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DEVELOPMENT

Communication in cross-cultural consultations in primary care in Europe: the case for improvement. The rationale for the RESTORE FP 7 project

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The purpose of this paper is to substantiate the importance of research about barriers and levers to the implementation of supports for cross-cultural communication in primary care settings in Europe. After an overview of migrant health issues, with the focus on communication in cross-cultural consultations in primary care and the importance of language barriers, we highlight the fact that there are serious problems in routine practice that persist over time and across different European settings. Language and cultural barriers hamper communication in consultations between doctors and migrants, with a range of negative effects including poorer compliance and a greater propensity to access emergency services. It is well established that there is a need for skilled interpreters and for professionals who are culturally competent to address this problem. A range of professional guidelines and training initiatives exist that support the communication in cross-cultural consultations in primary care. However, these are commonly not implemented in daily practice. It is as yet unknown why professionals do not accept or implement these guidelines and interventions, or under what circumstances they would do so. A new study involving six European countries, RESTORE (REsearch into implementation STrategies to support patients of different ORigins and language background in a variety of European primary care settings), aims to address these gaps in knowledge. It uses a unique combination of a contemporary social theory, normalisation process theory (NPT) and participatory learning and action (PLA) research. This should enhance understanding of the levers and barriers to implementation, as well as providing stakeholders, with the opportunity to generate creative solutions to problems experienced with the implementation of such interventions.

Key words: cross-cultural communication; general practice; immigrants; language barrier; normalisation process theory (NPT); participatory learning and action (PLA)

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Introduction

The feeling of being understood and accepted is a key component of trust in the doctor–patient relationship in primary care settings and is highly associated with patient satisfaction (Baker *et al.*, 2003). The physician's verbal behaviour, especially the way in which patient's experiences of the disease and illness is explored, affects to a large extent whether trust is built and maintained (Fiscella *et al.*, 2004). However, how can trust and mutual understanding be established in doctor–patient encounters where there is no shared language or cultural background? Often, these consultations proceed without the support of professional, trained interpreters or mediators, despite the potential benefits of such services (Flores, 2005; Martin and Phelan, 2010), and despite international health policy imperatives to ensure that health care is culturally appropriate [Council of Europe, 2000; World Health Organization (WHO), 2010]. The negative consequences of not providing such supports for patients from migrant communities are well documented in a range of international settings (Szczepura *et al.*, 2005; Scheppers *et al.*, 2006; O'Donnell *et al.*, 2008; MacFarlane *et al.*, 2009a; Kokanovic *et al.*, 2010; Arocha and Moore, 2011). However, it is unclear to what extent such gaps in service provision are being addressed in different health-care systems, or what work has been carried out in implementing supports for cross-cultural communication in a European setting. Given the projected patterns for global migration [International Organisation for Migration (IOM), 2010], it is important that the translational gap described above is addressed by primary care researchers, as this still seems to be a 'blind spot' (Meeuwesen, 2012).

The purpose of this paper is to substantiate the importance of research about barriers and levers to the implementation of supports for cross-cultural communication in primary care settings in Europe. After an overview of migrant health issues, with the focus on communication in cross-cultural consultations in primary care and the importance of language barriers, we highlight the fact that there are serious problems and challenges in routine practice that persist over time and across different European settings. The current financial crisis in Europe and its impact on health-care and welfare systems has increased these problems even more (Koehler *et al.*, 2010; Skeldon, 2010). We conclude with an argument for theoretically informed, action-oriented research to investigate and support the implementation of guidelines and/or training initiatives meant to support cross-cultural communication in primary care consultations. We refer specifically to an ongoing project entitled RESTORE (REsearch into implementation STrategies to support patients of different ORigins and language background in a variety of European primary care settings) that has received funding from the European Union's Seventh Framework Programme (FP7/2007–2013) under grant agreement n°257258 and seeks to investigate and test how interventions developed to support cross-cultural communication within primary care consultations can be implemented in six European countries: Ireland, Scotland, England, The Netherlands, Austria and Greece (www.fp7RESTORE.eu, MacFarlane *et al.*, 2012).

