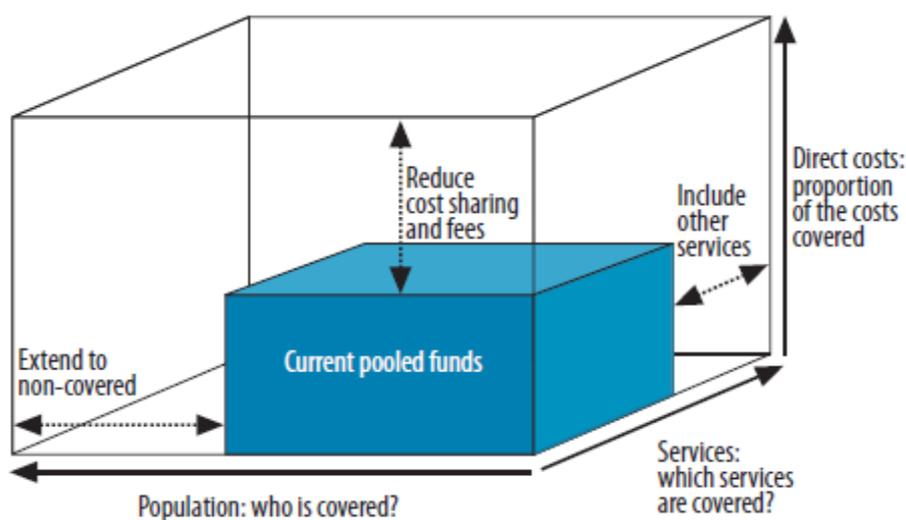
basic health care facilities for all. A threshold right of access to health care – such as free aid in emergency situations – is argued to be a moral obligation upon those providing health services in order to respect the dignity and autonomy of each member and every part of the population (Menzel, 2011 and Giesen, 1994).

The provision of universal health coverage has been achieved by most developed countries, particularly for their own citizens (WHO, 2014), and is currently being advocated by the global health community as an essential future health goal for all countries (Clark, 2014). Universal coverage, if achieved, brings the hope for better health and protection from poverty caused or exacerbated by ill health for hundreds of millions of people, especially those in the most vulnerable situations, such as some immigrant populations.

The motivation of the state is the main critical factor for the establishment or not of universal health coverage. Szreter and Woolcock (2004) have recognised three main motives for the state to provide care to various social groups (including immigrants): the first factor derives from the constitutional sense of the ways in which the state does or does not underwrite equally the health needs and entitlements to health care for all residents, regardless of gender, age, ethnicity and creed; the second lies in the moral sense of the positive or negative disposition of people towards the collective protection of the population of which they form a part; and the third consists of the role of the state as the appropriate public arbiter and redistributor of the collective public resources.

In order to estimate the extent of the population's health care coverage, the WHO has devised an explanatory framework which includes three dimensions: (1) population (which people are entitled?); (2) services (which services are provided?); and (3) costs (which costs are covered?). These parameters are presented schematically below in Figure 6.2. Guinto and colleagues (2015) suggest that the question of whether immigrants are considered enrolled and covered falls under all of these three dimensions:

Figure 6.2: The Three Dimensions of the Parameters towards Universal Coverage



Source: WHO, 2010

Even health systems with full coverage for all residents in a country do not always secure sufficient access for immigrants to health services because immigrant populations – especially persons with unauthorised presence – even if they are allowed to access health care, are usually subjected to complicated and strict procedures of scrutiny. However, tax-based national health systems may allow for wider access to care for the various categories of immigrants in comparison with other systems. In social security-based health systems, proof of insurance must be presented, impeding access for uninsured or illegal immigrants. Ironically, it has been argued that health systems operating under private initiatives can often be deemed better for immigrants, especially undocumented ones, because these systems are often able to accommodate patients with less administrative visibility, although financial barriers can prevent their access to private care (Castañeda, 2010).

Despite the wide acceptance of the importance of the human right to health, much work still needs to be done for the achievement of universal health coverage because weak political commitments, lack of institutional and financial resources and global economic interests may pose limitations (Chapman, 2009). The framing of health as a universal right, like all human rights, imposes three obligations on states (see Yamin, 2008 and Gostin, 2001). Firstly, states must respect this right and refrain from actions that interfere with its enjoyment. Secondly, they must act protectively by taking measures to prevent individuals and businesses from interfering with the right to health.

Thirdly, states must fulfil the right by facilitating and promoting a fair access to health care. Health professionals are also responsible in three ways (London, 2008). A health professional has to guard the operation of health systems and report any violation of the right to health. Moreover, he/she is obliged to work without any discrimination against individuals on the basis of race, gender, religion or other personal characteristics. Finally, human rights in general must be viewed as an essential part of one's professional conduct. After all, the reliance on ethical frameworks as guidance for health professionals has a limited effect, despite the plethora of international statements and agreements, unless health workers are morally devoted to protecting people's right to health (Rubenstein and London, 1998).

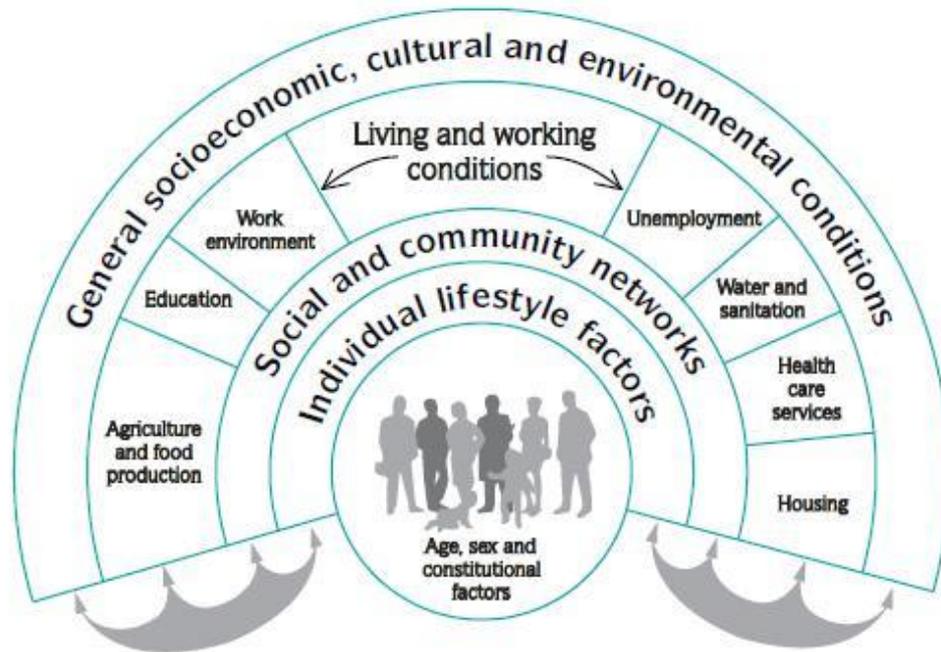
Although the establishment of universal health coverage is an institutional issue and the accountability of its preservation is mainly a task of governments and societies, health professionals constitute a valuable element in implementing it and monitoring potential violations. Importantly for the present study, the promotion (or not) of equity in health care is regulated mainly by political orientations and governmental decisions (Greer and Méndez, 2015) and thus the relevant theories mainly refer to the macro-level of health care. However, theories about equity in care also provide explanations relevant in the meso- and micro-levels, especially in the public health care sector where the operation of health services and health workers' professional ethics and practice are largely driven by concepts of equity in health care.

#### **6.4. Health and Health Care in the Context of Economic Crisis**

A variety of factors combine to shape the health experiences of individuals and their communities. Whether people are healthy or not is determined to a great extent by the prevailing circumstances in which they live and work. Among these factors, the social determinants of health are of great importance. These include the conditions of everyday life that determine a person's chances of maintaining good health, namely the circumstances in which they are born, grow, live, work and age, such as income, education, employment, housing, socio-economic conditions and environmental exposures (Commission on Social Determinants of Health, 2008). These factors interact to cumulatively affect the health and disease burden of individuals and populations and create health inequities across and within countries (see Zangerle, 2016; de Andrade, et al, 2014; and Marmot, 2005). Figure 6.3 below demonstrates the determinants of health

as layers of influence, starting with individual factors and extending gradually to wider aspects within the community (Dahlgren and Whitehead, 2007):

Figure 6.3: The Multitude of Determinants that Influence Health



Source: Dahlgren and Whitehead, 2007

Individuals are at the centre of the circle of influence with a set of fixed genes. The surrounding layers consist of potentially modifiable factors. The first layer consists of the personal behaviour, including the ways of living that can promote or damage health (such as the choice to smoke or not). The second layer includes social and community influences which can provide support or not, for members of the community in certain conditions or even have a negative effect. In this layer, individuals are affected by family relationships, friendship patterns and social norms. The third layer consists of living and working conditions which are regulated through social rules and circumstances, national policies and global forces. These regulations allow people to have access to essential goods, services and facilities, or not. The provision of health care belongs to this category. The outer layer includes all the general social, economic, cultural and environmental conditions. However, the layers of the social determinants of health do not act totally independently but are deeply connected and form clusters of influences across time and place. Various interactions among influences may produce

different mechanisms of illness generation and progression in individuals and populations (see Starfield, 2006).

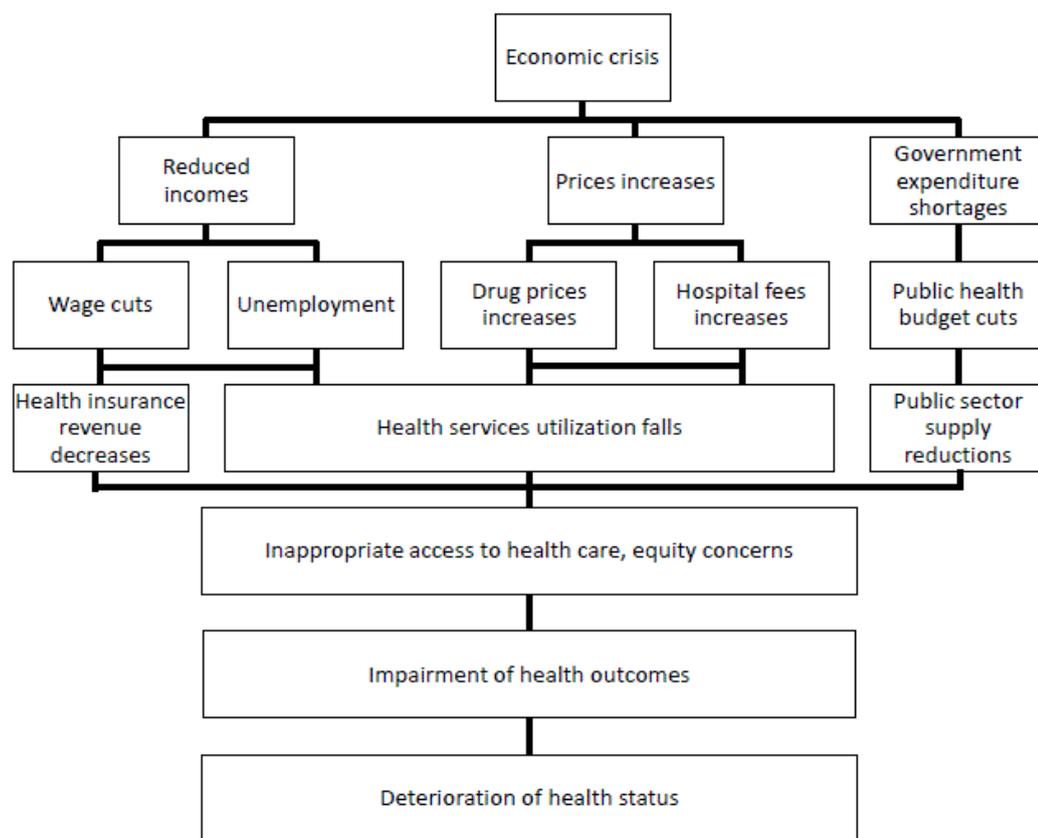
The appearance of an economic crisis, either global or local, can affect all the layers of health determinants to a lesser or greater extent (except the people's genetic identity) and hence affect health outcomes among the population. The public health effects of an economic downturn depend on several key issues, such as the scale of the crisis, the nature of governmental responses, the pre-existing conditions before the crisis and the extent of the populations' exposure (Cylus, et al, 2012). Theoretically, many links may be involved and lots of mechanisms of action may participate in the production of the final health outcomes. An economic crisis can lead to a reduction in people's income, high unemployment rates, wage cuts, rising prices of medicines and hospitalisation costs, while at the same time there are considerable limitations in governmental expenditures including funding for health and social care. The relationship between economic crises and health is fundamentally counter-cyclical which means that when economic conditions worsen, so do physical and mental health, while mortality tends to rise (Catalano, et al, 2011).

A financial crisis within a society can have dual negative effects on people's health status since health outcomes can be influenced both directly and indirectly through its negative impact on health services. Although the present study focuses on the provision of health care, it is important that some theory for the direct effect of economic downturns on populations' health is summarised. Indeed, the economic recession and its related phenomena can directly cause serious effects on people's physical and mental health. Poor living conditions, increased financial insecurity, stress, decline in working conditions, dietary deficiencies, addiction problems, adoption of unhealthy lifestyles and mental health burdens are the main routes which are involved in causing adverse effects on populations' health and this is true for countries in southern Europe that are facing an ongoing financial crisis (Charonis, et al, 2017; Petrelli, et al, 2017; and Córdoba-Doña, et al, 2016). According to Catalano and colleagues (2011), economic recession affects the somatic and psychological health of people through three essential mechanisms. Firstly, the pressure arising from a stressful job and financial events or even the anticipation of stressful experiences – including job loss and difficulties in meeting financial obligations – is an important source of morbidity. Secondly, feelings of frustration and aggression associated with economic decline can lead people to exhibit antisocial behaviour or cope with emerging problems

through substance abuse. Thirdly, limited time, energy and money may dissociate people from activities which improve health status by altering the priorities to which the available resources are dedicated.

The present study focuses mainly on the context of health care which is greatly affected during periods of economic recession. Figure 6.4 below shows a schematic representation of the direct and indirect effects of the economic crisis on health care through pathways of breakdowns:

Figure 6.4: Impact of the Economic Crisis on the Utilisation of Health Services



Source: Yang, et al, 2001 (modified)

Yang and colleagues (2001) have identified three main routes which connect the economic crisis with the negative consequences on health care and in turn health status: first, the decrease in family income through wage cuts and loss of insurance coverage because of unemployment can lead the population to use less costly health services and use more free or low-cost public health care, while private insurance premiums and social funds contributions are likely to be reduced because of the loss of family income and the rise of unemployment, respectively; second, increases in the prices of health

products and services can also lead to inappropriate utilisation patterns of health care; and third, limitations in the state's budget can reduce the size or diminish the quality of the available health care to the population due to financial shortages and cuts. Depending on the type of health system – tax-based, social security-based and/or private – each of the three pathways is affected variably. In mixed systems, such as the Greek health system, all three pathways are likely to emerge.

The effects of economic crisis on health care are unlikely to be linear either within the population or across countries. At an intra-national level, they are likely to be concentrated on low-income families or unemployed persons who cannot bear either the direct payments or the cost-sharing of expenses. Further, when a state faces financial difficulties, it cannot absorb the net increases in prices by lowering the contribution rates for the payment of health services and products and thus it cannot support the protection of vulnerable population groups (Matsaganis, 2013). In fact, Yang and colleagues (2001) have expressed major concern that necessary services for poor social groups – but not unnecessary services for rich ones – are most adversely affected by economic austerity. At an international level, although almost all countries can be affected by a global economic crisis, there is an increased risk for certain states. The latter include countries, like Greece, with large loan commitments, which have to impose substantial austerity measures, usually including reductions in public expenditure together with increases in taxation, in order to support loan repayments (Stuckler, et al, 2010). However, the risk for downgrading health care provision is visible worldwide regardless of each state's political orientation and their particular health system (Stuckler, et al, 2011).

Although there is not an established formal theory about the effects of economic crisis on health care, many researchers, as discussed earlier, have highlighted the mechanisms through which restrictive economic conditions and austerity measures affect the provision of health services (such as changing the breadth of population coverage, changing the reach of health service packages and reducing the level of public financing) (Giovannella and Stegmüller, 2014). The suggested theories about the effects of economic crisis and the political theories about equity in health care are directly interrelated and both tax-based and social security-based health systems are affected. Consequently, states with either system may fail to achieve universal health care coverage (see figure 6.2 above). In the opposite direction, policy-making around universal health care coverage largely considers the economic sustainability of health

care and, as such, decisions about the restriction of health care coverage are strongly driven by economic difficulties (Borgonovi and Compagni, 2013). It is essential to understand the factors that determine the pathways through which economic crisis acts in order to explain how those pathways shape health care for certain populations (such as some immigrants) in particular settings.

## **6.5. Culturally Competent Care**

### **6.5.1. Theories of culturally competent care**

Due to increasing immigration, health staff and organisations are faced with caring for patients with diverse cultural backgrounds during professional and personal interactions that represent more complex health challenges. In response to these changes, the exploration of intercultural clinical encounters in the health services' setting have received increased attention as health care professionals and institutions seek to meet the needs of immigrants in addition to serving the native population (Truong, et al, 2014). Discourses regarding cultural diversity in health care – and the necessity to adapt to the needs deriving from distinct cultural features of patients – are widespread.

One of the recurrent themes in health and social research is the concept of *belonging*: people, including both health professionals and patients, have a sense of belonging to a specific group in society distinct from other social groups. This notion establishes the differentiation of 'us' from the 'others': this is known as the 'othering' process (see Kirkham, 2003 and Canales, 2000). Kirkham (2003) suggests that in health care, the perception of belonging is framed by a range of subtle or even overt messages about cultural identity, although health workers may hesitate to make connections between the community they live in and the clinical environment they work in. The characteristics that form the subjective notion of belonging mainly include language, religion, citizenship and contribution to taxes (Kirkham, 2003). The presence of a common language, in particular, is very powerful as it prescribes modes of communication and inscribes social identity (Eastman, 1985).

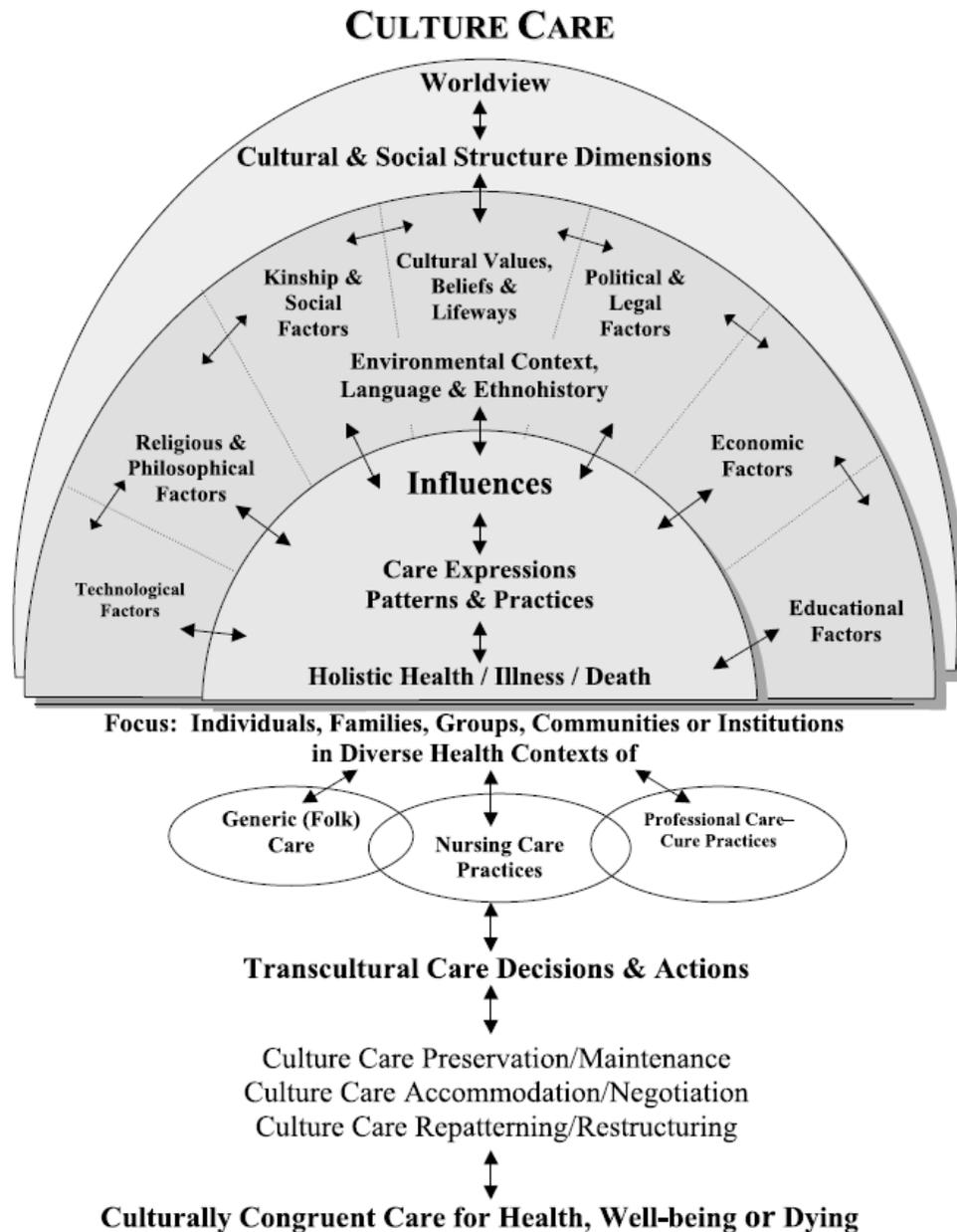
The concept of 'othering' explains how various population subgroups, such as some immigrants, individually or as groups, are often left on the margins of social systems and possibly of care services (Derose, et al, 2007). 'Othering' is responsible for adverse health professional-patient encounters, especially in cases where patients are differentiated into racial and ethnic categories by care providers and are treated in a

subordinating way because of their perceived ‘otherness’ (Browne, 2007). This process reinforces a dominant standard in health care which favours interactions of health professionals with persons who are perceived to belong to the same group as them and generates exclusionary relationships with patients who are identified as ‘others’ (Canales, 2010). In following this notion, marginalisation can be understood as an outcome of ‘othering’ (Roberts and Schiavenato, 2017).

Since the process of ‘othering’ can occur in health care settings, new knowledge and practices about intercultural encounters are essential for health professionals to function in a rapidly changing multicultural world, such as the one being shaped by global immigration. Therefore, substantive theory-based research is necessary and should be used to critically explore caring for people with diverse cultures (the ‘others’). Culturally competent care is important for reducing health care disparities among ethnically and culturally diverse populations through the introduction of culturally sensitive policies and practices (Betancourt, et al, 2005) and contributing to greater cultural competence in health care is an essential goal of the present study. Since care is the core component of medical consultation and nursing, doctors and nurses need an in-depth knowledge of how to approach cultural diversities and their expressions. Culturally competent care theory is known for its broad, yet culture-specific focus to discover and promote appropriate care to people with different cultural backgrounds, such as immigrant populations (Gustafson, 2005; Leininger, 1996a; and Leininger, 1991).

According to Leininger (2002), the purposes of culturally competent care theory are to discover and explain both universal and specific culturally-based care factors that influence the experience of health, well-being, illness and death of individuals or groups, and use research findings to provide culturally congruent, safe and appropriate care to persons of diverse cultures with a view to promoting health. Figure 6.5 below presents the parameters and procedures that regulate the establishment of the provision of culturally competent care. Although terminology in the literature varies (Isaacson, 2014 and Grant, et al, 2013), Leininger’s term of ‘culturally congruent care’ has been typically replaced by ‘culturally competent care’ (Cai, 2016):

Figure 6.5: Leininger's Model of the Dimensions of Culturally Competent Care



Source: Leininger, 2002

Betancourt and colleagues (2003) define ‘culturally competent care’ as one that acknowledges and incorporates – at all levels – the importance of social and cultural influences on patients’ health knowledge and behaviours, considers how these factors interact at multiple levels of care and applies interventions that take these issues into account in order to assure quality health care delivery to patients from diverse populations (Betancourt, et al, 2003: 295, 297). In accordance with this notion, Kirkham (2003) suggests that the integration of diversity as a core value in the provision of health care to immigrants is achieved not only at a macro-level by legislating and forming

administrative procedures, policy planning, securing the enforcement of the relevant policies and properly allocating the resources, but also at a meso- and a micro-level through everyday integration of elements of culturally competent care (such as negotiation of suitable visiting hours, incorporation of alternative therapies and the provision of interpretation services). The views and experiences of health professionals are a fundamental component in designing models of appropriate health care delivery in a multicultural context because they provide data from direct contact with immigrants of different cultural backgrounds (see Hargreaves, et al, 2008).

Regarding the work of health professionals – at micro-level – Lipson and Steiger (1996) suggest that effective cross-cultural encounters involve affective, cognitive and behavioural strategies. The affective strategies include: respect for, appreciation of and comfort with cultural differences; enjoyment of learning through cultural exchange; ability to observe behaviour without judging; awareness of one's own cultural values and biases; and belief in cultural relativity. The cognitive strategies involve: knowledge about different cultures; an ability to recognise distinct cultural features; and an understanding that concepts can differ across cultures. The behavioural strategies encompass: flexibility in verbal and non-verbal communicational styles; an ability to speak clearly; an ability to encourage others to express themselves; proficiency in communication with sincere interest, sympathy and patience; and an ability to observe and intervene when there is a misunderstanding. Furthermore, Leininger (1997) suggests that health professionals should avoid any cultural imposition by giving prominence to their own customs and ideas and recognise that people from different cultures may have different values. Donnelly (2000) supports the ethical obligation of health staff to provide culturally competent care. This requires knowledge and understanding of a patient's cultural identity, including language, patterns of interaction and attitudes towards health and illness (*ibid.*). Vidaeff and colleagues (2015) suggest that culturally competent health professionals have to consider their own identities, values and beliefs, recognise and understand the similarities and differences across cultures, be able to bridge differences and accomplish clear and effective communication in order to overcome the appearing difficulties in culturally dissimilar interactions and eventually remove cross-cultural barriers from health care.

In relation to the operation of health systems – at meso-level – Anderson and colleagues (2003) argue that cultural and verbal competence is achieved through a set of congruent behaviours, attitudes and policies which are combined in a system, an

institution or amongst professionals and enable effective work in cross-cultural situations. They also support that the goals of culturally competent care are to assure the provision of appropriate services by reducing misunderstandings arising from differences in language or culture and improve the efficiency of care by limiting unnecessary diagnostic testing. For the above reasons, health services should be motivated to provide culturally competent care through various actions, including ongoing training and evaluation of staff; collecting data on patients' cultural background for quality improvement purposes; and ensuring the provision of translation services and appropriate signage (see Taylor and Lurie, 2004).

Efforts for establishing culturally competent care typically involve some type of training for health professionals in the cultural features, demographics and special morbidity of immigrant populations as well as reforms in health care systems and agencies (Giger, et al, 2006 and de Leon Siantz, 2008) with the goal of providing tailored services. Delphin-Rittmon and colleagues (2013) offer seven essential strategies for promoting and sustaining organisational and systematic cultural competence. These strategies are devoted to: (1) providing executive level support and accountability; (2) fostering patient, community and stakeholder participation and partnerships; (3) conducting organisational cultural competence assessments; (4) developing incremental and realistic cultural competence action plans; (5) ensuring verbal competence; (6) diversifying, developing and retaining a culturally competent workforce; and (7) developing an agency or system strategy for managing staff and patient grievances. Educational programmes on culturally competent care can positively affect the provision of health care to culturally diverse patients (Horvat, et al, 2014).

The provision of culturally competent health care in Greece, in Europe and worldwide is an essential need because of the continual rise in the presence of immigrants that has generated a proliferation of foreign languages and cultures in singular settings. These populations are often underprivileged in social and economic terms. Health inequalities related to socio-economic disadvantage can be partly alleviated by creating and maintaining culturally competent health services that can at least overcome communication barriers during the procedures of diagnosis, treatment and follow-up (Brach and Fraser, 2002). In response to this expanding cultural diversity, health systems are paying increased attention to the need for culturally (including linguistically) appropriate services. Linguistic and cultural competence reflects the ability of health systems to bridge language gaps and respond to the psychosocial needs

of users. Cultural competence is a key element in the provision of health care because it can improve health outcomes, reduce health care disparities and promote patients' and professionals' satisfaction (Darnell and Hickson, 2015 and Brach and Fraser, 2000).

Understanding and implementing the concepts of cultural competence in research is often difficult (Canales and Bowers, 2001). The constellation of culturally competent care theories focuses on the professional-patient relationship to solve this problem. By studying theories about culturally competent care, the researcher comes to know another human being (the health professionals, in this study) within his/her personal social setting (the health services context, in this particular research) and how he/she interacts with anyone perceived as different from him/herself (Lancellotti, 2008). Therefore, through the theory of culturally competent care, researchers and clinical practitioners can be familiarised with issues emerging from the patient-professional encounter and, in turn, from the health system's operation within the setting of cultural diversity (Engebretson, et al, 2008). These are major factors in the present study.

Theories on culturally competent care have been criticised on the grounds that they refer to cultural groups primarily in terms of ethnicity without taking into account diversity within groups which results in a rather narrow view of culture (Mulholland, 1995; McKenzie and Crowcroft, 1994; and Bruni, 1988) and, in turn, in a generic approach to care (Duffy, 2001). Nevertheless, the application of culturally competent care theory can involve features other than ethnicity – such as gender, socio-economic status, and/or (dis)ability and age – illuminates the complexities of culture's influences on care and contributes to the realisation that culture contains several characteristics beyond ethnicity alone (Albarran, et al, 2011; Williamson and Harrison, 2010; and Leininger, 2001). Therefore, health services and practitioners seeking to provide culturally competent care can draw upon a broad range of cultural features either of a person or within a population group. Such care reaches beyond the content of ethnicity to capture the uniqueness of each patient. Thinking of an individual as a member of his/her ethnicity provides an incomplete picture unless other important characteristics, such as cultural values, education, religion, socio-economic status, are considered (Gale, 2006). In conclusion, theories on culturally competent care have the potential to guide innovative thinking towards critical perspectives about clinical practice and the health system's operation, especially if the researcher takes into account that the concept of culture contains multiple elements beyond ethnicity alone.

### **6.5.2. Language barriers in the provision of health care**

A central element of theories about culturally competent care regards communication between health staff and patients. The lack of a common language between users and professionals of care is a dominant aspect of cultural diversity that can create obstacles in the provision of health care and existing theories seek to provide explanations for this. Due to the scientific nature of health services and products, there is unequal knowledge and information between the supplier of services or goods – the hospital, clinic, diagnostic laboratory or pharmaceutical company, for example – and the consumer (the patient). This means that the consumer-patient, due to lack of expertise, is not usually capable of knowing the health services or products he/she needs. In theory, the equalisation of this asymmetrical relationship is achieved through the doctor's (or another health professional's) mediation. Indeed, the patient and the doctor have a 'principal and agent' relationship (Weinstein, 2001 and Scott and Vick, 1999). Here, the doctor (agent) represents the patient (principal) and stands in for him/her in decision-making on the use of services and consumption of goods in health care. An essential prerequisite for this interdependence to work effectively is the patient's confidence in the doctor's role and the doctor's responsibility to protect the patient's health (Buchanan, 1988). The doctor-patient relationship is based on the assumption that the medical profession has a unique technical competence and is devoted to the benefit of the sick (Relman, 1985). Similar scientific standards and moral commitments also exist in the role of other categories of health professionals (Sarikonda-Woitas and Robinson, 2002).

The exchange of information through conversation between doctors and patients is of fundamental importance for diagnosis and treatment and thus it is an essential parameter within the patient-doctor relationship. Labson (2000) suggests that the efficiency of the doctor-patient verbal interaction is related to bi-directionally transferred information and depends on whether the doctor is able to listen and understand the patient's symptoms, history and degree of concern, organise the provided information in a comprehensible way and guide the patient in issues (such as diagnosis, medication and treatment). The clinical significance of the doctor-patient informational interaction has been demonstrated by many researchers (Sandhu, et al, 2013; Priebe, et al, 2011; Jensen, et al, 2011; Jirwe, et al, 2010; and Walchter, et al, 2006) and was discussed in detail in Chapter 5. However, language barriers may hinder this relationship for immigrant patients in a foreign host country and, in turn, the

essential principal-agent relationship. Therefore, the process of care as well as the outcome of treatment may be compromised.