Migration patterns

It is estimated that, in 2010, there were 47.3 million foreign-born residents in the European Union (EU), equivalent to 9.4% of the population (Vasileva, 2011). Two-thirds (31.4 million) were born outside the EU; the remainder originated from member states, but are now residing in a different member state from the one of their birth. These figures, however, conceal the heterogeneity of patterns and rates of migration apparent throughout the EU, which are influenced by a range of social, economic, political, legal and cultural contexts. Migrants form a very heterogeneous group. They include those staying in a country not of their birth legally, who have come there for work or study or family reunion, but also those seeking protection (such as asylum seekers), and individuals without legal status (undocumented migrants). As a result, the experiences of migration, legal status within a country and access to welfare and health systems may vary significantly between different migrant groups (Gushulak *et al.*, 2010; Anderson and Binder, 2011). For example, undocumented migrants' access to health care varies considerably between member states [see European Union Fundamental Rights Agency (EUFRA), 2011]. This has led the EU, in recent years, to develop a common framework

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and practices around immigration policy. Nonetheless, there remains variation between countries owing to national laws and policies, interpretation of those laws, 'integration' policies and practices (Messina, 2011).

Table 1 summarises the overall recent migration experiences of the RESTORE partner countries. RESTORE countries are host to a range of migrant groups, who come from diverse socio-economic and cultural backgrounds and have various reasons for migrating to destination countries. Migration to specific countries is driven by the historical relationship between origin and destination countries (eg, colonial relations) and the status accorded to migrants in accessing health and welfare systems (Gushulak *et al.*, 2010; Messina, 2011; Salt, 2011). Historical relationships explain the ties of Austria, The Netherlands and the United Kingdom to Turkey, Suriname and Pakistan, respectively. The changing geopolitics of Europe throughout the 1990s and 2000s has also resulted in economic migration from the EU8 countries and former Soviet states to all of the RESTORE countries. The EU is also a key provider of asylum for those seeking refugee status, with over a quarter of a million applications received in 2010 (Eurostat, 2011). The reception of asylum seekers, long established in England and The Netherlands, is a relatively recent phenomenon for Ireland, Scotland, Austria and Greece, whose migration histories in the last century have been defined by emigration until relatively recently. Greece, in particular, has experienced major shifts of migration, starting from the mid-1970s, resulting in the highest proportion of migrants in relation to its labour force in the EU in the 1990s (IOM, 2008).

Although it is difficult to determine the actual numbers of undocumented migrants, an estimated 1.9–3.8 million people are residing illegally in the EU (in 2008, http://www.nowhereland.info/), with marked variation between countries (see Table 1). Greece has been a focus of irregular migration because of its border with Turkey, where over half (63%) of all detected illegal crossings into the EU took place [European Migration Network (EMN), 2011; OECD, 2011]. Once migrants have arrived in a particular country, they are faced with different health-care systems and rights within those systems. This is particularly apparent in relation to primary care, as illustrated when we compare the primary

Table 1 Immigration patterns in RESTORE countries 2010

Country	Significant Inward Migration	Population 2009 (%)[a]	Estimated Amount of undocumented immigrants[b]	Most common countries of origin – economic migrants	Most common countries of origin – asylum seekers[c]
Ireland	Recent	17% of population 4.4 million (2009)	Unknown	Poland, Russia, Ukraine, Lithuania	Nigeria, Democratic Republic of Congo, China Afghanistan, Pakistan
England and Scotland	England: Longstanding Scotland: Recent	11.3% of 62 million (2009)[d]	260 000[d]	Poland, China, Germany Pakistan…	Afghanistan. Zimbabwe, Iran, Pakistan, Sri Lanka
Austria	Recent	15.5% of 8.7million (2009)	38 000	Poland, former Yugoslavia, Turkey	Russia, Afghanistan, Kosovo, Nigeria, India
Netherlands	Longstanding	11.1% of 16.5 million	88 000	Turkey, Poland, Germany, EU8	Somalia, Iraq, Afghanistan, Iran
Greece	Recent	7.4% of 11 million (2009) OECD Eurostat (8.4%)	260 000	Albania. Bulgaria, Romania. Ukraine. Pakistan. Georgia	Pakistan, Georgia, Bangladesh, Albania, China

[a] OECD (2011), International Migration Outlook (2011).
[b] European Migration Network (EMN) (2011); OECD, (2011): 284, Maroukis (2009), Vollmer (2009), Van der Leun (2009), Kraler (2009).
[c] Main citizenships of non EU-27 asylum applicants, Eurostat (2011) online data code migr_asyappcta.
[d] This figure is for the whole of the United Kingdom.

Table 2 Primary care system and GP services in six European countries

Countries	Funding base	Primary care system[a]	No. of GPS[b]	Registration with GP[c]	Choice of GP[d]	Gatekeeping function?
Austria	Social insurance	Weak	12 220	Free	Limited	No
Greece	Tax, social insurance	Weak	1540 (2006)	Free	Free	No
Ireland	Tax	Weak	2138 (2005)	Obligatory (medical card holders) free	Free	Yes
Netherlands	Social insurance	Strong	8673	Required	Free	Yes
United Kingdom	Tax	Strong	49 947	Required	Limited	Yes
Scotland	Tax	Strong	4937	Required	Limited	Yes
England	Tax	Strong	40 269	Required	Limited	Yes

[a] Kringos (2012).
[b] Boyle (2011), Economou (2010), McDaid *et al.* (2009), Hofmarcher (2006), Schäfer (2010).
[c] Wendt (2009: 437).
[d] Reibling and Wendt (2012: 500).

care systems, and in particular general practice, of the participating RESTORE countries.

Role and position of general practitioners (GPs) in primary care

The organisation of primary care in the participating RESTORE countries differs (see Table 2). In The Netherlands, Ireland and the United Kingdom, GPs have a central role as gatekeepers to secondary care (Government of Ireland, 2001; de Maeseneer, 2008; Schäfer, 2010; Van Weel *et al.*, 2012). They generally work in group practices with more than one GP and a team of primary care professionals, in particular practice nurses, but also other professional groups, sometimes including psychologists or social workers. GPs deal with the entire spectrum of medical ailments. They take part in prevention and manage chronic illness. In Austria, the health-care system ensures free access to a GP of choice and to most specialist services. GPs are not gatekeepers. Here GPs usually work in single-handed practices that they own. In Greece, GPs still represent a small proportion of the total number of Greek physicians and GPs are less acknowledged compared with other medical specialties (Lionis, 2000; 2010; Liangas and Lionis, 2004). In this respect, general practice in Greece is yet to become integrated, such as in other European countries.

In all these settings, GPs are primarily responsible for the provision of comprehensive and continuing, person-centred generalist care to every individual seeking medical care (European Academy of Teachers in General Practice (EURACT), 2007; Royal College of General Practitioners, 2007; World Organization of Family Doctors (WONCA) Europe, 2011).

Migrants' health issues

Despite the heterogeneity of migrant populations described earlier, migrants share commonalities in health problems and needs (Gushulak and MacPherson, 2006). Although migrants entering Western Europe are often healthier than native-born residents (the healthy migrant effect (Razum *et al.*, 2000), once arrived in the host country, their health status often deteriorates. Migrants often rate their health as worse compared with natives of the same socio-economic status (Nielsen and Krasnik, 2010). The most vulnerable groups of people, for example, those seeking protection/asylum, refugees, undocumented and low-income migrants, particularly, experience worse health than other people (Schoevers *et al.*, 2009). Robust data on the health of migrants are only available for a few European countries, for example, the United Kingdom and The Netherlands (Rafnsson and Bhopal, 2009), and similar ethnic minority groups living in different European countries differ in mortality rates, possibly reflecting local context (Bhopal *et al.*, 2011). However, it is clear that, overall,