Jacobs and colleagues (2006) suggest that there are three main questions regarding the investigation and management of language barriers within health services: (1) do language barriers have important consequences in caring for patients with limited proficiency of the language of the host country?; (2) are there effective interventions to tackle language barriers in health services and benefit patients and health professionals?; and (3) what are the economic and other costs for patients and providers of offering linguistic assistance services to patients with limited proficiency of the language of the host country? The answers to these questions should determine whether the language barriers in health care need to be addressed and to what extent.

Previous researchers have found that immigrants with limited proficiency in the host country's language are more likely to receive less appropriate care compared with people who speak the local language (Akhavan, 2012; Dauvrin, et al 2012; Priebe, et al, 2011; Jirwe, et al, 2010; Harmsen, et al, 2008; Cooper, et al, 2003; and Timmins, 2002). Physicians may be more likely to be overcautious when they feel they cannot rely on extracting information from the patient's history and description of symptoms and spend excessive time and resources to assess the needs of those patients (Priebe, et al, 2011; Meeuwesen, et al, 2006; Kravitz, et al, 2000; and Hampers, et al, 1999). Furthermore, patients have a poorer understanding of the received care (Wilson, et al, 2005) and are less likely to follow recommendations for treatment (Karter, et al, 2000) and follow-up visits (Hedemalm, et al, 2007) when oral communication gaps are present. Therefore, existing evidence suggests that language barriers adversely affect the provision of care.

In general, there are only two broad categories of interventions to reduce language barriers in clinical settings: (1) matching foreign-speaking patients with professionals who speak their primary language; and (2) finding a third person who speaks both the language of the host country and the patients' primary language (Pottie, et al, 2014 and Jacobs, et al, 2006). The former path is preferable to the latter because it does not violate the proximity of the relationship between the health professional and the patient. However, it is not widely feasible, especially in the case of Greece, because the majority of health professionals do not speak the mother languages of immigrants. The second solution for the reduction of language barriers is achieved through the intervention of either professional mediators or 'ad hoc' interpreters, like family members (sometimes

children), relatives, friends, other patients and escorts and untrained non-clinical employees. The presence of professional mediators or interpreters, especially those with previous training, results in a significantly lower likelihood of translation errors than having ad hoc or no interpreters (Flores, et al, 2012 and Karliner, et al, 2007). Their role in the clinical context can contribute to a more effective and efficient provision of care but their presence is often not a desirable or possible choice mainly because of the risk of violating confidentiality, the limited feasibility and the high cost, particularly when the need for language services varies due to different geographic, cultural and clinical contexts.

The role and concept of medical interpreters and cultural mediators are distinct. The medical interpreter's duty is to bridge the language barrier by conveying the information accurately and as completely as possible. This process is needed to enable communication between the health care professional and the health care user. However, bridging the language gap is a necessary but not always sufficient requirement for establishing satisfactory communications between health staff and patients. Cultural mediation is further required when lack of cultural awareness amongst health professionals and lack of understanding of the health system and services amongst immigrants are significant impediments for the immigrant population to access and benefit from health care. Erroneous assumptions and judgemental attitudes from both health professionals and patients can cause their interactions to be conflictual and tense. Engaging cultural mediators can improve these interactions because they can facilitate a constructive relationship by fostering mutual understanding and intercultural communication (Martín and Phelan, 2010).

## **6.6. Conclusions**

As the cultural composition of Europe continues to diversify through immigration, the frequency of contacts between health professionals and immigrant patients becomes more intense. Consequently, the need for researchers to provide knowledge on the experience of caring for immigrants becomes essential. As this chapter has argued, Leininger and subsequent authors have established a strong theoretical foundation for the importance of the provision of culturally competent care to diverse populations. Despite the existence of significant relevant literature, there is no broad consensus on the content and application of theories about key components of culturally competent care and how this can be achieved. After all, even the concept of culture does not have

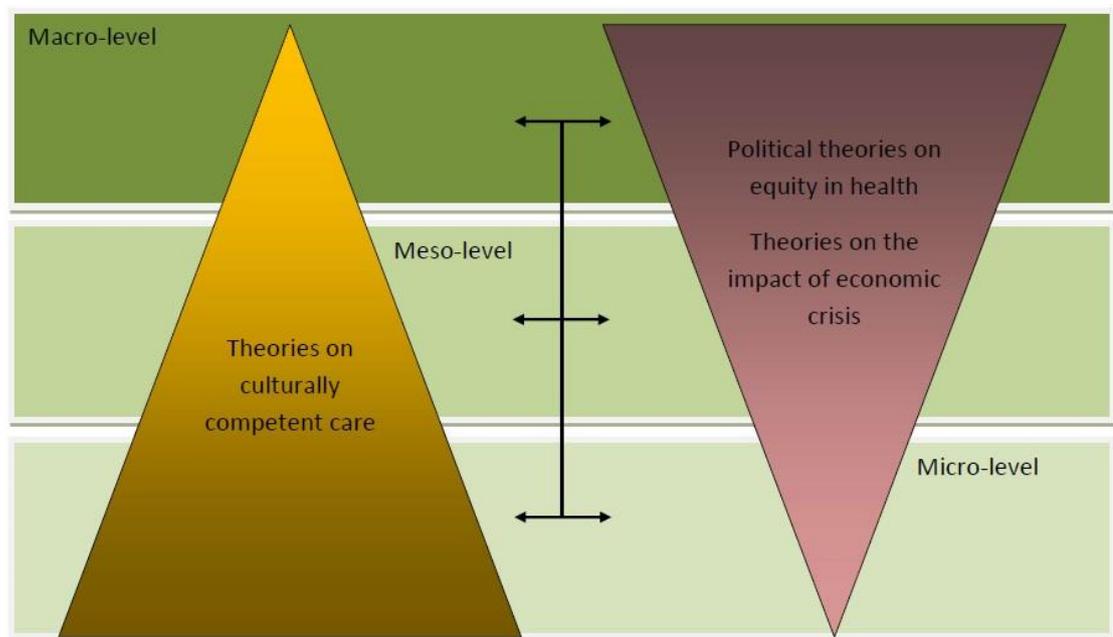
a fixed or static meaning. However, culturally competent care theories have great potential for addressing discrepancies in health care related to cultural features. These theories can be instruments for clinical practice as they offer guidance to health professionals and agencies in treating patients of various cultural backgrounds and can also be theoretical frameworks to be tested or further elaborated in research by providing possible explanations for the phenomena that occur during interactions between health professionals and people from diverse cultural backgrounds (Leininger, 1996b).

Much existing theory on culturally competent care offers insight into the characteristics of more effective professional-patient encounters because it mainly focuses on the promotion of personal knowledge, attitudes and skills among professionals that can support the provision of appropriate care for people across different languages and cultural groups. Therefore, its significance and values lie largely at the micro-level, providing possible solutions for health workers to improve communication with their patients and facilitate improved diagnosis and treatment. Moreover, such insights give prominence to the need for health systems to adapt their procedures in order to establish successful engagement with culturally diverse patients and enhance the quality of health care, thus extending their impact into the meso-level of health care. These theories are also relevant at the macro-level as they argue for the formation of health policies to facilitate more appropriate health care for culturally diverse populations. Figure 6.6 below illustrates the varied ways in which theories of culturally competent care can ‘speak’ to these different layers of health care.

Political theories stress the importance of equity in health care on social, medical and moral grounds. These theories can help us to understand the processes and conditions which enable immigrants to enjoy (or not) their right to health and secure access (or not) to a range of health services. This is particularly important if we want clarity as to the impact of health policies on immigrants’ care in the prevailing general socio-economic conditions (de Leeuw, et al, 2014). Implementing and safekeeping people’s right to health care on equal terms is mainly a political issue and thus the relevant political theories speak mostly to the macro-level of health care. However, both health organisations and health workers can be guided by political theories to promote equity in health care by monitoring the implementation of the relevant policies and working without discrimination. As we have seen earlier in this thesis, some scholars have illuminated the pathways through which an economic crisis can adversely impact

on health and health care: explanations about the effects of the social determinants of health, personal behaviours and the utilisation of and access to health services have been explored. Managing general economic conditions is primarily a task for national governments and thus these theories speak largely to the macro-level of health care. However, financial resources influence the operation of health services and professionals' job satisfaction too so theories about the impact of economic crises or austerity can also speak to the meso- and micro-level of health care, as Figure 6.6 below shows:

*Figure 6.6: The Extent of Cultural, Political and Economic Theories within Macro-, Meso- and Micro-Levels in Health Care*



*The surface of the triangles indicates the relevance of the respective theories at each level of health care. The arrows indicate the influence between political/economic theories and notions of culturally competent care.*

As explained earlier in this chapter, and as Figure 6.6 above graphically highlights, political theories about equity in health care and about economic crisis and concepts of culturally competent care are separate frameworks used to interpret phenomena in the macro-, meso- and micro-context of the provision of health care to immigrants. However, these separate theoretical approaches may interrelate in either a positive or a negative way, especially in settings where high levels of immigration and severe economic crisis exist simultaneously. After all, culture is an inescapable feature of human life, and since policy and economics are (or should be) about human life, it

would seem reasonable that political and socio-economic orientations and culturally competent care are mutually influenced. Nevertheless, the existing literature connecting these different theoretical frameworks on health care is non-existent. This is despite there being some clearer analytical leverage if these two frameworks were linked. For example, as immigrants' care becomes a growing public health concern, the formation of relevant policies to address this issue is expected. As such, central political decisions and organisational strategies can be angled to enhance the interest in and the implementation of culturally competent behaviours amongst health services and professionals in their effort to achieve equity in health care. These actions can be managed through influential leadership (Dauvrin and Lorant, 2015), the dedication of social capital to trusting relationships (Mason, 2016), the reduction of legal and administrative barriers to care (Hernández Quevedo and Jiménez Rubio, 2010) and training and mentorship for practitioners and inter-sectoral cooperation for services (Pottie, et al, 2014). At the same time, restrictive policies towards the provision of care to immigrants and adverse circumstances due to the economic crisis could lead to lower priority being given to the need for health services and workers to provide culturally competent care for immigrant populations. Two main factors can be responsible for this negative impact: (1) the limited available funding may mean that the promotion of culturally competent care is neglected in decisions regarding resource allocation, especially in relation to caring for vulnerable immigrant groups (Browne, et al, 2012); and (2) the arrival of multicultural immigrant populations may create social conditions in the host society that exceed the tolerance limits of health services and staff to provide culturally competent care (although there is no relevant literature to confirm this). The links between culturally competent care theories and equity in health care are far less clear. The provision of culturally competent care cannot directly achieve equity in health care because the latter is mainly regulated by legal and socio-economic factors dictating immigrants' access to care. However, culturally competent care can improve health outcomes among immigrant populations who receive it and thus contribute to the reduction of health inequities. Our understanding of the wider context of immigrants' care can be more nuanced when these separate theoretical frameworks are brought into the same critical gaze.

In conclusion, it is noted that the political theories about equity in health care and economic crisis and theories about cultural competency illuminate pathways that can operate both independently and interactively to produce effects on the accessibility and

quality of health care for immigrant individuals and populations. Firstly, cultural competency theories point to the need for policies focused on equity in health care in order to discover, explain and reduce disparities in care. Political theories about equity in health care illuminate processes that can promote culturally competent care through governmental regulations, structures and operations of health units. They also point to the need for learning processes through which health systems, services and professionals develop the mechanisms, attitudes and behaviours for effective cross-cultural interactions. Therefore, the successful implementation of cultural competence in daily clinical practice is strongly driven by political decisions and priorities. Theory suggests that economic forces can either facilitate or impede policies aimed at the establishment of culturally competent care depending on the availability of resources (Weech-Maldonado, et al, 2012). Secondly, culturally competent health care is intended to introduce practices that remove the barriers to health care caused by discrimination due to distinct cultural features and ultimately to decrease disparities in health outcomes and promote the concept of equity in health care (Butler, et al, 2016).

Despite the potential advantages of delivering equitable and culturally competent care, not all health systems are doing so. This study used a combination of theories to reveal and better understand the challenges being faced by those providing health care for immigrants that arise from complex interacting processes operating within and across the three levels of health care (macro-, meso- and micro-setting).

This chapter has provided an overview of the theoretical framework that will be drawn on to make sense of the experiences and perceptions of Greek health care professionals who provide care to immigrants. It has argued that bringing together political theories about equity in health care and about the effects of economic crisis on health care with philosophies of culturally competent care will provide a better analytical framework for understanding how health care is shaped at the macro-, meso- and micro-level in the face of increasing immigration flows. The next chapter reflects on the study's methodology and describes in detail the methods which were used to collect and analyse the empirical data.

## **Chapter 7**

### **Research Methods**

#### **7.1. Introduction**

The previous chapters have described the growing immigration trends and the associated pressures on health services and staff to provide care to these diverse populations in Greece and in Europe. This description served as the basis for the development and conduction of the present research. A critical review of the literature about health professionals' views and experiences of caring for immigrants was also provided. Moreover, an analytical and critical description of the appropriate theories that frame the present study on a conceptual basis was reported. The present chapter is concerned with the justification of the selected methods to approach the research questions and the description of the research techniques that were applied for collecting and analysing data.

#### **7.2. Research Questions**

In recent years, cross-border immigration has gained significant attention in policy dialogues in numerous countries worldwide. The growing trend of immigration has been mirrored by a demand for a re-orientation of health policies to better protect both immigrants' health and public health (Macpherson, et al, 2007). Challenges associated with the provision of health care for immigrants are tightly linked to the legal status of immigrants, their health needs and their socio-economic conditions on the one hand and with national policy, organisational factors and health workers' personal behaviours and attitudes on the other. The quality of care depends on the degree to which health systems and services increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Many actors are involved in the promotion of quality care. Front-line health professionals are important stakeholders due to their role in delivering care (Berghout, 2015). Giangrande (1998) acknowledges that the perspectives of health professionals are valuable because they can recognise the needs and preferences of the users of health services, identify problems and suggest solutions for the improvement of the health system and have the capacity to integrate scientific knowledge with social aspects of care.

The aim of the present study was to explore perceptions and experiences of various categories of front-line health workers regarding the provision of care to immigrant patients within the context of rising immigration and the current financial crisis in Greece. The study focused on three main research questions:

- What are Greek health professionals' perspectives on possible problems deriving from providing health care to immigrant patients?
- What is the impact of the current financial crisis on the provision of health care to immigrants in Greece according to Greek health professionals?
- What do Greek health professionals think about potential measures to promote and protect the quality of care provided to immigrants?

The study explored the perceptions and experiences of a sample of clinical service providers on the basis of their professional contact with immigrants, but also in relation to their ideologies and personal experiences of interacting with immigrants. Data were collected via interviews with health professionals who worked in the clinical sectors of various health services in Attica and Central Greece. The research obtained ethical approval from the General Directorate of Public Health and Social Welfare of the Region of Central Greece and Lancaster University's Faculty of Health and Medicine Research Ethics Committee. Engagement with the literature can enhance the analysis by sensitising the researcher to issues related to the topic under examination and stimulating questions to be asked (Tuckett, 2005). For this purpose, the relevant literature was reviewed extensively to identify the type and amount of knowledge that already existed in the field and to inform the study's research questions and the interview topic guide.

The views of immigrant users of Greek public health care services are also important. However, an investigation of the perspectives and experiences of both the Greek health professionals and the immigrant patients in this research would have required increased technical support (such as interpretation services and access to private rooms for interviews) which was not readily available. In addition, the inclusion of both users and providers of health services in the study population carried the risk that the depth of the investigation would have been sacrificed to some extent. For these reasons, it was decided that the study population would consist only of health professional service providers. Nevertheless, the findings of this research can be combined with the results of existing and future studies focused on immigrant patients'

views to inform discussions and policy decision making in relation to the provision and quality of health care for immigrant populations.

### **7.3. Research Framework**

#### **7.3.1. Paradigm**

In designing this study, the philosophical anchors of ontology (the nature of reality), epistemology (the way of obtaining knowledge about reality) and methodology (the process and procedures of the research) were taken into account (Rawnsley, 1998). In the interpretive paradigm, reality is individually constructed and emerges when each person's senses engage with the aspects of the world he/she lives in. Knowledge about reality is generated from the interaction between humans and their social context. Therefore, the social world can be optimally explored through the point of view of individuals who are related to the phenomenon under examination. Research methodology is directed at choosing the most appropriate technique to produce knowledge from the participants' perspective, investigating interaction among individuals in the context in which they act (Scotland, 2012).

The present research was conducted with a view to constructing knowledge about the perspectives of social actors (health professionals) within the context (health services) in which they operate (see Creswell and Miller, 2000). Therefore, the interpretive paradigm formed the framework of the study because, according to this position, the social world can be optimally understood from the standpoint of individuals who are participating in it (Cohen, et al, 2011). Following this, the present research aimed at yielding insights from health professionals' views of the provision of health care to immigrants and understanding interactions within health services from their perspective. For this purpose, rich evidence can be generated mainly from the interactive researcher-participant dialogue and the production of qualitative data (Ponterotto, 2005) and thus it was decided to conduct interviews with various categories of health workers that have clinical experience in providing care to immigrants.

This study focused on phenomena as they were viewed by the participants (Flood, 2010). Research into people's accounts and/or experiences of a particular phenomenon and its setting are important because it uncovers essences of phenomena and the contextual features of experiences (Lopez and Willis, 2004). In the case of the research reported here the phenomenon of interest was health care professionals' experiences of

providing care to immigrant service users. As Kleiman (2004) has suggested, the researcher conducted all the interviews himself in order to develop an in-depth understanding of these experiences and the meanings attached to them. According to a phenomenological perspective, each participant will attach a unique meaning to a particular phenomenon (Converse, 2012). Qualitative research provides generalisable insights into experiences and the meaning attached to them by linking the data collected at the individual level to an underlying theoretical framework (Leech and Onwuegbuzie, 2007).

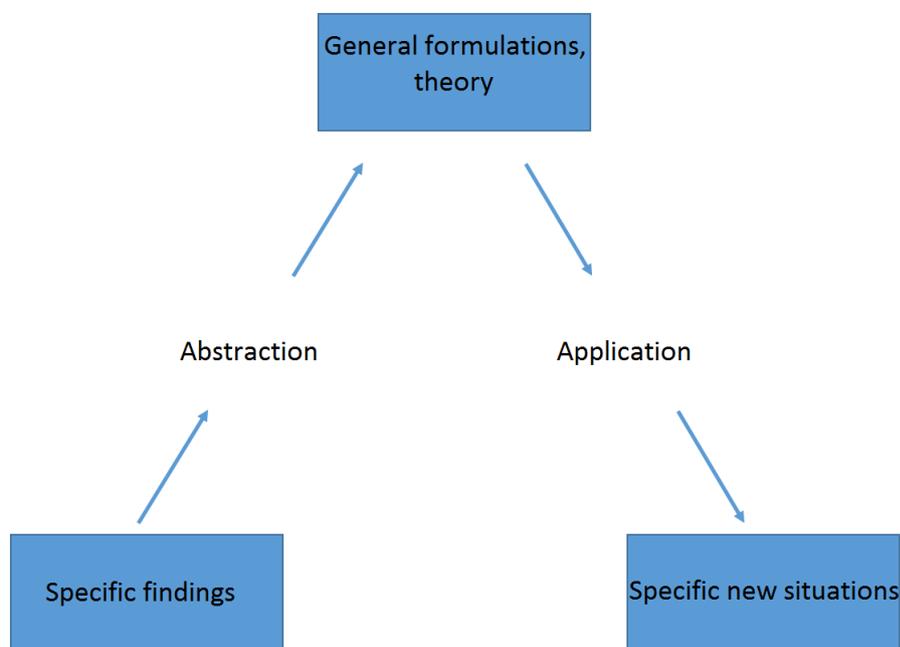
### **7.3.2. Research design**

Although qualitative research methods derive from the social sciences, sociology and anthropology in particular, they are now being used in a wide range of fields and disciplines, including health services research and medicine. The valuable contribution of qualitative research to the study of the provision of health care is increasingly being recognised (Mori and Nakayama, 2013) and, as Clarke (2004) has argued, health practitioners can have confidence in the value of such research. Qualitative research is concerned with the nature of human experiences and the meanings people attach to these experiences through investigating, understanding and interpreting their experiences and actions within the context that they occur (Fossey, et al, 2002). In this kind of research, the focus is generally on the subjects in their naturally-occurring settings. Qualitative research is also open-ended and flexible and research questions may be modified as the study progresses and new data are collected.

Qualitative methods enable the investigators to access areas which are not amenable to quantitative research, such as the meanings attached to personal views. They are a proficient way of providing rich descriptions of complex phenomena, tracking unique or unexpected events, illuminating experiences and interpretations of events and developing theories (Sofaer, 1999). In health research, qualitative techniques have been applied to the investigation of issues such as the organisation of health services, the interactions between health personnel and patients and the roles of health professionals (see Pope and Mays, 1995). The conduct of qualitative research in this field aims to produce findings that are theoretically generalisable to other settings. Generalisability within the qualitative approach is of a different kind to that of experiments or other quantitative studies. Indeed, the findings from a qualitative study are not considered as facts that are applicable to the population at large, but rather as

descriptions and notions applicable within a specified setting (Malterud, 2001). Therefore, the goal is to produce findings which are theoretically generalisable rather than probabilistically so (Popay, 2003). Generalisability in qualitative research refers to the process through which theory that is developed within the context of a study can be exported to provide an explanatory framework for the experiences and perceptions of participants in other studies with comparable situations (Horsburgh, 2003). This process is depicted below in Figure 7.1:

*Figure 7.1: The Process of Generalisation in Qualitative Research*



*Source: Mayring, 2007 (modified)*

#### **7.4. Researcher's Background**

The rapid expansion of research about health services depends heavily on doctors and other health professionals undertaking the role of investigators, participants and evaluators (Pope and Mays, 1995). The present study included a process where a medical doctor (the researcher) working in the Greek public health care system interviewed Greek health professionals (the research participants) who worked in the same occupational sector as the researcher about phenomena and situations that occur in a familiar context (public health care services). Therefore, particular issues of reflexivity arise from these conditions as interpretations of data and theoretical assumptions by the researcher are probably not neutral but derive from the development

of relationships with participants (who have similar professional roles as the interviewer) and his own perceptions of reality.

The concept and process of reflexivity concerns the conscious self-awareness by a researcher of the potential impact that his/her personal experiences and reasoning can have throughout the research process (Råheim, et al, 2016). Rather than seeing such influences as potential contamination of the data, reflexivity seeks to assist researchers to grow their capacity to understand the significance of the knowledge, feelings and values that they bring into the research field in relation to the formation of research questions, the implementation of the research methods to collect data and evaluate findings and the development of arguments and conclusions (Attia and Edge, 2017). In the present research, certain practices were followed to protect the critical rigour of the research process (Haynes, 2012):

- Theoretical assumptions and presuppositions about the subject of the research were noted and revisited throughout the research process, thereby assessing how they may have shifted and if a revision of focus or findings was needed. An example of a theoretical misconception by the researcher in this study was the identification of ethnicity with cultural identity for some immigrant groups. In the early days of the project, during the formation of the theoretical background, it was noted that not all culturally-distinct groups have a separate ethnicity and not all ethnic groups have the same cultural features. Consequently, the wording of interview questions was adjusted accordingly;
- A research diary was kept for fieldwork notes that logged observations, interactions, incidents, conversations, emotions and responses during the research process;
- Tape recordings of interviews were listened to in a critical way to ascertain if the presence or interaction of the researcher affected the process; and
- Participants' responses were anonymised and their interpretations were discussed with fellow researchers not actively involved in the project.

### **7.5. Sampling and Participants**

In qualitative research, the purpose of sampling is not to establish a random or representative sample drawn from a population but rather to identify specific groups of people who either possess certain characteristics or live in circumstances relevant to the

social phenomenon which is being studied. Sampling strategies in qualitative studies include: convenience sampling (the procedure of selecting informants who are easily accessible, although a minimum reasonable set of inclusion criteria may be applied); purposeful sampling (the recruitment of informants that are most likely to provide appropriate and useful data); and theoretical sampling (the selection of participants according to the dictates of theory) (Kelly, 2010 and Coyne, 1997). Due to the objectives and conditions of the present study, purposeful sampling was adopted in order to recruit informants who met predetermined inclusion criteria and who could enable the exploration of the particular aspects of the research questions and provide important sources of knowledge (Mays and Pope, 1995).

In this study, a heterogeneous sample of informants was recruited. This kind of study population consists of individuals who differ from each other in certain aspects (Holloway and Wheeler, 2010). This study wished to explore the perception of medical and nursing staff who care for immigrant patients. A purposeful approach was mainly used for sampling (Petty, et al, 2012 and Forman, et al, 2008).

The researcher directly approached health professionals in public health care services and introduced himself and the study's background. The participant information sheet was distributed among health staff and the purposes of the study, health professionals' clinical background and arrangements for further communication were discussed with interested individuals. The researcher asked health professionals with relevant experience to participate. In addition, the researcher asked already recruited respondents to indicate other health professionals with knowledge on the particular topic who might also be willing to take part in the study (this is known as snowball sampling, see Atkinson and Flint, 2001). The inclusion criteria required certain characteristics for the selection of the study population: (1) occupation in a health professional role as a medical doctor (general practitioner, specialist or resident), nurse (or health visitor) or midwife; (2) of Greek ethnicity; (3) have employment in the public health care services of the National Health System on a permanent or temporary contract in Attica and Central Greece (with the exception of professionals having worked exclusively in psychiatric and paediatric departments due to the particularity of their clinical encounters with patients); and (4) have at least two years of professional and clinical experience of providing direct-contact clinical care to immigrants in the public health care system. The selection of the final study sample ensured that participants' characteristics differed by professional role, gender, age, occupational

experience, working environment and place of practice so a wide range of experiences and perspectives could emerge from the study (as shown in Table 7.1 below):

*Table 7.1: The Interviewees*

<b>Number</b>	<b>Pseudonym</b>	<b>Gender</b>	<b>Age</b>	<b>Job title</b>	<b>Clinical service</b>	<b>Years of experience</b>
01	P01	Male	63	Doctor (specialised)	Polyclinic	32
02	P02	Male	36	Doctor (resident)	Hospital	7
03	P03	Female	49	Nurse	Health centre	26
04	P04	Female	32	Nurse	Hospital	8
05	P05	Female	44	Health visitor	Health centre	20
06	P06	Female	40	Health visitor	Hospital	14
07	P07	Female	45	Nurse	Hospital	21
08	P08	Male	34	Doctor (resident)	Hospital	6
09	P09	Female	33	Nurse	Hospital	7
10	P10	Male	32	Nurse	Hospital	10
11	P11	Female	36	Nurse	Hospital	12
12	P12	Female	39	Doctor (specialised)	Polyclinic	14
13	P13	Female	42	Nurse	Hospital	15
14	P14	Female	33	Doctor (resident)	Hospital	5
15	P15	Female	56	Doctor (specialised)	Hospital	30
16	P16	Female	48	Midwife	Hospital	22
17	P17	Male	67	Doctor (specialised)	Hospital	39
18	P18	Female	51	Midwife	Hospital	28
19	P19	Female	35	Nurse	Hospital	12
20	P20	Female	43	Midwife	Hospital	20

*Note: All the above information was stated by the participants and was accepted without validation or objections.*

There are no general guidelines about what constitutes a sufficient sample size in qualitative studies. In general, qualitative samples consist of small sampling units that are studied in depth (Holloway and Wheeler, 2010 and Crouch and McKenzie, 2006). The main principle that defines the number of participants required in a study is the concept of saturation, if this can be achieved and clearly established (Mason, 2010). Saturation is a tool used for ensuring that adequate and meaningful data are collected to support the study (Walker, 2012). The final number of participants is usually defined when saturation is reached: that is, when no important new issues are identified with the examination of additional units. In this study, the ‘units’ of comparison and reflection were themes or intermediate categories identified in the interview transcripts (see Table 7.3 below for examples). According to the constant comparison process, which is discussed later, the cycle of comparison and reflection on ‘old’ and ‘new’ material was repeated several times and when analysis of new interview transcripts did not identify any new themes – meaning that all the new data could be assigned to one of the already existing themes or categories (Boeije, 2002) – saturation was judged to have been achieved and no new data would be needed. The final number of participants in the present study was 20 and was determined using the aforementioned criteria of saturation.

## **7.6. Data Collection**

There are various techniques for data collection in qualitative research, including observations, textual or visual analysis, individual interviews or focus groups (Draper, 2004). Although focus groups would be appropriate for exploring participants’ knowledge and experiences (Kitzinger, 1995), individual interviews were chosen for this study for specific reasons. Firstly, the members of a focus group may hesitate to express their honest, personal views on immigration due to the sensitivity of the topic, especially when their views oppose socially accepted norms and political correctness. Secondly, an ‘outspoken’ person may dominate the discussion and prevent other participants expressing their personal views (Leung and Savithiri, 2009). Thirdly, practical arrangements for conducting focus groups would have been difficult in this study due to the heavy work schedule of the participants and the wide geographical spread of the study.

There are three broad types of individual interviews: structured, semi-structured and unstructured. Structured interviews consist of the completion of a questionnaire, in

which a list of predetermined questions require responses from a defined set of options, such as 'yes', 'no' or 'unsure', with little or no follow-up questions. Although they are relatively fast and easy to conduct and useful if certain questions have to be answered, they only allow for limited participant responses and are, thus, of little use for in-depth, qualitative exploration (Gill, et al, 2008). In contrast, unstructured interviews do not include any preconceived topics and can be therefore difficult to manage. They are used mainly in studies where complete freedom in terms of planning, implementing and organising the interview is desired (Gill, et al, 2008 and Dörnyei, 2007). Semi-structured interviews retain the flexibility of qualitative research, while permitting some degree of standardisation and so are suitable when the researcher intends to focus on an individual's perspectives on a specific phenomenon rather than holistic experiences (Kelly, 2010). In general, they include a set of topic areas which allow open discussion around relevant questions. They are well suited for the exploration of deeper understandings of respondents' views on a particular topic, especially in relation to sensitive issues, and enable probing for more information and the clarification of answers (Fylan, 2005). As the present study aimed to explore individual health professionals' perceptions on a socially and professionally sensitive issue, individual semi-structured interviews that used a topic guide related to the main research questions were conducted to elicit informants' perspectives in a systematic, comprehensive way (Dicicco-Bloom and Crabtree, 2006). The interview structure included three main fields for exploration focused on the research questions: (1) perceived issues regarding the provision of care to immigrants; (2) perceived influence of the modern financial crisis on the provision of care to immigrants; and (3) proposed measures to address existing difficulties in providing care to immigrants. The interview guide was pilot-tested before its application. Interviews took place privately either in the facilities of the Region of Central Greece (in the researcher's office) or at the work place of the participants (in a private room) and were conducted in Greek. They were audio-taped and transcribed by the researcher.

The informants' decision to participate was both voluntary (without coercion) and informed. Individuals who wished to participate were encouraged to contact the researcher for further details and those who met the inclusion criteria were informed about the study and what they could expect to be asked during the interview. They were also assured of confidentiality and anonymity and the right to withdraw from the study at any time. Interested individuals were encouraged to contact the researcher by

telephone, e-mail or letter to ask further questions. If they were still interested in proceeding, they were asked to give their written consent to participate in the study and they were further reassured that information gathered from the interview would be treated confidentially, would not be passed on to a third party and that participants as well as the information they provided would remain anonymous in any presentation or publication arising from the study. The participant information sheet, consent form and topic guide are presented in the *Appendix*. None of the participants expressed distress during the interviews. Every necessary action was taken to guarantee confidentiality (such as safely storing confidential information and undertaking anonymised procedures for processing the raw data) (see Ford and Reutter, 1990).

### **7.7. Data Analysis**

Qualitative analysis does not consist of a single approach but includes various methods that share a similar goal in that they seek to arrive at an understanding of a particular phenomenon from the perspective of those experiencing it (Al-Busaidi, 2008). In the present research, thematic analysis was used for identifying, analysing and reporting patterns or themes within the data. This technique is a tool for the organisation and description of the source information as well as for the interpretation of the various aspects of the research findings (Braun and Clarke, 2006). It constitutes a foundational form of qualitative analysis and it includes core elements which are widely used in almost every other method of qualitative research. Indeed, Holloway and Todres (2003: 347) identify the process of ‘thematising meanings’ as one of a few shared generic skills across qualitative analysis. With this method, it is possible to classify words, phrases and sentences into content-related categories (Sandelowski, 1995).