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cardiovascular diseases, being overweight and diabetes mellitus are much more prevalent among migrant groups, especially those originating from South Asia, Africa and the Caribbean (Vandenheede *et al.*, 2009; Rafnsson *et al.*, 2013). Although genetically based differences in morbidity patterns may contribute to this high incidence, there is also growing evidence of the relationship between migration-related social problems and chronic stress and the rapid development of metabolic diseases such as hypertension, overweight and diabetes in migrants (Schulz *et al.*, 2008; Pyykkönen *et al.*, 2010; Agyemang *et al.*, 2011). This migration-related stress is also responsible for the high prevalence of mental health problems among migrants (Carta *et al.*, 2005), in particular people seeking protection/asylum and undocumented migrants (McMahon *et al.*, 2007; Schoevers *et al.*, 2009; Craig, 2010; Murray and Davidson, 2010; Vijayakumar, 2010). It is even more visible in countries such as Greece that are struggling with the financial crisis where control measures to protect public health have taken under pressure without proper design and consensus with stakeholders (Nikolas, 2012).

In general, health problems often overlap with deprivation and poor living conditions, highlighting the relationship between poverty, poor health and lack of access to health care (Stanciole and Huber, 2009; Pieper *et al.*, 2011). For migrants, the social determinants of health are not favourable.

Migrants' access to health care and the importance of language and cultural barriers

Documented or regular migrants and asylum seekers in all RESTORE countries are entitled to some form of health-care insurance that covers most of the costs in primary care and of at least basic treatment for acute diseases and antenatal care (Stanciole and Huber, 2009). Although the right to medical care for all is an acknowledged human right (UN economic saCRC, 2000), and medical professionals are bound to deliver all necessary medical care irrespective of finances or legal status [World Medical Association (WMA), 2006], undocumented migrants in all six RESTORE countries face financial and administrative barriers in accessing health care (Chauvin *et al.*, 2009; Karl-Trummer *et al.*, 2009). In most countries, they have no right to health insurance and are required to cover the costs of health care themselves, although some form of 'emergency' care is provided for and, in some situations, health-care workers can get some reimbursement if the migrants are not able to pay. Since 2001, in Greece, migrants' access to emergency care until stabilisation is available, although the hospital director was obligated to inform the authorities about all migrant users (Law 2910/2001, Article 51). Since 2005, the hospital director no longer has to inform the authorities of the migrant health-care users (Law 3386/2005, Article 84). Therefore, although undocumented migrants experience many health problems (Schoevers *et al.*, 2009), they make far less use of health-care services, including primary care than do native-born residents or other migrants (Schoevers *et al.*, 2010; de Jonge *et al.*, 2011).

Despite their entitlements to health care, many documented migrants have also been found to have inadequate access to health services. This is a common feature in the six described European countries (Rafnsson and Bhopal, 2008). This is because of other kinds of barriers to access, which occur at three different levels: the patient, the provider and the system. At each level, language and cultural differences play an important role (Huber *et al.*, 2008; Pieper *et al.*, 2011). At patient level, access is hampered by lack of knowledge of the health-care system and this is compounded by language and cultural barriers. At provider level, weak communication skills and lack of cultural competence act as a barrier. A Dutch study showed that GPs communicate differently with migrants compared with non-migrants in that consultations with migrants were shorter, the GPs were more verbally dominant and migrants less demanding (Meeuwesen *et al.*, 2006). In addition, and surprisingly, although GPs emphasise that language and cultural differences are a major problem from their perspective, they rarely make use of available, formal interpreters in routine practice (Crowley, 2003; Greenhalgh *et al.*, 2006; MacFarlane and O Reilly-de Brun, 2009b; Meeuwesen and Twilt, 2011; Papic *et al.*, 2012).