There are some terms which are related to this method. The ‘unit of analysis’ commonly refers to a whole interview or an observational protocol. Graneheim and Lundman (2004) recognise the following terms of gradual coding as more data are accumulated in each grade. A ‘content unit’ is a constellation of statements which relate to the same meaning. Furthermore, the parts of the text which deal with a specific topic are referred as a ‘content area’. A ‘category’ is a group of contents that share a commonality. Categories must be complete and exclusive. This means that no data related to the purpose of the study should be excluded due to a lack of a suitable category and no data should fall between two categories or fit into more than one category. Moreover, a ‘theme’ is defined as threads of meaning that describe a certain aspect of a

phenomenon. Of course, ‘sub-categories’ and ‘sub-themes’ are also described for pieces of data and include an intermediate content. In this way, thematic analysis processes narrative materials by breaking the text into relatively small units of content (Sparker, 2005). The goal of the above process is to filter the textual data to reveal the ‘essence’ of the phenomenon which derives from the text (Sandelowski, 1993b).

Thematic analysis processes data in great detail as it allows the researcher to understand a phenomenon from its elemental components up to its associations with other situations within the context they appear (Thomas and Harden, 2008). This process gives an opportunity to understand the potential of any issue more widely (Marks and Yardley, 2004). Thematic analysis is capable of detecting and identifying participants’ actions and thoughts and constitutes a source for explanations of phenomena (Alhojailan, 2012). In addition, it allows the management of data, starting from a precise content and then moving to broader conclusions and ultimately to theories (Alhojailan, 2012). Due to the flexibility of this method, researchers are free to make their subjective assumptions (Bristowe, et al, 2015) provided that they are clear about what they are doing, how and why (Attride-Stirling, 2001). Finally, Vaismoradi and colleagues (2013) argue that this approach is robust enough to be used for conducting an introductory study on a novel phenomenon, for which the quality of its data depends on the amount of energy and time the researcher spends on the process of data collection and analysis.

The raw data of the present research consisted of the interview transcripts. As DeSantis and Ugarriza (2000) suggest, the thematic analysis in the present study involved the search for, and identification of, common threads that extended across a set of interviews. The process of analysis started with the initial search for, and identification of, patterns of meanings and issues of potential interest in the data and was completed through reporting established themes and providing relevant interpretations. The present study was mainly concerned with producing knowledge based on existing theory. Therefore, the data analysis – that is, the search for, and formation of, themes – was guided by the theoretical framework presented in Chapter 6. However, the researcher was alert during the analysis to notice and analyse other novel patterns or themes.

The analytical procedure in the present study mirrored the phases identified by Braun and Clarke (2006) and Burnard (1996) and is summarised in Table 7.2 below:

*Table 7.2: Phases of the Thematic Analysis in the Present Research*

<b>Phase</b>	<b>Brief description of the process</b>
1. Familiarising with the data	Transcribing data, reading and re-reading the material, noting down initial ideas.
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire set of information, collating data relevant to each code.
3. Searching for and creating themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes	Checking the themes work in relation to the coded extracts and the entire data set, generating a thematic plan of the analysis.
5. Defining and analysing themes	Ongoing analysis to refine the specifics of each theme, generating clear definitions and names for each theme, analysing each theme in detail.
6. Writing up	Selecting vivid and compelling extract examples, refining the analysis, relating the analysis to the research questions and literature, producing a scholarly report.

*Source: Braun and Clarke (2006) (modified)*

The application of these analytical phases in this study is described in more detail below. However, it is important to note that the process was not linear but iterative with constant moves back and forth between the entire set of information, the coded extracts of the transcripts, the emerging categories/themes and the relevant notes, as is usually the case with qualitative analysis (Vaismoradi, et al, 2013). This process reflects the method of constant comparison. Following this principle, the researcher decided on the basis of prior interviews and preliminary analysis, which issues would be given emphasis in subsequent interviews and how analysis of new data would develop (Boeije, 2002). As soon as two interviews had been recorded and transcribed, analysis began and the content of these and subsequent interviews was compared. In this way, some questions were given particular emphasis in subsequent interviews in order to elude information on issues that were raised by the comparison process (Boeije, 2002). For example, issues about language barriers, cultural diversity, the effects of economic

crisis and the provision of care to undocumented immigrants were given special importance by the participants from the first interviews so the relevant questions were elaborated accordingly in the following interviews. Writing was an integral and constant part of the analysis and not something that took place at the end.

***Phase 1 – Familiarisation with the data:*** In qualitative research, it is vital for the researchers to immerse themselves in the data to the extent that they are familiar with the depth and breadth of the content. This procedure was the bedrock for the rest of the analysis. Since the data of the present study consisted of verbal material, the interviews needed to be transcribed into written form prior to the onset of the thematic analysis. The process of transcription was an excellent way for the researcher to obtain an initial awareness of the data, rather than a mechanical procedure, as some researchers suggest (Bird, 2005 and Lapadat and Lindsay, 1999). For this reason, a verbatim transcription of all the verbal information was produced in a way which was practically suited to the purpose of analysis (Edwards, 1993). Afterwards, the first phase of the process involved repeated reading of the transcripts. This reading was oriented in an active way, as it included searching for meanings and patterns. The entire information was read through at least twice before the onset of coding. The familiarisation with all aspects of the data, whether they were semantic or latent, was important. Moreover, during this phase, notes were taken regarding the appearance of concepts. These notes could be retrieved and reviewed in subsequent phases of the analysis. Gathering and analysing data are often conducted concurrently in qualitative approaches, thus adding to the depth and quality of data analysis (Vaismoradi, 2013). However, it is also common to collect all the data before examining them to determine what they reveal (Chamberlain, et al, 2004). In the present research, only preliminary analysis was conducted prior to the concentration of the entire information. Furthermore, all the transcribed interviews were translated into English so the analysis could be discussed with the research supervisors and the findings could be presented in the last phase. The researcher made the translations himself so he could secure not only an accurate transfer of the literal content, but also elaborate the essence of the meanings contained in the use of metaphors by the informants.

***Phase 2 – Generation of the initial codes:*** The second phase involved the production of initial codes from the data. These codes identified features of the information content (semantic or latent) that appeared interesting and seemed relevant to the research

questions. The initial codes represented the most elementary information that could be assessed in a meaningful way (Clarke, et al, 2008) regarding the exploration of health professionals' experiences about and perspectives on the provision of health care to immigrants. Coding was conducted manually because this approach allows for a human interpretation of data – that is, a reading ‘between the lines’ – and perfects the ability of the coder to combine categories and have a better idea of how to best organise data (Bright and O’Connor, 2007). The researcher worked systematically through the entire dataset, giving full and equal attention to each data item and identified interesting aspects in the texts’ segments that seemed to form the basis of repeated patterns, marking them with highlighters and then labelling them. Examples of initial codes are presented in Table 7.3 below.

***Phase 3 – Search for and creation of categories and themes:*** After all the relevant pieces of information had been initially coded, there was a long list of the different codes that were identified across the dataset. The third phase’s goal was to re-focus the analysis on the broader level of categories and themes by merging related different codes into compositions (Braun and Clarke, 2006). A practical procedure was used in which the name of each code and a brief description were written on a separate piece of paper, code-piles were created and diagrammatic thematic maps were drawn. Thematic maps referred to the visual presentation of themes, codes and their relationships, involving a detailed account and description of each theme, their criteria, examples and other similar details. As part of the data analysis, thematic maps helped with reviewing themes and achieving the aim of identifying coherent but distinctive contents (Ritchie and Spencer, 2002). In other words, this phase included the exploration and formation of relationships by collating parts of data. Examples of intermediate categories are presented in Table 7.3 below.

***Phase 4 – Review of themes:*** The fourth phase involved the refinement of the set of candidate themes that had already been devised (Braun and Clarke, 2006). The process of thematic revision occasionally led to merging, splitting, transforming and omitting themes. An example is presented in Table 7.3 below. After this review, data within themes cohered together meaningfully, while there were clear and identifiable distinctions between themes. The process of thematic review was performed at all levels of units of meanings such as content areas, categories and themes (Braun and Clarke,

2006). The fourth phase was completed when further refinements were not adding anything substantial to the analysis. At the end of this phase, there was a fairly good idea of what the different themes were, how they fitted together and what the overall story was.

***Phase 5 – Definition and analysis of themes:*** At this point, definition and further refinement of the themes were conducted by identifying the essence of meaning that each theme included and determining what aspect of the data each theme captured (Braun and Clarke, 2006). In addition, names for the themes were produced. These names needed to be concise and clear in order to give the reader immediately a sense of what the theme was about. By the end of this phase, a final diagrammatic thematic map of the data was produced and a satisfactory analysis of every theme was developed.

***Phase 6 – Writing up:*** The sixth phase included the final analysis and preparation of the findings' chapters. The goal was to produce a concise, coherent, logical, non-repetitive and interesting presentation of the findings within and across themes. For this purpose, vivid and representative anonymised extracts of the transcripts were selected and presented to depict the points that the research is demonstrating, without unnecessary complexity. Moreover, extracts were embedded within an analytical narrative to illustrate the data which had been explored and the conclusions which had emerged from the study (Braun and Clarke, 2006).

Table 7.3: Examples of the Progress of Coding During the Analysis

Initial codes	Intermediate categories	Candidate themes	Final theme
'poor housing conditions'	'poor housing and poverty'	'low socio-economic status'	'social and health disadvantages'
'obstacles in house rental'			
'low or lack of income'			
'uninsured employment'	'lack of social insurance'		
'unemployment'	'harsh working conditions'		
'occupational physical hazards'			
'heavy working schedule'	'communicable diseases'	'health issues'	
'tuberculosis'			
'tropical diseases'			
'sexually transmitted diseases'			

The final thematic maps are depicted in the respective results chapters (Figures 8.1, 9.1, 10.1).

### 7.7.1. Research issues due to language differences

Language differences in conducting research may have consequences, because concepts in one language may be understood differently in another. This is particularly important for qualitative research where language is a central issue in all phases from data collection to analysis and representation of the textual data (Squires, 2009). The relationship between views and language is a two-way process; language is used to express meanings, but also language influences how meanings are constructed (Polkinghorne, 2005). The messages communicated in the source language of this study (Greek) were interpreted by the researcher himself and transferred into English which was the language in which the quality of the empirical research was to be assessed. In this research, no language barriers were present in data collection, transcription and analysis because the researcher and the participants communicated in the same language. The conversion challenges occurred in the translation of the findings into English, in the representation of quotes in the final text and in the discussions throughout the fieldwork/analysis stage with the supervisors. As Van Nes and colleagues (2010) suggest, a record of these discussions with supervisors was kept by the researcher and was useful to make the development of the interpretations transparent when in the later phases of writing up the translations needed to be presented. The

researcher obtained support from a professional translator to further ensure credibility and confirmability of the most important aspects of the translated data and findings (Van Nes, et al, 2010 and Squires, 2009).

### **7.8. Quality Assurance**

Research findings should be as trustworthy as possible and thus this study should be evaluated in relation to the procedures used to generate findings. Within the tradition of qualitative analysis, the concepts of ‘validity’, ‘reliability’ and ‘generalisability’ have been traditionally used to evaluate trustworthiness (Leung, 2015 and Graneheim and Lundman, 2004): ‘validity’ (or ‘credibility’) refers to the confidence in how well data and processes of analysis addressed the intended focus of the research; ‘reliability’ (or ‘dependability’) refers to the replicability of processes and results as data content and analysis change over time; and ‘generalisability’ (or ‘transferability’) is concerned with the extent to which the findings of one study can be applied to other populations and situations.

Certain actions were taken to improve the validity of the present study. The selection of interviewees with various professional experiences, genders and ages contributed to a richer content of the perceptions of phenomena under study which increased the possibility of shedding light on the research questions. Furthermore, the most appropriate methods for data collection and analysis were applied in order to explore the complexity of phenomena and establish the quality of the findings and conclusions. In relation to reliability, the data deriving from this research are plentiful and the collection extended over approximately two and a half years, so there is a risk of inconsistency in the data content. On one hand, it was important to explore the same topics with all the participants. On the other hand, interviewing was an evolving process during which the researcher acquired new insights into the study subject that contributed to the formation of follow-up questions. The extent to which judgements about similarities and differences of content evolved over time was addressed by a continuous dialogue with the supervisors so the reliability of the research was promoted. Finally, the present study explored a specific subject – that is, the provision of care to immigrants – among participants working in specific localities (Attica and Central Greece) in a particular context (public health care services). Findings and interpretations in this study can be generalised to other contexts under similar social conditions. To enhance generalisability, the present study provided a clear and distinct description of the

research setting, the characteristics of the participants and the processes of data collection and analysis. A rich and vigorous presentation of the findings accompanied with appropriate quotations was also applied.

## **7.9. Conclusions**

This chapter has discussed various aspects of qualitative research and its application in the present study. Qualitative research involves the collection, analysis and interpretation of data that are related to social interactions settings and the perceptions of people within these (Anderson, 2010). Semi-structured interviews and thematic analysis were applied in order to elicit and explore the perspectives of medical and nursing staff working in the Greek public health care system on the provision of care to immigrants in the context of the current financial crisis. The main goal of the present study was to understand the problems experienced by these health professionals in providing care to migrants during their daily clinical practice and to explore with them ways in which these might be addressed. The following chapters (8-11) present the findings that emerge from interviewing the research participants, while *Chapter 12* discusses interpretations and implications of the results.

## Chapter 8

### Macro-Level Issues in the Provision of Health Care to Immigrants

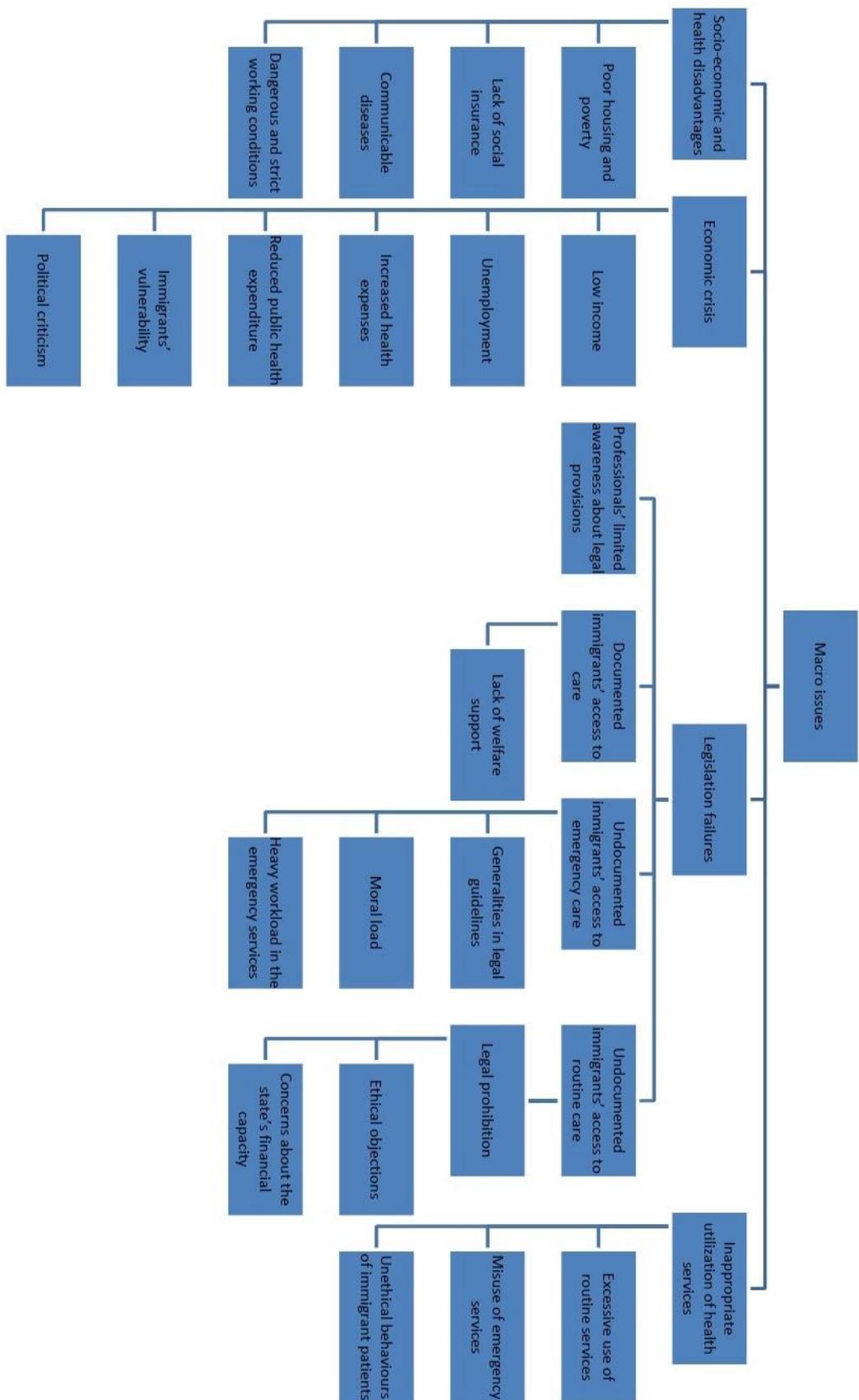
#### 8.1 Introduction

From the interviews with the participants, various difficulties regarding the provision of health care to immigrants were recognised. They can be classified into macro- (political and socio-economic), meso- (operational) and micro- (interpersonal) issues: the first category, the focus of this first data analysis chapter, includes problems which mainly derived from legislative inexpediencies, social integration failures and adverse economic conditions; the second category refers to difficulties due to the organisation of health services (as discussed in *Chapter 9*); and the third category is related to the contact between members of the health staff and the immigrant population (as discussed in *Chapter 10*).

The macro-level in the field of health care refers to the political and socio-economic factors that regulate the provision of care. Accordingly, this chapter includes themes that emerged from interviewing participants regarding socio-economic conditions and legal provisions regulating immigrants' entitlement to health care. As the utilisation of health care is mainly determined by socio-economic, political and legal factors, issues in immigrants' patterns of use of health services are also included in this chapter.

The participants' accounts included many reported difficulties in providing health care to immigrants that had their roots at the macro-level. These difficulties emerged from perspectives on: (1) socio-economic and health disadvantages of immigrants; (2) the impact of the current economic crisis on caring for immigrants; (3) immigrants' entitlement to health care; and (4) utilisation patterns of public health care services by immigrants. Figure 8.1 below presents schematically the relevant themes that emerged from the analysis. It is noted that 'entitlement to' and 'utilisation of' health services are two terms with different meaning. Entitlement to health care refers to the eligibility of a person to access the various types of health services according to legal provisions and governmental regulations (Murray and Skull, 2005), while utilisation is the actual use of health services which is influenced not only by the entitlement to health care, but also by health policy and socio-economic conditions (Van der Stuyft, et al, 1989):

Figure 8.1: Themes in Relation to Macro-Issues in Caring for Immigrants



## **8.2. Socio-Economic and Health Disadvantages of Immigrants**

Participants referred to several special characteristics of immigrant populations that affected the provision of health services. The socio-economic situation of immigrants, communicable diseases and occupational burdens were reported to cause difficulties in providing health care either directly through their impact on the provision of health services or indirectly through their effect on immigrant populations' health status.

### **8.2.1. Difficulties posed by the socio-economic situation of immigrants**

Some respondents highlighted that the housing conditions of some immigrant groups are often less propitious than those of Greek citizens. In fact, it was reported that illegal immigrants face major obstacles in accessing good quality houses because their lack of official documents and low or unstable incomes can lead them to debarment from official rental housing, discrimination and abusive practices on the part of landlords. This can lead to them living in conditions of overcrowding and poor sanitation. The existence of homeless immigrants was also mentioned:

*'... immigrants who found themselves in Greece, without being able to leave ... either live ... on the street in the cold winter and the summer heat or find shelter in miserable, regarding hygiene, homes ...' [P08, resident doctor (male), 34 years old]*

Some respondents reported that poor housing facilities and poverty in general directly affect people's health status and thus create increased demands on the health system. The health system was reported to be liable to manage the harmful effects on the health of immigrant groups and on public health in general:

*'Their main problem is poverty and all that emanates from it, including ... the poor living conditions and their inability to buy basic goods such as food, clothes and medicines. Some immigrants do not have electricity at home and for this reason they cannot store medications that require refrigeration.'*  
*[P06, health visitor (female), 40 years old]*

Many informants stated that economic poverty is a major disadvantage making access to health services and products difficult even for patients who are covered by an

insurance fund. Indeed, it was alleged that even insured immigrants often cannot pay the expenses which are inevitably created by the use of health services, such as providing ordinary contributions to paying for laboratory tests and medications:

*'... a GLP-1 agonist [medication used for the treatment of diabetes] ... costs about €130 and charges the insured around €13. The uninsured has to pay the whole amount. If the patient finds it difficult to cover such an expense (or even the contribution), I am forced to prescribe drugs of another category, cheaper and perhaps less effective ... . There are also tests ... which are not covered by the security funds and are therefore unfeasible to be asked from economically weak patients.'* [P01, consultant doctor (male), 63 years old]

Several respondents noted that this situation may result in poor compliance with medical instructions and can increase workloads for staff employed in public hospitals, where health care is less costly. In addition, it was reported that immigrants who cannot afford to use health services often try to get instructions for their health condition over the telephone or get information from other patients with similar problems. This practice was considered to be dangerous for their health. Moreover, as some respondents noted, health services frequently pick up more neglected cases because the financial hardships faced by immigrants may delay them in seeking treatment for their illness at the earliest point, meaning that they are not accessing services until their condition is advanced and more medically serious.

The illegal informal occupation and unemployment of some immigrants were cited as the reasons for the lack of insurance coverage. Moreover, some informants stated that uninsured employment may be preferred by some immigrants to avoid paying social security contributions so that money could be sent home or cover expenses associated with living in a foreign country. According to these accounts, uninsured immigrants are obliged to pay the full cost for tests and medications and this is a significant barrier to their utilisation of health services, resulting in them receiving only partial care.

### 8.2.2. Communicable diseases among immigrant populations

Several respondents recognised that infectious diseases among immigrant populations can pose significant risks for public health as well as for the operation of health services. In fact, it was noted that after the onset of huge numbers of immigrants arriving in Greece, communicable diseases that had previously vanished or decreased significantly (such as malaria) reappeared in the country. Tuberculosis was reported to be a serious risk because of its prevalence amongst immigrants:

*'... (the hospitalisation of immigrants) constitutes a danger for both the staff and the operation of the clinic. ... there is an increased risk of exposure to Mycobacterium ... for the staff. ... patients must be hospitalised in isolation, so ... an entire chamber is bound, while there is lack of beds and space. ... these patients are a source of transmission ... for the rest of the ... patients, attendants and visitors.'* [P04, nurse (female), 32 years old]

*'(Because of living conditions) it is expected to have increased disease spread among these populations which leads them to hospitals. ... . We are talking about simple diseases such as some mild respiratory tract infections and gastroenteritis, but also about much more serious (ones), such as tuberculosis.'* [P10, nurse (male), 32 years old]

Furthermore, the various forms of viral hepatitis and HIV infection among immigrant populations were reported to be frequent and constitute a serious risk to clinical personnel's health because of the potential exposure to infectious fluids in daily practice. Although this issue was not extensively discussed during the interviews, in a few statements the causes of the increased frequency of infectious diseases among immigrant populations were attributed to the living conditions in their country of origin, the conditions through which they migrated and the disadvantaged conditions they experienced in Greece.

Some respondents offered explanations for the high prevalence of sexually transmitted diseases among immigrant populations. It was suggested that many male immigrants arrive in Greece without being accompanied by a spouse or partner and because of social exclusion and ghettoisation, many of these men are not able to enter into regular sexual relationships and thus turn to casual sexual habits and illegal

commercial sex. The same risk was reported to exist also among foreign women who were illegal sex workers (either by their own will or because of their exploitation by trafficking networks). Some respondents expressed concerns that blood-transmitted sexual diseases directly affect the work of health professionals, since they pose transmission risks in the course of clinical practice.

### **8.2.3. Immigrants' occupational burdens**

Some participants highlighted the employment of many male immigrants in manual employment as a factor for the increased incidence of musculoskeletal disorders:

*'... immigrant men ... often visit the clinic for orthopaedic problems, especially pain in the back, but also in the knees. ... all these are mainly the result of their work, because very often they lift weights ...' [P03, nurse (female), 49 years old]*

Accidents and pathological symptoms were estimated by a few participants as more common among male immigrants because of their employment in dangerous and unhealthy occupations, such as in construction and agricultural work, the lack of education in the workplace and language problems that hinder the comprehension of rules and instructions. For this reason, it was found that immigrant workers often resort to the emergency departments due to injuries and physical complaints. Moreover, it was noted that some female immigrant employees do not take maternity leave because they feared dismissal. Finally, it was also reported that the strict working conditions many immigrants face do not allow them to devote the necessary time for using health services:

*'... immigrant men cannot easily visit the hospital in the hours of the regular outpatients' clinics because they are working. ... this is also a problem for the spouses who need an escort for the visit because ... they do not speak Greek or they do not have the means to come alone or this is imposed by their habits. ... (in case of hospitalisation) immigrant men rush to get discharged in order to return to their work and not lose a lot of wages, while women are in a hurry to return home and take care of the children.'* [P06, health visitor (female), 40 years old]

### **8.3. The Impact of the Economic Crisis on Caring for Immigrants**

One of the aims of the research was to explore the views of health professionals about the consequences of the economic crisis on immigrants' health care. All participants agreed that the current financial difficulties prevailing in Greece have had a significant negative impact on the provision of health services. The adverse effects were reported to disturb the majority of the population, including immigrants.

#### **8.3.1. Consequences of the economic crisis for health care**

According to the respondents, the economic crisis influences the provision of health care in three key ways, as discussed below:

*(a) Impaired access to suitable health care:* During the interviews, it was widely mentioned that in the setting of economic crisis there is a significant reduction in personal and family income and an extended loss of insurance coverage among the population due to the rise of unemployment. The inability of those without social insurance to cover their health care costs using personal expenses was reported to constitute a significant limitation to their access to health services. The impact of unemployment on immigrants' care was given special mention because both the lack of social insurance and the restrictive legal provisions and administrative rules that do not permit immigrants to access welfare benefits come together to further exclude immigrants from using health care. Different economic orientations among some immigrants were also reported:

*'... immigrants ... often work occasionally or in the "black" work as uninsured ... . ... for most immigrants no benefits of social welfare are granted ... so the uninsured immigrants are obliged to cover all their costs ... , if they have the ... money, of course.'* [P08, resident doctor (male), 34 years old]

*'... immigrants ... have a savings strategy and many of them invest or send money home, so they have no money left over for their health care.'* [P03, nurse (female), 49 years old]

**(b) *Rising cost of health care:*** Several respondents felt that there was a slight increase in the cost of health care for patients due to the economic crisis. The rise was reported to consist mainly of small increases in the co-payment schemes of certain medicines and the temporary introduction of a fee for visiting outpatients' departments of health services. Additional hidden costs were mentioned such as the establishment of fees for the execution of prescriptions, payments for telephone calls to schedule appointments with doctors and expenses for consumable supplies and pharmaceutical products. It was noted that although the overall increase in costs is seemingly small, it can be unbearable for vulnerable groups, such as financially weak immigrants, and thus it can significantly affect the provision of care to these populations.

Despite the reported increase in health care costs, most informants felt that the economic crisis created an increasing number of patients, including immigrants, to the less costly services provided by the public health sector. Furthermore, many health professionals believed that the health system was operating under adverse conditions in terms of funding. In fact, some participants noted that the insurance funds were struggling to cover the costs of caring for their members because social security contributions had fallen dramatically due to the rise in unemployment. Unpaid bills or delayed payments by insurance funds and private clients were reported to create budget deficits within health services. In addition, the cutbacks of benefits by social insurance organisations were suggested to further abase the potentials for health care.

**(c) *Limitations in public health expenditure:*** Several participants referred to the cuts in public health expenditure introduced by the state that were intended to address the excessive deficit. The financial constraints were reported to impair health services' budgets and cause elements of malfunction. Participants noted the appearance of shortages in equipment and consumables, lack of staff, merges, downgrades and rescissions of hospital departments and other health facilities, long waiting lists for scheduled appointments and delayed services.

It was noted by many informants that the reductions in health services' funding is the reason for suspending the recruitment of new health professionals in the public sector by the state. The limited potential for the replacement of retiring health personnel and the coverage of new posts were mentioned as consequences that result in a gradual reduction of the number of health professionals serving in public hospitals and clinics. The loss of previously secured labour rights and benefits was said to contribute to the

negative image that health professionals have for working in public health care services and the high rate of early retirement:

*'... (retired) colleagues tried to establish in time some of their pension rights, which undergo continuous degradation. ... there is a general feeling of dissatisfaction ... because of working conditions and wage reductions which encourage health professionals to retire early. ... we are talking about experienced executives who knew how to manage difficult situations ... and in many cases leave an irreplaceable space.'* [P01, consultant doctor (male), 63 years old]

*'There is a great shortage of staff of nurses. This is the alpha and omega. There always was, but after the crisis the situation has escaped every limit. In the night shift I work alone, without an assistant, and I am often responsible for ... over thirty patients.'* [P19, nurse (female), 35 years old]

It was also widely reported that, for the same economic reasons, there was a reduction in the remunerations of medical and nursing staff, which had created disappointment amongst health professionals and led to some feeling devalued:

*'... there is job instability and insecurity. Even permanence ... for those working in the public (sector), now does not exist. ... our earnings have fallen significantly.'* [P03, nurse (female), 49 years old]

Occupational stress, disappointment and dissatisfaction were also highlighted as consequences of the existing financial constraints in health services:

*'Now, there is professional uncertainty about the future. I was working at another hospital, I was suspended and after a few months I was appointed to the hospital that I am now. You understand that I went through much stress until I got my job back.'* [P06, health visitor (female), 40 years old]

*'... there is a great reduction in salaries ... especially for nurses ... . This is evidence of impaired recognition of our work ... and causes major problems,*

*even for our survival. ... promotions are frozen, official working hours were increased, involuntary movements of employees were executed and, most importantly, ... there is no certainty anymore ... making the risk of job loss visible ...* [P07, nurse (female), 45 years old]

*'The willingness to offer ... is lost. The execution of our work has become a formality.'* [P16, midwife (female), 48 years old]

In fact, many participants stated that a considerable number of doctors and nurses had left or were considering leaving the Greek national health system entirely to seek higher salaries and better working conditions abroad. Moreover, these shortages in personnel were progressively worsening:

*'The difficulties in daily routine in the hospital and the reduction of wages ... have led many capable doctors and nurses to look for a job abroad ... . Even I have thought to look for better luck abroad and not necessarily as a nurse, but I would go as a cook too.'* [P04, nurse (female), 32 years old]

In addition, many participants felt that the shortages in health staff created a rise in workload. However, some participants suggested that the increased occupational dedication of health professionals in public health care services may compensate for the lack of personnel:

*'... while the official length of the shift is eight hours, we have reached a point where each nurse ... works up to ten hours on each shift, without, of course, an additional payment. ... despite the lack of staff, nursing care levels have not decreased, since nurses work very hard in order to manage the entire workload ...'* [P04, nurse (female), 32 years old]

Besides the consequences for the operation of health services, many informants stated that the restrictions in public health expenditure had caused difficulties in maintaining the existence of public health programmes which in turn could have a direct negative impact on population health.

### **8.3.2. Immigrants as a special population group**

Most participants acknowledged that the consequences of the financial crisis concern the provision of health care to the majority of the population in Greece. However, it was broadly supported that the effects of adverse financial changes are more distressing to disadvantaged social groups, such as financially weak immigrants. These population groups face major economic problems and usually suffer from more frequent and intense health problems due to their poorer general health condition, their harsher living conditions and the difficulties they face using health services:

*'I cannot say that there are different consequences, the crisis touches everyone. The gravity of the consequences is what is different. ... the most vulnerable to the induced effects are the weakest social groups, such as immigrants, who do not have the financial capacity to cope.'* [P05, health visitor (female), 44 years old]

Caring for immigrants was reported to be accompanied by special problems, such as communication barriers, legal limitations, inappropriate health care use, cultural and social issues and operational difficulties which were supported to worsen or at least be unresolved because of inefficiencies created by the economic crisis. Moreover, it was reported that immigrants' difficulties in accessing health services due to the economic crisis could lead to an exacerbation of the prevalence of communicable diseases and threaten public health.

### **8.3.3. Political criticism**

The appearance and establishment of the modern economic crisis was a springboard for criticism among some participants for prior state health care policies in relation to immigrants. About half of the participants expressed strong objections to the uncontrolled expenses for immigrants' care previously prevailing in the health system. That situation, according to some informants, favoured the emergence of exploitative practices of public health care services among some immigrants, even to an extent that far exceeded the limits of legality. The criticism mainly regarded the immoderate consumption of resources for the treatment of immigrants who either were not entitled to use the entire range of health services or their contribution to taxation and social

insurance contributions was negligible. Some respondents considered that such fraudulent actions were a trigger for the economic crisis in the first place:

*'... before the onset of the financial crisis ... (there was an) excessive use of health services, especially primary health care services. ... . It was dreadful to see an uninsured illegal immigrant to spend everything without (him/her) paying anything. At least, insured immigrants were paying their contributions. However, illegal immigrants or those who deliberately worked (as) uninsured did not pay anything. Nevertheless, ... the state let them use everything for free, doctor visits, tests, vaccines. And exactly because all these were offered free of charge, they had come to a point to bring their relatives from their country of origin in order to take advantage of these free benefits of the Greek state. We are talking about entire clans. How could the economy not fall out? How could the health system not create deficits?' [P03, nurse (female), 49 years old]*

*'All that changed after the onset of the economic crisis is the availability of money. Until a few years ago there was a terrible waste of money ... which could cover everybody's needs, including immigrants. ... we used to offer everything for free, tests, medications, vaccines, whatever you can put in your mind. We did not care if the immigrant was insured or uninsured, legal or illegal. ... . Perhaps we, as health professionals, were partly at fault. Maybe the immigrants were spoiled in this way and perhaps that is why they became demanding. ... . We did not think that the system's potentials were finite and that it is not possible to offer ... everything. We did not understand that we lived in the era of fat cows and so we did not care to prepare for the era of lean cows.' [P05, health visitor (female), 44 years old]*

*'The care of immigrants, especially the illegal (ones), was based on the humanism of health professionals and the tolerance of the state, but cost incredible amounts to Greek taxpayers and insured (persons) and it is largely responsible for the collapse of the health system in Greece.' [P12, consultant doctor (female), 39 years old]*

These criticisms mainly concerned respondents' perceptions of uncontrolled spending on what were perceived to be the provision of excessive and unreasonable levels of routine health care to people who were not entitled to such support. Typically, these were identified as illegal immigrants. Some respondents, who expressed such negative views about immigrants' use of health care, also favoured the necessity of providing emergency health coverage for undocumented immigrant populations from a humanitarian point of view. This apparent contradiction is discussed further in later sections of this chapter and in the concluding chapter.

#### **8.4. Immigrants' Entitlement to Health Care**

The legislation defining the entitlement of the various categories of immigrants to the different types of health care in Greece was explained earlier in *Chapter 4*. An important goal of health policy for immigrants is to facilitate their access to health care for the benefit of both individual and public health but also to protect public health care services from undue pressures that may be placed upon them by immigrants who are unlawfully in the country (Law No. 4368/2016, article 33 and Law No. 4251/2014, article 26). This policy in Greece is mainly expressed through legal provisions and governmental circulars which define both the overall rules and the details regulating the provision of care to immigrants. Some participants had low awareness of the relevant legislation, whilst others highlighted a number of flaws within the existing legal and administrative framework regulating immigrants' access to health care.

##### **8.4.1. Health personnel's awareness of the relevant legal provisions**

The interviews revealed that participants were not usually familiar with the provisions in Greek law that relate to immigrants' access to health services:

*'I want to tell you the truth. I do not know what is required by the law on this issue. ... . When a foreign patient comes to the clinic, I send him to issue a ticket at the cashiers, as indeed happens with the Greek patients, and so I rely on the administrative clerks (to check the right to access).'* [P06, health visitor (female), 40 years old]

*'... I do not know ... the exact wording of the law. I have only learned what generally applies from the daily practice since I became a head (midwife). Before (that), I knew nothing.'* [P18, midwife (female), 51 years old]

The reason for this scarcity in knowledge was partly attributed to the limited information provided to health workers by the administrative services of health agencies. However, some respondents also felt that health professionals should not engage with issues about immigrants' entitlement to health care. As such, there may be a subtle or deliberate unwillingness on the part of some health professionals to become familiar with the relevant legal provisions:

*'I have no opinion on such matters. I am a health visitor and my role is to care for the promotion of people's health. It is not my job to check who has the right to come to the hospital and who does not. My obligation is to help patients when they need me. These (issues) should be regulated by administrative services of hospitals rather than health professionals.'* [P06, health visitor (female), 40 years old]

The lack of awareness about the law's provisions was reported to have a direct impact on daily clinical practice and health personnel's decisions to care for immigrant patients:

*'(Doctors are afraid of) a possible misdiagnosis or violating the law by refusing to offer all the potentials for care to an illegal immigrant. Besides, do not believe that doctors or nurses know what the law says on this subject.'* [P09, nurse (female), 33 years old]

When health professionals are not adequately informed about the laws that regulate immigrants' care, violations of immigrant patients' rights may occur during the provision of health services, as a few informants noted:

*'... health professionals themselves often violate, mainly due to ignorance, the rights of immigrants to health care, putting them, for example, to pay for services which should normally be provided for free. ... most doctors and*

*nurses are simply not able to inform immigrant patients for their rights ...'*  
*[P08, resident doctor (male), 34 years old]*

#### **8.4.2. Documented immigrants' access to health care**

Despite low awareness of immigrants' legal entitlement to health care, many participants expressed the notion that legal immigrants have sufficient access to health services and products as long as they are socially insured. According to many interviewees, insured immigrants' access to health care is equivalent to the respective access of Greek citizens and consists of full rights to consultation, tests, hospitalisation and treatment. The existence of this grade of access was suggested to be justifiable from a moral view because of the equivalent participation of the documented insured immigrants in taxation and social security contributions, although some objections were raised on the applicability of the law because of the large population of immigrants in the country:

*'... I have no objection when the state provides services to people who pay taxes and levies and respect the laws of the country hosting them. ... but I have the impression that the legislator had in mind that in the country there would be a manageable number of immigrants, not this chaos prevailing today.'* [P12, consultant doctor (female), 39 years old]

On the other hand, it was also suggested by some respondents that uninsured documented immigrants have inadequate access to health care because they have to pay for services and products. These participants recognised shortages in social protection in this case because of immigrants' minimal entitlement to welfare support which creates an inability to freely access health services. However, most of the informants suggested that certain groups of immigrants (such as refugees, asylum seekers and immigrants with special health needs) are sufficiently covered by the public hospitals' services in accordance with the relevant legal provisions.

#### **8.4.3. Undocumented immigrants' access to emergency care**

Most participants reported greater issues in undocumented immigrants' entitlement to use the various types of health services. As the existing provisions of Greek law allowed the provision of health care to undocumented immigrants only in emergency cases,

respondents mentioned a series of practical problems deriving from this regulation. It was reported that there was vagueness in the law regarding the type of care that undocumented immigrants are entitled to. The lack of clarity in the legal provisions was said to create difficulties amongst health workers in treating immigrant patients without documents. The health professionals' predicament was reported to depend on various parameters. Firstly, it was stated that it was difficult or even impossible to define some health conditions as urgent or non-urgent and thus similar cases may elicit different responses from health professionals. Secondly, informants mentioned that the immediate diagnosis of a medical condition as urgent is often impossible and thus a direct positive or negative decision for the provision of care is not feasible. Thirdly, it was raised that if a non-emergency situation was left untreated it could develop into an urgent condition. Additionally, it was suggested that the concept of emergency excludes the situations that are not life-threatening but substantially affect the physical and, in turn, the social life of the individual:

*'I cannot treat complications without treating the basic disease. This is wrong, not only from a moral but mainly from a medical perspective.'* [P17, consultant doctor (male), 67 years old]

*'... the philosophy of the law is unrealistic in practice. ... we cannot provide partial care. The needs for emergency and regular health services are related, especially in chronic diseases.'* [P18, midwife (female), 51 years old]

Furthermore, it was noted that pregnancy is not considered as an emergency situation and thus health care for undocumented pregnant immigrants is only provided at delivery thus missing opportunities for the identification of potential complications during the pregnancy itself:

*'... pregnant immigrants, who have no papers, are not covered for prenatal care, are not monitored during pregnancy and arrive at the hospital shortly before birth ... with all the risks that this entails for the mother and the child.'* [P08, resident doctor (male), 34 years old]

The responsibility for making a positive or negative decision to provide emergency care to undocumented immigrant patients appeared to burden health staff, mainly doctors, and was reported to create a heavy moral load:

*'... the moral dilemma of whether to help or not (is put on health professionals). How can you deny? In all cases, the decision depends on the willingness of each doctor. Practically, it is in the discretion of a doctor to examine or not the immigrant patient.'* [P03, nurse (female), 49 years old]

*'What can the doctor say? Can he oust a patient because he is illegal? ... . Eventually, all (immigrants) are examined and so dilemmas are avoided.'* [P18, midwife (female), 51 years old]

In practice, most informants felt that all immigrant patients were treated without restriction in emergency departments, regardless of the urgency of their condition and the legality of their presence in the country. The ethical dilemmas as well as the ambiguities of immigration law were avoided by providing full care:

*'... there is a fear on the part of health professionals, especially doctors, that if they refuse to provide services to an illegal immigrant and then anything happens to the health of the person, they will be held responsible for their refusal.'* [P03, nurse (female), 49 years old]

This situation was seen by some informants to burden the operation of emergency departments, leading also to an unsustainable rise in the cost of care. The combination of these drawbacks was felt by some respondents to endanger the provision of health care to the indigenous population:

*'... health care to illegal immigrants must be offered only in truly exceptional cases. At some point the Greek hospitals must stop offering unlimited services to people who have come illegally in the country, charging in this way the Greek citizens who have paid too expensively (for) the public health system and result in several cases to have deficient care.'* [P09, nurse (female), 33 years old]

#### **8.4.4. Undocumented immigrants' access to routine care**

According to existing law, illegal immigrants are not entitled to use non-emergency health services. A variety of relevant medical and ethical consequences were reported in the interviews. By not having access to regular care, an increased risk of worsening morbidity among the illegal immigrant population was reported, creating a medical and moral obligation for protection. Furthermore, it was widely stated that the restrictions on undocumented immigrants' access to non-emergency health services led patients from these populations to visit the emergency departments which, in turn, results in fragmented medical surveillance and incomplete treatment of these populations, thereby exacerbating the morbidity risks for both the immigrant and the general population:

*'... the visits of illegal immigrants to health services take an occasional character. The majority of these people will visit the emergency department only once, they are not going to come back for reassessment, it is doubtful whether they will take treatment and no one can know what the course of their health will be.'* [P05, health visitor (female), 44 years old]

*'... (in) the emergency room ... (no) file is kept, so there are blanks in the medical supervision of the patient.'* [P09, nurse (female), 33 years old]

The lack of undocumented immigrants' entitlement to routine care was reported to create obstacles in daily clinical practice. Some participants mentioned informal ways of bypassing these obstacles when there is crucial need. However, it was suggested that the effectiveness of these solutions cannot compensate for the lack of formal access to routine care:

*'... we try to reduce hospital days to the minimum duration, so they will be charged less. ... . Sometimes we ask favours from the laboratory to make tests without charge. Unfortunately, such favours cannot be made in cases of hospitalisation, perhaps because they must be officially recorded.'* [P13, nurse (female), 42 years old]

From a humanitarian point of view, several objections were expressed regarding the legal prohibition of the provision of regular health services to illegal immigrants. These

objections were related to the creation of inequalities in health which were said to be contrary to prevailing professional ethical standards. Moreover, participants were aware that immigrants often belong to poor economic classes and are therefore unable to pay for the use of private health services:

*'We must not forget that illegal immigrants are people too. Once found in Greece, they have the right to get well if they fall ill. If the state does not want them here, it must send them away. If they are not useful to society, they should not be here. In an organised society, no illegal immigrants should be present.'* [P11, nurse (female), 36 years old]

*'... all people should have the right to care. It should not matter whether an immigrant is illegal or not. Besides, do we not serve prisoners? They have also broken the law in some way. However, the protection of human health is a separate issue.'* [P13, nurse (female), 42 years old]

Despite these negative consequences, it was felt by several participants that the state cannot fully cover the provision of health care to undocumented immigrants due to financial constraints and organisational barriers which provide a moral and operational justification for this prohibition:

*'Normally, all people should have the same rights for access to the health system. That would be correct morally. ... in reality, there is no such possibility currently. ... First, the economic problems must be solved and the (national health system) has to be built again and then we can change the laws.'* [P10, nurse (male), 32 years old]

#### **8.4.5. Coverage of undocumented immigrants' as a threat to the legal population's care**

Several respondents expressed the fear that the quality and availability of health services might be threatened by the demands placed on them by undocumented immigrants. A number of informants also argued that the relevant provisions within immigration law were justifiable because the idea of the availability of full care services to undocumented immigrants was not totally acceptable amongst health personnel and in

society more generally since these people do not contribute to taxation and social funding in contrast to Greek citizens and legal immigrants:

*'... it is unacceptable to provide all possibilities for care to people of foreign nationality who neither have social security nor pay anything for their hospitalisation. ... if the hospitals treated totally free all illegal immigrants, the cost of their care would be exorbitant and transferred onto the shoulders of the legally insured and taxpayers, Greek citizens and ... insured immigrants, and this fact ... I think is unfair.'* [P04, nurse (female), 32 years old]

*'I disagree with any action overloading the system, especially under the present circumstances. The volume of refugees is too large ... . The health system does not completely cover anymore the Greeks. Instead, refugees enjoy everything for free. ... Greeks pay for a lot ...'* [P16, midwife (female), 48 years old]

Concerns and distress about the rising cost of care were expressed through participants' statements demanding the coverage of expenses by immigrant patients themselves:

*'I do not care what kind of access (immigrants) will have. All I care is that they pay ...'* [P14, resident doctor (female), 33 years old]

Some participants estimated that a potential full coverage for undocumented immigrants' access to health care could cause negative outcomes. The latter include a possible social reaction, which was also said to explain the political reluctance for any change, an economic aggravation due to the rise in operational costs and an increase to health staff's workload. Nevertheless, the legal obligation for the protection of immigrants' health in emergency conditions as a necessary ethical and medical measure was questioned by no one in the research.

#### **8.4.6. General aspects on undocumented immigrants' care**

In conclusion, a wide range of views were expressed in relation to the provision of full health care to undocumented immigrants. Although full health care coverage was

recognised and accepted by many informants as a basic right as well as a medical necessity, there were doubts regarding the ability of the state to offer it, especially under the current financial circumstances. This conflict was also revealed through the expression of dilemmas about undocumented immigrants' access to health care:

*'... the legislation concerning the treatment of illegally staying immigrants is debatable. I do not dare to say whether it is fair or unfair, surely, however, it is controversial. ... perhaps the law should allow wider access, including the right to care in cases of serious diseases, which are not emergencies. However, I hesitate to express this view with certainty, because I understand that there may be a large economic and social cost from such a decision.'* [P05, health visitor (female), 44 years old]

*'It is very difficult to answer this question (about the right of undocumented immigrants to access health services openly). Certainly, all people are in need of medical services. However, if this means that there will be Greek cancer patients or children that will be excluded from suitable care, the situation becomes complicated ...'* [P17, consultant doctor (male), 67 years old]

*'Full access for all immigrants is the right decision from an ethical standpoint. With that in mind, however, everything must be offered for free. Then, immigrants will have no reason to become legal.'* [P20, midwife (female), 43 years old]

From the participants' responses, it appears that there were concerns about the resources spent on immigrants' health care. Although almost all informants accepted that the 'lawfully present' immigrants should be entitled to the use of health services without limitations, there were worries about or objections to undocumented persons' eligibility for health care. Anti-immigrant sentiments – such as prejudice, xenophobia or even racism – may have shaped these views. As a consequence, many informants gave priority to health care for authorised residents – Greek citizens and legal immigrants – even though such a view is contrary to medical and nursing ethics which were also prevalent amongst the study population.

No special patterns of views were recognised in relation to the various characteristics of the health professionals participating in the research. Perhaps the expressed perspectives depend on the political ideologies of the respondents which were not explored as a parameter in the present study. Interestingly, some respondents stated that the restrictive provisions within immigration law are ignored in the daily clinical practice as health services are often perceived to freely provide care to all the categories of immigrants either officially, on a voluntary basis or because the application of the relevant rules is de facto impossible:

*'... for illegal immigrants, it is not possible to transfer the debt to the tax service, since these people are not recorded anywhere, so the hospital usually cannot demand the payment of medical expenses in any way. Especially in the clinic where I work, the more incidents are related to emergencies and we never look if the immigrant is legal or illegal.'* [P11, nurse (female), 36 years old]

### **8.5. Utilisation Patterns of Public Health Care Services by Immigrants**

A constant theme that emerged across the interviews was the perceived inappropriate utilisation of public health care services by immigrants in Greece. The type and intensity of the reported misuse appeared to depend mainly on the legality of their presence in the country and their socio-economic status. Therefore, the patterns of health services' utilisation, as they were described by informants, were determined by the existence of the aforementioned themes in this chapter and consequently were considered to lie at the macro-level.

Several participants mentioned that the use of routine health services by legal immigrants was greater than what was expected and compared with the respective use by the native population. The social integration of legal immigrants as well as their awareness about the operation of the health system appeared to favour immigrants' use of public health care services according to participants' accounts. In addition, when immigrants have social security, the use of public hospitals' and clinics' services was reported to be greater:

*'... immigrants make great use of the whole range of public health (care) services and, in general, avoid private health (care) services. ... I often see*

*in the history of hospitalised immigrants that they have only visited doctors in the public (sector) for their condition or that their tests are only from public laboratories. ... there is more flexibility in the use of health services on the part of immigrants when they are insured in a fund.' [P04, nurse (female), 32 years old]*

The participants offered various kinds of explanations for this situation. Some of the reasons that were felt to have led immigrants to a higher utilisation of public health care services were presented as understandable and acceptable to some extent. Firstly, it was in part justified among some informants by the harsh economic situation for many immigrants:

*'... immigrants make extensive use of the free health services offered by the public (sector). But this makes sense to some degree. These are vulnerable populations who largely face significant financial problems ...' [P04, nurse (female), 32 years old]*

*'Many immigrants cannot afford to visit private doctors, so they turn to public hospitals and the (primary national health network), whose services are free.' [P13, nurse (female), 42 years old]*

Public health care services are offered at no or minimal cost and this allows those without much income to make use of such services. Private health services were reported to be prohibitively expensive for a large portion of the immigrant population.

The use of emergency services was also higher by immigrants, according to the responses of several informants. Respondents acknowledged comprehensible reasons for this situation. Immigrants' morbidity – due to a higher exposure to unhealthy occupational and housing conditions – was mentioned as a reason for their greater utilisation of emergency services. Furthermore, the lack of social insurance or a residence permit was suggested to lead unemployed or illegally occupied and undocumented immigrants to turn to the emergency departments which, in general, do not require the existence of social security or documentation:

*'Often, immigrants stay illegally in Greece or work in the "black" labour and are therefore not insured, so they do not have access to clinics in the (primary national health network) and ... the emergency departments are their only access route to health services.'* [P08, resident doctor (male), 34 years old]

Moreover, the open nature of emergency departments was identified as a reason why immigrants were reported to favour their use. Immigrants are often employed in jobs with extensive working hours and thus face difficulties in establishing and keeping scheduled appointments in the regular clinics:

*'... the (emergency) departments operate throughout the day, the whole week, so immigrants, whose works have generally a very heavy schedule, are accommodated.'* [P01, consultant doctor (male), 63 years old]

It was also mentioned that immigrant families usually lack a regular family doctor that could provide care for them, when needed, and prevent them from inappropriately visiting the emergency room:

*'... many immigrants do not have a family doctor or attending physician who monitors them regularly for their chronic diseases. For this reason, they find as a solution to turn to the hospitals' emergency departments, even for problems that do not need urgent attention.'* [P08, resident doctor (male), 34 years old]

*'... there is no one to guide them properly. ... . Even doctors of non-governmental organisations sent them unnecessarily to the emergencies' (department).'* [P14, resident doctor (female), 33 years old]

Regarding newly arrived immigrants, their access to regular care was said to be impeded by practical and operational factors, motivating them to visit the emergency care services:

*'... maybe the lack of knowledge for the health system's way of functioning and language barriers can drive them more easily to the emergencies (department). They may, for example, not know or cannot make arrangements by telephone to make an appointment at the regular clinic.'*  
[P10, nurse (male), 32 years old]

However, some respondents felt that the degree of emergency services' utilisation by immigrants often exceeded acceptable levels and included improper tactics on the part of some immigrants. Tales of emergency services exploitation were described, such as systematic utilisation of emergency departments for routine care and irrational use of ambulances for transportation to health services. Respondents, who believed that immigrants acted in this way, described feelings of intense uneasiness:

*'I disagree with any tactic that attempts to manipulate unfairly the system, because it shows that there is no respect for the institutions.'* [P06, health visitor (female), 40 years old]

Some participants also described elements of unethical behaviour among some immigrants in order to overcome the legal barriers to health care. Typical examples included false claims on the part of undocumented immigrants about non-existing or minor urgent symptoms in addition to the primary non-urgent clinical problem, as well as the accumulation of unpaid expenses from using services:

*'... in emergencies ... the requirement of payment may be deferred for later, when the patient overcomes his problem. ... in most cases immigrant patients either do not really have or claim to have no money, so the debt remains unpaid. Many times, ... an immigrant patient presents to the doctor intentionally, besides his permanent basic problem, also an urgent symptom, which may not really exist or if it exists, it is exaggerated in order to be considered as an emergency ... . This is a common tactic. I suspect ... that they communicate together and follow this tactic to achieve ... free care. ... after so many years in Greece, they have learned how the system works and how to exploit its weaknesses.'* [P03, nurse (female), 49 years old]

*'Many immigrants, especially those who are illegally in Greece, cannot afford to pay the hospital fees. For this reason, ... (many) illegal immigrants leave the hospital without paying, ... they abscond before they discharge, even after a surgery.'* [P11, nurse (female), 36 years old]

Some respondents attributed what they perceived to be a tendency for excessive exploitation of the health system by some immigrants to their disadvantageous position in life, although most participants did not justify this on a moral basis. It was suggested that some immigrants sought to receive health care because they considered this action a way to compensate for the existence of barriers to economic success and social recognition in the host country:

*'... among immigrants there is an attitude of overexploitation of all the rights offered to them by the state. They might think that there should be a favourable treatment of them by the services because of their economic and social weakness.'* [P01, consultant doctor (male), 63 years old]

Some informants also suggested that immigrants overused health services because most of them lacked similar benefits in their country of origin so the existence of comprehensive and low-cost care in Greece was seen to have created a desire for overexploitation:

*'... there is no essential care in their country. Open access (to health services) is an opportunity that is presented to them and they take advantage of it.'* [P14, resident doctor (female), 33 years old]

*'Most immigrants come from countries where benefits are almost non-existent. Perhaps, this has caused to them a culture of exploitation of all available public services, including health services.'* [P18, midwife (female), 51 years old]

Even the meaning of open access to health care was reported to be distorted among some immigrants because of incorrect perceptions about the necessity to use free health services:

*'... many immigrants, especially from Albania, have a wrong perception about the concept of free health care. They do not seem to understand that free health care should only be provided to people who have a real need, because this cost is ultimately paid by all of us.'* [P02, resident doctor (male), 36 years old]

*'... the majority of immigrants do not have the mentality to pay for health services. They believe that care is a state's duty. Of course, this is a paradox because in their country the offered care was rudimentary.'* [P13, nurse (female), 42 years old]

It was also suggested that increased health services' utilisation was partly based on immigrants' feelings of insecurity that are created because of their presence in a foreign place:

*'Care services exude a security for people and for this reason perhaps they are a magnet for non-privileged populations, such as immigrants.'* [P01, consultant doctor (male), 63 years old]

Moreover, a few informants suggested that some immigrants may interpret the act of receiving health care as an element of acceptance and integration in the host society:

*'... the visit to the doctor and generally the health services ... creates a feeling of acceptance in some immigrants. ... they feel that they have been integrated by the system, since public clinics, particularly of primary care, due to the nature of their service, are a place in which all people are equal and acceptable.'* [P05, health visitor (female), 44 years old]

It might be expected that immigrant populations would have a limited knowledge of the health system's operation. However, some informants felt that there were many immigrants who were fully aware of their entitlements to health care and who took advantage of deficiencies in public administration:

*'... immigrants know their rights very well, maybe more than what the Greeks (do). ... . It is common practice that some purely economic immigrants follow the process of applying for asylum to legalise at least temporarily their staying in the country. Because, indeed, the relevant departments are too slow in processing their applications and responding about their right for residence, these immigrants are using completely legitimately the public health (care) services ... as candidate refugees.'* [P06, health visitor (female), 40 years old]

Further practices of manipulation of the public health system were reported, such as attempts by uninsured immigrants to overcome the rules of entitlement to health care:

*'... (insured) foreigners ... give their health booklets to uninsured compatriots of them and cheat in this way the health system.'* [P03, nurse (female), 49 years old]

Some respondents argued that health workers were either unable to recognise the deception or deliberately permit the manipulation of the system out of feelings of compassion or empathy:

*'It is often difficult to identify the photo in the health booklet ... . At other times, the impersonation is perceived by staff, but there is tolerance. ... for humanitarian reasons and depending on the severity of the incident, the staff can overlook the fraud. ... . If the uninsured immigrant was able to be insured or had the financial capacity to pay, probably he would not use another (person's) booklet. The need is the main reason that pushes them to this practice.'* [P03, nurse (female), 49 years old]

*'I have no doubt that it is not right. These solutions are small dodges in which we turn to with "heavy" heart to help people in need. We have nothing to win.'* [P13, nurse (female), 42 years old]

Nevertheless, some respondents expressed concerns that the personnel may be held responsible for failing to identify elements of unethical behaviour on the part of immigrants:

*'... the nurses of the shift ... take the blame when patients stealth out of the clinic (leaving unpaid hospital fees). But this is unfair. Nurses do not have police powers. It is humanly impossible to monitor the patient continuously ... . If someone wants to escape, he can do it. The hospital is not a prison.'*  
[P11, nurse (female), 36 years old]

## **8.6. Conclusions**

As the findings show, it has become apparent that the respondents in this study identified a series of issues associated with the provision of care to immigrants within the macro-context of health care. Firstly, the participants suggested that there are several disadvantages posed to groups of immigrant populations by economic and social conditions. All informants agreed that the current economic crisis creates obstacles to immigrants' use of care through exacerbating the social disadvantages of some immigrants and causing restrictive health policies. Moreover, the analysis of the data revealed several flaws created by the existing legal framework that regulates the provision of care to immigrants. Most of the reported problems in everyday clinical practice appeared to be related to undocumented immigrants' care. Indeed, there were concerns about the restrictions of the existing legal framework and several considerations about moral and public health consequences arising from barriers to health services' access. At the same time, however, some informants felt that the health system had reached or even exceeded its ability to accommodate increasing numbers of patients, including immigrants, without reducing accessibility or lowering quality of care. For many informants, the existing legal framework has failed to adequately regulate immigrants' access to care. As a result, some respondents, despite their positive views on the need for equity in health care, believed that the unrestricted use of services by immigrants posed a possible threat to the operation of the health system as a whole. Finally, there was a high degree of consensus among participants about the factors determining the patterns of health services' utilisation by immigrants. The professional status, age and clinical experience of the informants did not seem to differentiate the views expressed in the interviews. Many participants expressed strongly held views

about the excessive or inappropriate use of health services by immigrants that could be described as stereotypical. These findings are discussed further in *Chapter 12*.

## Chapter 9

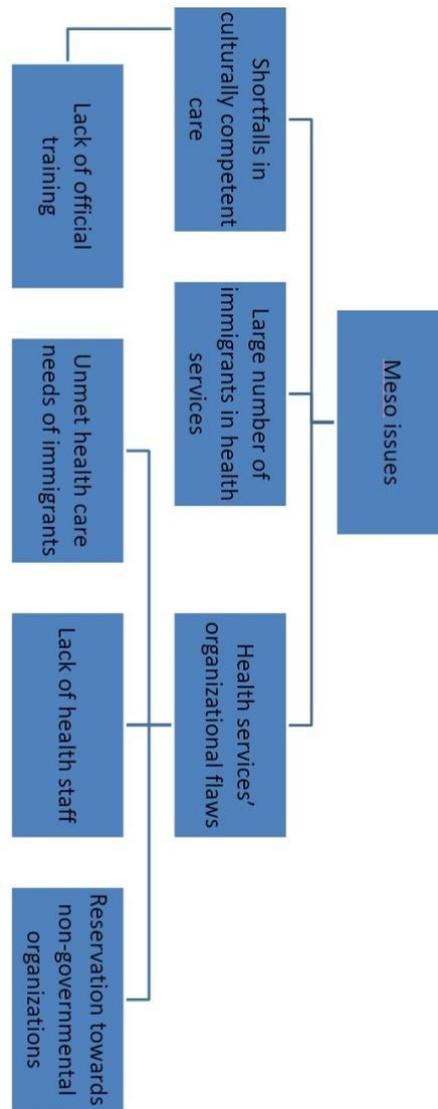
### Meso-Level Issues in the Provision of Health Care to Immigrants

#### 9.1. Introduction

As explained in *Chapter 6*, the meso-level in the provision of health care refers to the organisation and operation of health services. Health facilities – mainly hospitals, polyclinics and health centres – constitute the public clinical sector of the meso-level in the Greek health system. These services are devoted to the clinical treatment of patients, but also assist health staff by providing them with the expertise and tools they need to perform their role. Health staff have to make good use of the available resources with the ultimate purpose of serving the community and protecting the health system from unnecessary burdens. A series of deficiencies in treating the immigrant population were identified within the operation of public health care services. Informants' raised three key issues in this regard: (1) shortfalls in providing culturally competent care; (2) insufficiency in serving the large number of immigrant users; and (3) organisational flaws within health services (see Figure 9.1 below).

Perhaps unsurprisingly given its 'middle' nature and the strong connections between the three levels of health care, some issues raised in this chapter lie at the interface between the meso- and the macro-level and between the meso- and the micro-level. Indeed, the operation of health services (meso-level) is largely regulated by state policies and rules (macro-level), especially in a health care system with significant central governance, as in Greece. Additionally, the pressure on the operation of health services (meso-level) from the large number of immigrant users is obviously related to the large numbers of immigrants more generally in Greece which is mainly a political issue (macro-level). Moreover, culturally competent care is provided to patients both individually by each health worker (micro-level) and by health services as a whole constituting an institutional feature of health care (meso-level) also. Notwithstanding this interconnectedness – *Chapter 12* brings together these three separate themes into the one analytical gaze – this chapter focuses specifically on those informants' views that spoke to health services' deficiencies of an operational nature only (meso-level shortfalls).

Figure 9.1: Themes in Relation to Meso-Issues in Caring for Immigrants



## 9.2. Shortfalls in Providing Culturally Competent Care

Participants expressed high levels of confidence in the Greek health system in terms of health workers' clinical skills and health services' technical expertise. Almost all informants suggested that the scientific training of most Greek health professionals was satisfactory and met the clinical duty to treat. However, some respondents raised concerns about the lack of official, specific training for health staff in approaching the nature and implications of cultural diversity amongst patients. Several informants expressed doubts about the ability of health professionals to comprehend the many and varied social problems faced by immigrants and respond in a culturally competent way:

*'... I answer with a big "no" (to the question about the existence of health professionals' training in immigrants' care issues) and this is mainly true*

*for the professionals of the nursing sector. There is no specialisation in the intercultural part of nursing care. In Greece, we have put to “sleep” the issue of intercultural nursing.’ [P10, nurse (male), 32 years old]*

*‘There is lack of information for health professionals in (cultural) matters. Without such information, it needs great maturity from a health professional ... to understand that (he/she) is morally obliged to serve an immigrant. Perhaps most of us do not understand that immigrants were forced in one way or another to come here. Under other circumstances we could be in their place.’ [P13, nurse (female), 42 years old]*

Because of the lack of specific training, some participants stated that familiarisation with the problems immigrants may have and the needs they presented with was achieved through their daily clinical contact with this population and, more informally, through personal undertakings to attend relevant conferences and lectures, to read pertinent books and research articles and to exchange views with colleagues.