Finally at the system level, health-care facilities are not adapted for migrants with particular problems in terms of poor availability of translated health information materials and poor

organisational practices and resources to support the use of formal interpreters (Greenhalgh *et al.*, 2006; MacFarlane and O'Reilly-de Brún, 2009b). Furthermore, not all health systems have resources for paying formal interpreters or, as is the case in The Netherlands, such resources have recently been withdrawn.

One very serious implication of these barriers is that family members and friends, including children, are often used as interpreters as a pragmatic response by migrants and GPs to address the language and cultural differences between them (eg, Greenhalgh *et al.*, 2006; O'Donnell *et al.*, 2008; MacFarlane *et al.*, 2009a).

Migrants make less use of public health facilities, screening and preventive programmes, antenatal services and homecare provisions (de Graaff and Francke, 2003; Alderliesten *et al.*, 2007; Denktaş *et al.*, 2009; Norredam *et al.*, 2009; Vermeer and van den Muijsenbergh, 2010) than the general population. Use of general practice care and of emergency services, on the other hand, is generally higher among migrants, even when compared with native patients of the same socio-economic level and health status (McMahon *et al.*, 2007; Uiters *et al.*, 2009). This has been related to inadequate access to other services. Another explanation is that, because of communication problems, cross-cultural consultations more often end without mutual understanding being reached, leading to poorer compliance and less patient satisfaction (Campbell *et al.*, 2001; Harmsen *et al.*, 2005; MacFarlane *et al.*, 2009c; MacFarlane and de Brún, 2010). As a result, in health-care systems with low-threshold access to general practice, the migrant keeps coming back in an effort to resolve his health and social care needs.

There are indications that not only the access but also the effectiveness of care in some fields is lower for migrants (Huber *et al.*, 2008; Lanting *et al.*, 2008; Denktaş *et al.*, 2009). Several factors are responsible but, again, there is evidence that language and cultural barriers play a decisive role here (Smedley *et al.*, 2003; Joint Commission, 2006; Sievers, 2012). Lack of a common language is one of the major factors that limits the use and effectiveness of health care because it jeopardises effective communication between ethnic minority patients and health-care personnel (Scheppers *et al.*, 2006). Ineffective communication enlarges cultural differences as experienced by professionals and patients, leading to even less mutual understanding (Baraldi and Gavioli, 2012). GP registrars, in particular, have mentioned their concerns about their reduced ability to deliver good-quality holistic general practice care in such consultations (Pieper and MacFarlane, 2011).

Adequate person-centred communication is a cornerstone of good clinical practice. Key features of patient-centred communication in general practice are: providing room for the patient's story; attention to the context as well as the problems of that person; an emphasis on a dialogue between patient and health-care provider; exploring emotional cues and showing empathy; adjusting information and advice to the persons' context, and framing it in a positive way; and involving patients in decisions on management of illness (Stewart, 2005; Zandbelt *et al.*, 2007). If communication is hampered, patients and professionals are less satisfied, and the health outcomes for patients are less positive (Turner *et al.*, 1994; Stewart *et al.*, 2000; Di Blasi *et al.*, 2001; van Os *et al.*, 2005; Pieper and MacFarlane, 2011).

Discussion

We have shown in this paper that language and cultural barriers hamper communication in consultations with doctors and migrants with a range of negative effects including poorer compliance and a greater propensity to access emergency services (Van Wieringen *et al.*, 2003). This has been the case for some time and across country settings and has been seen both in countries with established patterns of inward migration, as well as in countries where this is a more recent phenomenon. This has been the case in times of economic boom and through the current recession. All in all, this is a serious problem that persists and compromises migrants' access to health care in a significant and fundamental way. It is well established that there is a need for skilled interpreters and for professionals who are culturally competent to address this problem (Andrulis and Brach, 2007; Karliner *et al.*, 2007; Bischoff, 2012).