Some participants expressed negative attitudes towards immigrants and resisted adapting to distinct cultural issues. These perceptions and behaviours could be argued to be xenophobic and certainly revealed considerable hostility towards immigrant patients. An indicative example is depicted in the statements of two participants, in which they expressed their objections towards some Muslim women’s desire to be examined only by female staff:

*‘... when (immigrant women) ask to be examined by a female doctor, I call a male doctor on purpose, although I may be available, because these people should not get used to such tactics. They have to respect the system’s operation.’ [P14, resident doctor (female), 33 years old]*

*‘I find this attitude very peculiar. There are also Greek women who prefer to be examined by a woman doctor, so they will not feel embarrassed, but they do not demand it on a religious basis.’ [P18, midwife (female), 51 years old]*

### **9.3. Deficiencies in Serving the Large Number of Immigrant Users**

The negative impact on the health system from the presence of a high number of immigrants in Greece was given great importance in many interviews but these views differed in substantial ways. On the one hand, some respondents felt that the government's response to the large influx of immigrants in recent years had been inadequate leaving the Greek health system unsupported to deal with the increasing demands and this had put its effectiveness and efficacy into question:

*'... public health care services were asked to deal with an unmanageable number of people from foreign countries without the state having cared for the creation of the proper structures and the strengthening and training of the personnel. ... I can say that the health system was taken aback by the sudden and massive entry of foreign citizens, as after all was also the Greek society ...' [P07, nurse (female), 45 years old]*

On the other hand, some respondents felt that the government's response had been unfair upon the health services' operation and the health system's resource allocation favouring immigrant patients over and above Greek users. A latent xenophobia may have underpinned these perceptions:

*'No ... (immigrant) pays, only the Greeks pay. Currently, refugees have the best access to health services. They pay nothing, they come to the hospital accompanied, they do not have to make an appointment. Which Greek has such access to the hospital?' [P14, resident doctor (female), 33 years old]*

*'You can feel the injustice. We serve so many immigrants for free, while there are Greeks who sleep on benches. At least, (the latter) have paid taxes at some point in their lives.' [P16, midwife (female), 48 years old]*

*'I know Greeks ... who do not have full access (to the health system) and the doctor has to intervene, if he can, in some cases. ... . In contrast, immigrants have access to everything in an official or unofficial way.' [P20, midwife (female), 43 years old]*

#### 9.4. Organisational Flaws in Public Health Care Services

Certain flaws in the organisation of health services were also identified. Some of them were exclusively related to caring for immigrants, whilst others referred to deficiencies in caring for the whole population, but respondents noted that these had bigger implications for immigrants' care. Firstly, it was widely testified that there was not an appropriate health services' mechanism or institution to assess and treat immigrants' health problems at the time of their entry into Greece. Indeed, some informants stated that immigrants were not medically examined upon entering the country and thus public services were unable to determine their specific health issues and care needs. However, it was suggested in the interviews this was largely not feasible because of the perceived clandestine ways of entry many immigrants had taken into Greece.

Additionally, several respondents reported that primary care services have not been given the necessary importance in the operation of the Greek health system. Consequently, it was suggested that diseases are often left untreated at the early stages and sometimes led to patients presenting at hospital with much more advanced health conditions (as observed from the perspective of the macro-level in *Chapter 8*). This was reported to be particularly important for undocumented immigrants whose entitlement to non-emergency hospital services is restricted:

*'... the primary care system and institutions in Greece were and still remain to some extent insufficient ... (to) face ... the problems of immigrants at a pre-hospital level. Unfortunately, even institutions which have been established, such as the family doctor, have not been implemented to the extent that they should ... . Thus, immigrants are either compelled to (visit) hospitals or left without comprehensive care.'* [P07, nurse (female), 45 years old]

*'The Greek health system is designed to operate in practice through hospitals and does not include services in the community either in special structures or at the (immigrant) patients' homes.'* [P13, nurse (female), 42 years old]

Furthermore, it was mentioned in some interviews that there were no official structures (such as clinics and/or offices) created to provide health services and information on

care issues to immigrants specifically, especially those who are undocumented and uninsured.

Many participants referred to a shortage of both medical and nursing staff in the health system and presented it as an underlying reason for health services' inability to provide sufficient care to immigrant populations:

*'... there is obvious understaffing of the health system in nurses. ... in the Greek health system, the ratio of nurses to population is ... too small. Indeed, the trend is worsening in recent years.'* [P04, nurse (female), 32 years old]

*'Unfortunately, the health system is based on the mettle of its employees to survive from this situation. The tedious work and the sensitivity of health professionals ... is the only force that manages the care of the huge number of immigrants.'* [P10, nurse (male), 32 years old]

A lack of staff would influence the provision of care to the entire population. However, many informants perceived that the impact on immigrants' care is especially important because of language barriers and special health issues which often demand more time and effort:

*'Sometimes the care of an immigrant demands the cooperation of several employees. Apart from the clinical duties, someone may have to find an interpreter or another one may have to solve administrative issues. Nowadays, hospitals do not have the luxury to work like that ...'* [P17, consultant doctor (male), 67 years old]

According to some interviewees, public health care services' operational deficiencies to provide sufficient care to immigrants are demonstrated by the intense activation of non-governmental organisations in caring for these populations. However, the presence and operation of these organisations in immigrants' health care were looked upon with caution by some participants and seemed to cause some negative views of the national health system and public administration more generally:

*'The non-governmental organisations appeared to fill the gaps, which were present in the public health (care) system, and spend primarily governmental grants to cover rudimentarily some basic health needs of immigrants that the state ought to face. ... there is a substitution of the state's responsibility on this matter by them using indeed public money. ... surely they have a role in managing extreme situations (through) collecting money mainly from the state for small-scale projects. They soften the corners of an acute problem with actions of small or doubtful effectiveness.'* [P08, resident doctor (male), 34 years old]

*'For the hospitality and care of immigrants, dozens of non-governmental organisations are involved. However, I did not see the same interest of such organisations in the health situation of the Greeks who are in a dire financial position. There are so many immigrant accommodation centres with social workers and doctors, but there are still many Greek homeless (people) in Athens. Is there no humanity about them?'* [P12, consultant doctor (female), 39 years old]

The second quote also echoes the concerns described earlier about the apparent priority being given to immigrants compared with Greek citizens living in difficult socio-economic circumstances.

## **9.5. Conclusions**

The operation of health services is at the intersection of political, legal and socio-economic influences on one side and the personal behaviours of staff and patients on the other. This study revealed some perceptions amongst participants that spoke to the operational deficiencies of health services in serving immigrants. Shortfalls in providing culturally competent care, weaknesses in serving the large immigrant population and organisational flaws that impede the delivery of sufficient care to immigrants were identified in respondents' accounts. Furthermore, a recurring theme in the participants' accounts regarded the apparent unfair treatment of socio-economically disadvantaged Greek citizens in comparison with the treatment of immigrants. These views could denote underlying prejudiced or xenophobic attitudes towards immigrant

groups. The importance of the meso-level issues and their relationship to the macro- and micro-levels are discussed later in *Chapter 12*.

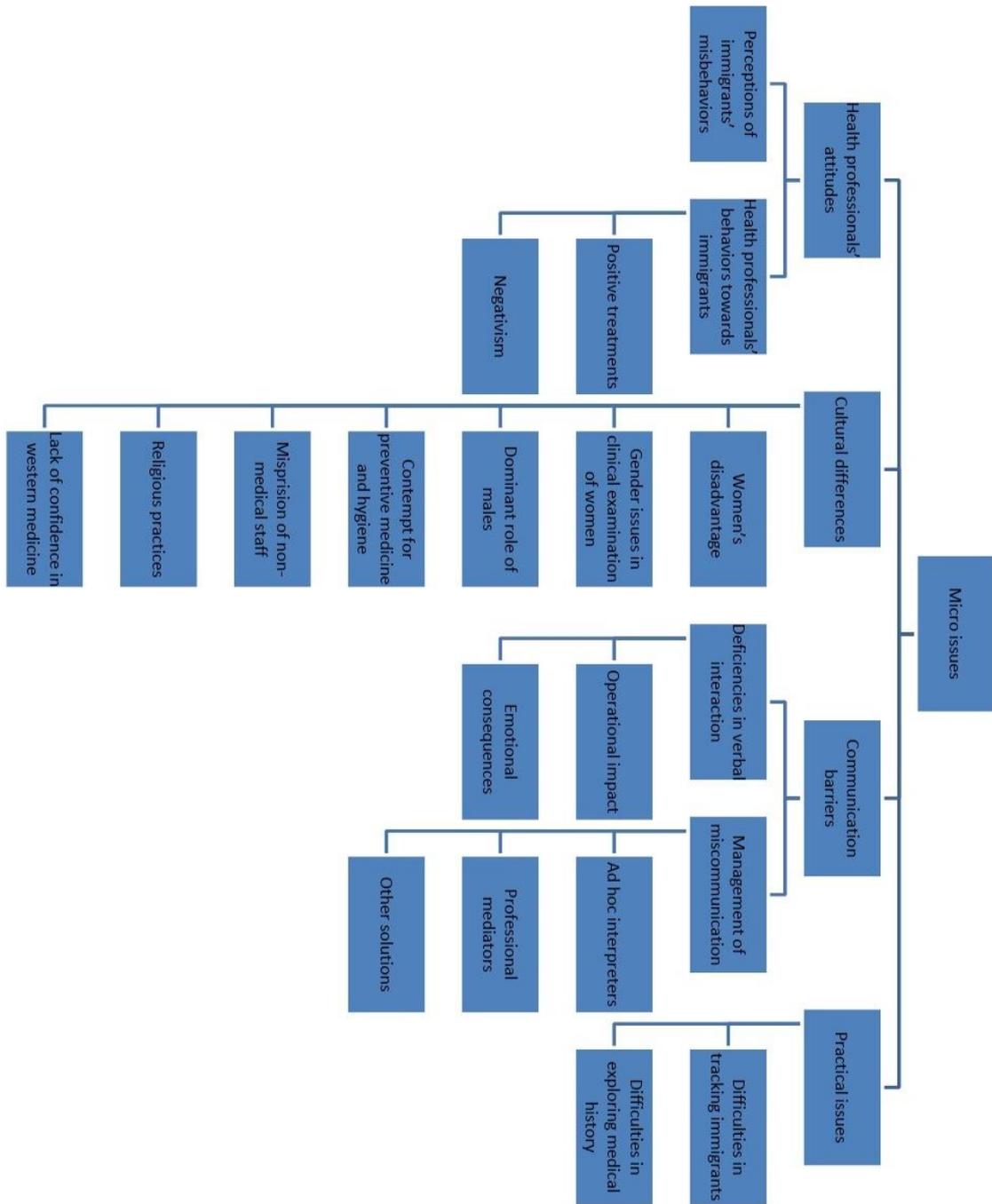
## Chapter 10

### Micro-Level Issues in the Provision of Health Care for Immigrants

#### 10.1. Introduction

As explained in *Chapter 6*, the micro-level of health care refers to the direct interaction between health professionals and patients. Difficulties in the contact between health staff and immigrants were prominent in participants' accounts. Participants raised issues related to: (1) health professionals' attitudes towards immigrants; (2) cultural differences between Greeks and immigrant populations; (3) language differences and barriers in communication with immigrant patients and their families/friends; and (4) practical problems, including difficulties in tracking immigrants beyond health services and in exploring the medical history of immigrant patients. Figure 10.1 below presents schematically the themes that emerged from the data within the micro-level of health care. Although language is an essential aspect of culture, communication barriers are dealt separately in the present chapter because their impact on clinical encounters was distinctively and widely discussed by almost all participants:

Figure 10.1: Themes in Relation to Micro-Issues in Caring for Immigrants



## 10.2. Health Professionals' Attitudes towards Immigrants

Although none of the respondents mentioned or admitted having negative personal views towards immigrants, there were certainly examples of implied disapproval by some health professionals when discussing their interactions with immigrants. Most criticisms raised during the interviews were related to perceived misconduct on the part

of people of specific ethnic origin (particularly Albanians who constitute the majority of immigrants in Greece):

*'... the Albanians are too demanding. They usually ask very imperatively to be served immediately, they do not like to wait and they complain too strongly or object to payment. ... they are very "thug" and treat with ... rudeness. ... I would like to know, was the health system better in their country? Was the service better? Was it all free? I am sure not.'* [P03, nurse (female), 49 years old]

Other ethnic groups (such as Romanians, Bulgarians and Georgians) were accused to a lesser extent of presenting inappropriate behaviours in the health services' environment, whilst others (such as those from Africa or Poland) were praised for their attitudes. Perhaps these views were influenced by more general stereotypes in Greek society and reflect broader prejudice towards specific immigrant groups (see Sierp and Karner, 2017). Nevertheless, participants who expressed such concerns claimed that their conclusions did not derive from stereotypical opinions, but they were associated with general assessments based on their daily contact with immigrants of various nationalities. Most of them also acknowledged that generalisations cannot apply to all people in a population group. Explanations for the reported misbehaviours of some immigrants were attempted by a few participants but without much certainty about the actual causes. Social conditions, personal features, prejudice towards Greek society and the Greek health system and a sense of inferiority among some immigrants were reported to potentially generate misconduct.

Informants expressed both positive and negative views when asked general questions about the treatment of immigrants by health staff. A strong commitment by Greek health workers to the health system's mission of serving people in need was reported, even in cases where a subtle or even overt opposition might have existed towards immigrants. As this study did not involve observation of medical encounters, it is not possible to assess whether negative attitudes towards immigrants did shape the practice of these informants. However, moral obligation, sense of duty and compassion were reported by them as the main motives that drive the professional conduct of health professionals. Health workers were also described as tolerant, kind and good-natured towards immigrants:

*'... health professionals ... do not let their ideas influence their work. ... it is the nature of the medical ... tasks which leaves no other choice. The need for restoration of patients' health surpasses every ideology.'* [P02, resident doctor (male), 36 years old]

*'When immigrants come to health services, they are not only foreigners, but also patients. The property of patient overshadows the property of alien and so any negative or even racist views on immigrants are put aside.'* [P03, nurse (female), 49 years old]

Nevertheless, some respondents were more willing to admit to the existence of xenophobia and subtle racism towards immigrants, although more often among other professionals rather than themselves:

*'... due to the excessive increase in the number of foreigners in Greece, xenophobic attitudes have been created and have now begun to outweigh the tolerance towards foreigners ...'* [P11, nurse (female), 36 years old]

*'... there are mild racist ideas (among Greek health professionals). In theory we all say that we are not (racists), but in fact the opposite is true to some extent.'* [P18, midwife (female), 51 years old]

Some respondents stated that the quality of the interpersonal contact between health personnel and immigrant patients can be adversely influenced by negative feelings about immigrants by staff. In these cases, an impersonal treatment of immigrant patients was described as a possible consequence:

*'Fortunately, there are only isolated expressions of contempt ... (and) disdainful behaviours. ... however, ... a typical treatment (of patient immigrants) without patience and sensitivity (is frequent).'* [P18, midwife (female), 51 years old]

*'... (adverse ideas about immigrants) are expressed through perfunctory and superficial interaction with the patient. Only the minimum required time is spent ...' [P20, midwife (female), 43 years old]*

An example of subtle negativism towards immigrants was revealed in a doctor's statement about language barriers between health staff and immigrants, in which it is shown that adverse attitudes of health professionals can directly affect the provision of care:

*'Do I have to make calls or go around the clinics to find someone to translate? And if I do not make it even then, what should I do? What does the immigrant expect from me? It is his problem. He should take care of its solution. All I can do is to offer medical care.'* [P12, consultant doctor (female), 39 years old]

### **10.3. Cultural Differences between Greeks and Immigrant Populations**

This section includes themes that emerged from the participants' discussions about the cultural characteristics and customs of immigrants that posed problems in the clinical encounter. According to some respondents', these features were common across specific groups of immigrants, although personal idiosyncratic habits and attitudes play an important role in the outcome of the interaction between professionals and patients. The data from the interviews indicated that almost all informants believed that immigrant populations have special cultural characteristics that influence their perceptions towards health, disease, medicine and care. These cultural differences were perceived to shape the clinical encounter.

#### **10.3.1. Gender issues**

Several informants, mainly female staff, recognised the disadvantageous position of women among groups of immigrant populations. Features of inequality between genders in domestic, social and educational issues were mentioned by some participants. The inferior status of female immigrants, as it was perceived by health staff, was reported to affect the provision of health care by creating obstacles in the access to health services and impeding clinical interaction:

*'... some immigrant women can visit the doctor only if they have cared to finish or arrange their responsibilities at home. ... among immigrant populations, women are usually less educated which results in a less privileged position for the comprehension of medical instructions.'* [P10, nurse (male), 32 years old]

*'It is clearly obvious (during a conversation with the couple) that the husband has the upper hand. ... he talks to the doctor on behalf of his wife. Even when I ask about strictly feminine issues, such as the woman's period, it is the man who replies as if he knows everything about her ...'* [P15, consultant doctor (female), 56 years old]

As such, there was a widely held view that female immigrants suffer a double oppression both in wider society and within the immigrants' community specifically. This situation was felt to have a significant negative impact on their physical and mental health:

*'... I am opposed to the imposition of the strict religious clothing of women which obliges (them) to cover almost all parts of the body. It is an unhealthy and abusive practice ... which serves no purpose other than the degradation of the woman's personality. But this is the least. Even more important is the fact that women of some Muslim populations do not have the same access to education and professional development, thereby being disadvantaged at social level ... and economically dependent on their husbands.'* [P12, consultant doctor (female), 39 years old]

Several informants mentioned that Muslim women often want, either out of personal desire or after their husband's intervention, to be examined only by female doctors and some have also refused care by male nurses. This attitude was reported to cause problems in the operation of health services:

*'In my department there are only male surgeons and the examination requires almost always the removal of a part of clothing. So the desire to be*

*examined by a woman is impossible, in fact.’ [P13, nurse (female), 42 years old]*

*‘There is a command by the (hospital’s) administration to provide a woman to serve (women who ask for a female doctor) ... . We try, then, to find ... a woman doctor, even in clinics that are not on duty. Many times this is a waste of time and a source of conflict among staff.’ [P20, midwife (female), 43 years old]*

In addition, a few female participants mentioned the dominant role of some male immigrants which may be expressed through adverse reactions when interacting with female health staff. A female doctor attributed this phenomenon to underlying prejudice by some male immigrants towards the professional role of working women.

### **10.3.2. Health behaviour**

It was reported by some participants that certain immigrant groups do not give the necessary attention to behaviours that are consistent with the concepts of public health, including prevention, screening and early diagnosis of diseases. It was also argued by some non-medically qualified participants that immigrants have a wrong perception that only doctors are competent for consultation in health issues. In this way, the roles of nurses and the other non-medical health staff were felt to be disregarded:

*‘... many times ... I have a hard time to convince them about the value of ... the interventions of preventive medicine as well as the importance of my role as a health professional, just because I am not a doctor.’ [P06, health visitor (female), 40 years old]*

In addition, several participants stated that amongst some immigrant groups there were people who had a low perception for the value of personal hygiene to preserve and promote health. Some participants claimed that this attitude was a cause of morbidity that acts independently of and additionally to immigrants’ poorer socio-economic conditions:

*'... I have noticed ... that many people shave or wash together, sometimes using the same stuff, ... you know what I mean, razors, sponges ... . I often see immigrants who are sloppy, without clean clothes and behave in a totally unhealthy manner.'* [P04, nurse (female), 32 years old]

*'Refugees have other ideas about the neonate's care as well as about cleanliness and personal hygiene. They do not give the same importance as we do. That is why they are not interested ... in health education.'* [P16, midwife (female), 48 years old]

Again, these statements may derive from stereotypical impressions prevailing in health services or in society in general, although this was clearly denied by the participants when such a suggestion was implied by the interviewer.

### **10.3.3. Religious customs and philosophical views**

A special cultural characteristic that was widely mentioned during the interviews was associated with the religious practices of Muslim patients during Ramadan. Indeed, it was supported that the strict application of Ramadan rules can negatively affect the compliance of patients with dietary guidelines and medical instructions:

*'There are patients that (besides food) do not even want to take medicines during ... Ramadan. Previously, the department had a Muslim trainee doctor who achieved in some cases, ... not often, to convince them for the necessity of ... (following) therapeutic guidelines during Ramadan. The rest of us have a ... greater problem.'* [P07, nurse (female), 45 years old]

*'They follow the nutrition that is imposed by their religion even during pregnancy. ... . Especially for the pregnant women, this can affect the development of the foetus.'* [P20, midwife (female), 43 years old]

Other habits, such as the avoidance of pork meat by Muslim patients, were felt to cause only slight problems during hospitalisation because special arrangements for feeding them had to be made. Furthermore, according to the responses of some informants, various immigrant groups lacked any confidence in the value of Western medicine or

were unfamiliar with the environment and practices within health services in the Western world. A different approach, respectful of their ideas, was supported by some respondents to be required for the care of these patients.

It is noted that some participants, especially doctors, highlighted the need for tolerance of such cultural differences even when they are expressed through inappropriate behaviours. The scientific ability and the professional role of health personnel were considered valuable tools for the mitigation of cultural gaps and, in turn, the provision of suitable care to patients from different cultural backgrounds:

*'Health professionals ... have to explain to each immigrant that health care is not associated with religious, cultural or national issues. ... they must understand that medical care aims only at protecting their health and does not stem from bigotries. Unfortunately, not all will understand it or even if they will, some will not agree and will not comply. However, we should respect ... such peculiarities of immigrants, without, of course, making concessions to the quality of service.'* [P01, consultant doctor (male), 63 years old]

*'... the (cultural) characteristics do not cause problems in clinical interaction with any patient as long as there is mutual respect and understanding. ... . When the health of the patient is in risk ... , usually there is a mutual understanding ... due to the importance of the situation.'* [P02, resident doctor (male), 36 years old]

Importantly, one doctor expressly stated that respect for an individual's personality as well as composure and patience towards personal behaviours should be applied not only in health staff's interaction with immigrants but also in their dealings with the indigenous population.

#### **10.4. Language Differences and Barriers in Communication**

##### **10.4.1. Language gap between professionals and patients**

A strongly expressed view from almost all participants was that deficient communication was a common feature of the clinical interaction between health

professionals and immigrant patients. In fact, it was one of the most extensively mentioned issues during the interviews. The lack of a mutually understandable language between health personnel and immigrants was seen as an unhelpful constant in daily clinical practice. Communication between health staff and patients was reported to be both verbal and non-verbal. The forms of verbal communication mainly include conversations and textual materials, while non-verbal communication operates through facial expressions, gestures and exclamations. The participants mentioned difficulties in both types of communication but the difficulties in oral and written interactions were most important.

Most respondents recognised that verbal communication was an essential tool for the optimal provision of health care. As many informants described, the exchange of information through language was the means by which patients have access to and use health services. In addition, it was suggested that the process of clinical interaction depends on the expression of symptoms, examination of clinical signs, explanation of diagnostic conclusions and treatment instructions that were largely achieved through language. Therefore, problematic situations were seen by most informants to occur in the clinical context whenever there is miscommunication between the interacting sides. Most problems were found to arise when immigrant patients and their escorts (such as relatives and friends) either cannot speak Greek at all or have a very low competency of the language. The reported communication difficulties included problems in interaction for both clinical and administrative matters. The difficulties in oral communication between health professionals and immigrants appeared to be bi-directional: that is, that they are present in both the transmission and receiving of verbal messages. Therefore, deficits in expressing and understanding were noted to emerge on both sides, affecting the work of health staff on the one hand, and immigrant patients' use of health services on the other.

Communication difficulties were found to be more common when interacting with newly arrived immigrants because these are most often insufficiently familiar with the Greek language to enable a competent communication within the context of health services. As expected, these problems were minimised as the immigrants' length of stay in Greece was extended, thus those who have lived in Greece for a longer period, and for second generation immigrants, these communication problems were lessened since those immigrants had become more proficient in the Greek language. Besides the gradual learning of the Greek language which might derive from their accumulative

years of presence in the country, it was also noted that the incentives to learn Greek were greater as they sought more active integration into Greek society:

*'... immigrants, after a few years in Greece, care to learn the Greek language ... . I do not know if this is done out of a sense of responsibility, it can be so. But, certainly, it is a practical necessity in order to be served.'*  
[P01, consultant doctor (male), 63 years old]

However, most informants indicated that difficulties in oral interaction constituted an unavoidable and constant feature in daily clinical practice: it was constant because of the exceptionally large numbers of immigrants now using already-overstretched health services and this was exacerbated by continual new immigrant arrivals who saw Greece merely as a stepping stone to their final destination and so did not see the value of learning the Greek language:

*'... refugees (from North Africa and the Middle East) are not interested in learning the Greek language. Besides, they do not envision their future here. All they are interested in is being served on a temporary basis. They want to leave the country.'* [P16, midwife (female), 48 years old]

Respondents did feel that there were certain groups amongst the immigrant population with different volitions to learn Greek. This was felt to suggest varying degrees of desire or capability to assimilate in the host community.

The very nature of a conversation in a clinical environment was considered a demanding process by most participants. Even when some immigrant patients or their escorts have some competence in the Greek language, the achievement of a fully comprehensible interaction may not even be possible:

*'... health professionals, particularly doctors, are used to speaking rapidly, perhaps due to time pressure, using many medical terms and complete the provided information with written material. ... immigrants may have trouble understanding the information which is transferred in this way ...'* [P05, health visitor (female), 44 years old]

Furthermore, several respondents supported that the low educational level of some immigrants can constitute a communication barrier during a conversation with a health professional, especially when the exchange of information includes the use of printed material which is frequently used in the clinical setting:

*'... for many immigrants, illiteracy can be a serious problem. There are many foreigners, such as Bulgarian gypsies, who lack adequate literacy, both in Greek and in their native language in order to be able to read, understand and use written information.'* [P05, health visitor (female), 44 years old]

Some respondents argued that the less educated immigrants often cannot understand treatment guidelines and require additional time and effort from doctors and nurses.

Some informants stated that communication problems were sometimes greater with elderly and female immigrants because of their lower competence in Greek. The immigrants' nationality did not seem to play a direct role since the Greek language is not closely related to any of the immigrants' mother tongues. Many participants suggested that they were able to communicate with immigrants who speak English either as a primary or as a foreign language, because most professionals in Greece are proficient in this language. However, the use of the English language is not always an effective manner of communication because of varying knowledge of English, different accents and the inherent complexities in medical and nursing terminology:

*'... the English language is a solution. However, foreigners in Greece who know English are few. ... there are also other problems with using English. For example, Nigerians speak English with a strange accent and are not always understood. There is also the issue of medical and nursing terminology. Nevertheless, the consultation in English, when possible, is a good solution.'* [P06, health visitor (female), 40 years old]

In addition, the use the of English language in the context of health services was found to occasionally cause problems in communication when the interacting sides do not have sufficient competency:

*'I do not speak English fluently neither do the doctors in my department. Therefore, we can only say the basics having to do with the examination of the patient. In most cases, neither the patient speaks good English so someone else has to translate ... . That is translation to the translation. ... the probability of errors in understanding is extremely high.'* [P13, nurse (female), 42 years old]

Some participants also mentioned their ability of discussing with immigrants in other foreign languages (French, Italian or Spanish, for example) but attributed limited potentials to these other channels.

#### **10.4.2. Impact of miscommunication**

Respondents pointed to a wide range of ways in which barriers in verbal communication created difficulties in health care provision, including difficulties in making a diagnosis, organising operational processes, explaining health conditions, deciding on treatment options and managing follow-up pathways. The relative importance given to each of these problems varied mainly according to the informants' professional role and duties. The doctors in the sample tended to attach greater significance to the difficulty of exchanging clinical information – which is associated with the diagnostic and therapeutic process – while nurses and health visitors underlined the difficulty of completing administrative procedures as a major problem:

*'When there is a problem in communication, conditions for clinical impasses and medical errors are generated because the transferred information is incomplete or even non-existent.'* [P12, consultant doctor (female), 39 years old]

*'You cannot imagine how difficult it is to explain to someone how to go through the Secretariat, to indicate his name, where to go to take an x-ray or give blood, what is the procedure to get the discharge paper and every other related issue with such kind of procedures. And this load is charged to nurses, without, in fact, (this) being their job.'* [P09, nurse (female), 33 years old]

Many health professionals reported that they usually spend more time during a clinical encounter with an immigrant patient than with a Greek patient with a similar health condition. It was inferred that difficulties with mutual understanding often result in excessive time spent filling the language gaps with repeated questions and subsequent explanations or even with increased number of revisits. Thus, the efficacy of health services and professionals was felt to be significantly reduced in these cases due to the prolonged handling and the delay in processing the cases:

*'... (many) immigrant patients often come back to the clinic either to seek clarifications or because the treatment was not successful. For example, many diabetic immigrants find it hard to understand the instructions for the use of the insulin pen, despite the relevant tutoring ... by the health personnel, so they visit the health centre successive times either to re-watch the relevant tutoring or ask the nurse ... to administrate the injection.'* [P05, health visitor (female), 44 years old]

The entire procedure of clinical examination was reported to be disturbed. According to many participants, there was a risk that valuable information and important details could leak during the investigation of symptoms, particularly when there is time pressure, but sometimes even when sufficient or excessive time is spent. Therefore, there was a perception among many respondents that the establishment of diagnosis could be difficult and feature inaccuracies, uncertainties and errors, while the treatment may not be completely appropriate, the therapeutic guidelines may not be entirely understood by immigrant patients and the nursing care may not be optimal:

*'... the problems of poor communication can adversely affect nursing care ... . I have faced ... difficulties in trying to explain (to patients or their companions) how to count the 24-hour urine or understand if they are in pain and at which point.'* [P04, nurse (female), 32 years old]

At the same time, it was reported that the health worker-patient relationship is disrupted as it becomes impersonal:

*'(When the immigrant patient does not speak Greek), I do what I have to do and then I leave. I explain nothing and rely only on the information that I have ...' [P11, nurse (female), 36 years old]*

The situation was described as more severe in emergency care departments where there is intense time pressure because professionals manage patients with acute health problems and escorts are often absent:

*'In the emergencies' department ... a great amount of information must be detached from the patient in a relatively short time (and) ... the clinical problems are usually urgent and possibly more severe.'* [P02, resident doctor (male), 36 years old]

The problem was felt to be less severe in the regular outpatient departments due to the nature of their operation. Indeed, participants indicated that the examination was conducted after a pre-defined appointment, during which there was available time, and patients usually have sufficient knowledge of the operation of the Greek health care system, so if they do not speak Greek they will have arranged to be accompanied by a person who does.

Several respondents suggested that there was a significant burden on health services from the lack of communication between doctors and foreign patients. Indeed, it was reported that a substantial number of laboratory tests were ordered for the clarification of inaccuracies that arise from the clinical contact:

*'... I am forced to order too many tests, which ... could have been avoided if there was a possibility for a better communication with the patient. But there is no other way. ... the referral to a series of tests protects the patient and myself from a wrong treatment ...' [P01, consultant doctor (male), 63 years old]*

Furthermore, some respondents suggested that the operation of the hospitals' in-patient clinics was burdened with a greater number of admissions and prolonged hospitalisations of immigrant patients because of failures in diagnosis that arose from the lack of sufficient communication. As a result, it was implied that this situation could

cause significant additional economic costs for the health system and increase staff workload. In general, respondents in this study suggested that poor quality communication with patients from immigrant backgrounds could lead to an excessive consumption of human and material resources within the health system:

*'Especially nowadays, where there is huge resource poverty, overloading the system with unnecessary medical tests is completely unethical ... but in the case of immigrants, who do not speak Greek, this is inevitable. ... extra work volume is generated in laboratories, resulting in a delay in processing cases.'* [P01, consultant doctor (male), 63 years old]

*'The workload for nurses is huge ... and the available time is short and precious. ... spending additional time for consultation ... creates problems in the timely completion of all the duties ... . A lot of times ... the nurses of the shift are forced to remain at the clinic for much more time (than the duration of the shift) in order to complete their duties ...'* [P04, nurse (female), 32 years old]

#### **10.4.3. Emotional consequences**

The difficulties in communication may cause various negative emotions amongst health professionals. Informants described experiencing feelings of insecurity, disappointment, frustration, anxiety, sadness and distress. These feelings were reported to derive from the risk of possible failures in clinical practice, the inability of staff to adequately help immigrant patients and the time pressure to manage the resultant heavier workload. In addition, many respondents characterised the communication barriers with immigrants as a source of occupational stress and fatigue:

*'(The inability to communicate) irritates me immeasurably. In many cases, me and the patient sit and look at each other, without being able to exchange a word. Can you tell me why am I to experience this situation and be accountable for a problematic contact, in which there is no solution? Essentially, every time I have to cut a Gordian knot.'* [P12, consultant doctor (female), 39 years old]

Some informants mentioned that they felt exposed because of the greater possibility for medical errors due to communication difficulties and it was argued that there was a lack of legislative or administrative regulation which could protect them:

*'During a clinical contact with an immigrant, who bears the responsibility for translation, the doctor or the immigrant? ... is the doctor obliged to understand what the immigrant says in any way or does the immigrant have to have cared to bring someone with him to translate? ... . If a medical error occurs due to the poor communication with the patient, is there a medical responsibility on the part of the doctor or not? How is the doctor legally protected? There should be some adjustment for these issues ...' [P02, resident doctor (male), 36 years old]*

*'Every time that I examine a woman (who does not speak Greek) my career is imperilled. No state or corporate entity is concerned about protecting me. We do not do our work voluntarily. We are obliged to examine the immigrants. If I make a mistake, I may face penal consequences. Thus, there should be a protection framework for us in cases of error due to inadequate consultation.' [P16, midwife (female), 48 years old]*

Moreover, problems in the working relationship between staff were reported because of misunderstandings and unnecessary or disproportionate increases in workload as a result of these communication difficulties. For some respondents, when good quality verbal interaction with a patient cannot be achieved, the responsibility for communication is often transferred from one health professional to another without necessarily resulting in a satisfying solution. The situation was reported to result in a low quality of care for the patient, diminished job satisfaction and general increase in workload:

*'... when I have spent too much time (without results) ... I call the doctor to take over the communication. This, of course, is hardly a solution, since in the majority of these cases neither the doctor can communicate. In practice, then, it is just a pass of responsibility which serves nothing and also reduces the role of the nurse.' [P04, nurse (female), 32 years old]*

*'In my hospital, there is a Greek head midwife with Palestinian ancestry from her father's side, who speaks Arabic. ... everybody in the hospital turns to this woman whenever there are communication difficulties with Arab patients. However, this is unfair for her, because she is forced to neglect her own duties ... and get loaded with additional work without any reciprocation.'* [P17, consultant doctor (male), 67 years old]

Furthermore, some nurses reported feelings of disadvantage in comparison with the doctors because they cannot use laboratory tests to overcome the communication difficulties. It was also suggested that the lack of adequate communication can be a source of negative feelings for immigrants:

*'... many immigrants react with anger because they are not understood and do not understand the words of health professionals.'* [P05, health visitor (female), 44 years old]

However, other respondents felt that health professionals endured this burden more seriously than the immigrants themselves did:

*'The patient knows that no matter what happens, in the end he will be served and therefore has no particular stress beyond what his health problem creates. Instead, the nurse and the doctor are under stress because they are required to find each time the proper way to address the situation ...'* [P09, nurse (female), 33 years old]

#### **10.4.4. Applied practical solutions in daily practice and their implications**

In order to overcome these language difficulties with immigrant patients, most participants discussed the practical solutions they had found to ease this situation. In many cases, they used the patient's accompanying family members or friends to assist in translation:

*'(The translator) is a relative or friend of the patient. By his own initiative, the patient has cared for the presence of an attendant. Obviously, he knows he will face difficulties in conversation and has cared to bring along*

*someone who speaks Greek or even English.*’ [P13, nurse (female), 42 years old]

Many informants mentioned that there were cases whereby the person brought in to translate was unrelated to the patient: sometimes they may be another patient, or another patient’s escort, but there were times when the translator was randomly recruited by the health personnel or the patient for the purpose of translation:

*‘We often use the cleaning ladies from the cleaning crews to translate, because most of them, if not all, are immigrants, mainly from countries in Eastern Europe. It is funny only to think about it, but it happens.’* [P09, nurse (female), 33 years old]

*‘Someone, who is in the waiting room for any reason, can offer or be asked to translate.’* [P16, midwife (female), 48 years old]

The lack of available people to translate – or, indeed, the typically limited usefulness of a third person to translate – was reported as a potential cause of distress to health staff:

*‘... when it comes to complex issues, especially when dealing with the administrative procedures of nursing, there is a big problem, because the translator must necessarily be a relative of the patient to be able to devote time to the completion of the required actions.’* [P11, nurse (female), 36 years old]

None of the respondents spontaneously mentioned the systematic presence of official translators or cultural mediators in the various services of the public health care system, although cases of limited assistance by representatives of non-governmental and immigrant organisations were reported (mostly in cases of visits by refugees and asylum seekers). Some participants also mentioned the intervention of privately hired interpreters who accompanied immigrant patients and undertook the translation process. When asked directly, respondents expressed three main views on the value of official mediators: (1) interpreters were needed for mediation between health personnel and patients who do not speak Greek and their presence was desirable by health

professionals to better facilitate daily clinical practice; (2) the presence of translators was perceived as necessary by health workers due to the conditions of communication but that was not a pleasant situation; and (3) mediation by third persons for communication between patients with limited proficiency in Greek and health staff was unwanted because of the risk of breaching confidentiality and the possibility of inaccurate information transfer, although it was frequently applied as the only solution.

Some respondents suggested that the intervention of third persons, either official or unofficial, for interpretation constituted a risk of violation of medical privacy and trust between health professionals and patients and may have an impact on the provision of care:

*'... there is a moral bond (between the doctor and the patient). ... the existence of a third (person) ... constitutes a violation of this confidential relationship.'* [P02, resident doctor (male), 36 years old]

*'There are sensitive cases in which I do not accept the presence of a translator. I usually forbid them when I have to consult with men with andrology problems ... . How can I discuss ... matters (of) impotence or infertility or how can I examine a naked man in front of a third (person)? I prefer to exclude the patient.'* [P15 consultant doctor (female), 56 years old]

On the other hand, some did state that the purpose of translation was more important than the protection of medical confidentiality therefore rendering the presence of a third person a minor violation in these cases:

*'Those moments there are not many options. ... I do not like to examine in the presence of third (persons). I prefer, however, to rely on someone to translate rather than trying in vain to end up somewhere by myself.'* [P17, consultant doctor (male), 67 years old]

*'I am not concerned about medical confidentiality. At that moment, what matters is to talk with the patient, especially when there is great need because of her health condition.'* [P20, midwife (female), 43 years old]

Many informants stated that a patient could be put in an uncomfortable position because of the disclosure of personal matters to third persons. For those respondents, the amount of information extracted through the mediation of a third person depends on the identity of the translator and may vary because of the patients' reservations against revealing sensitive, personal issues:

*'(When the husband does the translation in) gynaecological issues, the situation is terribly uncomfortable and there is embarrassment to everyone. ... some women are reluctant to speak out due to the presence of their husbands and thus conceal important things either in order not to uncover something that the husband does not know or because they are ashamed.'* [P06, health visitor (female), 40 years old]

*'... the problem (of violating medical confidentiality) does not only concern us, but also the patients. So when it comes to sensitive issues, such as an abortion, the patient has brought along a ... person of trust. We do not assign such translations to the first person we meet.'* [P13, nurse (female), 42 years old]

Many respondents revealed that the result of the translation may contain inaccuracies which could be traced to the often-limited proficiency of the translators in the Greek language and the difficulty of translating medical conditions. In these cases, uncertainty about the effectiveness of the clinical contact was widely expressed:

*'Many times ... (the translator) does not know Greek well and thus either does not transfer properly the words of the patient or does not understand completely what the doctor says. Misunderstandings have happened to me ... , although I always try what I say to be simple and understandable.'* [P02, resident doctor (male), 36 years old]

*'Very often I have doubts about the translation ... . Many times I wonder if (the translator) ... has understood some sophisticated words that I have inevitably or unwittingly used.'* [P15, consultant doctor (female), 56 years old]

Cases in which the discussion was translated over the telephone either by an official or an unofficial mediator were also reported but the interaction was said to be problematic in most of these cases because of poor communication quality, delays and again a lack of available translators:

*'The sound quality is not so good in a telephone conversation on speakerphone. ... there are delays by repeated wordings of the questions and answers.'* [P12, consultant doctor (female), 39 years old]

*'... we may need to telephone several times in the course of the examination until we reach a point, which is tiring.'* [P18, midwife (female), 51 years old]

*'(The interpreter) does not always answer the telephone or he may be available only for a short time.'* [P19, nurse (female), 35 years old]

Finally, significant problems were found to arise from the use of minors as interpreters, a phenomenon that was reported to occur frequently, because immigrants' children are often better at speaking Greek than their parents. Most informants suggested that the clinical contact often includes sensitive issues, which cannot be revealed to a child, and there was also concern about the heavy emotional load knowing such medical facts may have on the minor:

*'... the sensitivity of the contents of a conversation between the health professional and the patient, the possible emotional charge from the process of the clinical interaction and the burden of the responsibility for the proper handling of the conversation ... are ... stress factors, to which a child of a tender age should not be exposed. Also, the gender of the child and the parent plays a role. For example, a boy cannot intervene in a debate on gynaecological issues of his mother and something similar applies to girls and their fathers. ... the undertaking of the role of the translator by the children is a bad solution, but unfortunately it is often the only one.'* [P07, nurse (female), 45 years old]

Other practical solutions for bridging the communication gap included the use of notes, software applications, gestures and facial and bodily expressions. Although it was claimed that these modes of communication can be useful to an extent, their efficiency was largely questioned and they were not presented as credible solutions. Non-verbal communication was reported to be inadequate for understanding details, especially when the patient is totally unfamiliar with the Greek language. Moreover, the use of computers or mobile phones for translation was considered to cause delays. Uncertainty about whether information had been understood was mentioned in all of the cases of non-verbal communication since such communication does not share a common language:

*'You cannot understand much with signs. When, for example, a woman shows her belly she may mean different things. She may want to say that it hurts or that she is pregnant or bleeding or whatever. Safe conclusions do not arise from signs. I can only understand rough elements.'* [P13, nurse (female), 42 years old]

*'Sometimes the translation is done through the computers, especially when I want to translate what I have to tell ... . It is a big waste of time. It is practical only for the translation of one or two words ...'* [P18, midwife (female), 51 years old]

*'I write a note with medical instructions in Greek or English and let the patient find someone to translate them ... . The problem ... is that I cannot be sure of the accuracy of the translation ...'* [P12, consultant doctor (female), 39 years old]

The use of single words in the language of immigrants by health professionals was also noted. These words do not represent a language competency. It was reported that they have become known to health staff through daily routine and, ultimately, have limited potential in bridging this communication gap:

*'... I use a couple of words in Albanian in order to say some basic (things) ... . Actually, I do not even know if they are completely correct ... . I learned them from older colleagues ...' [P20, midwife (female), 43 years old]*

Some informants indicated that communication between staff and immigrants from specific countries is achieved (to some extent) when the interaction involves either Greek doctors who have studied in the immigrants' country of origin (mainly Bulgaria and Romania) or health professionals of foreign or dual nationality employed in health services because these professionals are able to process the conversation in the immigrants' language.

### **10.5. Barriers in Tracking Immigrants outside Health Services**

Contacting immigrants at their home was presented as a frequent duty of health staff by some informants. When there is a situation in which the health professionals need to reach immigrants, this is significantly affected by whether the patient has eligible social security. Indeed, as informants' accounts indicated, the contact information of insured immigrants is valid and therefore communication with them is usually possible whenever it is necessary:

*'Insured immigrants are easily approached. ... . The telephone number is the most important (element), perhaps also the social security number for financial matters.'* [P09, nurse (female), 33 years old]

On the other hand, contacting uninsured immigrants was clearly described as more difficult because of the lack of an officially registered address and telephone number. Even greater difficulty was reported in contacting illegal immigrants since these people are not officially registered to any kind of institution and thus they are totally unknown to the system:

*'... for the illegal immigrants there are no contact details, so we cannot get in touch with them. Perhaps they can only be notified through the church or their children in school ... . But even then, the contact is extremely difficult and almost always without response.'* [P03, nurse (female), 49 years old]

In addition, some participants noted that illegal immigrants often provided false contact details due to their fear of being detected by the authorities (either they do not know that health staff are not required to notify the police of undocumented people they may treat or because they do not trust health professionals). That said, other informants pointed out that the fear of denunciation amongst immigrant populations was limited nowadays because of more tolerant state policies towards immigration.

Still, the use of mobile telephones was described as a valuable tool for health staff to overcome the fear of some immigrants for detection by the authorities and the problem of frequent moves by certain undocumented individuals. The ability to contact immigrants at home was also reported to depend on the type of health services which the immigrant patients used. Indeed, patients of routine care services were reported to be more easily accessible in comparison with patients of the emergency departments:

*'Each (regular patient) opens a follow-up file ... . We crosscheck the contact information for security reasons, especially ... for patients with serious diseases. ... (in the emergency department) there is no follow-up file and, when necessary, tracking patients is impossible.'* [P13, nurse (female), 42 years old]

#### **10.6. Difficulties in Exploring the Medical History of Immigrants**

It was argued by some participants that immigrants do not usually have medical records from their country and, even if they did carry medical certificates, they were almost always incomplete or written in a language which could not be understood. In any event, patients usually could not translate the scientific terminology of papers, whilst translations – formal or informal – are expensive and thus were rarely available to patients:

*'... the vaccination history ... may be unknown or we may not be able to figure out what medications a patient ... takes or there may be ignorance about any allergies ...'* [P02, resident doctor (male), 36 years old]

Various reasons for the lack of an organised medical history of immigrants were given. Firstly, it was argued that health systems in their countries of origin do not offer specialised services due to the shortages in modern infrastructure and that there was

limited access to them due to financial barriers. Secondly, it was claimed that some immigrant populations do not have the proper attitude or even a sufficient educational background to maintain personal or family medical files:

*'... I have found that many immigrant women have not been subjected in their country to prenatal control or they do not consider it necessary, many (women) do not even know the birth weight of their children, while in other cases some immigrants do not recall ... the medication they were taking or have no records for surgeries they had in their homeland.'* [P07, nurse (female), 45 years old]

*'... among immigrants there are several people who are illiterate or have some limited literacy. The majority of these people usually do not keep records of their health matters.'* [P10, nurse (male), 32 years old]

However, most respondents said that over the years the medical history of immigrants was built and monitored by their doctors in Greece, so the problems are being gradually mitigated. Nevertheless, gaps and ambiguities in obtaining the medical history were reported to continue to exist due to certain characteristics of immigrant populations (such as communication barriers, false identities and incorrect contact details):

*'Neither here does a correct history for immigrants exist. And this, in fact, is somehow strange because, while they frequently use health services ... there is no correct, regular history. For this, however, neither the health services nor the personnel are responsible. ... many foreigners do not indicate a real name when they visit the clinic because they fear that they may be later asked for money or that we may notify the police. This results in making it impossible to keep even a basic history. ... some uninsured immigrants borrow health booklets from other compatriots ... who are insured ... to gain access to health care without paying.'* [P03, nurse (female), 49 years old]

Moreover, a couple of participants reported cases where – in their opinion at least – an immigrant patient provided inaccurate data in order to obtain a favourable management by the state:

*'Perhaps ... the patient wants to avoid the postponement of a surgery or a further examination process. He may even have the wrong impression that if he reveals some details from his (medical) history, this can lead to his arrest or deportation.'* [P09, nurse (female), 33 years old]

Organisational factors were also reported to cause minor faults in the exploration of certain immigrant groups' medical history:

*'The refugees are able to receive treatment in the public hospitals, but their visits are not recorded in the electronic prescription system and referrals and prescriptions are issued manually. Therefore, there is no available online record of their history, like the insured patients ...'* [P12, consultant doctor (female), 39 years old]

Finally, it was also mentioned that some immigrant patients, especially from neighbouring countries to Greece, are occasionally monitored by doctors in their homeland which may cause further confusion in their medical history.

Many participants presented the investigation of medical history as an important element of a clinical encounter, especially for new patients visiting a medical outpatient clinic. The doctors within the sample tended to place more emphasis on the difficulties in exploring the medical history of immigrants than other categories of health professionals. The reason for this may derive from the nature of medical duties which often oblige doctors to rely heavily on data from the patients' medical past.

## **10.7. Conclusions**

The data revealed contradictory views and distinctive attitudes among the study participants regarding the acceptance of cultural diversity. Although respondents identified a range of difficulties for their practice relating to the characteristics of the immigrants they worked with, some thought that health professionals needed to respect the existence of different lifestyles and customs. However, elements of xenophobia or

even racism were also present in the perceptions of immigrants and immigration presented by some respondents, possibly reflecting negative stereotypes of immigrants held more widely in Greek society. This interview-based study was unable to consider whether these negative attitudes had any impact on professional practice. Nevertheless, there is some suggestion in the data that they could negatively affect the relationships that are so central to effective clinical encounters.

Moreover, language barriers were presented as a source of adverse effects on access to health care, quality of care, satisfaction of patients and professionals and health outcomes. Barriers in contact with immigrants outside health services for health or administrative issues were also reported to exist mainly due to a lack of valid contact details and more frequent moves of immigrant persons and families. Finally, difficulties in exploring the medical history of patients were highlighted. Chapters 8-10 have explored participants' perceptions on difficulties in the provision of care to immigrants. The next chapter investigates their suggestions about potential measures to address the problematic situations emerging from immigrants' care.

## Chapter 11

# Health Professionals' Perspectives on Improving Health Care for Immigrants

### 11.1 Introduction

The final part of each interview consisted of participants' own proposals about potential measures that could be taken to improve the provision of care to immigrant populations in Greece in terms of clinical practice and health outcomes. The proposed measures were reported spontaneously and concerned solutions at political, medical, social, operational and personal junctures. They can be classified as actions taken to address difficulties at the macro-, meso- and micro-level of health care.

### 11.2. Measures at the Macro-Level

Most of the proposed solutions sat within the macro-level of health care largely because the management of financial, social and political restrictions was considered a prerequisite for almost all the steps towards better immigrants' health care.

#### 11.2.1. Attraction of resources and international cooperation

The need to find funding resources for health services in order to manage the demands of the provision of care to immigrants was raised by all participants. A common view was that improving health care conditions for immigrants is very difficult in the prevailing financial circumstances in Greece. It was widely suggested that all the proposed measures required considerable expenses. However, the available funds were reported to be limited, so most informants admitted that there was a risk that the existing problems may persist or worsen in future. Despite the very real financial constraints because of the economic crisis, the necessity for maintaining or increasing the health system's funding was recognised by many respondents:

*'Surely the situation is difficult. However, health services should be excluded from the cuts in order to protect people's health. The answer to the crisis should be a social turn so it can put less weight to the system for the care of people who are disadvantaged ...' [P09, nurse (female), 33 years old]*

When the participants were asked to indicate possible sources of funding, the main responses included the EU and its member states. Given that immigration concerns the entirety of Europe, many interviewees stated that all EU countries should be called upon to contribute to the achievement of the best possible management of immigrants' health care issues where ever they presented within Europe. Financial support for countries which receive large volumes of immigrants – such as Greece – was a typical proposal across the interviews:

*'Solidarity is one of the essential elements of the vision for a united Europe, as is the protection of the weak. At the moment, Greece is facing alone a pan-European problem. This cannot go on any longer... . The European Union should support Greece, which, due to its geographical position, is susceptible to illegal immigration ...' [P02, resident doctor (male), 36 years old]*

*'Why does Greece have to face the problem alone? Just because it happens to be at the entrance of Europe? There must be a common European and international address ... . ... an effective management ... would be the refinancing of security funds by the European Union or even better the adoption by the European Union of covering the huge cost of treatment for illegal immigrants that Greece has been forced to host.' [P12, consultant doctor (female), 39 years old]*

Other reported sources of financing included the home countries of immigrants and the international, national and local organisations (such as UNICEF, Amnesty International, non-governmental organisations, the Church, volunteers and immigrant associations).

Despite the need for further financial resources, most participants hesitated to openly propose a rise in public expenditure because they realised the limited economic potential of the current situation:

*'I try ... to be practical. I know that there are not many possibilities due to the economic situation in which the country is.' [P10, nurse (male), 32 years old]*

*'I do not know where (the state) can find the (necessary) money (for immigrants' care). Where can it cut costs from? Now the health system operates with significant restrictions ...' [P18, midwife (female), 51 years old]*

Moreover, concerns were expressed about the European states' desire and ability to cover part of the expenses that emerged from the provision of care to immigrants:

*'I do not believe that (EU member states) are willing to spend money to improve a problem that exists in another country. Besides, many of these states have their own economic problems.'* [P11, nurse (female), 36 years old]

### **11.2.2. Integration and broad access to health care**

Many participants noted the importance of integrating immigrants within Greek society to address some of the problems regarding the provision of health care to immigrants. Social integration has a beneficial effect through two main routes: (1) the improvement of living and working conditions was understood to improve and protect the health status of immigrants and thus reduce their dependence on health services; and (2) greater awareness amongst the general population – including health professionals – about the medical needs and social characteristics of immigrants was recognised as a way to weaken negative attitudes that may exist among staff towards foreign patients.

Allowing broader access by immigrants to primary care, prenatal care, preventive medicine, care for chronic diseases and pharmaceutical care was reported by some informants as ethically necessary to improve the health status of immigrant populations and protect public health:

*'... (the) aim should be to maintain open access for immigrants in hospitals, at least at the current level and to ensure the basic food and living conditions. If we overcome the economic and immigration crisis, we can discuss other measures.'* [P11, nurse (female), 36 years old]

Nevertheless, there was an acknowledgement of the financial realities that came with such proposals:

*'There are ... services that are important, such as rehabilitation of injured, administration of prosthetics in cases of amputations and others. However, since these are very expensive benefits, I understand that it is difficult to include illegal immigrants among the beneficiaries ...' [P02, resident doctor (male), 36 years old]*

Other participants argued that the need to reduce costs should not be a barrier to the expansion of health care of immigrants:

*'Beyond the moral reasons requiring the (establishment of immigrants' care), in the long term the state would benefit financially ... because the care cost will be reduced due to the prevention and the earlier treatment of immigrants' diseases and the improvement of the general level of public health in the country.' [P07, nurse (female), 45 years old]*

Finally, it was strongly argued that intergovernmental agreements could be adopted between Greece and the other EU states for a common policy on managing the problems arising from the provision of health services to immigrants. According to the responses, the main building blocks here should be the formation of unified legislation on immigrants' rights for residence permits and access to health care.

### **11.2.3. Reducing the number of immigrants in Greece**

According to many interviewees, the delivery of health care to immigrants is directly influenced by the country's immigration policy. Through this prism, strong perspectives were expressed towards a policy to decrease the number of immigrants residing in Greece:

*'... all the possible measures are destined to fail unless there is ... a drastic reduction in the number of immigrants in Greece. ... only then immigrants' access to completed health services can be promoted, tailored to their needs and the capabilities of the health system.' [P01, consultant doctor (male), 63 years old]*

Informants claimed that this solution was a feasible way to improve the effectiveness and efficiency of public health care services and provide pre-eminent care both to Greek citizens and immigrants:

*'If we do something, we have to do it for all. We cannot spend money solely for serving all these immigrants, while the situation is hard for the Greeks as well.'* [P15, consultant doctor (female), 56 years old]

Many participants noted that the presence of a large number of immigrants in Greece exacerbates the demands on the host society in general. A proper management of the inflow of immigration, particularly regarding illegal immigrants, was presented as a necessary measure to prevent further rises in public expenditure, especially given the modern economic crisis:

*'All these years Greece has become Europe's ghetto ... . All immigrant populations were accumulated here, initially from Eastern Europe and now the Middle East ... . This situation must end ... because (the Greek) society has collapsed and the people's patience is exhausted.'* [P17, consultant doctor (male), 67 years old]

As such, some believed that the other EU member states should rehome some of these immigrants within their own territories:

*'... the countries of the European Union should share the immigrant population according to their capabilities. Currently, Greece is struggling to manage a situation that far exceeds its capacity.'* [P10, nurse (male), 32 years old]

However, in some instances the need for immigrant populations to be limited was presented in a way that suggested a distinctly anti-immigrant perspective:

*'I understand that these people came to our country to seek a better future. Especially, the second-generation immigrants believe that here is their home and do not want to leave. ... but unfortunately, the health system is unable*

*to serve them due to their number. Health professionals of public health care services have become “slaves” in their attempt to satisfy the needs and demands of immigrants.’ [P03, nurse (female), 49 years old]*

#### **11.2.4. Enhancement and structural reforms of the health care system**

Many participants stated that the understaffing of public health care services after the onset of the economic crisis in Greece should be addressed with new recruitment campaigns to manage some of the personnel deficiencies in public hospitals and clinics. Most of the respondents understood that the state struggles to cover the salary costs of health personnel due to the constraints on public expenditure. However, new appointments were perceived as a necessary measure because health services were suggested to have reached a point where they could no longer operate with the required efficiency and that working conditions had become unbearable due to this increased workload.

Wider changes were also proposed in some interviews for the improvement of the health system’s efficiency. Indeed, the expansion of the existing primary health care network mainly in large urban areas was suggested as an appropriate measure that could improve caring for the entire population, including immigrants. In particular, the establishment of more urban health centres and the wider application of the institution of the family doctor were supported. It was reported that strengthening primary health care could relieve functionally and economically the hospitals’ outpatient departments, make the health system more accessible to all citizens (including immigrants), and provide more effective care due to more timely treatment of health problems:

*‘Due to the proximity to the population, the family doctor can be reached easily by immigrants, ... provide ... immediate solutions and refer them to specialised medical services only when it is necessary.’ [P07, nurse (female), 45 years old]*

The establishment of specialised units for the provision of targeted medical and social care to immigrants was also suggested, despite the risk of marginalisation to these populations:

*'I would recommend that health units should be established for the exclusive service of immigrants. ... discrimination can also happen in the common health services. In fact, it may be more likely in places where both Greeks and foreigners are served at the same time ...' [P20, midwife (female), 43 years old]*

According to some respondents, these services could operate exclusively for the provision of health services to specific categories of immigrants, such as refugees and illegal immigrants, and could either be independent or act as special departments of the national health system. The existence of mobile units that could visit foreign populations in their neighbourhoods was also proposed.

### **11.3. Measures at the Meso-Level**

Besides the aforementioned centralised reforms in the health system, changes in the operation of health services were suggested in order to improve the conditions within which immigrants' health care was provided.

#### **11.3.1. Control of immigrants' health**

Some respondents championed a better monitoring of immigrants' health conditions – including tests for infectious diseases both upon arrival and during their stay in Greece – as an imperative necessity. For this purpose, health surveillance of immigrant populations by public services was proposed. Indeed, it was mentioned that there was a need to offer to all immigrants – legal and illegal – the possibility of free testing for a range of infectious diseases that constitute a danger to public health more generally. This approach was considered as one step within a more general shift towards a public health-oriented approach of the operation of health services:

*'... in recent years ... in Greece we have focused on clinical medicine and therapeutics and we have neglected prevention. This attitude must be changed, especially in the case of managing foreign people who have intense morbidity problems with infectious diseases, a situation that had disappeared from Greece for decades.'* [P01, consultant doctor (male), 63 years old]

*'... both the immigrants' health ... and public health will be protected, since (monitoring) facilitates early diagnosis and management of infectious cases before they spread. Of course, this health control must be independent of documentation controls and sanctions, otherwise no immigrant will come ...' [P02, resident doctor (male), 36 years old]*

Funding and conducting the necessary programmes were proposed to be exercised by state health agencies at the expense of the state budget or by private bodies on a voluntary or compulsory basis. Additionally, the systematic collection of statistical data on immigrants' health in a credible and comparable manner was suggested as a useful tool for the accurate assessment of their health needs in order to overcome the most basic problems in their care.

### **11.3.2. Provision of information to immigrants**

Many participants suggested that the creation of a mechanism within health services for informing immigrants about the operation of the Greek health system would be useful. According to these responses, information for immigrants can be achieved with the production and distribution of printed material about: access rights and the obligations of immigrants in public health care services; the procedures required to receive care; and the prospects for guidance by the various responsible institutions. It was suggested that the relevant forms could be translated into the languages of immigrants with the widest presence in Greece and be available in open social places (like the entrances of public care services) so to supplement or even replace in part the role of translators. According to some interviewees, the internet could also be a source of information for immigrants through posting leaflets in various languages. For the same purpose, it was also supported that special information services for immigrants could be created and be responsible for providing comprehensive information to immigrants about public health issues and how to use the Greek health system either at the time of their reception in the country or later on:

*'The information for immigrants about how the hospitals work is very important, so there is no unnecessary burden (of services) and inconvenience for all patients.'* [P14, resident doctor (female), 33 years old]

Several institutions were identified for involvement in an immigrants' health care information network, including administration services, social care institutions, public health care services, foreign embassies, immigration agencies and non-governmental organisations. Not surprisingly, respondents were conscious of the need to exclude the police or other immigration control authorities from this network so that immigrants were not deterred from using it.

### **11.3.3. Support to health professionals**

Many participants in the research asked for the introduction of clear and standardised procedures that identified the type of care to which the various categories of immigrants were entitled to when presenting with specific health problems. In this way, it was claimed that subjective decisions by health workers – as well as any possible legal implications and ethical concerns caused by them – could be avoided:

*'... a very important measure is the release ... of ... more straightforward guidelines on the management of illegal immigrants depending on their state of health. The current situation is unclear and loads health professionals, particularly doctors, with excessive responsibility.'* [P02, resident doctor (male), 36 years old]

*'... an important step ... is to propound an explicit protocol which will accurately determine how immigrant patients will be treated in the various cases ... (so) health professionals will be safeguarded ... . It is ... necessary to create algorithms for treatment and financial charges which will be applied to specific symptoms and pathologies.'* [P03, nurse (female), 49 years old]

Moreover, a full absolution of health professionals' duties from all administrative procedures and controls that were related to checking the legality of immigrants' access to health services was proposed in some interviews:

*'... the (admission) ... of immigrants ... to the clinics should be controlled by non-health services. If an immigrant patient arrives at the office, then ... health workers are morally obliged to offer their assistance. If the state*

*thinks that some immigrants are not entitled to care, it must introduce appropriate mechanisms to ensure this ban. Health staff must be fully protected so they can be devoted exclusively to the care of patients' [P06, health visitor (female), 40 years old]*

Training and updating medical and nursing staff on aspects of immigrants' care were reported as positive measures to improve the provision of health services to immigrant populations. Relevant training was proposed to be introduced both at the undergraduate level – by including it in the school curriculum – and at the postgraduate level (through the introduction of seminars, workshops and lectures). According to these informants, the content of this education could include topics of intercultural medical and nursing care, ethical issues, psychological support and the management of burnout syndrome:

*'With the prevailing conditions in Greece and Europe ... it is necessary that some nurses acquire the necessary knowledge and skills in order to be able to respond to intercultural differences of their patients and provide them with appropriate care as well as protection of their rights. This is an indisputable reality in modern societies.'* [P10, nurse (male), 32 years old]

#### **11.4. Measures at the Micro-Level**

Measures aiming to promote a more effective clinical contact between health professionals and immigrant patients were focused on mediation issues.

##### **11.4.1. Translators/intercultural mediators in care services**

Participants who were in favour of the role of professional interpreters proposed the recruitment within health care facilities for mediators who were qualified to speak Greek as well as the language of foreign patients and were knowledgeable about the operation of the health system:

*'... translators should be placed in hospitals to solve as much as possible, the problem of understanding between health personnel and foreign-speaking patients. This is essential ... in order to enable immigrant patients, who do not speak Greek, to express their problems, facilitate the work of*

*doctors and nurses (and) ... gain time for serving better the rest of the patients too.* [P08, resident doctor (male), 34 years old]

According to many informants, the mediators could establish a channel of communication between health professionals and immigrants and thus facilitate the use of health services by immigrants and improve the performance of the medical and nursing staff. It was also argued that the intervention of mediators could be even more important for newly arrived immigrants who may have greater verbal communication problems and understandable ignorance as to how the Greek health system operates.

Respondents demanded that the translators should have specific skills so to be able to fulfil the goals of their role. They should be properly trained and legally bound to respect the rules of medical ethics, such as confidentiality. They should also be competent bilingual speakers, especially because medical terminology often includes difficult words and meanings. For this reason, it was suggested that doctors or paramedical staff of Greek or foreign nationality could potentially assume the role of translator after meeting the requirements of language proficiency. It emerged from the participants' accounts that mediators should definitely be able to process the translation, but they must be further able to facilitate the provision of health services to people with different cultural backgrounds. For this purpose, it was suggested that mediators should be well aware of immigrants' cultural and religious traditions and have sufficient communication skills and qualifications for negotiation and dispute resolution.