A range of professional guidelines, recommendations and training initiatives exist that advocate and are designed to support the use of such professionals and the establishment of cultural competencies, for instance, in The Netherlands

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and in Ireland (Betancourt *et al.*, 2003; Beach *et al.*, 2005; 2006, http://knmg.artsennet.nl/Publicaties/KNMGpublicatie/KNMGstandpunt-Tolken-in-de-zorg-2011.htm, http://www.nuigalway.ie/general_practice/news.html), although in other countries, for example Greece, this subject seems to be rather neglected. Some of these guidelines and training initiatives have been proven to be effective in research settings (Harmsen *et al.*, 2005; Chips *et al.*, 2008). However, as we have shown above, it is clear that they are not being implemented in daily practice. This highlights that the problem described in this paper is a significant translational gap between evidence and practice. Yet surprisingly, despite some exceptions (eg, Greenhalgh *et al.*, 2006; MacFarlane and O'Reilly-de Brún, 2009b), there has been very little research about this translational gap. It is as yet unknown why professionals do not accept or implement these guidelines and interventions, or under what circumstances they would. One possible explanation is that these interventions are not developed and tested by relevant stakeholders, namely, migrants, interpreters and health-care workers, although we know that the involvement of key stakeholders in implementation processes can have a positive effect and is recommended in implementation research (Greenhalgh *et al.*, 2004; Edvardsson *et al.*, 2011). A participatory research strategy focussed on the implementation of interventions in daily practice that could help to elicit, from the perspective of all stakeholders, which interventions are helpful and feasible in primary care to overcome language and cultural barriers. This is the aim of the FP7 project RESTORE, which focusses on the implementation of guidelines and/or training initiatives to support communication in cross-cultural primary care.

It uses a unique combination of a contemporary social theory, normalisation process theory (NPT) (May and Finch, 2009; May *et al.*, 2009) and participatory learning and action (PLA) research (Chambers 1997; O'Reilly de Brún and de Brún, 2010). This should enhance understanding of the levers and barriers to implementation, as well as providing stakeholders with the opportunity to generate creative solutions to problems experienced with the implementation of such interventions (MacFarlane *et al.*, 2012).

In this multi-site qualitative case study, purposive and maximum variation sampling approaches will be used to identify and recruit a range of relevant stakeholders – migrant service users, GPs, primary care nurses, practice managers and administrative staff, interpreters, cultural mediators, service planners and policy makers in five settings: Ireland, England, The Netherlands, Austria and Greece. After a mapping exercise has identified relevant guidelines and training initiatives, a PLA-brokered dialogue will be initiated with those stakeholders in each setting, informed by the four constructs of NPT – coherence, cognitive participation, collective action and reflexive monitoring. Through this, stakeholders will be enabled to select a single guideline or training initiative for implementation in their local setting. Prospectively, the implementation journeys for the five selected interventions will be investigated and supported. Data will be generated using a PLA approach to interviews and focus groups. Data analysis will follow the principles of thematic analysis, will occur in iterative cycles throughout the project and will involve participatory co-analysis with key stakeholders to enhance the authenticity and veracity of findings (MacFarlane *et al.*, 2012).

Conclusion

Migration is a global phenomenon that presents challenges for host health-care systems. It is, and will continue to be an important issue in Europe, despite the current financial crisis. The health of migrants in general is worse compared with the native population. Language and cultural barriers are important obstacles to good medical care for migrants. GPs and other health-care workers express their concerns about this, and although guidelines and training initiatives to overcome these barriers are available, they are seldom implemented in daily practice. The reason for this contradiction is as yet unknown and requires research, using a participatory research strategy, focussed on normalisation of interventions in daily practice, which is the aim and research strategy of the FP7 project RESTORE. In RESTORE, GPs and other key stakeholders can serve as key actors working together in an effort to restore humanity in a changing world. Therefore, the findings of this research will have significant implications for migrant communities in terms of

enhancing knowledge about levers and barriers to the implementation of supports for cross-cultural communication, potentially improving access to interpreted consultations and culturally appropriate health care, and informing EU policy in relation to providing health care for such populations.

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