Of course, certain opposing views regarding the mediation of third persons were also present among health professionals:

*'... I am totally against the presence of interpreters. The solution to communication problems will arise with the assimilation of immigrants when their number is not excessive. The immigrants have to adapt to the ... rules of a country, not the contrary.'* [P05, health visitor (female), 44 years old]

The main reasons for the objection against the existence of mediators included the risk of breaching medical confidentiality and, as ever, funding. However, as the quote above illustrates, objections could also reflect a lack of tolerance of cultural diversity.

## **11.5. Conclusions**

During the interviews, actions to improve the delivery of health care to vulnerable immigrants were suggested. Attracting financial resources and protecting the health system from the adverse impact of the current economic crisis were considered as necessary actions to secure the provision of quality health services to immigrants. Prioritised strategies for financial support included international cooperation and EU engagement. As many participants suggested, social integration and wider access to health care were identified as essential conditions to secure better health services for immigrants and the wider public. These views reflected an important perspective from participants on how to act to improve the health of vulnerable immigrants and thus fulfil medical and ethical obligations. Hiring health staff and changes in the health system – mainly through comprehensiveness in primary health care and targeted services to immigrant populations – were also given importance by participants. Moreover, political actions towards the reduction of immigrant populations in Greece were suggested so the conditions and potentials of the health system are satisfying for both immigrants and the indigenous population. In most cases, limiting immigration was presented as a pragmatic response which did not appear to be underpinned by anti-migrant sentiments. That said, in some instances xenophobia and intolerance seemed to play a part.

As increasing numbers of immigrants are present in Greece, many respondents were in favour of adjustments in health services' practices in order to care for these populations. Here, the exploration and determination of immigrants' health care needs and the provision of information to immigrants about health and health care issues were associated with continuity of care and the appropriate use of health services and were suggested as necessary actions within the operation of the health system. Furthermore, clear guidelines for immigrants' entitlement to care and interdisciplinary training in managing culturally diverse patients were highlighted as supportive strategies that would create a safe professional environment for health workers and render health professionals able to encompass in clinical practice the many different cultural characteristics among immigrant populations.

Finally, interpretation services were suggested to be a priority measure to promote a more effective clinical encounter with immigrant users of health services. Although objections were raised, possibly indicating intolerance of cultural diversity in some cases, it was suggested by many participants that the existence of translation services in

health care settings through mediators could facilitate clinical interaction as long as qualified professionals are used and confidentiality is secured.

Chapters 8-11 have cited the difficulties in the provision of health care to immigrants as they emerged in interviews with the research participants. The next concluding chapter brings together a critical analysis of these findings to highlight new directions for theory and future research in this field. It reports the advantages and disadvantages of the study and summarizes the main conclusions of the thesis.

## **Chapter 12**

### **Discussion**

#### **12.1. Introduction**

The provision of health care to immigrant populations is a challenge for many European health systems, including the Greek one which serves a great number of immigrant patients with different legal, socio-economic, ethnic and cultural characteristics. Health workers are at the core of the health system and are aware of the circumstances under which health services operate. In daily practice, Greek health professionals are constantly experiencing the conditions of caring for immigrants and this contributes to the formation of their views and attitudes in relation to immigrants' care. The recent economic crisis and the subsequent austerity measures in Greece have also produced an impact on the provision of care to immigrants. However, there has been no analysis of service professionals' perceptions of delivering care to immigrant populations in the context of current financial restrictions. This study explored the perceptions of Greek health professionals on issues regarding caring for immigrants. It focused on the following questions: (1) what are Greek health professionals' perspectives on possible problems deriving from providing health care to immigrant patients?; (2) what is the impact of the current financial crisis on the provision of health care to immigrants in Greece according to Greek health professionals?; and (3) what do Greek health professionals think about potential measures to promote and protect the quality of care provided to immigrants?

This chapter is organised as follows. Firstly, it presents an overview of the main aspects that render the present research significant by describing the necessity of exploring the provision of health care to immigrants from the professionals' point of view and outlining the importance of the impact of immigration and the economic recession. Secondly, it summarizes the research findings, draws conclusions and identifies possible implications for clinical practice, for the organisation of health care and for health policy agendas. Thirdly, it analyses the contribution of this study to the expansion of existing theory, highlights key strengths and limitations of the study and suggests areas for future research.

## **12.2. Significance of the Study**

The study of the relationship between immigration and health care is exceptionally important in health and social research due to several conceptual reasons besides the traditional goal for the protection of public health. Firstly, the investigation of immigrants' potential to receive health care can highlight the existence of social inequalities because some groups of immigrants are examples of underprivileged social groups. Undocumented immigrants in particular represent a marginalised group within society (Nazroo, 1998). Although immigrant workers satisfy the needs of the host communities in labour and economic terms, some governments are not disposed to offer to them and their families equal access to available public resources, including health care. In other words, the availability of social resources for the protection of immigrants' health is an indicator of the level of hospitality offered by the receiving country to immigrants (Fassin, 2001). Secondly, immigration is an expression of today's globalisation which leads us to re-examine the traditional ideas of borders and national identities, since the presence of immigrants in host societies causes the simultaneous appearance of features of different cultures. Health services constitute a place in which numerous contacts between the local population and immigrants occur and thus their interaction is promoted (Dias and Gonçalves, 2007). Thirdly, the study of immigrants' health care can assist the clarification of the notion of culture and ethnicity and their impact on everyday clinical practice and health care settings through the study of different cultural identities and their interactions (Berger, 1998). The knowledge produced by this research can contribute to the formation of relevant political agendas towards the elimination of disparities in access to health care and consequently the creation of equity in health outcomes across social groups (Andrulis, 1998).

The regulation of the provision of health care to immigrants is an integral component of the immigration policy of every host state. Immigrants tend to be among the most disadvantaged social groups when it comes to medical care coverage, especially when their presence in the host country is unauthorised (Ku and Matani, 2001). Moreover, the state often puts restrictions on public benefits and welfare services to the various categories of immigrants, including limitations to health care options and social benefits (Corrigan, 2014). Other official or unofficial barriers to health care for people from immigrant groups include immigration or citizenship status, language barriers, limited financial resources, lack of familiarity with the health system, fear of

arrest and limited inclusion into the host society (Derose, et al, 2009). These barriers are not discrete factors, but rather act as an aggregation of effects that prevents or discourages immigrants from seeking health care (Heyman, et al, 2009). In addition, distinct aspects of culture may be responsible for a unique pattern of perceptions regarding the actual meaning of health and illness. In turn, these ideas may influence the recognition and interpretation of symptoms and ultimately affect the way and time that health services are sought (Crepeau, 1986). Host states should provide adequate health services to immigrants in order to protect public health, improve health behaviours, reduce social inequalities and eliminate discriminatory practices and policies (Bodenmann, et al, 2014).

Health professionals constitute a category of personnel with frequent encounters with immigrant patients. In this context, this research sought to identify their perceived difficulties in daily clinical practice with members of immigrant groups. Under the current conditions of the economic recession, the Greek public health care system is operating with severely limited resources and may be unable to meet the increased demands from the continuous access to health services of vulnerable population groups, such as refugees, socially underprivileged immigrant groups and undocumented immigrants. Furthermore, many fear that the increasing number of immigrants living in Greece and inevitably using health services threatens the very sustainability of the public health care system (Papadakaki, et al, 2017). Under these circumstances, an exploration of the perspectives of Greek health professionals on this issue is highly topical and may assist policy makers to form the necessary interventions to sustain the health system and protect public health.

As a result of the immigration waves in Greece over the last two to three decades, Greek society has become more multicultural than ever before. For this reason, there is an ongoing need for doctors and nurses as well as for health services as an institution to have adequate support to meet the needs of patients from different cultural backgrounds, while fulfilling their clinical duty to treat. The perceptions of health professionals in Greece regarding the clinical encounter with immigrants have not been adequately investigated as has been the case in other countries with a longer immigrating tradition. The present study attempted to fill this gap because immigration in Greece is a rapidly expanding phenomenon. Health professionals are the primary actors in caring for immigrants and thus they have the right to express their perspectives and these should be taken into account by the authorities. Furthermore, health systems should promote

feelings of job satisfaction among health staff. Knowledge about professionals' experiences can assist the fulfilment of this purpose.

The presence of numerous immigrant patients from multiple cultural backgrounds in health services and possible harsh socio-economic conditions may constitute an important obstacle to health care access for these immigrants by biasing clinicians and affecting their practices (Topa, et al, 2013). Research on attitudes of health professionals towards immigrants is scant. Nevertheless, there is evidence that reveals discrepancies between the human rights' perspective for equity in health care and some health workers' views who feel they have the duty to protect their country's resources against what they understand as exploitation (Crush and Tawodzera, 2014 and Vanthuyne, et al, 2013). Therefore, it is important to explore the extent to which there is intolerance or even xenophobic and racist views amongst health professionals and the ways in which these might influence the accessibility and quality of care for immigrant populations.

The present study obtains further importance due to the current financial crisis. From a social point of view, an important consequence of the modern economic recession is a potential expansion of the restrictions on the access of lower socio-economic groups, such as some immigrants, to high-quality health services because access to medical care depends largely on the available financial resources. Therefore, if a country decreases the amount of funding for health care because of the crisis, the situation could result in a reduction of population coverage, range of services and quality of care. The financial pressure on the health system can lead a country to review policies on health care provision in order to increase efficiency, while at the same time attempt to retain as much as possible the level of effectiveness. This is another factor that may increase disparities in access to care and affect the working conditions of health professionals.

In Greece, drastic curtailing of government spending has significantly affected the structure and operation of public hospitals resulting in understaffing, deficits and shortage of pharmaceuticals and medical equipment (Ifanti, et al, 2013). Several studies have documented an association between lower staffing levels – especially among nursing personnel – and higher rates of some adverse patient outcomes regarding safety and quality of health care provision (Mark, et al, 2007; Cho, et al, 2003 and Needleman, et al, 2002). Health personnel shortages can make health professionals' tasks more strenuous. Burn-out, job dissatisfaction and low or deteriorating quality of care are more

likely to be reported by staff in hospitals with high patient-to-nurse ratios (Rafferty, et al, 2007 and Aiken, et al, 2002). In Greece, physicians have already expressed an urgent need for guidance on how to act in their daily practice in order to prevent the reduction of quality and promote equity in health care in the current period of financial constraints and severely limited resources (Tsiligianni, et al, 2013). Given these economic barriers and the specific difficulties immigrant groups have in accessing health care, the investigation of Greek health professionals' perceptions regarding the provision of care to immigrants is particularly important.

### **12.3. Overview and Significance of the Study Results**

This study has sought to fill certain gaps in the existing knowledge about the provision of health care to immigrants by exploring health professionals' point of view. A central concern in public health is the reduction of inequalities in health and health care. These inequalities have been widely observed in health care provision to immigrant groups across a broad range of health services and have been highlighted in the existing literature. However, in most studies evidence is not moved into theory. This study has identified challenges for the provision of health care to immigrants and mapped these on to components of theory thereby facilitating potential interventions at different levels of health care that could reduce inequalities. Furthermore, this study theorises the effects on caring for disadvantaged social groups of the restrictions on health care resources.

Nowadays, there is growing research activity in the field of 'cultural competence' in health care provision. This study has identified components of culturally competent care operating under the special conditions of large-scale immigration and the presence of people from multiple cultural groups. These components can be incorporated into practice to enhance quality of care towards immigrant groups. They can also be material for expanding theories about culturally competent care.

This interview-based qualitative study explored the experiences and views of Greek health professionals providing publicly-funded health care to immigrants in the contemporary context of high levels of immigration and economic crisis. The perspectives offered by the interviewed health professionals have been interpreted through the lens provided by a number of pre-existing theoretical perspectives, notably: (1) theories about culturally competent care; (2) political theories about equity in health; and (3) economic theories about the effects of economic crisis. The analysis generated

a typology of care issues encompassing structural/political, organisational and individual factors located at three inter-related levels within the health care system: macro-, meso- and micro-levels of health care. The study findings suggest that the provision of health services to immigrants is a dynamic process that is impacted by a series of interacting factors at all three levels of health care.

Macro-level legal and socio-economic issues were identified as influencing access to and the availability of health services for immigrants. At the meso-level, the organisation and delivery of health services, including the health system's operational shortfalls and deficiencies in culturally competent care, were found to affect the provision of health care to immigrant populations. Finally, a range of factors operating at the individual micro-level, residing with both health workers and immigrants (and the encounters between them) were found to have an important impact on the interpersonal contact between health staff and immigrant patients. The informants were also asked to indicate potential measures for the improvement of immigrants' care issues. Factors found to be operating at these levels are considered in more detail below.

#### **12.3.1. Macro-level factors: socio-economic conditions and legal framework**

The study findings suggest that Greek health professionals have a good understanding of the notion that any degradation of social determinants of health can be expected to impact on disadvantaged immigrant groups. Indeed, participants emphasised that continuous exposure to hazardous living and working conditions and financial hardship can render certain immigrant groups sensitive to potential damage to their health which causes greater needs for care and thus increases the demands on health services. Informants clearly supported that precarious socio-economic conditions are of special importance in the case of undocumented immigrants because of often limited access to health and social care. A greater use of the emergency services by undocumented immigrants was reported as a consequence, since this type of care is their only means of legitimate access in Greece. In this way, a discontinuity of care and increased costs for the system were perceived as probable due to fragmented and late management of health issues. However, vulnerability is not static since the circumstances under which people and groups live can be modified through transformation of the relevant factors. Therefore, the reduction of social inequalities should be one of the priorities in the agenda of immigration policies (Carey, et al, 2015).

Many informants felt that immigrants' social integration can improve their health status as well as their clinical encounters within health services. According to Paloma and colleagues (2014), a fair multicultural society would offer everyone the opportunity for well-being and thus immigrants could benefit from good working and living conditions and be treated properly in terms of a multicultural approach. However, most participants in the present study argued that the burden on the Greek health system from the large immigrant population in the country was overwhelming, especially in terms of emerging costs and workload. For this reason, a restriction of the number of immigrants in Greece was widely proposed. In some cases respondents' calls for a reduction in immigrants' numbers reflected xenophobic attitudes including for example, the suggestion that health professionals had become 'slaves' to immigrants and that some Greek citizens were unfairly treated because immigrants received better access than they did, despite the absence of research evidence to support such a view. However, the need for reduced numbers of immigrants was also linked to health workers' occupational fatigue and concerns about the health system's financial situation. Moreover, objections were raised in relation to the weaknesses exhibited by the state to fully integrate the immigrant population into the host society. Indeed, Castañeda (2012) states that delayed and conflicted responses to the social inclusion of immigrants can result in deficits in the health system's operation.

Limitations on access and reduced quality of care particularly for vulnerable populations were felt by all the informants to be important negative consequences of the economic crisis. It is confirmed in the literature that harsh socio-economic conditions and austerity measures strongly undermine the effectiveness of the population's health care because of restrictions on available resources, deregulation of the health market and increased demand for imposition of fees for services (Brall, et al, 2016). In Greece in particular, the utilisation of public in-patient and primary care services rose, while public expenditures fell after the onset of the financial crisis (Kondilis, et al, 2013). During a period of economic turmoil, the rising demands for public care collide with restrictive austerity policies and this conflict impacts negatively on the population's health care (Karanikolos and Kentikelenis, 2016). In a study by Papadakaki and colleagues (2017), health professionals in Greece expressed concerns about the rapid societal changes of financial crisis and their impact on the regular and continuous access to the health care system of vulnerable groups of the population (such as the uninsured and those with chronic diseases).

Many adverse results of the recent budget cuts in the Greek health services were identified in the interviews. Protracted waiting times, a reduced number of health workers, increased workload, lack of materials and medicines, lack of primary care services and impaired community public health programmes were suggested as the main negative consequences and were largely attributed to the state's response to the difficult economic situation. Most respondents recognised that caring for immigrants was particularly susceptible to the impact of economic crisis. Immigrants were reported to be more sensitive due to the presence of certain factors, including lack of social insurance or welfare coverage, low purchasing power, poor working conditions and language barriers.

Serious concerns emerged in this study about the sustainability of the Greek public health care system in the context of the economic crisis and the continuous arrival of new immigrant populations in Greece. Most participants argued that the management of the severe financial burden – which is still afflicting public administration – urgently calls for both finding funding resources and restricting wasteful practices. The situation was acknowledged by all the respondents as difficult to address. A few solutions were suggested, although most informants recognised a limited potential for their implementation. The political, financial and organisational cooperation of the European Union member states to mutually face the challenges of caring for immigrants was felt to be a necessary measure, especially because of the notion that immigration is a common issue across Europe. In this respect, respondents felt that the European states' governments and the European institutions should take joint actions from a continental perspective, including the management of economic, legal and social implications of caring for immigrants, in order to build cross-border plans. In their study, Pettoello-Mantovani and colleagues (2016) supported that such cooperation could indeed produce better health outcomes for immigrant patients and might contribute to a health system's sustainability. Furthermore, Taran (2001) suggests that governments should emphasise the need to define comprehensive and coordinated immigration policies and practices based on economic, social and development concerns rather than reactive control measures so they can ensure social harmony and dignified treatment of nationals and non-nationals.

Implementing components of good practice in the daily care of immigrants, as identified by participants in the present study, requires sufficient resources for recruitment of personnel, establishment of interpretation services, organisational

flexibility, staff training and provision of information. The limited availability of resources is a difficult challenge for the state to face and is likely to be impeded by political priorities. Some informants argued that alternative sources of funding among national and international organisations might be found, but most of them acknowledged that it would be unlikely to obtain funds to cover the high costs of immigrants' care by institutions other than the Greek state. Therefore, the rational allocation of resources is important for the best possible operation of the public health care system and it can be achieved by introducing the criteria of effectiveness and efficiency in decision-making (Cochrane, 1989 and Culyer, 1983). The concept of efficiency refers to the optimal implementation of interventions at the appropriate time and place and in the right way. In other words, efficiency expresses the relationship between costs and resultant outcomes. Effectiveness refers to the implementation of interventions that have an undoubted positive impact on patients' health.

Although numerous international conventions and declarations call for securing immigrants' right to health care, many participants justified the lack of entitlement of illegal immigrants to non-emergency care, as this is imposed by the existing legal framework. It was argued that neither the state nor the insured citizens/tax payers can bear the high health care costs of caring for undocumented immigrants, providing an economic foundation for this exclusion. However, most informants suggested that clinical practice is also guided by professional ethics. Respondents argued that health professionals, mainly doctors, often manage to provide care to non-beneficiary immigrants in their daily practice, despite the relevant legal prohibitions. Straßmayr and colleagues (2012) and Grimm and Wells (2009) gave prominence in their studies to the ethical dilemma among health professionals (mental health professionals and nurses, respectively) of either acting according to the legislation and institutional rules or providing care without authorisation for humanitarian reasons. The present study highlighted the concurrent existence of contradictory views on the provision of full access rights to undocumented immigrants among the participants and within a single individual's statements. On one hand, those views arguing against universal access derived from the perception that illegal immigrants tend to abuse the country's health system and deprive the existing sparse resources. On the other hand, there were opinions supporting free care as an essential human right for everyone, including illegal immigrants. Some respondents accepted the need for universal access to health services

only for particularly vulnerable groups of immigrants, such as pregnant women and HIV-positive patients.

According to the respondents' views, the legal restrictions imposed on undocumented immigrants' access to health services have both medical and ethical consequences. The most important concerns referred to the impact on individual immigrants' health from patients remaining untreated as well as on public health due to the risk of spread of communicable diseases. For these reasons, some participants were in favour of introducing wider access to a variety of non-emergency health services for undocumented immigrants, although concerns for the cost coverage were strongly expressed. This issue seemed to be a field of conflicts between ethical and medical obligations on one side and the need for cost containment on the other.

Many informants in the study expressed distress about the responsibility put on the shoulders of health professionals to decide on the eligibility of an immigrant patient to receive care. This screening procedure was perceived to be alien to the duties of health workers. Van Der Leun (2006) found that shifting the responsibility for prohibiting illegal immigrants to access health care services from immigration control authorities to health staff causes an obvious tension for the latter. This situation made participants in the present study feel exposed and some expressed fear of unintentionally breaking the law either by providing non-authorized services or by not offering care to immigrant patients. For this reason, some participants asked for the implementation of policies for legal and administrative protection by the central health authorities. Many informants in the study stated their lack of knowledge about the exact legal framework that determines the rights of the various categories of immigrants to care. This finding was also reported in another study (McCoil, et al, 2006).

The issue of legal immigrants' access to the public health care system was also given emphasis by participants. Although health coverage for insured legal immigrants was accepted as morally and financially justified, the provision of health care to uninsured immigrants raised ethical questions and practical challenges even if these populations were legally present in the country. Most informants in the study recognised that documented but uninsured immigrants constitute a special part of the population regarding access to health care. According to previous governmental guidelines, only vulnerable groups of uninsured immigrants (pregnant women, minors, refugees and persons with recognised serious diseases) had free access to public health care services (Joint Ministerial Decision No. Y4a/48566, 2005). In contrast, in general the uninsured

unemployed documented economic immigrants were not included in the provisions for welfare support, despite living legally and permanently in the country. Therefore, the previous legal status permitted large numbers of socially uninsured immigrants to reside legally across the country. Greece was not alone among industrialised nations with publicly-funded health care schemes in struggling with this reality. For example, Caulford and D'Andrade (2012) identified a similar situation in Canada. In 2016, the Greek government recognised the need to cover the entire uninsured population due to the adverse economic and social conditions in the country and issued new guidelines which included uninsured third country nationals who were legal and permanent residents in Greece in the entitlement to free medical care (Joint Ministerial Decision No. A3(γ)/ΓΠ/οικ.25132, 2016). However, this new policy has only recently started being applied in everyday practice. Therefore, the views of health professionals regarding uninsured documented immigrants' access to public health care may change and become more positive in the near future.

### **12.3.2. Meso-level factors: the health system's operation**

An important finding in relation to the Greek health system's lack of preparation to care for immigrants regarded the almost non-existent control of immigrants' health condition at the time of their entry in the country, especially for those arriving illegally. Indeed, this situation poses serious public health hazards. After collecting data for newly arrived immigrants at the Greek-Turkish border, Eonomopoulou and colleagues (2017) identified a high risk of spreading communicable diseases. Therefore, the authors concluded that there was a need to strengthen surveillance and implement harmonised screening procedures for newly arrived immigrants. The views of most participants in this study supported the implementation of necessary health controls of newcomers so special health care needs and risks are addressed at an earlier stage. However, the necessity for systematic screening for tropical diseases remains a controversial issue, both from the point of view of its clinical utility and from an ethical approach (Coker, 2004).

Some respondents supported that the provision of information to immigrants upon their arrival in Greece on the operation of the health system and on health behaviour issues can generate care and health benefits during their subsequent presence in the country. Indeed, Suurmond and colleagues (2013) identified that certain issues need to be addressed in first contacts with immigrants, including evaluation of their current

health condition, assessment of health risks, provision of information about the host health system and health education.

In the present study, the lack of an organised primary health care network directed exclusively to immigrant patients was reported as a limitation of the Greek health system by some participants. However, immigrant-oriented health services were rejected by others. Indeed, such a project contains a risk for discriminatory treatment and the ghettoisation of immigrant populations. In fact, the study by Karamitri and colleagues (2013) concluded that health experts do not agree on whether or not separate facilities for immigrants are useful to increase the efficiency of health care delivery, while there is a risk that they might emphasise the perception of ethnic inequity.

Some respondents argued that non-governmental and international organisations could contribute to overcoming problems regarding the provision of health care to immigrants. Organisations of the voluntary sector often have stronger links with immigrant communities than those of governmental structures. This is particularly important with refugees, asylum-seekers and undocumented immigrants where trust is an issue. Voluntary organisations have a great deal of expertise and they are also much smaller than statutory organisations, so they can be more flexible in their actions. In Greece, several non-governmental organisations are active in immigrants' assistance, including health care. Nevertheless, some participants in the present study recognised a limited potential of these organisations to provide adequate care services due to financial restrictions and limited operational capacities. Moreover, several respondents felt that the state must be the primary provider of health care and non-governmental organisations can only have a complementary role. Indeed, Gilson and colleagues (1994) suggest that the provision and regulation of health services always require a strong governmental presence.

The weaknesses in managing health care of immigrants can be expected to worsen due to the large number of asylum seekers from the Middle East who have arrived in Greece recently without a feasible route to travel to Europe in the near future. Although, at least for now, these immigrant groups are a small part of the total immigrant population in Greece, they have already created an additional load in the state's operation primarily in relation to their settlement and distribution throughout the country. Moreover, the difficult living conditions of asylum seekers can potentially create both sanitary problems among them and dangers for public health.

### **12.3.3. Micro-level factors: interaction between health staff and immigrants**

A significant part of the findings of this study regarded communication and cultural challenges deriving from the interpersonal contact between health professionals and immigrant patients. Almost all the participants claimed that language barriers were a constant phenomenon during clinical encounters with immigrants with limited proficiency of the Greek language and critically hindered effective communication between patients and staff. For this reason, it appeared that health professionals, primarily doctors, may tend to be more superficial during an interaction with immigrant patients, relying mostly on laboratory data and often neglecting to delve into details beyond physical illness. As such, referring patients for testing serves also as a substitute for verbal communication. However, a valuable part of the professional-patient interaction is lost in this way because, as Samarasinghe and colleagues (2010) suggest, health workers need to adopt a holistic approach towards immigrants in order to achieve better results in health promotion and cultural transition. In addition, as nurses usually do not have access to tests referral, they may disregard their own needs to communicate well with immigrant patients, considering that their practice is not important enough and, thus, downgrading their contribution to the clinical encounters (Blackford, et al, 1997).

In the present study, the use of patients' relatives for translation was found to be standard clinical practice accepted at least to an extent by most informants, especially when patients' clinical situations were uncomplicated and superficial information was exchanged. Juckett and Unger (2014) argue that children should never be used as interpreters except in emergencies. Indeed, many informants in this study expressed concerns about the mediation of patients' children due to the heavy emotional load and the responsibility that derives from a clinical interaction. Some participants sought to enhance the face-to-face encounter with translated printed materials. However, the effectiveness of using these was widely questioned. As Singleton and Krause (2010) suggest, printed health materials have a limited contribution to care because they are usually written in the host language, they are not accompanied by an oral presentation and their illustrations may fail to correctly represent familiar situations. Further practical measures, such as interpretations over the telephone and the use of software applications, were considered ineffective or even dangerous. This means that clinical interactions depend essentially on direct contact and exchange of information.

No participants mentioned the existence of official systematic interpretation services in their working environment. However, the introduction of professional translators was proposed by several participants as a necessary measure to improve clinical encounters with patients not speaking Greek, while others expressed some concerns. The clinical benefit from the mediation of officially trained interpreters was supported as a solid reason for their utilisation, when the primary goal is the protection of patients' health and the facilitation of health professionals' work. Additionally, the use of ad hoc interpreters was found to have an opportunistic cost for health staff in the form of time lost in trying to find solutions for communication rather than performing their primary job which could be avoided with the presence of trained mediators. However, findings from this study also suggest that the complexity of overcoming language barriers cannot be solved solely by recruiting professional interpreters, but also needs to address the special circumstances prevailing in the health system and the health services' setting and to meet the matched needs of both immigrant patients and health professionals.

Mediators should be trained to understand and negotiate between the two interacting parties and be adaptive and responsive to the demands of the communicative process in a health care setting (Hsieh, 2010). The establishment of trustworthiness is also necessary (Hadziabdic and Hjelm, 2013 and Wallin and Ahlström, 2006). There is evidence that the use of professional mediators is associated with improved clinical care, especially in comparison with ad hoc interpreters (Garcia, et al, 2004). However, the introduction of interpretation services is not free from drawbacks. Farley and colleagues (2014) and Bischoff and Hudelson (2010b) found that, while health professionals recognise advantages in the availability of interpretation services, the procedure for using them is labour intensive, cost and time consuming and obstructed by the use of medical terms. In addition, Hadziabdic and colleagues (2011) and Eklöf and colleagues (2015) found that such services support the communication between health workers and patients but can increase the amount of work undertaken by personnel and lead to incorrect use of time and resources. These difficulties are of special importance in the context of the Greek health system in which health services already face a shortage of funding and an increase in workload. After all, Bischoff and Hudelson (2010a) found that professional mediators cannot guarantee a high accuracy of translation. Moreover, caring for patients is normally delivered on a 24-hour basis and thus the constant availability of translation services can be impractical or financially

prohibitive, while some patients may consider the presence of interpreters during the encounter to be undesirable (Gray, et al, 2011 and Gerrish, et al, 2004).

Particular cultural features among some immigrant groups, especially related to gender roles, were also identified by some respondents as contributing to the emergence of difficulties in the provision of health services. The statements of several participants revealed that female nurses often perceive a lack of respect from some immigrant patients. Furthermore, the demand of female patients, either willingly or under their husband's orders, to be examined by female staff only was felt by some informants to be a cause of conflict between health professionals and patients. Many researchers have explored this issue (for example, Ozolins and Hjelm, 2003) and it has been established that cultural heterogeneity can pose barriers to the provision of suitable care due to gender roles. In the present study, respondents suggested that females are in a less dominant position in comparison with males because of social norms and values among certain immigrant populations. From this perspective, immigrant women often fall simultaneously into two vulnerable categories: as females facing difficulties due to inferior family and social status and as immigrants having to adjust to a new language and social context.

The present study found that there is limited application of the concept of culturally competent care in daily practice in the Greek public health care system. Participants identified the lack of special training as the major reason, although they considered culturally competent care as highly topical in the modern setting of health services due to the presence of patients of various cultural identities. It was suggested that most of their knowledge was a result of personal experience from daily practice or self-initiated pursuit of further study. This deficiency in training has also been detected in other studies in southern Europe (Manara, et al, 2013 and Chevannes, 2002) and Greece in particular (Papadakaki, et al, 2017) and may indicate the relatively recent transformation of these countries to immigration destinations. However, culturally competent care is an effective means for better managing the health needs of immigrants because it promotes trust and collaboration between staff and patients (Isaacs, et al, 2013) and helps to ensure patient satisfaction and positive outcomes (Maier-Lorentz, 2008). Therefore, training in culturally competent care could strengthen the work of health staff. Accreditation standards for curriculum material that address cultural competence in medical and nursing schools at both undergraduate and postgraduate

level may have the potential to equip present and future health professionals to overcome cultural biases in the delivery of health care (Liu, et al, 2015).

In this study, a series of difficulties in clinical encounters due to reservation and intolerance amongst health workers against certain cultural characteristics of specific immigrant groups was revealed. This conclusion is in harmony with Meershoek and colleagues' study (2011) in which the authors observed that, even though racism is not openly expressed, Dutch doctors assigned the stereotype of 'problematic patients' to immigrants more often than to Dutch patients. This bias may explain why some participants in the present study were intolerant of some distinct cultural practices and expressed stereotypical views of some immigrant groups. Kemppainen and colleagues (2017) found that prejudiced and unfair attitudes towards Russian immigrants in the context of health services in Finland were associated with higher odds for seeking cross-border health care by patients in their country of origin. Participants in the present study reported an occasional parallel utilisation of health services by immigrants of neighbouring countries in Greece and in their homelands. However, it remains unclear whether this concurrent use is due to discrimination expressed by health professionals.

Johnson and colleagues (2004) suggest that 'othering' is a process that identifies certain people as outside of the mainstream social group. Statements of 'othering' were noticeable in some interviews and may indicate positions of alienation towards immigrants. According to Johnson and colleagues (ibid.), the separation of patients by the health staff, under the notion of 'othering', can possibly reflect a lack of critical self-awareness of discriminatory attitudes. It is possible that participants' perceptions of immigrants' cultural traits were influenced by stereotypical views and attitudes prevailing in Greece. This phenomenon may have an impact on clinical practice. For example, in the study by Papadakaki and colleagues (2017), primary care doctors and nurses expressed more sympathy and volition to care for the impoverished Greek population in comparison with immigrants. Appropriate training in culturally competent care can render health professionals capable of identifying and avoiding processes of stereotyping.

Research suggests that the cognitive effort to assess and process a person's individual characteristics appears to be greater than that required to quickly categorise a person into a specific group with particular characteristics (Burgess, et al, 2004). This may explain why some participants expressed negative stereotypical views of particular immigrant groups. While such short cuts in thinking may be useful in certain situations,

quick categorisations are unsuitable when providers are seeking to establish good relationships with their patients and deliver equitable and culturally competent health care (Hall, et al, 2015). In this study, negative features were attributed wholesale to some immigrant groups. These negative perceptions among some informants may have been driven by the stressful working conditions that the large-scale immigration and the economic collapse had created. However, such xenophobic and racist views and attitudes can be expected to have an impact on the provision of care.

#### **12.4. Theoretical Perspectives**

The present study has utilized and built on the somewhat disparate body of existing theory discussed in *Chapter 6*. The findings summarized in the previous section reveal complex interrelationships between macro-level (political), meso-level (organisational) and micro-level (individual) factors that health professionals perceive to shape the accessibility and quality of the health care provided to immigrants in contemporary Greece. Importantly, these interrelationships neither are particularly visible in the existing theory discussed in *Chapter 6* nor are inferred from the reviewed studies discussed in *Chapter 5*. The findings of this study point to two ways for the development of theory in this field: (1) theorising the links between the three levels of health system dynamics; and (2) expanding the theorisation of culturally competent care.

##### **12.4.1. Theorising the links between the three levels of health system dynamics**

The accounts provided by the health professionals interviewed in the present study revealed complex interrelationships between political (macro), organisational (meso) and individual (micro) factors in the provision of health care to immigrants. The influence of macro-level factors on meso- and micro-level health care emerged through a number of pathways. Legal rules influence the operation of health services and the behaviour of health professionals by imposing obligations and establishing guidelines, while governmental policies may be filtered through professional ethics and personal ideologies. Moreover, the pressure created by economic crisis on health organisations and health workers may act as an incentive to adopt new ways of working that potentially lead to improved efficiency. However, on the other hand, clinical practice faces turbulences due to economic restrictions and thus barriers in the delivery of care may exist. The meso-level factors were found to be related to the clinical encounter between health staff and immigrant patients. Health services can assist health

professionals through training and mentoring to gain knowledge about immigrants' care. Furthermore, the existence of suitable strategies and necessary tools within the context of health services creates confidence to both health workers and patients and facilitates clinical contact. In reverse, experiences and outcomes from the operation of health services may provide feedback to policy makers for the design and implementation of new interventions. With regard to the micro-level factors, the phenomena that occur when health professionals and immigrant patients interact, reflect the outcome of political and organisational interventions and constitute an ongoing source of information for changes that can produce a greater chance of success in offering high quality care.

The concept of equity of access to health care was an essential objective of many participants in this study. Nevertheless, the implementation of this concept in health policies, health services organisations and interpersonal interaction in relation to caring for immigrants was found to be rather elusive. The respondents were well aware of the consequences of the modern economic crisis on health care and consequently their perspectives were often not straightforward or consistent to define whether inequities in access have to be completely tackled, especially for undocumented immigrants, in the context of austerity. In other words, participants were often reluctant to call for universal access to health care regardless of residence and employment status because they feared that the efficiency of the health system would be sacrificed in the pursuit of equity. From a political perspective, the public financial barriers emerged as the main justification for the acceptance of legal restrictions to the open accessibility to health services. From a personal perspective, the dissatisfaction of health professionals from the harsh occupational conditions and the inadequate operation of health services is the main reason for occasional propensities to offer suboptimal treatment to immigrant patients.

The present study placed health professionals at the starting point of exploring the interconnections between macro-, meso- and micro-levels of health care. The data demonstrated that in order to perceive and address challenges in immigrants' care, theory has to move away from the rationalistic model which depicts the provision of health care as independent macro-, meso- and micro-layers and has to consider the process of health care as a network of interconnected factors between them. It was highlighted that the quality of health care provided to immigrants depends simultaneously on a series of related influences which include immigration and health

policy and socio-economic conditions, health services' operation and capacities and individual or interpersonal characteristics such as personal motivation, cultural features, political orientation and emotion. It is important to conceptualise these relations in order to understand the complicated phenomena that occur in the process of providing care to immigrants and implement measures to manage the relevant challenges.

#### **12.4.2. Racism in care delivery and equity in health**

The concept of racism refers not only to discrimination on the grounds of race, but also discrimination towards ethnic, religious and other groups (Ford and Kelly, 2005). In the context of health services, racism can be either personal or institutional (Peek, et al, 2005 and Williams and Rucker, 2000). Personal actions of racism appear when an individual member of health staff treats immigrant patients less favourably because of racial prejudice, such as taking less time to interact with or having less interest in immigrant patients. The concept of institutional racism refers to the collective failure of an organisation to provide an appropriate service to people because of their culture or ethnic identity. An example of institutional racism would be the failure of a health care system or unit to make accurate diagnoses because it fails to provide interpretation services to achieve communication with immigrant patients.

The philosophy and orientation of health services of modern, industrialized societies with patient-centred health care is not compatible with the existence of either individual or institutional racism (Bhopal, 2007). Racism and other xenophobic attitudes – such as prejudice – violate the meaning and imperatives of equity in health and contribute to disparities in health status and in quality of health care. Even in the modern, democratic, high income states, health services have not removed prejudiced and discriminatory attitudes and practices, despite well-intentioned policies. Immigrant groups (and other minority groups such as Roma people) often receive lower quality of health care, which is less likely to meet their needs, sometimes in the context of higher utilisation rates (Ben, et al, 2017 and Paradies, 2006).

The present study revealed some degree of prejudice amongst Greek health care providers towards certain groups of immigrant service users, particularly Albanians and Muslims. In fact, it is possible that the extent of prejudicial and/or racist attitudes in the sample may have been greater than the data suggest as some interviewees may have hesitated to express views widely seen to be publicly unacceptable. Nevertheless, some

participants' perceptions clearly reflected xenophobia, prejudice, thoughtlessness and stereotyping against some immigrant people.

The findings suggest that the abrupt and significant rise in ethnic minority populations in Greece as a result of immigration and the continuous austerity may have fuelled racism in health care services at least at a subconscious level. The negative views of immigrants expressed by some respondents often existed at the margins of awareness and thus were difficult to consciously acknowledge and control. It is likely that such attitudes develop or deepen under stressful working conditions and could influence human behaviour without conscious volition. There were various expressions of subconscious racism in this study (see Plous, 2003 for a detailed description of the various types of subconscious racism). For example, some participants, although they rejected the concept of racism, expressed opposition to policies that promote universal access to health care for all immigrants or experienced emotional conflicts and dilemmas between positive and negative feelings from caring for immigrant patients. Other informants, despite their commitment to egalitarian principles, perceived immigrants to be making unfair demands or receiving too many resources from health services or expressed a personal aversion towards particular immigrant groups.

The concerns of health staff were found to be mainly focused on serving the needs of the majority Greek population, whilst those of the minority populations were widely seen to be problematic and for some respondents unwelcome. The need for extra resources to meet the needs of underprivileged immigrants and indeed Greek citizens experiencing severe socio-economic difficulties as a result of the economic crisis was largely recognised by participants but was perceived as not available due to austerity. Therefore, the form in which health services are being provided in Greece marginalises disadvantaged groups, including some immigrants, at the expense of equity in health care and reduces the capacity of the providers of services to operate to the highest levels of professional care. For this reason, researchers, policy-makers and practitioners need to contribute vigorously to international discussions and evidence on identifying actions that can secure the operational stability of public health systems and protect equitable access to health care, particularly in light of national and global economic restrictions. The topic demands great attention with the ultimate goal of producing effective interventions that can lead to harmonious, healthy and fair multi-cultural societies.

### **12.4.3. Expanding the theorisation of culturally competent care**

An important theoretical aspect of the present research is health professionals' views of the value of offering health services that are culturally competent. As immigration continues to grow in host societies, health services and health personnel need to respond to immigrant patients' varied perspectives, behaviours and needs. Failure to do this may have significant health consequences for minority immigrant groups. Cultural competence in the health system can be understood as the ability of services and staff to provide tailored care to patients with diverse values, beliefs and behaviours.

As emerged from the participants' perspectives, cultural competence within the interpersonal contact extends beyond a narrowly defined competence that involves only the creation of standardised clinical encounters and the view that culture is a barrier in interaction that health workers have to overcome. As understood in this study, the concept of culturally competent care also refers to the development of health care that is based on health professionals' interest in and knowledge of intercultural clinical contacts and awareness of the meaning of cultural heterogeneity and its implications on health care. In light of the increasing numbers and diversity of immigrants, this study's findings challenge the static, mono-cultural models of health care provision and recognise the dynamic nature of cultures in producing new characteristics over time.

In Greece, as in many other countries, a majority cultural identity exists and influences public attitudes, customs and use of language. In this study, the dominant 'Greek' culture provided a frame of reference through which health professionals define themselves and select attitudes towards individuals and groups of people with different cultural characteristics. This study suggested that the identification by health workers of properties among patients distinct from their own cultural identity may result in problematic stereotyping when the presence of 'outsiders' exceeds the tolerance limits of both the society and the health system. In this case, the 'different' cultural features of immigrant groups may be perceived as a source of distress or even threat to the indigenous persons' cultural worldview, as this study indicates. For this reason, motivational processes of adjustment – in which health care providers need to adapt both their cognitions and behaviours in order to decrease or avoid negatively charged interactions, improve their ability to interact and gain the positive consequences from clinical encounters with immigrants – emerged as a priority for policy and personal action from the present study.

Cultural and ethnic identities serve important functions, including the development of a sense of 'belonging' and the formation of social relations. Culturally competent care theories underline the importance of health staff being aware of the significance of cultural diversity in order to be able to recognise and meet the different needs of people of various cultural backgrounds. For this reason, policy-makers seeking to develop interventions to decrease prejudice should consider multiple targets, including primary education for students of health professions, training of clinicians actively working with patients and systemic plans to remove institutionalised cultural biases in health care settings.

### **12.5. Strengths and Limitations of the Study**

A significant strength of the study can be found in the applied qualitative methods which prioritised exploring the depth and details of immigrants' care from the health professionals' point of view. Data derived from human experience renders the study more compelling and powerful to recognise the parameters of the phenomena in their natural setting. Additionally, this study recruited a heterogeneous group of participants consisting of health professionals of various specialties (specialised doctors, residents, nurses, health visitors, midwives) practicing in different locations and health services (primary, secondary and tertiary health care). The informants varied also by clinical experience and age. Therefore, the structure of the study population allowed a comprehensive approach to the research questions and the drawing of conclusions on if, how and why accounts vary according to participants' characteristics. A well-selected and diversified study population is important because it is likely to strengthen the generalisability of the findings (Daly and Lumley, 2002). Furthermore, an advantage of this study is its originality because it is the first to explore the experiences of clinical practitioners with immigrants in Greece. The research was conducted under international and local social circumstances documenting an intensification of immigration. The emergence and consolidation of the economic crisis in Greece is an additional research factor that attaches particular importance to the present study. Moreover, this study approached the issue of the provision of care to immigrants from various aspects. Indeed, it explored the situation at all different levels of health care (macro-, meso- and micro-level) and drew links between them.

On the other hand, limitations are also present. As in every study, the researcher's background and personality, including personal preconceptions, experiences,

motivations, qualifications and interests, may have affected the approach to the various stages of the research and the interpretation of the findings. The professional status of the researcher as a clinician and his experiences from medical practice may have influenced all the stages of the research. Indeed, the motivation came from subjective assessments by the researcher about problems in caring for immigrants as they appeared in his professional experience. Moreover, the processes of conducting interviews, analysing and interpreting data and drawing conclusions may have been affected by a possible attitude of the researcher to investigate the relevant issues from the perspective of a medical professional. However, attempts to manage these sources of potential bias were made through the establishment of an agenda for processing the research and the continuous cooperation with the research supervisors. It should also be noted a selection bias was possible. The subject of the investigation is a sensitive issue with serious political implications. For this reason, one might expect that health professionals with negative views towards immigrants and immigration were most likely to avoid participation. In addition, health workers with favourable ideas may have given information emphasising the generally accepted social norms. Consequently, certain results of the study may represent a more positive outcome. On the other hand, it could also be assumed that persons with strong negative views of the presence of immigrants in health services might have wanted to express their frustration and were more likely to respond, providing also exaggerated information. As such, the selection bias may have been directed in both ways.

Another potential limitation of this research is due to language issues. The interviews were conducted and transcribed in the Greek language and the analysis of the data was also conducted in Greek. However, the translation of the interviews was necessary for the purposes of supervision and the presentation of the results. The translation was done by the researcher. This process involved the risk of translation inaccuracies and inconsistencies in the literal representation of the content of the data, especially in the translation of complex meanings and interpretations. However, the greatest possible effort was made to produce an accurate translation and to remain ‘true’ to the meaning of the informants’ narratives.

## **12.6. Future Research Prospects**

Immigration plays a significant role in changes in population composition at a local and national level through the creation of cultural diversity in communities and within a

country. Such changes can have an important impact on the provision of health services which need to respond to the individual health needs, health expectations of (immigrant and other) groups and public health imperatives. Researchers have responded to the increase in immigration over the past few decades by providing a growing understanding of the related phenomena (reasons for immigration, rights and entitlements associated with immigration status and health and health care burden of immigrant populations). Therefore, the produced findings can be incorporated into the design and delivery of health and social care services. The present study added new knowledge in the field of immigrants' care by exploring health professionals' perspectives in a continuously demanding context because of the massive immigration inflows and the severe economic crisis.

The existing knowledge and the findings of the present study offer the prospects for future research which could resolve further issues related to the provision of health care to immigrants. Firstly, there is an urgent need to understand better the factors influencing how integration issues are framed in national and European policies. Giannoni and colleagues (2016) have found that problems in immigrants' integration policies influence negatively all of the three measures of health (self-reported health status, limiting long-standing illnesses and self-reported chronic illness) among foreign people living in European countries. Future studies could confirm whether and how integration policy models could make a difference on immigrants' health care outcomes through socio-economic pathways and health care provision.

Secondly, further research should contextualise the recent immigration inflows in relation to their impact on health care by highlighting continuity and differences with previous waves of immigration. The reaction of host societies from a political, organisational and interpersonal point of view is associated with concepts of hospitality, solidarity and recognition of rights. However, local societies are under pressure due to the large-scale arrival of newcomers with cultural diversity. Therefore, comprehensive cross-national comparative knowledge on the effects of immigration on social structures, including health care, is required to determine the tolerance limits of host societies.

Thirdly, some immigrant groups may experience negative treatment when they access and use public health care services partly because of the existence of xenophobic and racist views amongst some health professionals that could be leading to poor quality care. Therefore, it would be valuable to understand immigrants' views of receiving

health care and to explore how these views compare with those of health professionals on the same issue. These studies could contribute to the design and implementation of strategies for addressing the challenges and improving the outcomes of immigrants' health care. There is recent literature about the perspectives of various categories of immigrants in Europe (see van Loenen, et al, 2018), but further research is needed in order to gain the knowledge that could guide health policy interventions.

### **12.7. Epilogue**

With the constant global flows of immigration, health systems are continually faced with caring for patients who represent a wide diversity of cultures and have different legal residency statuses. The operation of health services is often aggravated by the existing financial crisis. The present situation raises the question of the state of health care provided to immigrants today and whether health care is offered differently to the indigenous population and their non-indigenous counterparts. In other words, a critical point in modern health care research is the investigation of the possible differences between the treatment of people who belong to the 'mainstream' social fabric and that of persons who are left out of the dominant social group (such as undocumented or socially disadvantaged immigrants). The health workers' views are of special importance because they are at the frontline of health services. The present study depicted the situation of caring for immigrants through the health professionals' lens and hopefully may constitute a step towards health policies that preserve suitable access to health care for the entire population, health services tailored to the patients' needs and clinical practices that favour intercultural contacts.

Indeed, the findings of the present study shed light on some of the key issues that governments/policy-makers, researchers and institutions/care providers could consider as the major issues of caring for immigrants. For policy-makers who may aim to legislate and implement health reforms, the findings of this study illustrate that a more expansive policy in relation to income and documentation status is needed to reduce shortages in entitlement to health care access and health inequalities among the population. For researchers in the fields of political science, sociology and health research, this study could enhance their understanding of the multifaceted ways that humans interact with each other, but are also affected by political, economic, structural and organisational processes in the complex conditions of the health care context. For health care providers and institutions, the findings presented in this study could provide

insights into the barriers and challenges that immigrant patients often face in accessing care. Such insights could generate motives for the development of more culturally competent health care staff, practices and facilities.

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## Appendix

*Table A.1: Studies on health professionals' perspectives and experiences in relation to the provision of health care to immigrants in Europe (international studies)*

<b>Research</b>	<b>Period</b>	<b>Method</b>	<b>Subjects</b>	<b>Working environment</b>	<b>Area</b>
Sandhu, et al, 2013	2008 – 2010	Qualitative (individual interviews)	17 psychiatrists, 9 mental health nurses, 5 psychologists, 1 therapist, 2 social workers, 14 managers in mental health services	Mental health services	16 European Union member states
Dauvrin, et al, 2012	2008 – 2010	Qualitative (individual interviews)	Clinicians (mostly doctors and nurses) and managers (240 in total)	Primary care services, mental health services, accident and emergency departments	16 European Union member states
Devillé, et al, 2011	June 2008 – January 2009	Qualitative (individual interviews)	126 professionals of various disciplines (biochemistry, finance, geography, law, management, medicine, nursing, pedagogy, political science, psychology, public health, social work, sociology, theology)	Academic institutions, non-governmental organizations, policy-making actors, health care practice	16 European Union member states
Priebe, et al, 2011	2008 – 2010	Qualitative (individual interviews)	156 doctors, 44 nurses, 7 psychologists, 4 physiotherapists, 3 social workers, 26 administrators and managers	Primary care services, accident and emergency departments, community mental health institutions	16 European Union member states

*Table A.2: Studies on health professionals' perspectives and experiences in relation to the provision of health care to immigrants in the Nordic countries*

<b>Research</b>	<b>Period</b>	<b>Method</b>	<b>Subjects</b>	<b>Working environment</b>	<b>Area</b>
Akhavan, 2012	January 2009 – February 2010	Qualitative (individual semi-structured interviews)	10 midwives	Municipal health services	Western Sweden
Lyberg, et al, 2012	September – December 2010	Qualitative (multistage focus groups)	5 midwives and 1 public health nurse	Maternity care services	Norway
Nkulu Kalengayi, et al, 2012	March 2009 – April 2010	Qualitative (individual interviews)	2 nurses, 2 social workers, 4 doctors, 2 public health officers	Hospital, health centre, county council	Northern Sweden
Jensen, et al, 2011	September 2008 – January 2009	Qualitative (individual interviews)	9 general practitioners, 3 doctors in emergency rooms, 3 managers of psychiatric institutions	Primary care services, emergency departments, psychiatric residential units	Copenhagen, Denmark
Jirwe, et al, 2010		Qualitative (individual interviews)	10 final year nursing students	University	Sweden
Høye and Severinsson, 2008		Qualitative (multistage focus groups)	16 nurses	Intensive care units	Norway
Wachtler, et al, 2006	Summer 2003	Qualitative (individual semi-structured interviews)	20 general practitioners	Primary care centres	Scania province, Sweden
Hultsjö and Hjelm, 2005	November – December 2003	Qualitative (focus groups)	35 nurses and assistant nurses	Emergency ward, ambulance service, psychiatric intensive care unit	Southern Sweden
Michaelsen, et al, 2004	April – May 2001	Quantitative (questionnaire by post)	166 doctors, 231 nurses and 119 assistant nurses	Hospital clinical departments	Copenhagen, Denmark

Table A.3: Studies on health professionals' perspectives and experiences in relation to the provision of health care to immigrants in Central and Western Europe

Research	Period	Method	Subjects	Working environment	Area
Flye Sainte Marie, et al, 2015	March – July 2009	Mixed (questionnaire by post and focus groups)	<i>Questionnaire:</i> 385 general practitioners <i>Focus groups:</i> 28 general practitioners	Primary care medical practice	Meurthe-et-Moselle department, France
Boerleider, et al, 2013		Qualitative (individual semi-structured interviews and focus groups)	<i>Individual interviews:</i> 13 midwives <i>Focus groups:</i> 8 midwives	Midwifery practices	Netherlands
Hudelson, et al, 2010		Quantitative (questionnaire by post)	176 doctors in private practice, 306 hospital doctors, 137 medical students	Private practice, university hospital	Geneva, Switzerland
Kurth, et al, 2010		Qualitative (individual semi-structured interviews)	3 physicians, 3 nurses/midwives, 1 psychologist, 3 interpreters	University hospital	Basel, Switzerland

*Table A.4: Studies on health professionals' perspectives and experiences in relation to the provision of health care to immigrants in the United Kingdom*

<b>Research</b>	<b>Period</b>	<b>Method</b>	<b>Subjects</b>	<b>Working environment</b>	<b>Area</b>
Lindenmeyer, et al, 2016	2014 – 2015	Qualitative (semi-structured interviews)	6 general practitioners, 5 practice nurses, 6 administrative employees	Primary care practices	Birmingham, England
Tesfaye and Day, 2015	2012	Qualitative (individual semi-structured interviews)	8 health visitors	Health visiting practice	Merseyside, England
Burchill and Pevalin, 2012	2006	Qualitative (individual interviews)	14 health visitors	Health visiting practice	London, England
Worth, et al, 2009		Qualitative (individual semi-structured interviews, mainly by telephone)	13 general practitioners, 2 oncologists, 2 social workers, 1 nurse, 1 occupational therapist, 1 manager	Palliative care services	Central Scotland
Drennan and Joseph, 2005	2001	Qualitative (individual semi-structured interviews)	13 health visitors	Health visiting practice	Inner London, England
Hawthorne, et al, 2003		Qualitative (focus groups)	5 doctors, 6 nurses, 3 health visitors, 1 midwife, 12 receptionists, 3 managers	Health centres	Cardiff, Wales

Table A.5: Studies on health professionals' perspectives and experiences in relation to the provision of health care to immigrants in Spain

Research	Period	Method	Subjects	Working environment	Area
Otero-Garcia, et al, 2013	February 2008 – November 2009	Qualitative (individual interviews and field notes)	7 midwives	Rural primary health care services	Segovia, Castile and Leon, Spain
Llosada Gistau, et al, 2012	September – December 2007	Qualitative (individual semi-structured interviews and focus groups)	73 hospital and primary health care professionals (directors or coordinators, physicians, nurses and midwives, cultural mediators)	Hospital (emergency care, internal medicine, gynaecology-obstetrics) and primary care services	Barcelona, Spain
Terraza-Núñez, et al, 2011	January – October 2007	Qualitative (individual semi-structured interviews and focus groups)	<b>Individual interviews:</b> 6 family doctors, 5 paediatricians, 7 emergency doctors, 2 obstetricians, 7 nurses, 4 midwives, 1 social worker, 5 user services, 4 centre coordinators, 4 managers, 5 clinical directors <b>Focus groups:</b> 2 family doctors, 1 emergency physician, 4 nurses, 1 social worker, 1 user service, 2 centre coordinators, 4 clinical directors	Primary and secondary health care services	5 regions in Catalonia, Spain
Fuertes Goñi, et al, 2010		Qualitative (focus groups and individual interviews)	<b>Focus groups:</b> 19 doctors, 10 nurses, 4 paediatricians, 6 managers, 2 social workers <b>Individual interviews:</b> 2 doctors, 1 manager, 1 nurse, 1 social worker	Primary health care services	5 regions in Navarre, Spain

Table A.5: Studies on health professionals' perspectives and experiences in relation to the provision of health care to immigrants in Spain (continued)

Vázquez Navarrete, et al, 2009	January – October 2007	Qualitative (individual semi-structured interviews and focus groups)	<p><b>Individual interviews:</b> 6 family doctors, 5 paediatricians, 7 emergency doctors, 2 obstetricians, 7 nurses, 4 midwives, 1 social worker, 5 user services, 4 centre coordinators, 4 managers, 5 clinical directors</p> <p><b>Focus groups:</b> 2 family doctors, 1 emergency physician, 4 nurses, 1 social worker, 1 user service, 2 centre coordinators, 4 clinical directors</p>	Primary and specialised health care services	5 regions in Catalonia, Spain
Esteva, et al, 2006	April – May 2013	Quantitative (self-administered questionnaire)	120 family doctors, 20 paediatricians, 9 residents in family medicine, 10 doctors of unknown specialty	Primary health care services	Majorca, Spain (urban and rural areas)
Ramos, et al, 2001		Qualitative (focus and nominal groups and individual interviews)	<p><b>Focus and nominal groups:</b> Doctors and social workers (24 in total)</p> <p><b>Individual interviews:</b> 2 health administration officials</p>	Primary care and hospital care services	Majorca, Spain (urban and rural areas)

*Table A.6: Studies on health professionals' perspectives and experiences in relation to the provision of health care to immigrants in Portugal*

Dias, et al, 2012	January – April 2009	Quantitative (self-administered questionnaire)	91 doctors, 114 nurses, 115 office workers	Primary health care services	Region of Lisbon, Portugal
Dias, et al, 2011b	October 2008 – February 2009	Quantitative (self-administered questionnaire)	91 doctors, 114 nurses, 115 administrative officers	Primary health care services	Region of Lisbon and Tagus Valley, Portugal

*Table A.7: Studies on health professionals' perspectives and experiences in relation to the provision of health care to immigrants in Greece*

Papadakaki, et al, 2017	July – December 2013	Qualitative (focus groups)	5 primary care doctors, 4 primary care nurses	Primary health care services	Prefectures of Heraklion and Rethymnon, Cretan Region, Greece
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Figure A.1: The participant information sheet (translated from Greek).

## **Participant Information Sheet**

### ***Study Title: Provision of health care to immigrants in the context of economic crisis: The perceptions of health professionals in Central Greece***

My name is Charalampos Milionis and I am conducting this research as a student in the PhD in Health Research programme at Lancaster University, Lancaster, United Kingdom.

#### **What is the study about?**

The purpose of this study is to investigate potential existing variations in perceptions among different categories of health personnel with regard to the provision of care to immigrant patients in the context of financial crisis. Specifically, this research will attempt to identify possible barriers for the effective provision of care to the immigrant population and suggest specific measures for the improvement of health services' efficiency and the professional competence of the health care staff with regard to the treatment of immigrants.

#### **Why have I been approached?**

You have been approached because the study requires information from various categories of health personnel (doctors, nurses, health visitors and social workers) of Greek ethnicity from all clinical departments as long as their duties involve direct patient contact.

#### **Do I have to take part?**

No. It's completely up to you to decide whether or not you take part in individual semi-structured interviews with the researcher.

#### **What will I be asked to do if I take part?**

If you decide you would like to take part, you would be asked to discuss your experiences regarding your professional contact with immigrants in comparison with the provision of health care to the host population.

#### **Will my data be confidential?**

The information you provide is confidential. The anonymity of the participants will be secured. The data collected for this study will be stored securely and only the researcher conducting this study and his supervisors will have access to this data:

- Original audio recordings will be deleted after the thesis has been submitted and examined and the degree has been awarded by the University.
- Hard copies of transcriptions will be kept in a locked cabinet. They will be stored for ten years and then will be destroyed.
- The files on the computer will be encrypted (that is no one other than the researcher will be able to access them) and the computer itself will be password protected.
- At the end of the study, hard copies of transcriptions will be kept securely in a locked cabinet for ten years. At the end of this period, they will be destroyed.
- The typed version of your interview will be made anonymous by removing any identifying information including your name. Anonymized direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them.

There are some limits to confidentiality: If what is said in the interview makes the researcher think that there is an indication of harm to participants, patients or others, the researcher will have to break confidentiality and speak to a member of staff about this. If it is feasible, you will be notified for this.

**What will happen to the results?**

The results will be summarized and reported in a thesis and may be submitted for publication in an academic or professional journal.

**Are there any risks?**

There are no risks anticipated with participating in this study. However, if you experience any distress after your participation, you are encouraged to inform the researcher and contact the organizations which are provided at the end of this sheet.

**Are there any benefits from the participation?**

Although you may find participating interesting, there are no direct benefits from it.

**Who has reviewed the project?**

This study has been reviewed by the Faculty of Health and Medicine Research Ethics Committee, and approved by the University Research Ethics Committee at Lancaster University, the Directorate of Public Health and Social Welfare of the Regional Unit of Fthiotida and the Scientific Board of the General Hospital of Lamia.

**Where can I obtain further information about the study if I need it?**

If you have any questions about the study, please contact the main researcher or his supervisors:

Charalampos Milionis  
Public Health Physician  
Directorate of Public health, Region of Central Greece  
E-mail: [ch.milionis@fthiotida.pste.gov.gr](mailto:ch.milionis@fthiotida.pste.gov.gr), [c.milionis@lancaster.ac.uk](mailto:c.milionis@lancaster.ac.uk)  
Tel: +302231352825

Professor Jennie Popay  
Professor of Sociology and Public Health  
Division of Health Research, Faculty of Health and Medicine, Lancaster University  
E-mail: [j.popay@lancaster.ac.uk](mailto:j.popay@lancaster.ac.uk)

Dr Paula Holland  
Lecturer in Public Health  
Division of Health Research, Faculty of Health and Medicine, Lancaster University  
E-mail: [p.j.holland@lancaster.ac.uk](mailto:p.j.holland@lancaster.ac.uk)

**Complaints**

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Professor Susan Cartwright, Tel: +44 (01524) 592430  
Head of Department in the Division of Health Research, E-mail:  
[s.cartwright@lancaster.ac.uk](mailto:s.cartwright@lancaster.ac.uk)  
Faculty of Health and Medicine  
(Division of Health Research)  
Lancaster University  
Lancaster  
LA1 4YG

If you wish to speak to someone outside of the PhD in Health Research Program, you may also contact:

Professor Paul Bates, Tel: +44 (01524) 593718  
Associate Dean for Research, Email: [p.bates@lancaster.ac.uk](mailto:p.bates@lancaster.ac.uk)  
Faculty of Health and Medicine  
(Division of Biomedical and Life Sciences)  
Lancaster University  
Lancaster  
LA1 4YD

Thank you for taking the time to read this information sheet.

**Resources in the event of distress**

Should you feel distressed either as a result of taking part, or in the future, the following structures may be of assistance:

Chrysoula Florou, Tel: +302231352825  
Social Worker – Director of Social Welfare, E-mail: [x.florou@fthiotida.pste.gov.gr](mailto:x.florou@fthiotida.pste.gov.gr)  
Region of Central Greece  
(Directorate of Social Welfare)  
Enianon 2, 351 00  
Lamia

Figure A.2: The consent form (translated from Greek)

### Consent Form

#### Study Title: Provision of health care to immigrants in the context of economic crisis: The perceptions of health professionals in Central Greece

We are asking if you would like to take part in a research project which attempts to investigate the Greek health professionals' perceptions regarding the provision of care to immigrants within the modern economic crisis.

Before you consent to participating in the study we ask that you note your initials in each statement below, if you agree. If you have any questions or queries before signing the consent form, please speak to the principal investigator, Charalampos Milionis.

- Please initial after each statement
1. I confirm that I fully understand what is expected of me within this study.
  2. I confirm that I have had the opportunity to ask any questions and to have them answered.
  3. I understand that my interview will be audio recorded and then made into an anonymized written transcript.
  4. I understand that audio recordings will be kept until their content has been transferred to transcripts.
  5. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.
  6. I understand that once my data have been anonymized and incorporated into themes, it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of publication.
  7. I understand that the information from my interview will be pooled with other participants' responses, anonymized and may be published.
  8. I consent to information and quotations from my interview being used in reports, conferences and training events.
  9. I understand that any information I give will remain strictly confidential and anonymous unless there is an indication of harm to participants, patients or others.
  10. I consent to take part in the above study.

Name of Participant \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Name of Researcher \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

*Figure A.3: The topic guide (translated from Greek)*

## **Topic guide**

**Study Title: Provision of health care to immigrants in the context of economic crisis:  
The perceptions of health professionals in Central Greece**

Researcher: Charalampos Milionis, MD

### **Aim of the study**

The goal of this research is evolved around three main questions which will be addressed to the participants:

1. What are your experiences and views regarding the provision of health care to immigrants?
2. In your opinion, is there an impact of the modern financial crisis on the clinical encounter with immigrants? If yes, can you describe it?
3. In your opinion, what are the necessary measures which should be applied in order to deal with the issues which arise from caring for immigrants?

The second and third question are going to be addressed openly to the respondents, while the first question will be set openly at first and after the initial responses, the participants will be asked to provide their answers in relation with the following issues, if the latter have not been mentioned:

- i. Verbal and non-verbal communication with immigrants
- ii. Entitlement of immigrants to health care
- iii. Utilization of health services by immigrants
- iv. Monitoring, contacting and medical records of immigrants
- v. Cultural characteristics of immigrants
- vi. Social, economic and professional situation of immigrants
- vii. Health system's preparation to deal with immigrants
- viii. Training of health professionals to treat immigrants
- ix. Personal philosophy of health professional towards immigrants